Beth Israel Lahey Health
Beth Israel Deaconess Milton

2022 Community Health Needs Assessment

Acknowledgments

This 2022 Community Health Needs Assessment report for Beth Israel Deaconess Hospital-Milton (BID Milton) is the culmination of a collaborative process that began in September 2021. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key collaborators in BID Milton's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

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

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Introduction

Background

Beth Israel Deaconess Hospital-Milton (BID Milton) is a 100-bed acute care hospital with a complete complement of inpatient and outpatient health services, 24-hour emergency services, and more than 450 physicians on staff. BID Milton also includes Beth Israel Deaconess Milton Radiology at BILH Quincy Urgent Care Center. BID Milton's mission is to improve the health of the community by providing exceptional, personalized health care with dignity, compassion and respect.

BID Milton 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 Milton 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 Milton, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA).

This 2022 Community Health Needs Assessment report is an integral part of BID Milton's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BID Milton 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 Milton to engage the community and strengthen the community partnerships that are essential to BID Milton's success now and in the future. The assessment engaged more than 600 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responder (police, fire, ambulance officials), faith leaders, other government officials, and community residents.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of BID Milton's mission. Finally, this report allows BID Milton 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 Milton's commitment to promoting health and well-being, addressing health disparities and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BID Milton serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes and who have been historically underserved.

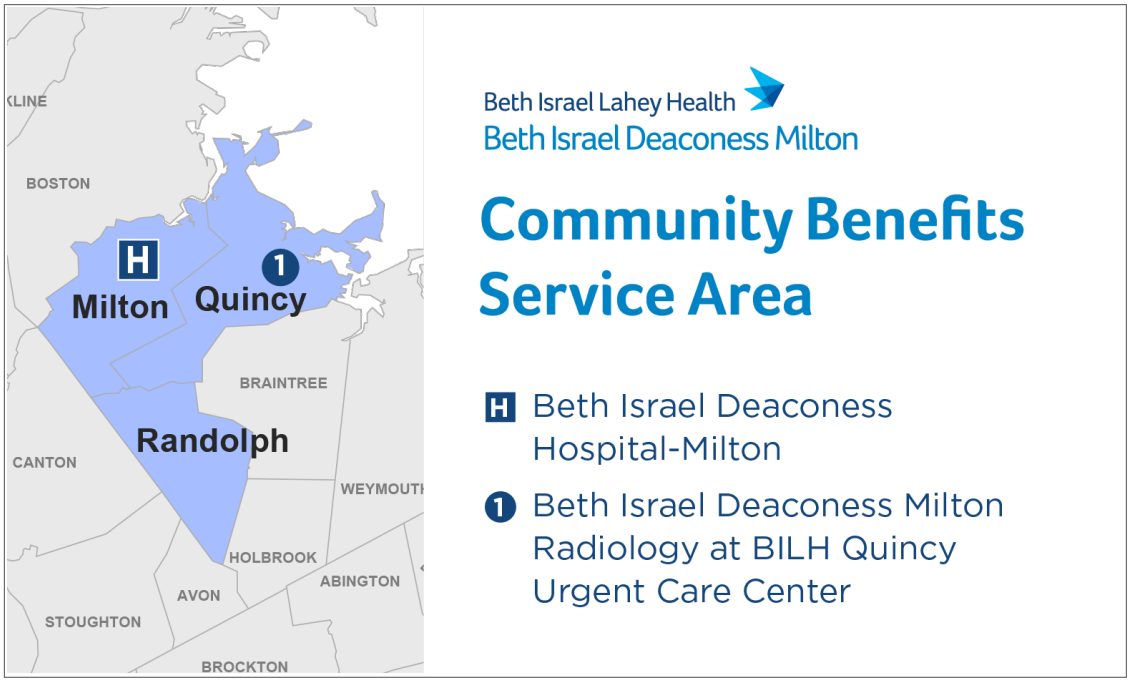
Prior to this current CHNA, BID Milton completed its last assessment in the summer of 2019 and the report, along with the associated 2020-2022 IS was approved by the BID Milton Board of Trustees on September 23, 2019. The 2019 CHNA report was posted on BID Milton's website before September 30, 2019 and, per federal compliance requirements, made available in paper copy, without charge, upon request. The assessment and planning work for this current report was conducted between September 2021 and September 2022 and BID Milton's Board of Trustees approved the 2022 report and adopted the 2023-2025 IS, included as Attachment E, on September 12, 2022.

Definition of Community Served

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

Description of Community Benefits Service Area

BID Milton's CBSA includes the three municipalities of Quincy, Milton, and Randolph, located to the south of the City of Boston. Collectively, 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 and suburban). There is also diversity with respect to community needs. There are segments of BID Milton'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 Milton 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 Milton is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.



BID Milton'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 Milton focuses community benefits activities to improve the health status of those who face health disparities, experience poverty, or who have been historically underserved. By prioritizing these cohorts, BID Milton is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

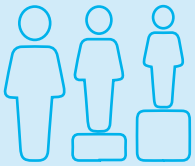
Assessment Approach & Methods

Approach

It would be difficult to overstate BID Milton's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BID Milton'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 Milton'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, who speak a language other than English, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

The CHNA and IS development process was guided by the following principles: equity, collaboration, engagement, capacity building, and intentionality.

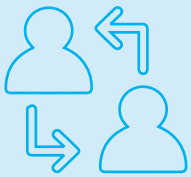


Equity:

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

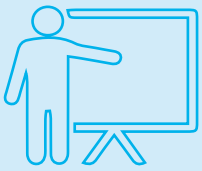
Collaboration:

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



Engagement:

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



Capacity Building:

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

Intentionality:

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

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

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

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

Methods

Oversight and Advisory Structures

The CBAC greatly informs BID Milton's assessment and planning activities. BID Milton'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 everyone throughout the region and are particularly focused on serving the medically underserved, those experiencing poverty, and those who face inequities due to their race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, age, disability status, or other personal characteristics.

The involvement of BID Milton's staff in the CBAC promotes transparency and communication, and ensures that there is a direct link between BID Milton and many of

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

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

the community's leading health and social service community-based organizations. The CBAC meets quarterly to support BID Milton's community benefits work and met six times during the course of the assessment and planning process. During these meetings, the CBAC provided invaluable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities.

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, BID Milton collected a wide range of quantitative data to characterize the communities served across BID Milton's CBSA. BID Milton 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 the 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 that includes all of the quantitative data gathered for this assessment, including the BID Milton 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, evidence-informed IS. Accordingly, BID Milton applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, BID Milton employed a variety of strategies to help ensure that community members were informed, consulted, involved ,and empowered throughout the assessment process. Between October 2021 and February 2022, BID Milton conducted 19 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 500 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

19 interviews
with community leaders

514 survey respondents

3 focus groups
- Asian immigrants
- Youth
- English language learners.

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across the broad continuum of services, including:

- Domestic violence
- Food assistance
- Housing
- Mental health and substance use
- Senior services
- Transportation.

The resource inventory was compiled using information from existing resource inventories and partner lists from BID Milton. BID Milton Community Benefits staff reviewed the hospital's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which included a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify key partners who may or may not be collaborating with BID Milton. The resource inventory can be found in Appendix C.

Prioritization, Planning and Reporting

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

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

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

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

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

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

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Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department and ambulance officials), faith leaders, other government officials, and community residents engaged in supporting the health and well-being of residents throughout BID Milton'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 databook that includes all of the quantitative data gathered for this assessment along with a summary of interviews and focus groups 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 Milton's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status and other characteristics.

Based on the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in BID Milton's CBSA were issues related to age, race/ethnicity, language, and immigration status. All three communities were diverse; the percentages of Black/African American residents in Randolph and Milton were significantly high compared to the Commonwealth, as was the percentage of Asian residents in Quincy.

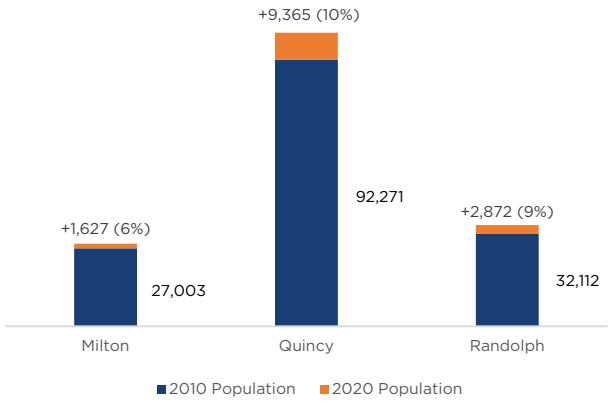
There was consensus among interviewees, focus group participants, and listening session attendees that immigrants, individuals best served in a language other than English, people of color, and individuals with disabilities face systemic challenges that limited their ability to access health care services. Participants reported that these segments of the population were impacted by language, racism, cultural barriers, and stigma that posed health literacy challenges, exacerbated isolation, and may have lead to discrimination and disparities in access and health outcomes.

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

Population Growth

Between 2010 and 2020, the population in BID Milton's CBSA increased by 9%, from 151,386 to 165,250 people. Quincy saw the greatest percentage increase (10%) and Milton saw the lowest (6%).

Population Changes by, Municipality, 2010 to 2020



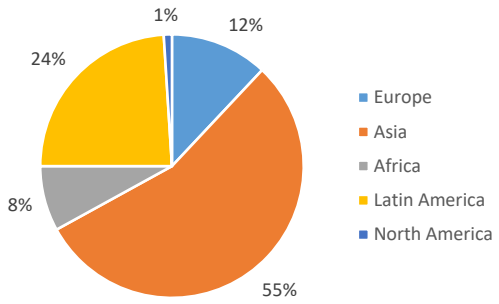
Source: US Census Bureau, 2010 and 2020 Decennial Census

Nation of Origin

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

31% of BID Milton's CBSA population was foreign-born.

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



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

Language

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

37% of BID Milton CBSA residents 5 years of age and older spoke a language other than English at home and of those,

48% spoke English less than "very well."

Source: US Census Bureau American Community Survey 2016-2020

Age

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

17%
of residents in the BID Milton CBSA were 65 years of age or older. The proportion of older adults is expected to increase by 2030, which may have implications for the provision of health and social services.

17%
of residents in the BID Milton CBSA were under 18 years of age.

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

Gender Identity and Sexual Orientation

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

5%
of adults in Massachusetts identify as LGBTQIA+. Data was not available at the municipal level.

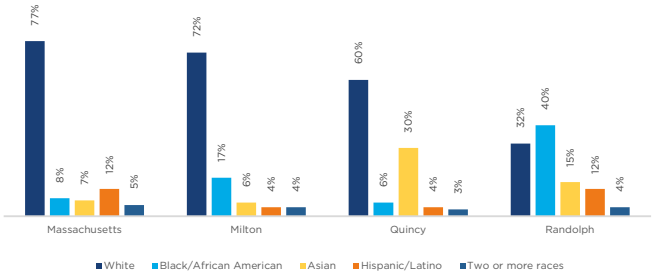
21%
of LGBTQIA+ adults in Massachusetts are raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

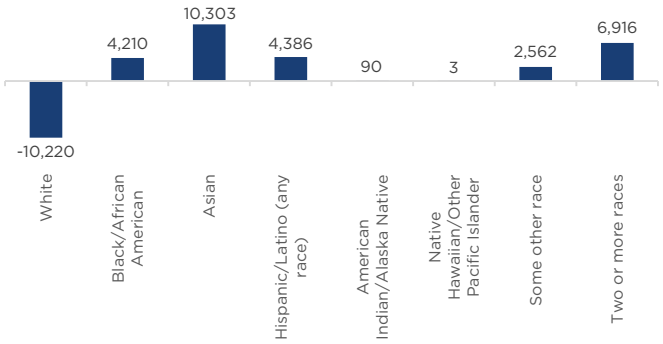
In the BID Milton CBSA overall, the number of residents who identified as white has decreased since 2010, while there was an increase in other census categories. Quincy has one of the highest percentages of Asian residents among all municipalities in the Commonwealth (30%). Randolph (40%), and Milton (17%) have some of the highest percentages of Black/African American residents.

Race/Ethnicity by Municipality, 2016-2020



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

CBSA Population Changes by Race/Ethnicity, 2010 to 2020



Source: US Census Bureau, 2010 and 2020 Decennial Census

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

Household Composition

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

27% of BID Milton households included one or more people under 18 years of age.

32% of BID Milton CBSA households included one or more people over 65 years of age.

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

Social Determinants of Health

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

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

Interviewees, focus groups, listening session participants, and BID Milton Community Health Survey respondents shared that access to safe and affordable housing was a significant challenge for many residents. This was particularly true for older adults, those experiencing poverty, those living on fixed incomes, and those with mental health or substance use disorders.

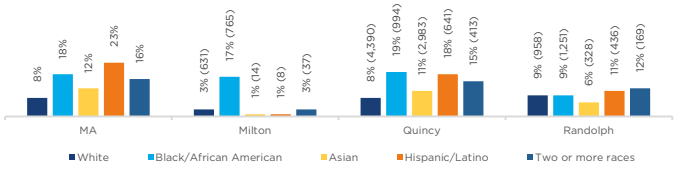
Interviewees, focus groups, listening session participants, and BID Milton Community Health Survey respondents also shared that food insecurity, food scarcity, and hunger presented significant challenges, particularly for individuals and families experiencing economic insecurity. These issues were largely driven by issues related to job loss, the inability to find employment that paid a livable wage, or living on an inadequate, fixed income, which impacted the ability of individuals and families to eat a healthy diet. Other social factors that were highlighted in a more limited way during the assessment but were thought to have an impact on health status and access to care were challenges related to the cost of childcare and access to transportation resources.

Economic Stability

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

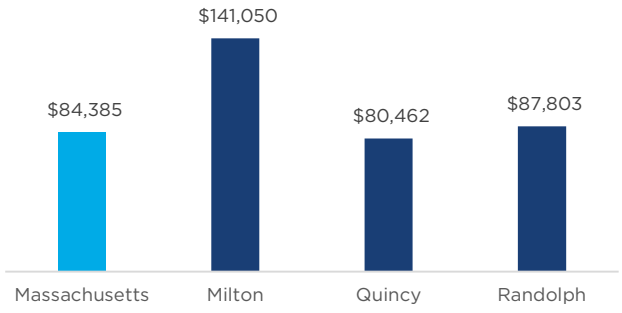
COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability.

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



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

Median Household Income, 2016-2020

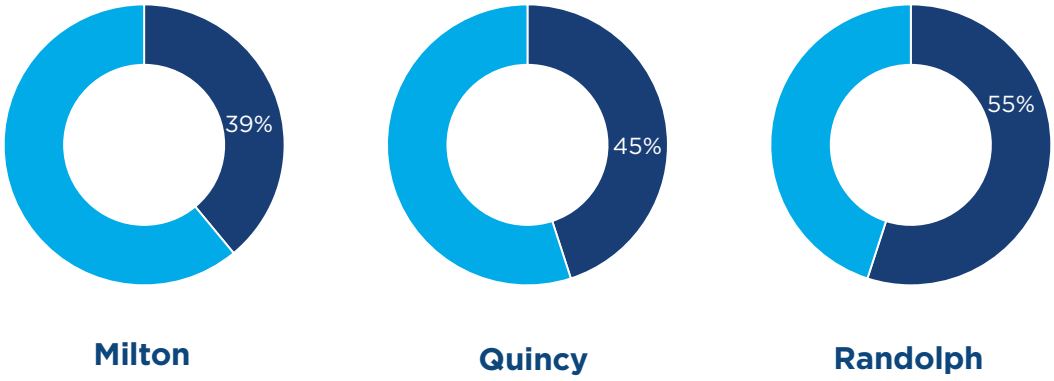


Source: US Census Bureau American Community Survey, 2016-2020

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

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

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



***Unweighted percentages displayed**

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

Education

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

89% of BID Milton CBSA residents 25 years of age and older had a high school degree or higher.

44% of BID Milton CBSA residents 25 years of age and older had a bachelor's degree or higher.

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

Social Determinants of Health

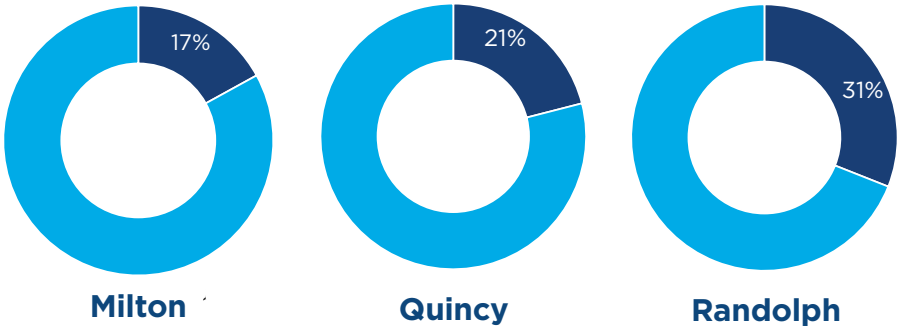
Food Insecurity and Nutrition

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

10%
of BID Milton households received SNAP benefits (formerly food stamps) within the past year. SNAP provides benefits to low-income families to help purchase healthy foods.

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

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



***Unweighted percentages displayed** Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Neighborhood and Built Environment

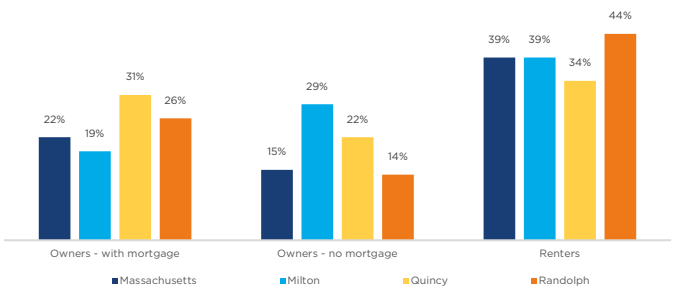
The conditions and environment in which one lives has significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks, and bike lanes improve health and quality of life.[11]

Housing

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

Interviewees, focus group participants, and survey respondents expressed concerns over the limited options for affordable housing throughout the BID Milton CBSA.

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



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

The percentage of owner-occupied housing units (with a mortgage) whose ownership costs were in excess of 35% of total household income was higher than the Commonwealth in Quincy and Randolph. Among owner-occupied units without a mortgage, costs were higher than the Commonwealth in Milton and Quincy. The percentage of rental units with costs in excess of 35% of total household income was higher than the Commonwealth in Randolph.

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

36% of BID Milton Community Health Survey respondents said "more affordable housing."

Transportation

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

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

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

27%
of BID Milton Community Health Survey respondents wanted more access to public transportation.

13%
of housing units in the BID Milton CBSA did not have an available vehicle.

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

"Getting to and from medical appointments is an issue for the population. There are issues with traffic in Milton because it is a cut-through town. It's not very walking friendly and has limited MBTA service."

- BID Milton interviewee

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.

32% of BID Milton Community Health Survey respondents identified a need for better roads.

24% of BID Milton Community Health Survey respondents identified a need for better sidewalks and trails.

Systemic Factors

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

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of color, non-English speakers, recent immigrants, individuals with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment reinforced the challenges that residents throughout the 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 particularly true with respect primary care, behavioral health, medical specialty care, and dental care services.

Interviewees, focus groups, and listening session participants reflected on linguistic and cultural barriers to care. The assessment findings also reflected how difficult it was for many residents to schedule appointments, coordinate care, and find the services they needed. Interviewees, focus groups, and listening session participants discussed the need for tools to support these efforts, such as resource inventories, case managers, recovery coaches, and healthcare navigators.

Interviewees, focus group, and listening session participants also identified lack of capacity of the healthcare workforce, cost/insurance issues, lack of information sharing across clinical and social service providers, and challenges related to technology as barriers to care and health-related services.

Racial Equity

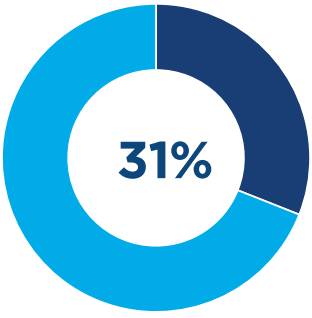
Racial equity is the condition where one's racial identity has no influence on how one fares in society.[14] Racism and discrimination influence the social, economic and physical development among Black, Indigenous and People of Color (BIPOC), resulting in poorer social and physical conditions in those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

"This community is very diverse, and the diversity is not adequately reflected in government, schools, and employment."

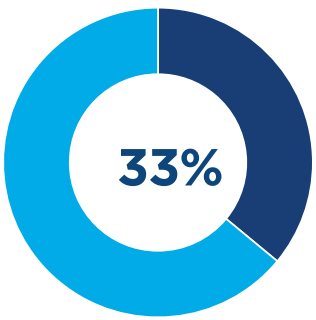
- BID Milton Community Health Survey respondent

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

Among BID Milton Community Health Survey respondents:



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



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

Accessing and Navigating the Health Care System

Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stemmed from the ways in which the system did or did not function. System-level issues included providers not accepting new patients, long wait times, and an inherently complicated healthcare system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Some individuals may struggle with cost and insurance barriers; being uninsured or underinsured may lead individuals to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication and issues of patient safety.[16] Finally, transportation was identified as a barrier for individuals without a personal vehicle, or those with mobility issues who may have challenges accessing public transportation.

Populations facing barriers and disparities:

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

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

"The cost of medications and health care is too expensive – especially for those who do not qualify for services [like those] who live under the poverty line."

- BID Milton interviewee

Community Connections and Information Sharing

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

Behavioral Factors

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

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 BID Milton's prioritization process, the information from the assessment supports the importance of incorporating these issues into the BID Milton's IS.

Nutrition

Adults who eat a healthy diet have increased life expectancy and decreased risk of chronic diseases and obesity; children require a healthy diet to grow and develop properly.[19] Access to affordable healthy foods is essential to a healthy diet.

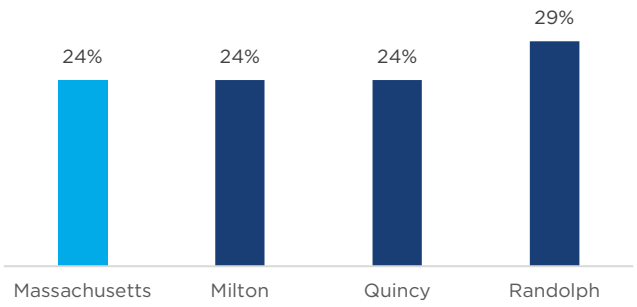
21% of BID Milton Community Health Survey respondents said they would like their community to have better access to healthy food.

Physical Activity

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

The percentage of adults who were obese (with a body mass index over 30) was higher than the Commonwealth in Randolph.

Percentage of Adults Who Were Obese, 2018

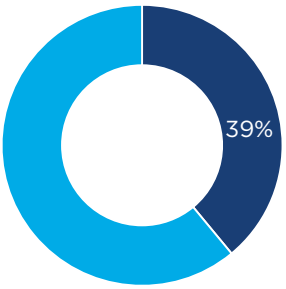


Source: Behavioral Risk Factor Surveillance System, 2018

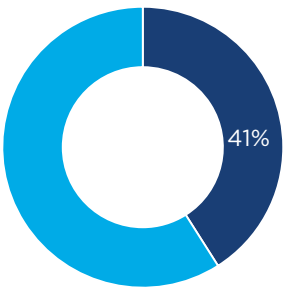
Alcohol, Marijuana and Tobacco Use

Though legal in the Commonwealth for those aged 21 years of age and older, long-term and excessive use of alcohol, marijuana and tobacco can lead to the development and exacerbation of chronic and complex conditions, including high blood pressure, cardiovascular disease and cancer. Clinical service providers reported an increase in substance use and relapse since the onset of the pandemic – potentially caused by increased stress and isolation and lapses in treatment.

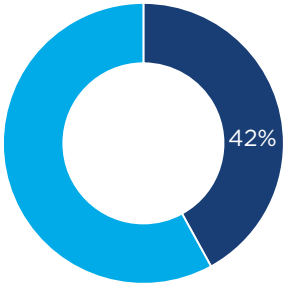
Percentage* of Current Substance Users Who Said They Are Using More Substances Than Before the Pandemic, Fall 2020



Milton



Quincy



Randolph

***Unweighted percentages displayed**

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

Health Conditions

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

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

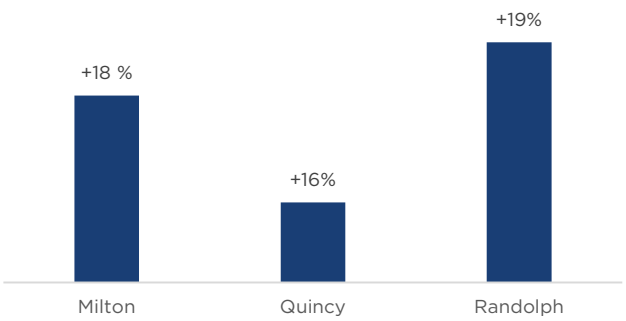
Mental Health

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

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

Youth mental health was a critical concern in the CBSA, including the significant prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated during the pandemic as a result of isolation, uncertainty, remote learning, and family dynamics.

Mental Health Inpatient Discharges (per 100,000) Among Those Under 18 Years of Age, 2019

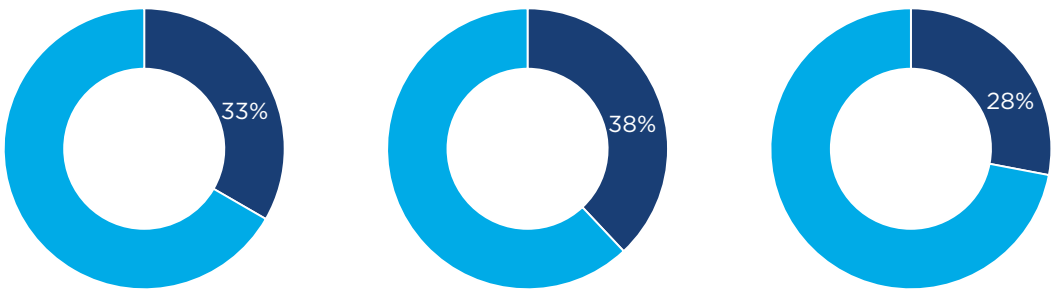


Source: Center for Health Information and Analysis, 2019

Inpatient discharges for individuals under 18 years of age for mental health conditions increase in BID Milton CBSA communities between FY2017 and FY2019.

A strength of the CBSA was the number of regional and municipal task forces, coalitions, and working groups dedicated to collaboration and information sharing in the realm of mental health.

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



***Unweighted percentages displayed**

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

Health Conditions

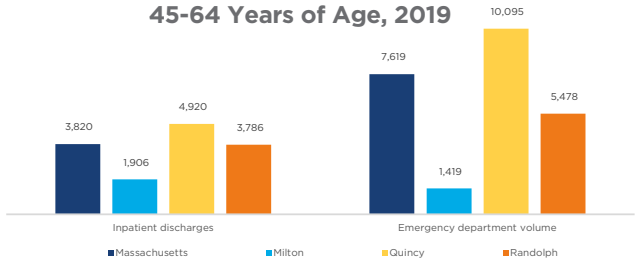
Substance Use

Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Interviewees, focus group, and listening session participants identified stigma as a barrier to treatment and reported a need for programs that address common co-occuring issues, including mental health issues and homelessness. Interviewees, focus groups, and listening session participants also identified alcohol misuse and addiction as a leading challenge. Many reflected on the need for programs that provide support for caregivers.

Interviewees, focus groups, and listening session participants identified a lack of substance use treatment and supportive services for both youth and adults, including:

- Inpatient treatment
- Outpatient treatment and supportive services
- Transitional and long-term residential housing
- Peer recovery coaches, support groups and case managers.

Inpatient and Emergency Department Discharges (per 100,000) for Substance Use Disorders Among Those 45-64 Years of Age, 2019



Source: Center for Health Information and Analysis, 2019

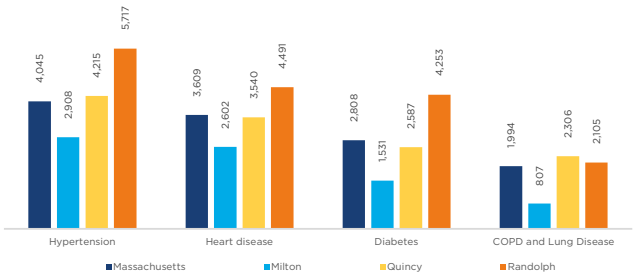
Inpatient and emergency department discharges were higher than the Commonwealth in Quincy.

Chronic and Complex Conditions

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

Inpatient discharge rates varied across conditions and communities. Inpatient discharge rates due to hypertension, heart disease, diabetes, and COPD/ lung diseases were higher in Randolph compared to the Commonwealth overall.

Cancer Inpatient Discharge Rates (per 100,000) Among Those 45-64 Years of Age, 2019



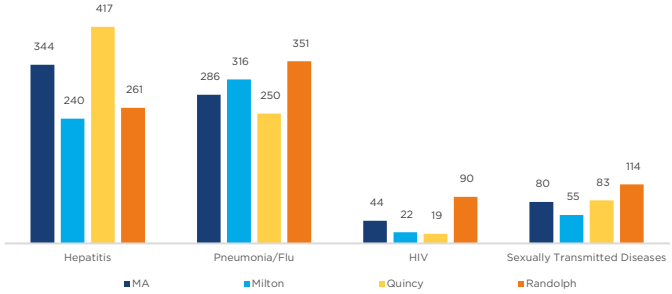
Source: Center for Health Information and Analysis, 2019

Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability, and even death - as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees, focus groups, or listening session participants, 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 inpatient discharge rates for Hepatitis were higher than the Commonwealth in Quincy. Inpatient discharge rates for pneumonia/flu were higher than the Commonwealth in Randolph and Milton. Rates for HIV and sexually transmitted diseases were also higher than the Commonwealth in Randolph.

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



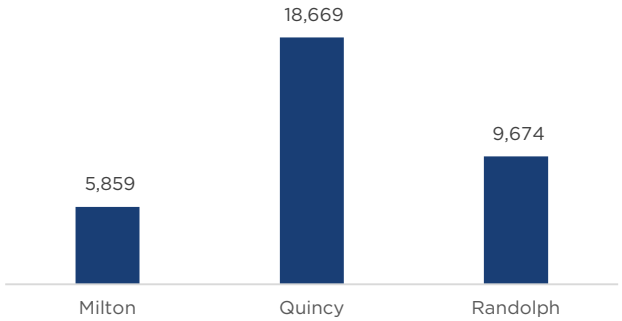
Source: Center for Health Information and Analysis, 2019

COVID-19

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

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

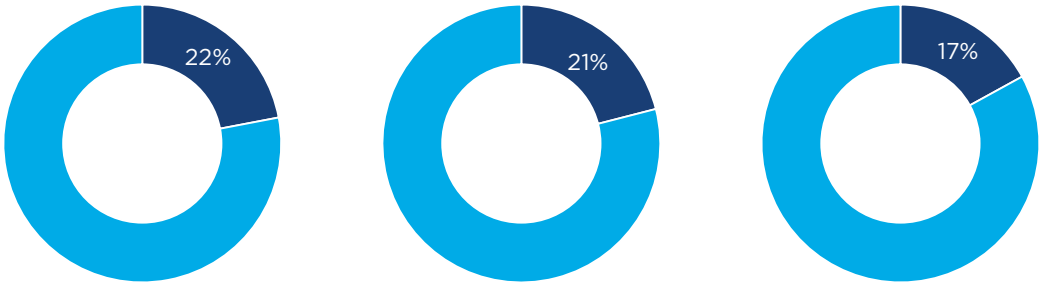
Total COVID-19 Case Counts Through April 28, 2022



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

In Milton and Quincy, more than 20% of MDPH COVID-19 Community Impact Survey respondents reported that they had not gotten the medical care they needed since July of 2020. Lapses in medical care may lead to increases in morbidity and mortality.

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



***Unweighted percentages displayed**

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

Priorities

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

Massachusetts Community Health Priorities

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

Community Health Priorities and Priority Cohorts

BID Milton 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 of the following priority cohorts and community health priority areas.

BID Milton Community Health Needs Assessment: Priority Cohorts

Youth

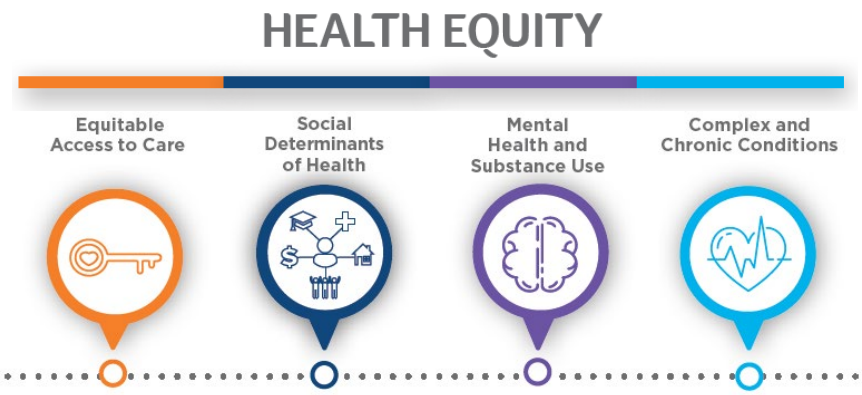
Older Adults

Racially, Ethnically and Linguistically Diverse Populations

Individuals with Disabilities

Low-Resourced Populations

BID Milton Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BID Milton

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

The issues that were identified in the BID Milton CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, transportation, economic insecurity, navigating SDOH resources, build capacity of workforce, navigation of healthcare system, linguistic access barriers, information and resource sharing, diversify provider workforce, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, racism/discrimination, culturally appropriate/competent health and community services, targeted outreach/engagement in DEI Issues, lack of education around diversity, equity, and inclusion (DEI), diversifying leadership, linguistic access/barriers to community resources/services, treatment programs that include/address mental health and co-occurring substance use/misuse issues, substance use outreach/education/prevention, caregiver support, and alcohol use prevention/treatment.

Implementation Strategy

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

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

Below is a brief discussion of the resources that BID Milton will invest to address the priorities identified by the CBAC and BID Milton'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 Milton 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 Milton and/or its partners to improve the health of those living in its CBSA. Finally, BID Milton supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, BID Milton will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Recognizing that community benefits planning is ongoing and will change with continued community input, BID Milton'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 Milton 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 Milton to respond to the CHNA findings and the prioritization and planning processes. Please refer to the full IS in Appendix E for more details.

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

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

Strategies to address the priority:

- Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.
- Promote access to health care, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.
- Provide and promote career support services and career mobility programs to hospital employees.

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:

- Provide support for impactful programs and community initiatives that address issues associated with the social determinants of health.
- Support programs that stabilize or create access to affordable housing.
- Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.
- Increase mentorship, training, and employment opportunities to increase employment and earnings and increase financial security for youth, young adults, and adults residing in the communities.
- Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.
- 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.

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 impactful programs that promote healthy development, support children, youth, and their families, and increase their resilience, coping and prevention skills.
- Build the capacity of community members to understand the importance of mental health and substance use, and reduce negative stereotypes, bias, and stigma around mental illness and substance use disorders.
- Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to increase resiliency, reduce youth substance use, and prevent opioid overdoses and deaths.
- Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.

COMPLEX AND CHRONIC CONDITIONS

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

Strategies to address the priority:

- Address barriers to timely cancer and chronic disease screenings and follow-up care through culturally appropriate navigation and innovative programs.
- Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.
- Ensure older adults have access to coordinated health and support services and resources to support overall health and age in place.

Evaluation of Impact of 2020-2022 Implementation Strategy

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

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

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

Priority Area	Summary of Accomplishments and Outcomes
Mental Health and Substance Use	BID Milton has supported the Milton Public Schools with a grant to implement evidence-based curriculum to address stress, anxiety and vaping. Nearly 500 students have participated in the Botvin LIfeSkills program. 82% indicated they learned a new coping mechanism for stress and/or anxiety such as progressive relaxation or guided imagery. The hospital also continues to be an active member of the Milton Substance Abuse Prevention Coalition, providing financial support and resources to implement educational programming centered on prevention as well as the Interface Behavioral Health Hotline.
Chronic Disease and Risk Factors	BID Milton provided a $5,000 grant to Enhance Asian Community on Health to implement and translate the Centers for Disease Control's "Prevent T-2: Diabetes Prevention" workshops in Chinese. Eight participants completed the course before course had to transition to virtual setting due to COVID. In FY21, five virtual Chronic Disease Self-Management Program workshops were conducted virtually with a total of 82 community members being engaged.
Social Determinants of Health and Access to Care	BID Milton issued a $45,000 grant ($15,000 for each year, F19-21) to Quincy Community Action Programs. The grant helps support QCAP's Housing Program which works to secure and stabilize housing for renters and homeowners, thereby reducing the number of homeless individuals and families. During the first two years of the grant, a total of 31 households/ 65 individuals have been prevented from eviction/homelessness. BID Milton began a Blessings in a Backpack Program at Randolph Public Schools, providing at-risk elementary aged students with food to bring home with them on the weekends. A total of 115 children have received food over the past two years. During COVID, BID Milton increased the amount of food provided to allow for additional meals to be taken home.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2020-2022 Implementation Strategy

Appendix E: 2023-2025 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

Beth Israel Lahey Health Community Health Assessment
Interview Guide

Please complete this section for each interview:

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

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

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

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

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

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

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

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

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

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

BID Milton Community Health Needs Assessment 2021-2022
Interview Summary

Interviewees

- Melinda Alexander, Coordinator, Southwest Community Food Center
- Noah Blohm, LGBTQ Advocacy and Outreach Coordinator, DOVE
- Marli Cassli, Public Health Commissioner, Quincy
- Gerard Cody, Public Health Commissioner, Town of Randolph
- Kevin Cook, Director of Veterans Services, Town of Randolph
- Taylor DeSanty, Triage Director, Father Bills & Mainspring
- Susan Dolan, Director, Milton Early Childhood Alliance
- James Jette, Superintendent, Milton Public Schools
- Caroline Kinsella, Director of Public Health, Milton
- Jeanette Kutash, DEI Commission and Commission on Disabilities, City of Quincy
- Peggy Montlouis, Community Health & Wellness Educator, Town of Randolph
- Warren Nicoli, Program Director, A New Way Recovery Center
- Matthew Riley, Executive Director, May Center School for Autism and Developmental Disabilities
- Christine Stanton, Executive Director, Milton Council on Aging
- Ashley Stockwell, Program Director, CHNA20 and Baystate Community Services
- Heidi Stucker, Senior Public Health Planner, MAPC
- Brian Tatro, Executive Director, Milton Housing Authority
- Jeannette Travaline, Executive Director, Randolph Chamber of Commerce
- Michelle Tyler, Town Planner, Town of Randolph
- Eugene Welch, South Cove Community Health Center

Key Findings

Community characteristics

- Extremely diverse communities – significant percentage of Asian, Black/African American, and Hispanic/Latino residents
    - "Every street is very diverse. It's not sections of town where only certain populations live. We're very heterogenous – that is our strength. My neighbors across the street are Haitian; the house next to them is Cape Verdean; and next to them is Vietnamese."
- Seeing an increase in residents whose first language is not English
- Easy access to highways
- Collaborative organizations
- Open spaces, walking trails
- Strong faith based organizations

Social Determinants of Health

- Significant concerns around housing – cost, availability of 'decent' affordable housing, veterans, recovery housing
    - "All of peoples issues stem from this (housing) – their ability to afford and live in their homes."

- Transportation - Significant number of community members reliant on public transportation to get them where they need to go. Many traffic issues in the area; very congested. This has implications for road/sidewalk safety and quality of life
- Economic insecurity – high cost of living
- Access to affordable foods – healthy foods are expensive; farmers market in Randolph went away
- Language barriers "are the biggest issue that leads to disparities"
    - "So many of our residents receive their healthcare outside of Randolph because of culture and language issues."

Mental health

- Significant prevalence of chronic stress, anxiety, depression
    - Exacerbated by COVID
    - Youth mental health was a significant focus – social pressures, balancing school and activities, social media, etc.
    - Stress/anxiety for parents trying to navigate changing dynamics at work/home
- Loneliness and isolation is a significant issue, especially for older adults and veterans
- Need for more training and education for professionals outside of the traditional 'healthcare' framework – need more training/education for law enforcement, other types of providers, etc.

Access to care

- Long wait lists, providers not taking new patients – this has been increasing problem since pandemic
- Cost and insurance barriers, especially in behavioral health space
- Many have difficulty understanding how to navigate system – especially problematic for individuals who do not speak English, or newer immigrants
- Language barriers are significant barrier to any type of care
- Health literacy and cultural barriers– understanding what is a disease, what isn't a disease
- Randolph in need of a federally qualified health center.
    - "We have been advocating for that for so long."
    - Need partner organizations – "which of the community health centers in the Commonwealth is willing to come operate here? Who is leading the charge? Is this community development? Is it health? What is it?"

Diversity, Equity, Inclusion

- Though service area communities are very diverse, there is varying levels of recognition and acceptance for this diversity. This leads to stress, anxiety, trauma, racism, discrimination among some BIPOC
- Significant economic diversity throughout service area – pockets of great affluence, but also pockets of great need
- Need significant focus on breaking down language and cultural barriers, given the diversity of the population

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Community Health Needs Assessment
Interview Guide

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

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

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

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

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

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

Does anyone have any questions before we begin?

Section One: Community Perceptions

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

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

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

   If yes, move on to Section 2.

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

   Let's talk more deeply about these concepts.

Section Two: Key Factors

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

For each issue they identified:

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

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

Section Three: Ideas and Recommendations

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

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

BID Milton Focus Group Summary: Enhance Asian Community Health (EACH)

THRIVE Framework: ***https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments***

Please complete this section for each interview:

Date: 10/26/21	Start Time: 10:00	End time: 11:00
Group Name and Location: EACH, 73 Newbury Ave, Quincy		
Number of participants: 13	Affiliate Hospital: BID Milton	

We reviewed the 3 main questions:

1. What keeps you healthy?
2. What makes it hard to be healthy?
3. What are some specific health challenges that could be the results of the last question, like mental health, diabetes, etc.?

Then, we explained that we will focus on 3-4 main factors and talk about ways to improve these factors.

Review community agreements:

1. Confidentiality
2. Honesty
3. What is said here, stays here but what is learned here, leaves here.
4. Don't leave without taking your gift card.

Section 1: Prioritized Topics

Cluster 1: People	

Date: 10/26/2021
Interview Group: EACH

Cluster 2: Equitable Opportunity	
Cluster 3: Place	

Key Factors to Health Noted (Section 1)

Factor	***Cluster***
Health/wellness and exercise facilities	2 and 3
Health education programs	2
Translation services	2
Healthy eating (nutrition)	2
Health benefits for insurance	2

Health Challenges Noted (Section 1)

Health Challenge	***Cluster***
Environmental factors (water and air quality)	***3***
Lack of coaching and education (awareness of resources and issues)	***2***
Culture and language: Hard to find doctors and then stay with the same doctors (especially those that can speak their language) - Hard to make appointments - Transportation (not public transport) - Language	***2***

Date: 10/26/2021
Interview Group: EACH

Navigating the healthcare system	

Section 2: Exploring Key Factors

Social-Environment (People) Cluster
1. Social Networks & Trust
2. Participation & Common Good
3. Norms & Culture
4. Racism

Physical / Built Environment (Place) Cluster
1. Look, Feel, and Safety
2. Parks & Open Space
3. Getting Around.
4. Housing

Date: 10/26/2021
Interview Group: EACH

5. ***Healthcare Access.*** How would you describe the health care options in your community?

    - Hard to make appointments/ Doctors who come and go.
    - Language difficulty. (8)
    - Transportation. (5)
    - Cost is a problem, older adults have no income. (10)

6. ***Natural Environment.*** How would you describe the air, water, and soil in your community?

Air: There are a lot of cars that make it hard to breathe.
Water an issue in Weymouth, Braintree, Wrentham. They boil water.

    a. How do the air, water, and/or soil affect people's health in your community?

Difficulty breathing

7. ***Arts and Culture.***
   Language and culture: This is a big barrier.

8. ***Racism/Discrimination.***
   Yes, this is a problem.
- People can look down on you.
- At the grocery store, the cashier sometimes treats you differently.

<u>Economic/Educational Environment (Equitable Opportunity) Cluster</u>

1. Living Wages

Date: 10/26/2021
Interview Group: EACH

2. Education. How would you describe the schools and adult education programs in your community? What types of learning do you want most?

Senior activities, some kind of exercise group and education on high cholesterol/diabetes, healthy eating, health and wellness education programs.

A program to help bridge the cultural gap between parents who are immigrants and their children who are raised in the United States.

More activities and social programs for the community that are intergenerational (like apple picking) that can help the emotional well being.

Educational activities focused on emotional well-being.

a. How do education opportunities affect people's health in your community?

Cultural barriers impact people's emotional well-being (stress).

3. Racism

Section 3: Ideas and Priorities

Ideas:

1. Hire more Chinese doctors
2. Hospital provide subsidies to lower cost of procedures
3. Improving communications
    a. More information translated to Chinese
    b. Discharge forms and all documents translated to Chinese
4. Health education programming
    a. A class on "How to be healthy"
        i. Talks about how to be healthy when you're older
        ii. Exercise
        iii. Emotional and social health
5. Give more money to community organizations to create programs that meet community needs

Date: 10/26/2021
Interview Group: EACH

Priorities (Top 3 Issues):

1. Health education
2. Cost of health care
3. Language

BID Milton Focus Group Summary: Milton Youth

Date: 10/26/21	Start Time: 7:00	End time: 8:00
Group Name and Location: Milton Youth Advocates for Change First Congregational Church, Milton, MA		

Overview of Topic to Frame Discussions:

The discussion today will focus on the following topics:

- Community Perceptions
- Exploring Key Factors
- Ideas and Recommendations

Section One: Community Perceptions

1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?
    a. Less time w/social media
    b. Self love/self talk
    c. Healthy foods
    d. Exercise
    e. Less Screen time
    f. Support system
    g. Hydration
    h. Time management
    i. Hygiene
    j. Communication skills
    k. Expressing emotions
    l. Sleep!
    m. Public safety
    n. Breaks
    o. Sports
    p. Outdoors
    q. Comfortable with self
    r. Routine
    s. Music

t. Positivity
u. Boundaries
v. Free time
w. Balanced life

2. What are some of the things that make it hard for you to be healthy?
    a. Lack of discipline
    b. Feeling stressed/overwhelmed
    c. Social pressure and Self pressure
        i. Pressure from adults
    d. Too many hobbies
        i. sports
    e. Isolation
    f. Lack of self-respect
    g. Not setting boundaries
    h. Social media and its negative culture
    i. Depression
    j. Hard home life
    k. Dehydration
    l. Not taking breaks
    m. Poor hygiene
    n. School
        i. Homework
    o. Bad habits/routines
        i. Bad sleep schedule
    p. Not embracing mistakes/not learning from them
    q. Busy weekends-no breaks
    r. Physically overexerting yourself
    s. Temptation of unhealthy foods
    t. Insecurities
    u. Not having health care
    v. Emotions building up
    w. Not having role models

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?
    a. Lifestyle
    b. Access
    c. Emotional/mental well being

    If yes, move on to Section 2. If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)

    Let's talk more deeply about these concepts.

Section Two: Key Factors

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

- d. Lifestyle
    - i. nutrition/diet
        1. Easy access to unhealthy foods
    - ii. Drug and alcohol use
    - iii. Money management
    - iv. Level of activity
- e. Access
    - i. Social, physical environment
    - ii. Access to unhealthy foods
    - iii. Access to resources
- f. Emotional/mental well being
    - i. Emotional well being
    - ii. Stress

Section Three: Ideas and Recommendations

1. **Ideas:** Thinking about what we have all talked about, what ideas do you have for ways in which service providers, community groups, and public servants can better serve members of our community at this time?
    a. Lifestyle
        i. Funding towards better food for marginalized communities

ii. Creating more opportunities for teens that allow them to succeed while enjoying it
iii. Don't have programs that simply tell teens not to do things
iv. Being honest about drugs and alcohol
v. Understanding certain thinks are OK in moderation
vi. Free therapy and normalizing therapy and mental health in general
vii. Learning more about your bodies

b. Access
    i. More access to healthy appetizing meals (free)
    ii. Required education on money management and bills
    iii. Having a mental health expert on campus for students to consult
    iv. Training for teachers to help with students with their mental health
    v. Non-appointment
    vi. More inclusive nurse/healthcare at school

c. Emotiional/Mental well-being
    i. Regulating assessments schools give us [amount]
    ii. Regulating time for activities (i.e., field hockey at 10 p.m. is a no)
    iii. More community events with student leads
    iv. Normalizing mental health days
        1. More check ins and support from schools
    v. More prominent or more adjustment counselors
    vi. More dedication towards mental health for students and adults (training for adults)
    vii. More access to mental health professionals
    viii. Break days for enjoyment to relieve stress (school pays)

Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

2. **Priorities**: What do you think should be the top 3 issues service providers should focus on to make your community healthier?
    a. Lifestyle
    b. Access
    c. Emotional/mental well-being

Group 1: Lifestyle

- Funding towards better food 4 marginalized communities
- creating more opportunities for teens that allow them to suceed while enjoying it
- Don't have programs that simply tell teens not to do things
- Being honest about drugs + alcohol
- understanding certain things are OK in Moderation
- free therapy + normalizing therapy + mental health in general
- learning more about your bodies

Group 2: Access

- more access to healthy appetizing meals (free)
- required education on money mogement and bills
- having a mental heath expert on campus for students to consult
- training for teachers to help with students' mental health
- NON-APPOINTMENT Take-S Room
- more conclusive nurse / healthcare at school

GROUP 3: emotional/ mental wellbeing

- regulating assessments school(s) give us [amount]
- regulating time for activities
- more community events (student leads) (ie field hockey @ 10pm is a no)
- normalizing mental health days
  - ↳more check-ins + support from schools
- more prominet/or more ajustment counslcurs
- more education towards mental health for students + adults (trainings for adults)
- more access to mental health professionals
- break days for enjoyment to relieve stress (schools pay:)

BID Milton Focus Group Summary: English Language Learners
Individuals learning the English language 11/4 Location:
Randolph High School

Health	
What does being healthy mean to you? • What does it look like? • What does it feel like?	- to be stress-free - entertainment - being able to have a good cry - being hydrated - having good habits - having healthy relationships - staying posititve - getting exercise - knowing how to manage time well - having a good income - being able to have alone time - being able to go on vacation - getting enough sleep - happy - rested - eating well, no junk food - having a balanced life - laughing - wash hands - being strong - not sick - planning things well
Healthy Factors	
What are some of the things that help you stay healthy? • Are there things in your community that help you stay healthy?	- affordable healthy food - parks - programs like english classes for adults
Are the things that help you stay healthy available to everyone or just a few groups of people?	*Facilitator did not have time to ask this question.*
Of the things that you've named as helping to keep you healthy, which would you like to see more of?	- more free/affordable childcare for those not under the poverty line

Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?	Top Factors 1. not knowing what resources are available in the community 2. affordable health care 3. access to mental health services 4. free-low cost childcare
Unhealthy Factors	
What are some of the things that make it hard for you to be healthy?	- lack of childcare - having to work 7 days a week - lack of accessible transportation - experiencing racism in the community, seeing how people treat you differently even if what they say isn't racist - the cost of medications and health care is too expensive, especially for those who DO NOT qualify for services for those under the poverty line
Do these things (that make it hard for you to be healthy) affect everyone or just a few groups of people?	Individuals who make very little money have access to some programs. But then once you start to learn English and can get a better job, you stop qualifying for these programs and it makes it hard to then be healthy. It is hard to afford things like childcare and healthy foods when you no longer qualify for help. It doesn't matter how much you make, all of these things are expensive in our community.
Why do you think the things that make it hard for you to be healthy exist?	*Facilitator did not have time to ask this question.*
Section 3: Ideas and Priorities	

Thinking about all that we have talked about, what ideas do you have for ways that hospitals can work with other groups to help make your community healthier?	1. A website that people can go to and there is a list of resources in your community 2. a community center in Randolph with activities 3. A low-cost gym in the community 4. adding a water feature in parks for kids 5. A program (similar to english language classes) that bring people of different cultures together so that they can learn from one another 6. support groups for people who experience racism (focused on mental health) 7. more free /low cost adult education programs
What do you think should be the top 3 issues that health service providers should focus on to make your community healthier?	1. affordable health care 2. access to mental health services 3. free/low cost child care
<u>Section 4: Final Remarks & Closing</u>	
Are there any other ideas you wanted to share before we leave today?	None.

Community Listening Sessions

- Presentation from Facilitation Training for community partners
- Facilitation guide for listening sessions
- Listening Session presentation
- Priority vote results and notes from January 20, 2022 listening session
- Priority vote results and notes from February 8, 2022 listening session

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

AGENDA

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

WHAT IS FACILITATION?

Facilitation is a dance, an artform.

INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish community agreements

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

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Design for different learning and processing styles

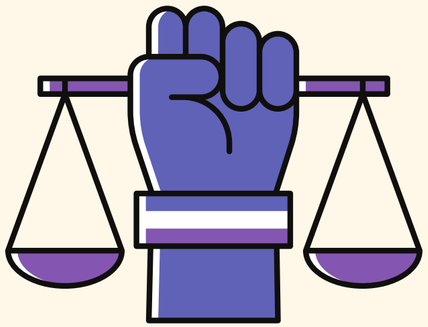
Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

Consider accessibility

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

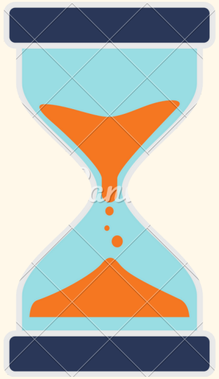
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

LET'S CONSIDER THE FOLLOWING

1

A participant seems to dominate the conversation.

2

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

3

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

THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

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

BILH Community Listening Session: Breakout Discussion Guide

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

Mentimeter link:
Jamboard link:

Ground rules and introductions (5 minutes)

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

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

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

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

Question 1 (5 minutes)

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

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

Notes:

Question 2 (15 minutes)

Part 1: 10 minutes

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

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

Notes on missing priority areas:

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

Part 2: 5 minutes

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

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

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

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

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

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

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

Question 3 (25 minutes)

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

Let's start with [Priority Area 1].

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

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

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

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

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

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

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

Notetakers will be taking notes within Jamboard.

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

Wrap Up (1 minute)

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

Notes:

BID MILTON
COMMUNITY LISTENING SESSION

January 20, 2022
February 8, 2022

Beth Israel Lahey Health

BID Milton Community Listening Session

Co-sponsors

Beth Israel Lahey Health

Beth Israel Deaconess Milton

Beth Israel Lahey Health

SIGNATURE HEALTHCARE

The mark of personal care™

BID Milton Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
6:00-6:05	Opening remarks	JSI
6:05-6:10	Overview of assessment purpose, process, and guiding principles	Laureane Marquez, Manager of Community Benefits/Community Relations, BID Milton
6:10-6:20	Presentation of preliminary themes and data findings	JSI
6:20-7:20	Breakout Groups	Community Facilitators
7:20-7:25	Sharing back	JSI
7:25-7:30	Wrap up: Closing statements and next steps	Laureane Marquez

Assessment Purpose and Process

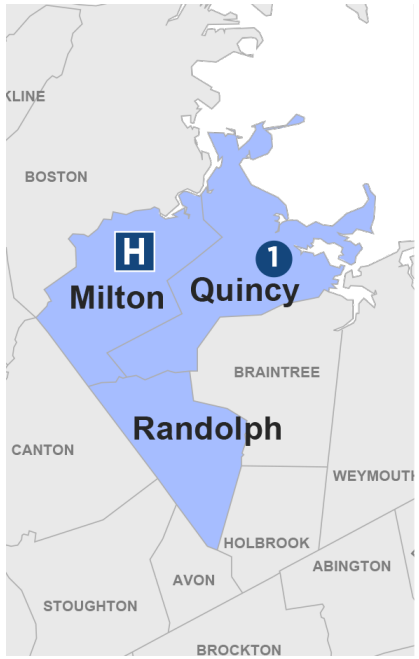
Assessment Purpose and Process

Purpose

Identify and prioritize the health-related and social needs of those living in Milton, Quincy, and Randolph with an emphasis on diverse populations and those experiencing inequities.

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

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



Beth Israel Lahey Health
Beth Israel Deaconess Milton

Community Benefits Service Area

- Beth Israel Deaconess Hospital-Milton
- Beth Israel Deaconess Milton Radiology at BILH Quincy Urgent Care Center

Assessment Purpose and Process

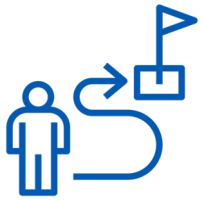
FY22 CHNA and Implementation Strategy Guiding Principles

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

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

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

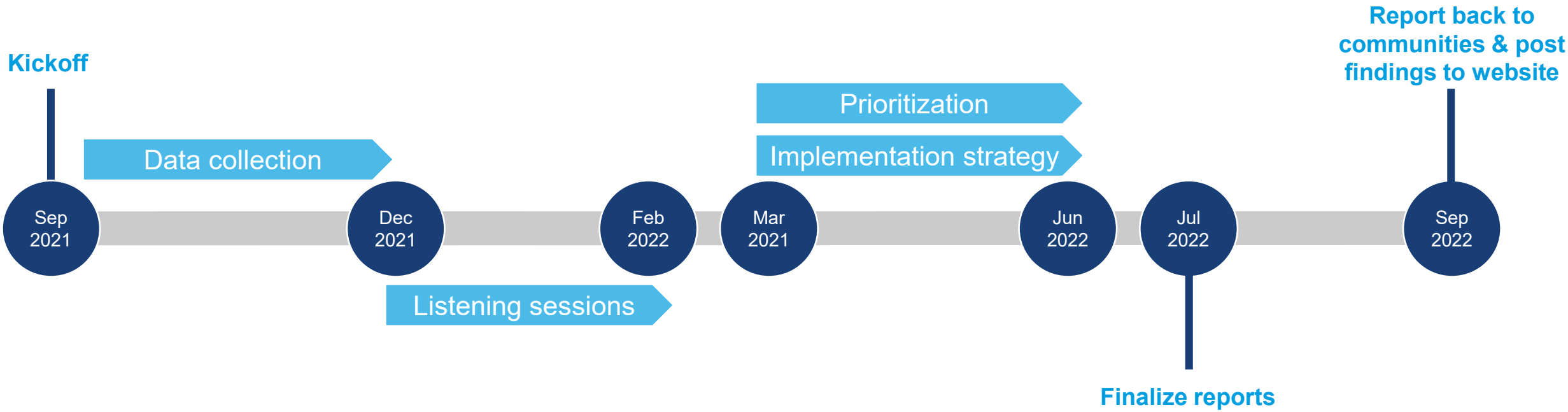
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



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

Assessment Purpose and Process

FY22 CHNA and Implementation Strategy Process

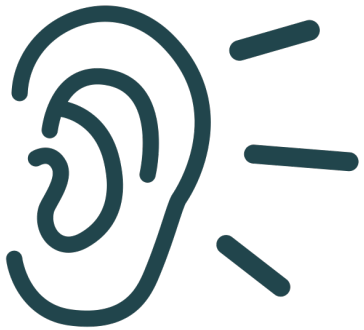


Assessment Purpose and Process

Meeting goals

Goals:

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



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

Preliminary Themes & Data Findings

CHNA Progress
Activities to date

Gathered Publicly Available Data, e.g.:

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

19 **Interviews with Community Leaders**

514 **Survey Respondents**

3 **Small Group Discussions**

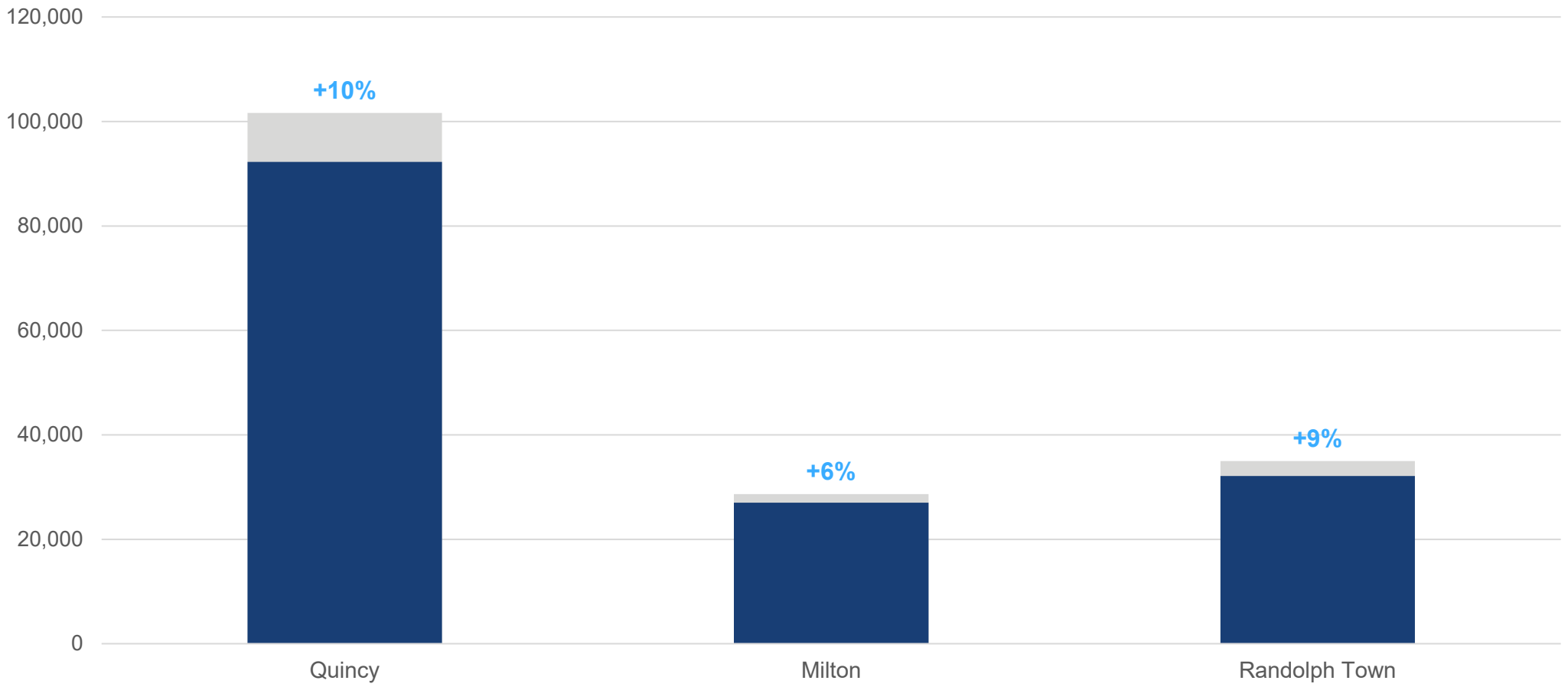
-Enhance Asian Community Health

-Milton Youth Action Council

-English language learners

CHNA Progress

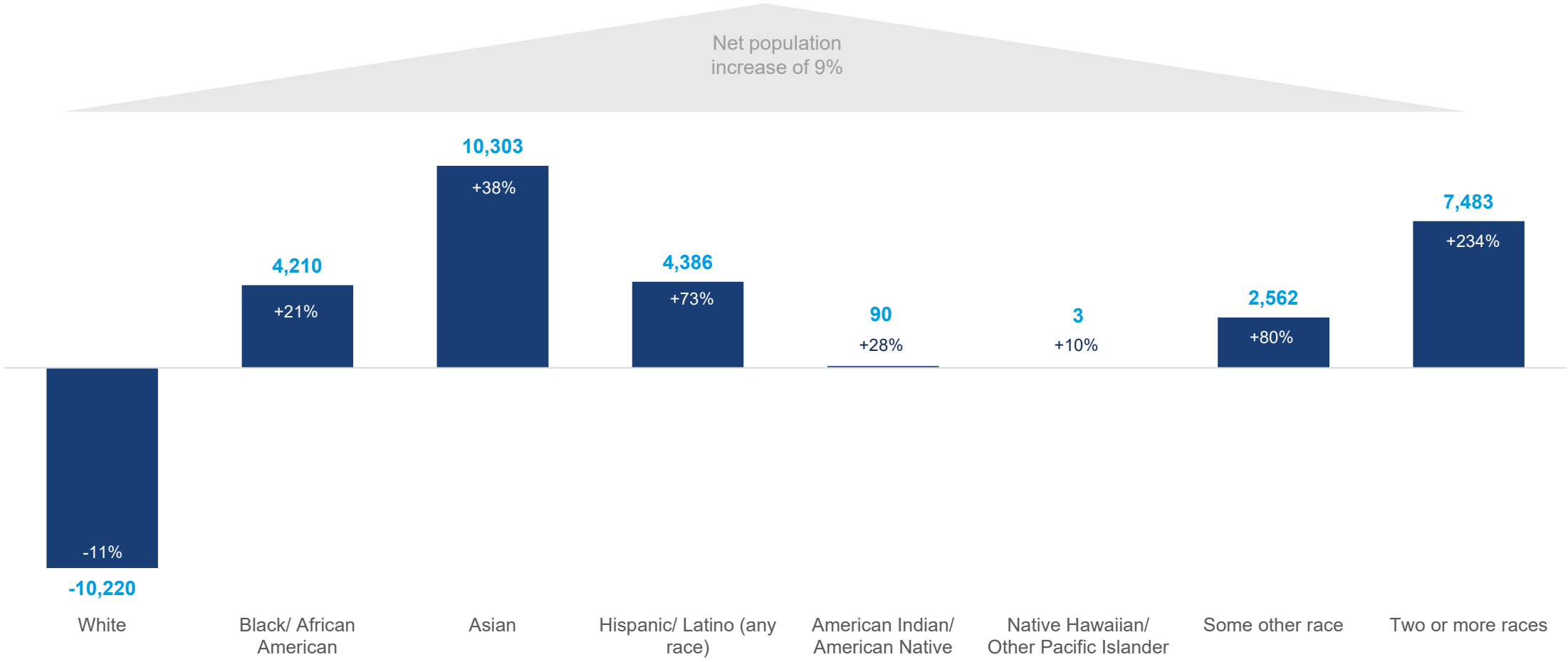
Population Change in Community Benefits Service Area 2010-2020



Total population increase of 9% (13,864)

CHNA Progress

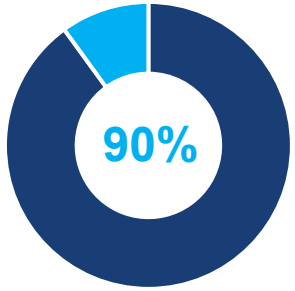
Race/Ethnicity Population Change in Community Benefits Service Area, 2010-2020



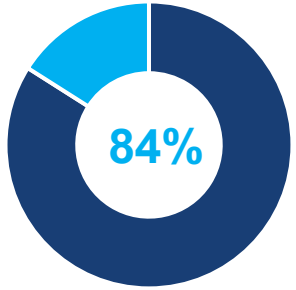
CHNA Progress
Community Strengths

- Extremely diverse – significant percentage of Asian, Black/African American, and Hispanic/Latino residents
- Strong sense of community
- Strong collaborations between community organizations and providers
- Rich in resources (e.g., community organizations, task forces, collaboratives, etc.

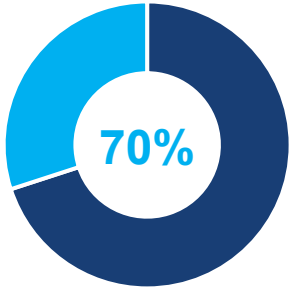
FROM BID MILTON COMMUNITY HEALTH SURVEY:



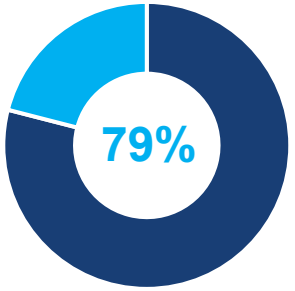
said they were **satisfied with the quality of life** in their community



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



said the community is a **good place to raise children**



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

CHNA Progress
Key Themes

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

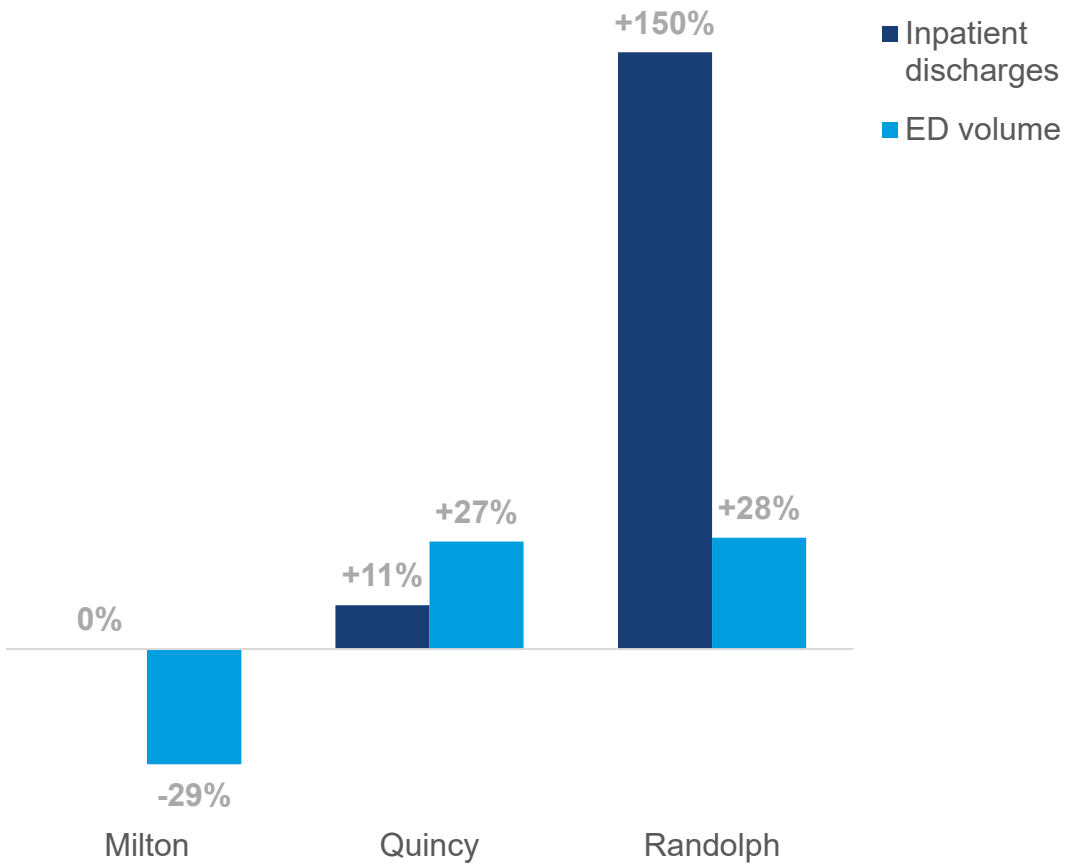
CHNA Progress
Key Themes: Mental Health (Youth)

Youth have significant social-emotional needs, exacerbated by COVID

- Anxiety, stress, depression

Youth identified social pressure (from peers, themselves, and adults), balance of schoolwork and activities, social media, lack of discipline, isolation, and body image/physical health issues as sources of stress

Change in mental health inpatient discharge and ED volume rates for 0-17 year olds, FY17-FY19



Data source: Massachusetts Center for Health Information and Analysis

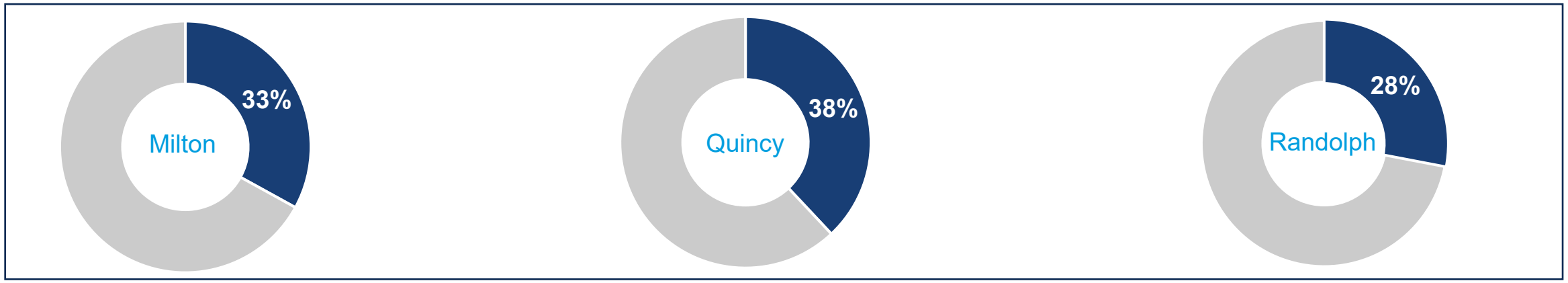
CHNA Progress
Key Themes: Mental Health (Adult)

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

- Significant stress and anxiety for parents – lack of childcare affecting ability to work
- Recognition of strong link between mental health and substance use disorder, for many individuals
- Common barriers to care include affordability, hours didn't fit schedule, fear of COVID exposure, no available providers/appointments

19% of BID Milton Community Health Survey respondents reported that within the last 12 months, they needed care for a mental health issue or crisis and were not able to get it.

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



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

Beth Israel Lahey Health

CHNA Progress
Key Themes: Social Determinants of Health

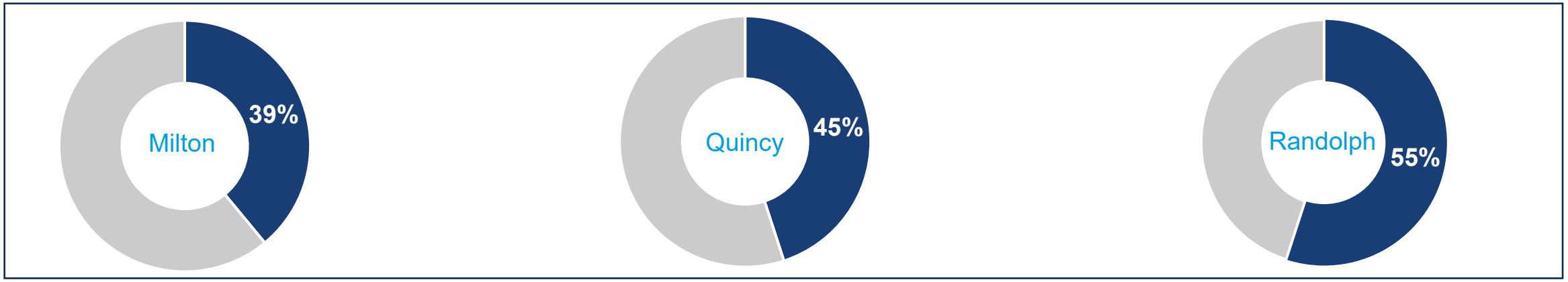
Primary concerns:

- Housing: lack of affordable housing, homelessness
- Access to childcare
- Transportation: access to public transport, traffic issues
- Economic insecurity/high cost of living
- Food insecurity

When asked what they'd like to improve in their community, the top response among BID Milton Community Health Survey respondents was:

"more affordable housing" (36%)

Percentage* worried about paying for one or more types of expenses/bills in coming weeks (Fall 2020)



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

CHNA Progress
Key Themes: Access to Care

- **Significant barriers to accessing and navigating care for certain segments of the population:**
  - Non-English speakers
  - Older adults without caregivers and transportation
  - Individuals without insurance

- **Providers not taking new patients or wait lists are too long (primary care, specialists, behavioral health, home health)**

- **Cost barriers to care, especially mental health services not covered by insurance**

"The cost of medications and health care is too expensive – especially for those who do not quality for services [like those] who live under the poverty line."

– Focus group participant

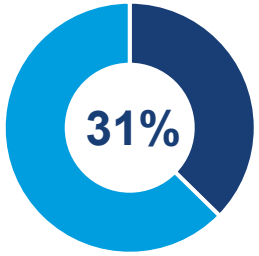
CHNA Progress
Key Themes: Diversity, Equity, and Inclusion

- **Service area is rich in diversity**
  - Varying levels of recognition and acceptance of this diversity
- **Significant economic diversity throughout service area**
- **Need for more health care and supportive services and providers for those best served in a language other than English**

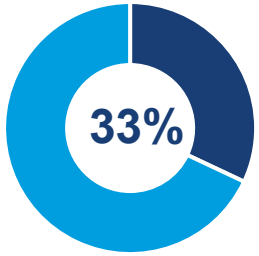
"This community is very diverse, and the diversity is not adequately reflected in government, schools, and employment."

– BILH Survey respondent

AMONG BID MILTON COMMUNITY HEALTH SURVEY RESPONDENTS:



31% agreed that the built, economic, and educational environments in the community are impacted by systemic racism



33% agreed that the community is impacted by individual racism

Breakout Sessions

Reconvene

Wrap-up
BID Milton Community Benefits

Laureane Marquez
Community Benefits/Community Relations Manager
617-313-1126
Laureane_marquez@bidmilton.org

Community Benefits Information on website:
https://www.bidmilton.org/events-and-education/community-benefits/

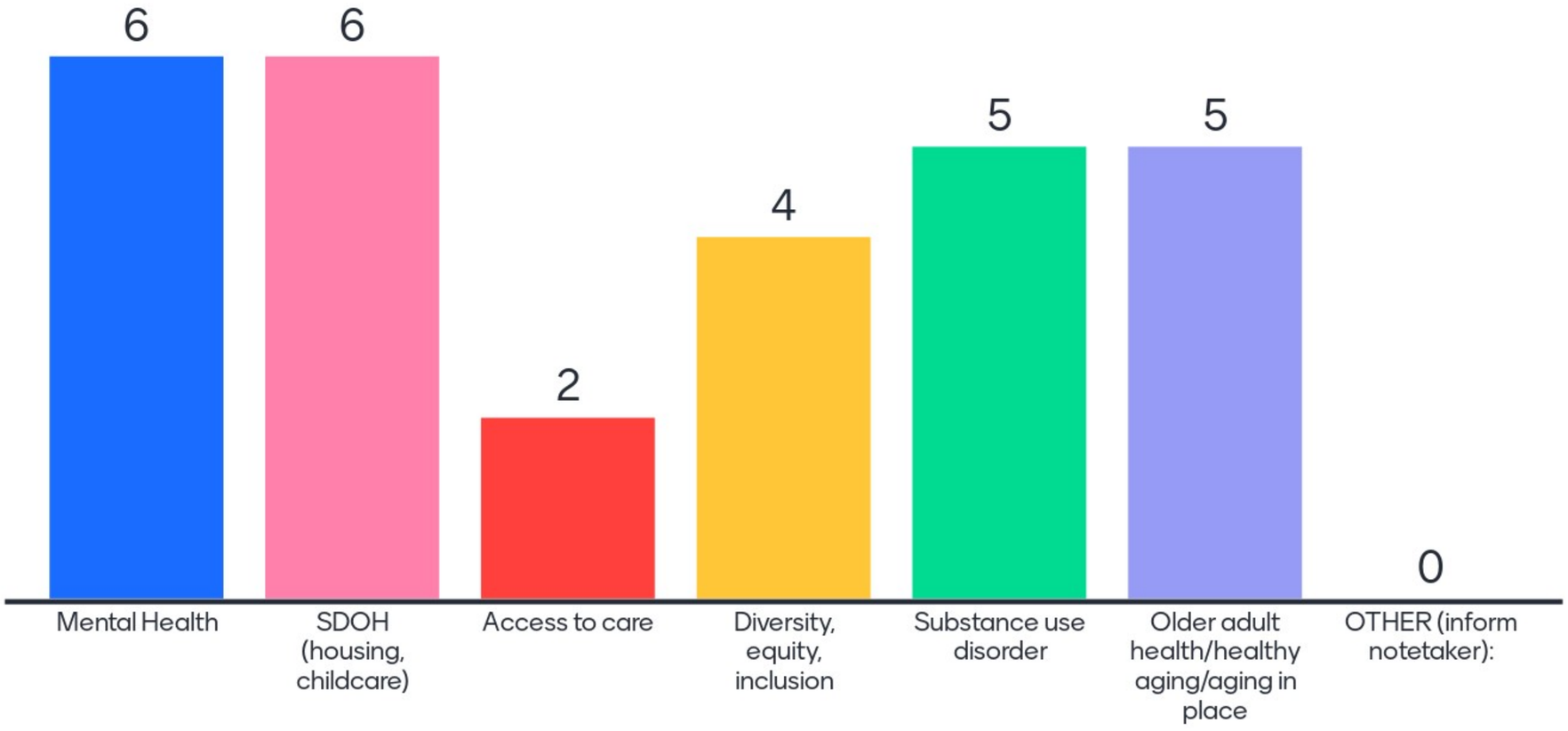
Community Benefits Annual Meeting in June (More info TBD)

Thank you!

Choose your top 4 priority areas.

Mentimeter

Priority vote results from Community Listening Session January 20, 2022



Priority Area 1: Mental Health

Notes from Listening Session January 20, 2022

Resources/Assets

- ESPT team
- more resources than people are aware of
- Milton's interfaith referral service
- clinicians embedded in police dept
- early intervention services
- DMH group homes
- Massachusetts is soon revamping the behavioral health system

Gaps/Barriers

- knowledge of available resources

- continuous outreach, tangible options like mail

- cost barriers when there's supposed to be parity
- lack of referral systems in Milton & Quincy

Priority Area 2: SDOH (housing, childcare)

Resources/Assets

food pantries

Milton Early Childcare Alliance

Quincy has more agencies that support housing

Lyft has a regional budget for community health

Medicaid patients have access to transportation

Gaps/Barriers

high costs as a significant market challenge

transportation, COVID increased waits

childcare costs and availability. stronger opportunity that housing for hospitals to support care providers.

increased costs of food

Priority Area 3: Substance Use

Resources/Assets

groups at health centers, hospitals

MAT

bridge clinic

shattuck

programs for pregnant and post-pregnant women

Gaps/Barriers

lack of education about alcoholism in particular, not enough press coverage as other substances

continuous preventative work

Priority Area 4: Older Adult/Healthy Aging

Resources/Assets

PACE programs

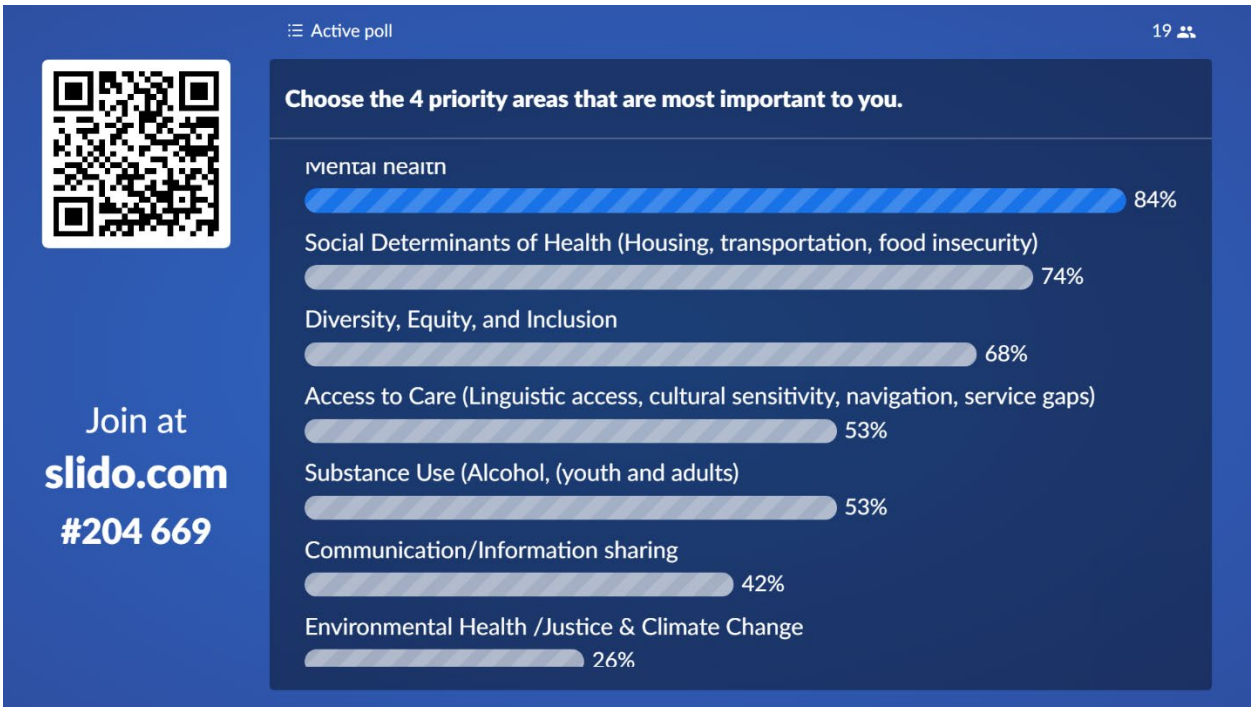
several senior housing facilities

Gaps/Barriers

affordability and accessibility of housing

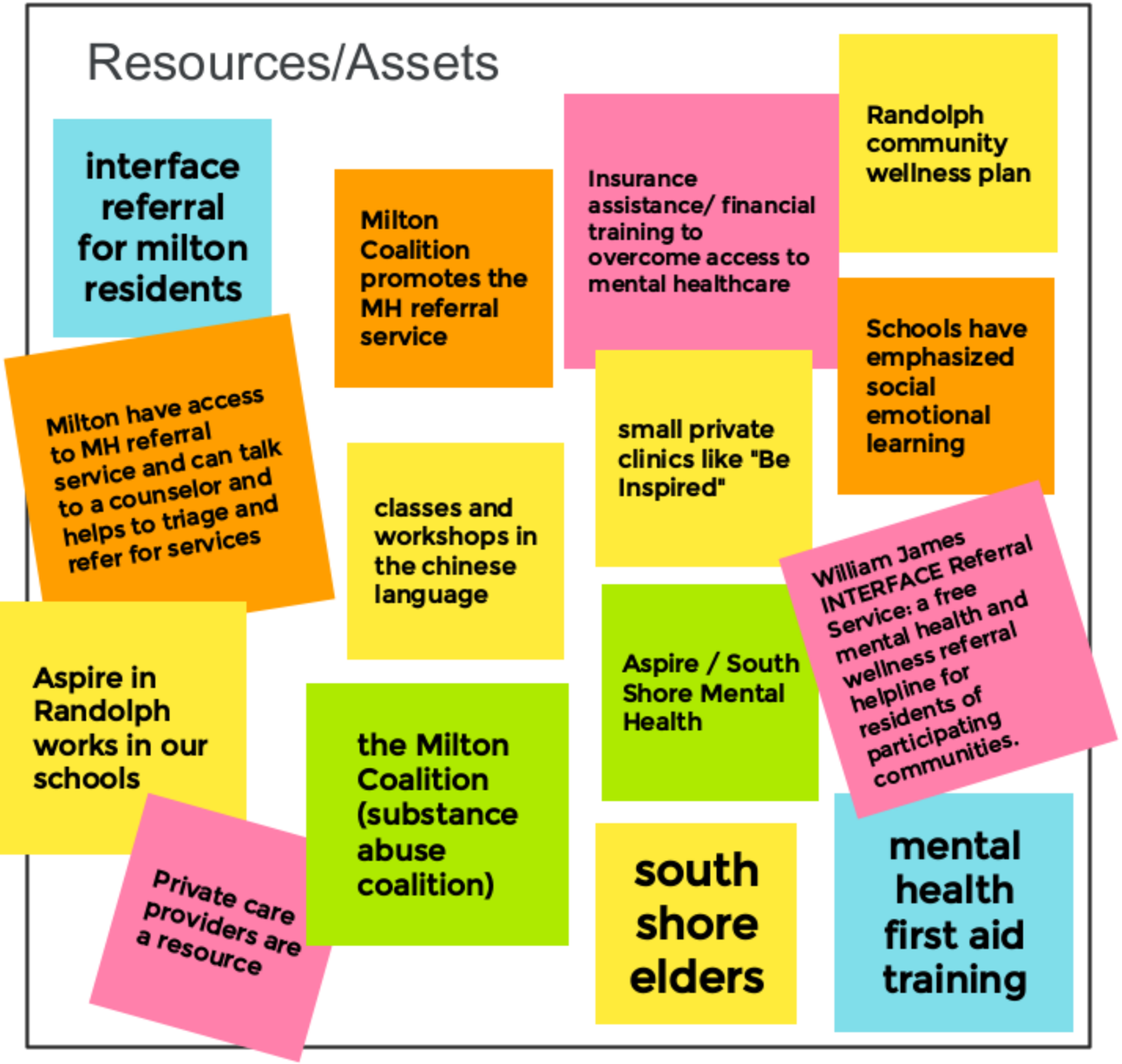
affordability and availability of home support services

Priority vote results from Community Listening Session February 8, 2022



Priority Area 1: Mental Health

Notes from session February 8, 2022



Priority Area 2: Social Determinants of Health

Resources/Assets

Transitory housing - 30% of income goes towards rent.

Milton Residents Fund

Housing vouchers have been issued.

Milton Council on Aging

Milton has 2 community food pantries and they appear to be successful

Food pantry services have increased during covid

Randolph food pantry

Milton council on aging provides transportation

Gaps/Barriers

milton should have a rental registry

Affordable housing is not available

there is a need to have housing available for emergencies

Supply chain issues are disrupting access to food and diminishing donations; particularly cereal, eggs etc.

Landlords are often unwilling to support housing vouchers or those with no credit history

Rental prices are not affordable

hospitals should partner with housing groups to look into increasing inventory for stable, long term housing

Mismatch between housing vouchers and availability of units

Milton DOH has ability to do inspections - but need is too great. More resources needed.

residents are afraid to reach out to public health departments for sanitary purposes due to retribution, there should be required inspections

Meals on wheels site has not re-opened

Water quality and access for those who cannot afford bottled options

Stigma related to food pantry services, can people get home deliveries privately?

Need to know if the food pantries are successful

Not enough town based caseworkers to help families navigate SDOH

Priority Area 3: Diversity, Equity, Inclusion

Resources/Assets

DEI committees within towns/cities

Quincy Asian Resources, Inc. (QARI), Enhance Asian Community on Health (EACH), and Boston Chinatown Neighborhood Center (BCNC) Quincy branch

18% to 36% of clients are Asian which represents the demographic change of the area. Need for interpreters as long-term investments

clergy in Milton are very active in engaging communities to be a part of committees

for the Asian communities, there are a lot of language barriers

Randolph community wellness plan

Gaps/Barriers

Milton has large Haitian/Creole community and we are unsure if we are really reaching them and updated on what is available and going on.

Non-english speaking populations have had trouble accessing covid funds

Need to make sure information on resources reaches ALL people. Need to improve access to info

Translation services to promote access to state/federal assistance

Have fantastic CBO's in Milton, it would be great to see more leadership that reflects the community

encouraging people to participate and share their voice and opinions (community ambassador programming)

we need to get creative on we engage diverse communities

Elderly digital divide/ digital literacy is lacking

we need more knowledge on what DEI actually is

Access to state and federal resources

Priority Area 4: Equal Access to Care

Resources/Assets

Milton Public Schools really served FAMILIES with children around food insecurity.

all providers should have language access resources

one stop shop for seeking care

Community Library - a resource headquarter for anyone to go to

Milton has the residents fund and the staff helps with insurance and resources.

Having a central repository for info would increase access

Gaps/Barriers

Lack a town based social worker to help access a care provider, especially those covered by certain types of insurance

Literacy with regards to the food pantry; volunteers are trained to respond to these

Investment into recruitment of mental health professionals is not matching up with results

Shelter waitlists due to covid

Entertainment access; consideration of those who cannot read or those that do not have access to television

Some residents cannot access electronic access to medical servces like ehealth record apps. Especially for the elderly or those not keen on technology.

Health care has become techno driven - not all residents are there yet. Televisits example

Most residents do not understand what their insurance covers and cannot navigate the healthcare system. Need an advocate specifically focussing on insurance benefits and coverage.

Priority Area 5: Substance Use

Resources/Assets

- Milton Coalition and focus is to promote MH and address SU
- Milton has a coalition that brings multiple entities in
- using data to help dictate outreach
- Milton CARES works in collaboration with the police

Gaps/Barriers

- More substance use/mental health (addressing both) needs to happen. Rise in MH issues directly impacts rise in SU likelihood.
- working coalitions should provide community ambassadors to help implement the same group in another town
- Large focus on opiod use disorders in US. But in Milton great need is to address alcohol use prevention and treatment
- May need a youth AA group or similar resources
- 
- Family members of those with SUD need help too.
- Need MH support for those getting alcohol treatment as well.

Appendix B:
Data Book

Secondary data

Key

Significantly low compared to the Commonwealth based on margin of error

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

			Community Benefits Service Area			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Demographics						
Population						US Census Bureau, American Community Survey 2016-2020
Total Population	6,873,003	703,740	27,590	94,389	34,214	
Male	48.5%	48.1%	46.8%	49.2%	47.8%	
Female	51.5%	51.9%	53.2%	50.8%	52.2%	
Age Distribution						US Census Bureau, American Community Survey 2016-2020
Under 5 years (%)	5.2%	5.3%	6.0%	5.3%	5.9%	
5 to 9 years	5.3%	5.5%	7.2%	3.3%	4.2%	
10 to 14 years	5.7%	6.2%	7.4%	3.9%	4.9%	
15 to 19 years	6.6%	6.4%	8.5%	3.5%	5.9%	
20 to 24 years	7.1%	6.2%	7.2%	6.4%	7.8%	
25 to 34 years	14.3%	12.9%	7.1%	21.6%	14.4%	
35 to 44 years	12.2%	12.6%	14.0%	14.3%	12.2%	
45 to 54 years	13.3%	14.1%	13.1%	11.7%	12.5%	
55 to 59 years	7.1%	7.4%	8.4%	7.1%	8.3%	
60 to 64 years	6.5%	6.5%	5.5%	6.0%	7.0%	
65 to 74 years	9.5%	9.4%	7.7%	9.7%	9.9%	
75 to 84 years	4.6%	4.8%	5.6%	4.3%	4.5%	
85 years and over	2.4%	2.6%	2.5%	2.9%	2.3%	
Under 18 years of age	19.8%	20.9%	24.7%	14.6%	19.1%	
Over 65 years of age	16.5%	16.8%	15.8%	16.8%	16.7%	
Race/Ethnicity						US Census Bureau, American Community Survey 2016-2020
White alone (%)	76.6%	76.1%	71.7%	60.0%	32.4%	
Black or African American alone (%)	7.5%	7.2%	17.1%	5.7%	40.0%	
Asian alone (%)	6.8%	11.3%	5.8%	29.8%	14.8%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.1%	0.1%	0.0%	

			Community Benefits Service Area			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
American Indian and Alaska Native (%) alone	0.2%	0.1%	0.4%	0.3%	0.0%	
Some Other Race alone (%)	4.2%	1.7%	0.7%	1.2%	8.5%	
Two or More Races (%)	4.8%	3.5%	4.1%	2.9%	4.3%	
Hispanic or Latino of Any Race (%)	12.0%	4.7%	3.5%	3.8%	11.5%	
Race/Ethnicity of Students in Public Schools						School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021
African American (%)	9.3		13.1	6.9	49.4	
Asian (%)	7.2		7.5	40.9	17.6	
Hispanic (%)	22.3		5.0	8.4	16.2	
White (%)	56.7		68.8	39.6	11.8	
Native American (%)	0.2		0.1	0.2	0.3	
Native Hawaiian, Pacific Islander (%)	0.1		0.1	0.3	0.1	
Multi-Race, Non-Hispanic (%)	4.10		5.4	3.7	4.6	
Foreign-born	17.0%	18.5%	16.9%	32.9%	35.8%	US Census Bureau, American Community Survey 2016-2020
Naturalized U.S. Citizen	54.2%	60.6%	60.3%	54.6%	72.9%	
Not a U.S. Citizen	45.8%	39.4%	39.7%	45.4%	27.1%	
Region of birth: Europe	20.0%	23.0%	17.1%	14.8%	3.0%	
Region of birth: Asia	31.1%	47.0%	18.1%	69.1%	32.8%	
Region of birth: Africa	9.3%	7.3%	5.4%	7.5%	12.0%	
Region of birth: Oceania	0.3%	0.3%	0.7%	0.0%	0.0%	
Region of birth: Latin America	36.7%	20.1%	56.7%	7.7%	51.4%	
Region of birth: Northern America	2.5%	2.3%	2.0%	0.8%	0.7%	
Language						US Census Bureau, American Community Survey 2016-2020
English only	76.1%	77.8%	79.4%	62.0%	54.2%	
Language other than English	23.9%	22.2%	20.6%	38.0%	45.8%	
Speak English less than "very well"	9.2%	8.2%	5.2%	20.7%	18.9%	
Spanish	9.1%	3.1%	3.7%	2.5%	8.2%	
Speak English less than "very well"	3.8%	0.6%	0.6%	0.7%	2.6%	
Other Indo-European languages	9.0%	9.1%	11.1%	8.9%	20.8%	
Speak English less than "very well"	3.0%	2.8%	2.5%	3.2%	7.6%	
Asian and Pacific Islander languages	4.4%	8.3%	4.6%	24.5%	12.9%	

			Community Benefits Service Area			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Speak English less than "very well"	2.0%	4.3%	1.8%	16.0%	8.2%	
Other languages	1.4%	1.7%	1.2%	2.0%	3.9%	
Speak English less than "very well"	0.4%	0.5%	0.4%	0.8%	0.4%	
Percent of public school student population that are English language learners (%)	10.5		2.1	15.7	16.1	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Employment						US Census Bureau, American Community Survey 2016-2020
Unemployment rate	5.1%	4.5%	3.3%	5.8%	6.7%	
Unemployment rate by race/ethnicity						
White alone	4.5%	4.1%	3.5%	5.3%	4.0%	
Black or African American alone	8.3%	8.2%	2.6%	17.5%	8.5%	
American Indian and Alaska Native alone	10.7%	0.0%	0.0%	0.0%	-	
Asian alone	4.2%	3.4%	4.6%	4.5%	4.2%	
Native Hawaiian and Other Pacific Islander alone	5.4%	0.0%	-	0.0%	0.0%	
Some other race alone	8.3%	5.8%	2.2%	10.3%	9.0%	
Two or more races	9.1%	7.7%	3.1%	1.5%	22.3%	
Hispanic or Latino origin (of any race)	8.3%	6.3%	7.3%	5.8%	6.7%	
Unemployment rate by educational attainment						
Less than high school graduate	9.7%	8.2%	13.1%	7.5%	19.3%	
High school graduate (includes equivalency)	5.9%	6.6%	4.7%	11.3%	7.0%	
Some college or associate's degree	4.5%	3.6%	1.3%	6.8%	1.1%	
Bachelor's degree or higher	2.8%	2.6%	1.9%	2.7%	0.9%	
Income and Poverty						US Census Bureau, American Community Survey 2016-2020
Median household income (dollars)	84,385	105,320	141,050	80,462	87,803	
Population living below the federal poverty line in the last 12 months						
Individuals	9.8%	6.0%	5.6%	9.8%	8.6%	
Families	6.6%	4.0%	3.0%	7.6%	7.6%	
Individuals under 18 years of age	12.2%	5.4%	3.1%	11.0%	10.5%	
Individuals over 65 years of age	8.9%	7.2%	9.4%	12.2%	9.9%	

			Community Benefits Service Area			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Female head of household, no spouse present	20.5%	14.4%	13.2%	20.0%	15.5%	
White alone	7.9%	5.1	3.4%	7.9%	8.9%	
Black or African American alone	17.6%	11.2	16.5%	18.7%	9.2%	
American Indian and Alaska Native alone	23.3%	7.4	0.0%	10.9%	100.0%	
Asian alone	11.8%	7.7	1.0%	10.6%	6.5%	
Native Hawaiian and Other Pacific Islander alone	11.9%	2.6	0.0%	0.0%	0.0%	
Some other race alone	22.2%	10.9	3.6%	34.2%	6.4%	
Two or more races	15.5%	7.7	3.4%	15.1%	11.6%	
Hispanic or Latino origin (of any race)	23.0%	11.5	0.9%	18.4%	11.2%	
Less than high school graduate	23.2%	15.8	12.3%	21.8%	18.4%	
High school graduate (includes equivalency)	11.7%	9.2	20.2%	10.2%	5.7%	
Some college, associate's degree	8.4%	6.6	6.5%	7.4%	9.6%	
Bachelor's degree or higher	3.9%	3.1	2.4%	6.4%	1.5%	
With Social Security	30.2%	29.5%	28.9%	27.5%	33.2%	
With retirement income	19.3%	19.7%	19.1%	16.7%	19.3%	
With Supplemental Security Income	5.9%	3.5%	3.1%	4.5%	8.3%	
With cash public assistance income	2.8%	1.9%	1.7%	2.9%	3.5%	
With Food Stamp/SNAP benefits in the past 12 months	11.6%	6.7%	3.5%	9.7%	17.3%	
Public School Distric Students Who are Low Income (%)	36.6		11.4	39.0	70.2	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Housing						US Census Bureau, American Community Survey 2016-2020
Occupied housing units						
Owner-occupied	62.5%	68.8%	83.1%	44.4%	68.9%	
Renter-occupied	37.5%	31.2%	16.9%	55.6%	31.1%	
Lacking complete plumbing facilities	0.3%	0.2%	0.0%	0.2%	0.3%	
Lacking complete kitchen facilities	0.8%	0.7%	0.0%	1.0%	0.1%	

			Community Benefits Service Area			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
No telephone service available	1.2%	1.0%	0.1%	1.4%	0.6%	
Monthly housing costs <35% of total household income						
Among owner-occupied housing units with a mortgage	22.0%	21.2%	19.4%	30.8%	26.1%	
Among owner-occupied units without a mortgage	15.2%	16.4%	28.7%	21.7%	14.4%	
Among occupied units paying rent	39.1%	37.5%	39.3%	33.5%	44.1%	
Eviction filings, 2018	34,200	2,000	26	375	232	Eviction Lab, 2018 Evictions
Access to Technology						US Census Bureau, American Community Survey 2016-2020
Among households						
Has smartphone	83.3%	85.4%	86.9%	83.3%	86.4%	
Has desktop or laptop	82.2%	87.1%	90.5%	81.3%	84.0%	
Has tablet or other portable wireless computer	64.8%	70.3%	73.3%	62.8%	62.2%	
No computer	7.4%	5.4%	3.9%	7.9%	4.7%	
With broadband internet	88.2%	91.5%	92.4%	89.1%	91.6%	
Transportation						US Census Bureau, American Community Survey 2016-2020
Mode of transportation to work for workers aged 16+						
Car, truck, or van -- drove alone	68.0%	65.0%	60.5%	54.7%	72.8%	
Car, truck, or van -- carpooled	7.3%	6.3%	6.5%	7.3%	9.8%	
Public transportation (excluding taxicab)	9.5%	13.5%	14.0%	25.2%	10.7%	
Walked	4.8%	3.6%	4.4%	3.7%	0.7%	
Other means	2.1%	1.7%	2.0%	2.3%	1.1%	
Worked from home	8.3%	9.9%	12.7%	6.9%	5.0%	
Mean travel time to work (minutes)	30	34.6	34.8	36.1	38	
Vehicles available among occupied housing units						
No vehicles available	12.2%	9.3%	6.6%	15.9%	7.5%	
1 vehicle available	35.1%	33.5%	24.6%	45.1%	36.3%	
2 vehicles available	36.1%	40.5%	49.9%	30.5%	37.0%	
3 or more vehicles available	16.5%	16.7%	18.9%	8.5%	19.2%	
Education						US Census Bureau, American Community Survey 2016-2020
Educational attainment of adults 25 years and older						

			Community Benefits Service Area			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Less than 9th grade (%)	4.2%	2.6%	2.4%	5.7%	6.7%	
9th to 12th grade, no diploma (%)	4.7%	3.3%	2.6%	5.1%	8.7%	
High school graduate (includes equivalency) (%)	23.5%	18.7%	15.5%	22.2%	28.5%	
Some college, no degree (%)	15.3%	13.5%	10.6%	13.6%	17.2%	
Associate's degree (%)	7.7%	7.3%	6.3%	7.7%	11.4%	
Bachelor's degree (%)	24.5%	28.8%	30.3%	26.3%	18.7%	
Graduate or professional degree (%)	20.0%	25.8%	32.1%	19.3%	8.9%	
High school graduate or higher (%)	91.1%	94.1%	95.0%	89.2%	84.6%	
Bachelor's degree or higher (%)	44.5%	54.6%	62.5%	45.6%	27.6%	
Educational attainment by race/ethnicity						
White alone						
High school graduate or higher	93.3%	96.4%	96.5%	95.2%	93.2%	
Bachelor's degree or higher	46.3%	55.9%	69.1%	47.6%	29.9%	
Black alone						
High school graduate or higher	86.2%	88.9%	92.4%	95.1%	83.6%	
Bachelor's degree or higher	27.6%	36.9%	36.9%	43.7%	28.5%	
American Indian or Alaska Native alone						
High school graduate or higher	81.0%	81.3%	89.7%	87.7%	100.0%	
Bachelor's degree or higher	21.9%	28.6%	15.0%	56.9%	0.0%	
Asian alone						
High school graduate or higher	85.7%	83.3%	87.0%	75.3%	68.5%	
Bachelor's degree or higher	61.8%	57.9%	67.7%	40.8%	27.1%	
Native Hawaiian and Other Pacific Islander alone						
High school graduate or higher	89.1%	76.3%	0.0%	100.0%	100.0%	
Bachelor's degree or higher	36.4%	52.6%	0.0%	100.0%	0.0%	
Some other race alone						
High school graduate or higher	69.9%	83.7%	96.0%	75.5%	85.2%	
Bachelor's degree or higher	15.7%	33.0%	51.1%	45.2%	10.9%	
Two or more races						
High school graduate or higher	81.3%	91.6%	94.9%	93.2%	70.9%	
Bachelor's degree or higher	34.9%	61.1%	68.4%	54.2%	33.0%	

			Community Benefits Service Area			
	MA	**Norfolk County**	**Milton**	**Quincy**	**Randolph**	**Source**
Hispanic or Latino Origin						
High school graduate or higher	72.4%	91.3%	83.0%	93.6%	93.2%	
Bachelor's degree or higher	20.9%	46.8%	65.1%	53.6%	15.3%	
4-Year Graduation Rate Among Public High School Students (%)	89.0		94.9	93.2	75.9	Massachusetts Department of Elementary and Secondary Education, 2020
Safety/Crime						Massachusetts Crime Statistics, 2021
Property Crimes Offenses (#)						
Burglary	9,592.0		11	224	44	
Larceny-theft	55,672.0		93	851	237	
Motor vehicle theft	7,045.0		7	143	46	
Arson	312.0		0	4	0	
Crimes Against Persons Offenses (#)						
Murder/non-negligent manslaughter	151		1	1	0	
Sex offenses	4,171		2	48	18	
Assaults	67,690		17	934	339	
Access to Care						
Ratio of population to primary care physicians	960 to 1	780 to 1				County Health Rankings, 2019
Ratio of population to mental health providers	140 to 1	150 to 1				County Health Rankings, 2021
Ratio of population to dentists	930 to 1	800 to 1				County Health Rankings, 2020
Health insurance coverage among civilian noninstitutionalized population (%)						American Community Survey (U.S. Census Bureau), 2016-2020
With health insurance coverage	97.3%	98.2%	99.0%	96.9%	96.7%	
With private health insurance	74.5%	82.9%	88.1%	72.3%	69.0%	
With public coverage	36.1%	28.4%	22.2%	36.6%	39.9%	
No health insurance coverage	2.7%	1.8%	1.0%	3.1%	3.3%	

Key

Significantly low compared to the Commonwealth based on margin of error

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

			Community Benefits Service Area			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	Source
Overall Health						
Mortality rate (age-adjusted per 100,000)	654	623.3	450.9	636.1	641.7	Massachusetts Death Report, 2019
Premature mortality rate (per 100,000)	272.8	242.2	154.5	289.9	276.5	
Leading causes of death (counts)						
Cancer	12,584	1314	48	207	61	
Heart Disease	11,779	1247	35	169	51	
Chronic Lower Respiratory Disease	2,842	243	5	36	7	
Stroke	2,463	244	13	32	14	
Disability						US Census Bureau, American Community Survey 2016-2020
Percent of population with a disability	11.7%	9.5%	6.9%	10.8%	12.7%	
Under 18	4.7%	3.2%	1.8%	4.4%	1.1%	
18-64	8.9%	6.8%	4.0%	7.3%	10.7%	
65+	31.3%	27.8%	26.3%	30.7%	33.7%	
Healthy Living						
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	26	26				Behavioral Risk Factor Surveillance System, 2019
Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%)	22.2					Behavioral Risk Factor Surveillance System, 2019
Population with adequate access to locations for physical activity (%)	89	88				County Health Rankings, 2021
Adults who consumed fruit less than one time per day (%)	32.7					Behavioral Risk Factor Surveillance System, 2019
Adults who consumed vegetables less than one time per day (%)	15.5					Behavioral Risk Factor Surveillance System, 2019
Population with limited access to healthy foods (%)	4	4				USDA Food Environment Atlas, 2019
Total Population that Did Not Have Access to a Reliable Source of Food During Past Year (food insecurity rate) (%)	8.2					Feeding America, Map the Meal Gap, 2019
Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted) (%)	34	35				Behavioral Risk Factor Surveillance System, 2018
Mental Health						
Average number of mentally unhealthy days in past 30 days (adults)	4.2	4.1				County Health Rankings, 2019
Youth Risk Behavior Survey (YRBS)						Youth Risk Behavior Survey - Report years indicated
	2019		**2019**			
% of students (grades 9-12) reporting depressive symptoms (%)	33.8		29.0			
% of students (grades 9-12) reporting persistent anxiety symptoms (%)			45.0			
% of students (grades 6-8) bullied on school property (%)	35.3					
% of students (grades 6-8) bullied electronically (%)	15.2					

			Community Benefits Service Area			
	Massachusetts	**Norfolk County**	**Milton**	**Quincy**	**Randolph**	Source
% of students (grades 9-12) bullied on school property (%)	16.3					
% of students (grades 9-12) bullied electronically (%)	13.9					
% of students (grades 6-8) reporting self harm (%)	21					
% of students (grades 9-12) reporting self harm (%)	16.4					
% of students (grades 6-8) reporting suicide ideation (%)	11.3					
% of students (grades 9-12) reporting suicide ideation (%)	17.5		15.0			
% of students (grades 6-8) reporting suicide attempt (%)	5					
% of students (grades 9-12) reporting suicide attempt (%)	7.3					
Admissions to DPH-funded treatment programs (count)	98944		116	1626	312	MA DPH, Bureau of Substance Abuse Services, 2017
Rate of injection drug user admissions to DPH-funded treatment program (%)	52.4		41.1	52.6	36.5	MA DPH, Bureau of Substance Abuse Services, 2017
Primary substance of use when entering treatment						MA DPH, Bureau of Substance Abuse Services, 2017
Alcohol (%)	32.8		56	33.2	39.4	
Crack/Cocaine (%)	4.1		-	3.6	4.8	
Heroin (%)	52.8		39.7	54.4	42.6	
Marijuana (%)	3.5		-	2.2	3.2	
Other Opioids (%)	4.6		-	4.6	7.1	
Other Sedatives/Hypnotics (%)	1.5		-	1.5	-	
Other Stimulants (%)	0.5		-	0.4	-	
Other (%)	0.3		-	-	-	
Adults who are current smokers (age-adjusted) (%)	12	12				Behavioral Risk Factor Surveillance System, 2019
Adults who report excessive drinking (binge or heavy drinking) (%)	22	26				Behavioral Risk Factor Surveillance System, 2019
Youth Risk Behavior Survey (YRBS)						Youth Risk Behavior Survey - Report years indicated
	2019		**2019**			
Students (grades 6-8) reporting lifetime alcohol use (%)	13.6					
Students (grades 6-8) reporting current alcohol use (%)	4.4					
Students (grades 9-12) reporting lifetime alcohol use (%)	ciga					
Students (grades 9-12) reporting current alcohol use (%)	29.8		37.0			
Students (grades 6-8) reporting current binge alcohol use (%)	0.9					
Students (grades 9-12) reporting current binge alcohol use (%)	15.0		24.0			
Students (grades 6-8) reporting lifetime cigarette use (%)	5.2					
Students (grades 6-8) reporting current cigarette use (%)	--					
Students (grades 9-12) reporting lifetime cigarette use (%)	17.7					

			Community Benefits Service Area			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	Source
Students (grades 9-12) reporting current cigarette use (%)	5.0					
Students (grades 6-8) reporting lifetime marijuana use (%)	7.0					
Students (grades 6-8) reporting current marijuana use (%)	3.0					
Students (grades 9-12) reporting lifetime marijuana use (%)	41.9					
Students (grades 9-12) reporting current marijuana use (%)	26.0		21.0			
Students (grades 6-8) reporting lifetime electronic tobacco use (%)	14.7					
Students (grades 6-8) reporting current electronic tobacco use (%)	--					
Students (grades 9-12) reporting lifetime electronic tobacco use (%)	50.7					
Students (grades 9-12) reporting current electronic tobacco use (%)	32.2		29.0			
Chronic Disease (more data on CHIA data tabs)						
Cancer mortality (all types, age-adjusted rate per 100,000)	149.92	144.67				Massachusetts Cancer Registry, 2014-2018
Cancer incidence (age-adjusted per 100,000)						
All sites	498.16	478.46				
Breast Cancer	176.35	196.7				
Cervical Cancer	5.5	4.17				
Coloretal Cancer	35.96	36.22				
Lung and Bronchus Cancer	61.41	60.42				
Prostate Cancer	108.84	113.74				
Risk factors						
Percent of Adults who are Obese (%)	24		24.3	23.6	28.8	Behavioral Risk Factor Surveillance System, 2018
Diagnosed diabetes among adults aged >=18 years (%)	8.6		6.6	8.3	9.8	Behavioral Risk Factor Surveillance System, 2018
Age-adjusted mortality due to heart disease per 100,000 population (%)	138.7					Massachusetts Department of Public Health, Population Health Information Tool, 2015
Adults ever told by doctor that they had angina or coronary heart disease (age-adjusted) (%)	4.7		4.3	5.2	5.4	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high blood pressure (age adjusted) (%)	26.8		26.4	27.7	No data	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high cholesterol (age-adjusted) (%)	33.1		28.4	30	No data	Behavioral Risk Factor Surveillance System, 2017
Reproductive Health						
Infant Mortality Rate (per 1,000 live births)	3.7	2.9				March of Dimes, 2019
Low birth weight (%)	7.4	7.2				March of Dimes, 2020
Mothers with late or no prenatal care (%)	3.9%	3				March of Dimes, 2020
Births to adolescent mothers (per 1,000 females ages 15-19)	8	2				National Center for Health Statistics, 2014-2020
Percent of mothers receiving publicly funded prenatal care 2016	38.60%					Massachusetts Births 2016

			Community Benefits Service Area			
	Massachusetts	**Norfolk County**	**Milton**	**Quincy**	**Randolph**	Source
Women screened for postpartum depression within 6 months after delivery (%)						MDPH January 2016-December 2016
White (non-Hispanic)	13.60%					
Black (non-Hispanic)	9.70%					
Asian or Pacific Islander (non-Hispanic)	14.60%					
American Indian/Alaska Native (non-Hispanic)	10.30%					
Other race (non-Hispanic)	13.30%					
Unknown race	12.40%					
Less than a high school diploma	8.00%					
With a high school diploma or GED	9.30%					
Some College/Associate Degree	11.40%					
Bachelor Degree	14.10%					
Graduate Degrees	15.20%					
Among individuals who had a full-term birth	12.10%					
Among individuals who had a pre-term birth	11.50%					
Among individuals who are not married	9.70%					
Among individuals who are married	13.70%					
Frequency of self-reported postpartum depressive symptoms 2017						MDPH 2019. CY18 Summary of Activities Related to Screening for Postpartum Depression
Rarely/Never	61.4%					
Often/Always	10.7%					
Sometimes	27.9%					
Communicable and Infectious Disease						
HIV prevalence (per 100,000 population 13 years and older)	355	234				National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention, 2019
STI infection cases (per 100,000)						Massachusetts Population Health Information Tool, 2018
Syphillis (case count)	1,164		0	18	13	
Gonorrhea (case count)	7,629		13	94	42	
Chlamydia	30,297		112	402	223	
Confirmed and probable Hepatitis B cases (per 100,000 population)	25.1	36.2				Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Hepatitis B Virus Infection 2020 Surveillance Report. https://www.mass.gov/lists/infectious-disease- data-reports-and-requests. Published February 2021
Rate of Hepatitis C (per 100,000)	97.9		31.7	89.3	92	Massachusetts Population Health Information Tool, 2018
Tuberculosis (case count)	204		0	6	No data	Massachusetts Population Health Information Tool, 2018
Medicare enrollees that had annual flu vaccination (%)	56%	59				Mapping Medicare Disparities, 2019

*Suppressed

	Massachusetts	Norfolk County	Area: Milton	Area: Quincy	Area: Randolph	Source
COVID-19 Community Impact Survey						MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole.
% very worried about getting infected with COVID-19		27%	21%	30%	35%	
% ever been tested for COVID		42%	41%	44%	49%	
% who have not gotten the medical care they needed since July 2020		14%	22%	21%	17%	
% with 15 or more of poor mental health days in the past 30 days		29%	33%	38%	28%	
% of substance users who said they are now using more substances than before the pandemic		39%	39%	41%	42%	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks		34%	39%	45%	55%	
% Worried about getting food or groceries in the coming weeks		19%	17%	21%	31%	
% Worried about getting face masks in the coming weeks		11%	6%	17%	18%	
% Worried about getting medication in the coming weeks		10%	5%	13%	15%	
% Worried about getting broadband in the coming weeks		8%	7%	12%	15%	
% of Employed residents who experienced job loss		8%	8%	5%	11%	
% of employed residents who experienced reduced work hours		11%	8%	10%	12%	
% Worried about paying mortgage, rent, or utilities related expenses		24%	20%	33%	49%	
% Worried they may have to move out of where they live in the next few months		14%	*	18%	16%	
Boston Indicators: COVID Community Data Lab						Boston Indicators
Unemployment claims (#) reported on 10/30/21	5,901					
Unemplyment rate as of 10/21/21	5.3%					
COVID-19 Layoff						Metropolitian Area Planning Council, The COVID-19 Layoff Housing Gap (October 2020)
Estimated number of households in need of assistance with no government aid (without any unmployment benefits)			215	1,719	657	
Unemployment claims (#)			1,021	7,207	2,802	

*Suppressed

	Massachusetts	Norfolk County	Community Benefits Service Area			Source
			Milton	Quincy	Randolph	
COVID-19 Community Impact Survey						MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole.
% very worried about getting infected with COVID-19		27%	21%	30%	35%	
% ever been tested for COVID		42%	41%	44%	49%	
% who have not gotten the medical care they needed since July 2020		14%	22%	21%	17%	
% with 15 or more of poor mental health days in the past 30 days		29%	33%	38%	28%	
% of substance users who said they are now using more substances than before the pandemic		39%	39%	41%	42%	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks		34%	39%	45%	55%	
% Worried about getting food or groceries in the coming weeks		19%	17%	21%	31%	
% Worried about getting face masks in the coming weeks		11%	6%	17%	18%	
% Worried about getting medication in the coming weeks		10%	5%	13%	15%	
% Worried about getting broadband in the coming weeks		8%	7%	12%	15%	
% of Employed residents who experienced job loss		8%	8%	5%	11%	
% of employed residents who experienced reduced work hours		11%	8%	10%	12%	
% Worried about paying mortgage, rent, or utilities related expenses		24%	20%	33%	49%	
% Worried they may have to move out of where they live in the next few months		14%	*	18%	16%	
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Estimated number of households in need of assistance with no government aid (without any unmployment benefits)			215	1,719	657	
Unemployment claims (#)			1,021	7,207	2,802	

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Milton

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

		BID Milton Community Benefits Service Area		
	MA	Milton	Quincy	Randolph
All Cause				
FY19 Inpatient Discharges (all cause) rate per 100,000	1,735	1,512	1,603	2,332
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-11%	-2%	40%
FY19 ED Volume (all cause) rate per 100,000	19,530	15,155	15,713	21,922
Change in ED Volume Rate FY17 to FY19	-1%	-17%	-6%	3%
Chronic Disease				
Asthma				
FY19 Inpatient Discharges rate per 100,000	333	403	311	546
Change in Inpatient Discharge Rate FY17 to FY19	-12%	-11%	2%	42%
FY19 ED Volume rate per 100,000	2,481	1,899	1,327	2,746
Change in ED Volume Rate FY17 to FY19	2%	-30%	0%	-21%
Diabetes Mellitus				
FY19 Inpatient Discharges rate per 100,000	53	67	29	44
Change in Inpatient Discharge Rate FY17 to FY19	7%	300%	-50%	50%
FY19 ED Volume rate per 100,000	117	50	35	148
Change in ED Volume Rate FY17 to FY19	-2%	200%	-45%	-62%
Obesity				
FY19 Inpatient Discharges rate per 100,000	61	17	35	89
Change in Inpatient Discharge Rate FY17 to FY19	6%	0%	-14%	50%
FY19 ED Volume rate per 100,000	81	0	47	74
Change in ED Volume Rate FY17 to FY19	0%	0%	300%	400%
Injuries and Infections				
Allergy				
FY19 Inpatient Discharges rate per 100,000	125	118	112	118
Change in Inpatient Discharge Rate FY17 to FY19	2%	0%	0%	14%
FY19 ED Volume rate per 100,000	1,874	1,512	1,274	1,683
Change in ED Volume Rate FY17 to FY19	-1%	-28%	-32%	1%
HIV Infection				
FY19 Inpatient Discharges rate per 100,000	1	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	18%	0%	0%	0%
FY19 ED Volume rate per 100,000	1	0	0	0
Change in ED Volume Rate FY17 to FY19	-23%	0%	0%	0%
Infections				
FY19 Inpatient Discharges rate per 100,000	767	605	810	1,048
Change in Inpatient Discharge Rate FY17 to FY19	-2%	-20%	6%	31%
FY19 ED Volume rate per 100,000	7,457	3,864	6,418	9,064
Change in ED Volume Rate FY17 to FY19	4%	-12%	0%	12%
Injuries				
FY19 Inpatient Discharges rate per 100,000	345	235	229	531
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-7%	-47%	50%
FY19 ED Volume rate per 100,000	7,024	7,359	6,483	7,381
Change in ED Volume Rate FY17 to FY19	-8%	-20%	-6%	-1%
Poisonings				
FY19 Inpatient Discharges rate per 100,000	85	17	70	133
Change in Inpatient Discharge Rate FY17 to FY19	-30%	-80%	-14%	0%
FY19 ED Volume rate per 100,000	501	185	211	413
Change in ED Volume Rate FY17 to FY19	32%	-15%	-20%	47%
Pneumonia/Influenza				
FY19 Inpatient Discharges rate per 100,000	213	437	223	251
Change in Inpatient Discharge Rate FY17 to FY19	3%	73%	-14%	70%
FY19 ED Volume rate per 100,000	1,098	874	940	1,432
Change in ED Volume Rate FY17 to FY19	38%	11%	12%	29%
Sexually Transmitted Diseases				
FY19 Inpatient Discharges rate per 100,000	4	0	6	0
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	0%	0%
FY19 ED Volume rate per 100,000	35	17	12	44
Change in ED Volume Rate FY17 to FY19	15%	0%	100%	50%
Other				
Attention Deficit Hyperactivity Disorder				
FY19 Inpatient Discharges rate per 100,000	141	118	88	148
Change in Inpatient Discharge Rate FY17 to FY19	-3%	133%	88%	400%
FY19 ED Volume rate per 100,000	588	353	341	384
Change in ED Volume Rate FY17 to FY19	17%	40%	57%	0%
Learning Disorders				

FY19 Inpatient Discharges rate per 100,000	135	67	70	148
Change in Inpatient Discharge Rate FY17 to FY19	12%	33%	-25%	100%
FY19 ED Volume rate per 100,000	103	34	123	162
Change in ED Volume Rate FY17 to FY19	84%	-67%	62%	83%
Mental Health				
FY19 Inpatient Discharges rate per 100,000	772	672	364	738
Change in Inpatient Discharge Rate FY17 to FY19	-5%	0%	11%	150%
FY19 ED Volume rate per 100,000	2,592	1,226	1,480	2,096
Change in ED Volume Rate FY17 to FY19	5%	-29%	27%	28%
Substance Use Disorders				
FY19 Inpatient Discharges rate per 100,000	53	34	35	30
Change in Inpatient Discharge Rate FY17 to FY19	-8%	100%	-14%	-50%
FY19 ED Volume rate per 100,000	343	118	276	44
Change in ED Volume Rate FY17 to FY19	-5%	-61%	31%	-50%
Complication of Medical Care				
FY19 Inpatient Discharges rate per 100,000	229	151	200	207
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-25%	3%	27%
FY19 ED Volume rate per 100,000	208	118	182	221
Change in ED Volume Rate FY17 to FY19	3%	-36%	3%	25%

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Milton

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

		BID Milton Community Benefits Service Area		
	MA	Milton	Quincy	Randolph
All Cause				
FY19 Inpatient Discharges (all cause) rate per 100,000	6,072	5,097	5,954	7,060
Change in Inpatient Discharge Rate FY17 to FY19	0%	1%	-1%	-1%
FY19 ED Volume (all cause) rate per 100,000	25,053	13,467	21,109	29,660
Change in ED Volume Rate FY17 to FY19	-1%	-10%	-3%	-7%
Cancer				
Breast Cancer				
FY19 Inpatient Discharges rate per 100,000	32	87	19	41
Change in Inpatient Discharge Rate FY17 to FY19	-10%	167%	-46%	-50%
FY19 ED Volume rate per 100,000	27	55	27	98
Change in ED Volume Rate FY17 to FY19	25%	400%	67%	33%
Colorectal Cancer				
FY19 Inpatient Discharges rate per 100,000	15	11	8	57
Change in Inpatient Discharge Rate FY17 to FY19	17%	0%	-67%	0%
FY19 ED Volume rate per 100,000	4	11	0	8
Change in ED Volume Rate FY17 to FY19	21%	0%	-100%	0%
GYN Cancer				
FY19 Inpatient Discharges rate per 100,000	41	22	30	24
Change in Inpatient Discharge Rate FY17 to FY19	11%	0%	-50%	-50%
FY19 ED Volume rate per 100,000	30	22	13	41
Change in ED Volume Rate FY17 to FY19	23%	-33%	-17%	150%
Lung Cancer				
FY19 Inpatient Discharges rate per 100,000	26	76	54	24
Change in Inpatient Discharge Rate FY17 to FY19	3%	17%	11%	-57%
FY19 ED Volume rate per 100,000	7	0	16	8
Change in ED Volume Rate FY17 to FY19	47%	0%	100%	0%
Prostate Cancer				
FY19 Inpatient Discharges rate per 100,000	1	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-15%	0%	0%	0%
FY19 ED Volume rate per 100,000	0	0	0	0
Change in ED Volume Rate FY17 to FY19	150%	0%	0%	0%
Other Cancer				
FY19 Inpatient Discharges rate per 100,000	304	458	344	261
Change in Inpatient Discharge Rate FY17 to FY19	2%	-5%	-3%	-45%
FY19 ED Volume rate per 100,000	142	153	145	73
Change in ED Volume Rate FY17 to FY19	29%	8%	108%	-47%
Chronic Disease				
Asthma				
FY19 Inpatient Discharges rate per 100,000	745	447	500	898
Change in Inpatient Discharge Rate FY17 to FY19	-5%	0%	3%	-15%
FY19 ED Volume rate per 100,000	2,649	1,626	1,594	3,926
Change in ED Volume Rate FY17 to FY19	3%	-30%	6%	-16%
Congestive Heart Failure				
FY19 Inpatient Discharges rate per 100,000	124	240	110	98
Change in Inpatient Discharge Rate FY17 to FY19	14%	100%	58%	100%
FY19 ED Volume rate per 100,000	56	131	48	41
Change in ED Volume Rate FY17 to FY19	42%	33%	-25%	67%
COPD and Lung Disease				
FY19 Inpatient Discharges rate per 100,000	136	131	121	131
Change in Inpatient Discharge Rate FY17 to FY19	-5%	200%	36%	-33%
FY19 ED Volume rate per 100,000	127	44	75	65
Change in ED Volume Rate FY17 to FY19	16%	-20%	-35%	-33%
Diabetes Mellitus				
FY19 Inpatient Discharges rate per 100,000	478	316	446	555
Change in Inpatient Discharge Rate FY17 to FY19	5%	81%	32%	-24%
FY19 ED Volume rate per 100,000	1,167	273	702	2,008
Change in ED Volume Rate FY17 to FY19	7%	-24%	-11%	32%
Heart Disease				
FY19 Inpatient Discharges rate per 100,000	445	491	384	449

Change in Inpatient Discharge Rate FY17 to FY19	6%	88%	55%	38%
FY19 ED Volume rate per 100,000	375	262	317	588
Change in ED Volume Rate FY17 to FY19	31%	140%	39%	177%
Hypertension				
FY19 Inpatient Discharges rate per 100,000	606	567	521	784
Change in Inpatient Discharge Rate FY17 to FY19	1%	86%	18%	-5%
FY19 ED Volume rate per 100,000	1,838	884	1,212	2,669
Change in ED Volume Rate FY17 to FY19	8%	-26%	-4%	12%
Liver Disease				
FY19 Inpatient Discharges rate per 100,000	427	207	438	555
Change in Inpatient Discharge Rate FY17 to FY19	15%	0%	14%	100%
FY19 ED Volume rate per 100,000	185	44	161	212
Change in ED Volume Rate FY17 to FY19	25%	-75%	-8%	160%
Obesity				
FY19 Inpatient Discharges rate per 100,000	919	524	683	1,314
Change in Inpatient Discharge Rate FY17 to FY19	6%	-13%	9%	1%
FY19 ED Volume rate per 100,000	530	142	253	571
Change in ED Volume Rate FY17 to FY19	11%	-19%	42%	-15%
Stroke and Other Neurovascular Diseases				
FY19 Inpatient Discharges rate per 100,000	71	65	78	114
Change in Inpatient Discharge Rate FY17 to FY19	9%	20%	45%	-18%
FY19 ED Volume rate per 100,000	28	44	38	24
Change in ED Volume Rate FY17 to FY19	11%	100%	180%	-57%
Injuries and Infections				
Allergy				
FY19 Inpatient Discharges rate per 100,000	553	262	331	514
Change in Inpatient Discharge Rate FY17 to FY19	13%	-27%	-28%	80%
FY19 ED Volume rate per 100,000	3,482	1,375	2,134	2,163
Change in ED Volume Rate FY17 to FY19	44%	114%	8%	48%
Hepatitis				
FY19 Inpatient Discharges rate per 100,000	344	240	417	261
Change in Inpatient Discharge Rate FY17 to FY19	-4%	57%	-20%	-11%
FY19 ED Volume rate per 100,000	195	33	269	196
Change in ED Volume Rate FY17 to FY19	1%	-50%	-14%	100%
HIV Infection				
FY19 Inpatient Discharges rate per 100,000	44	22	19	90
Change in Inpatient Discharge Rate FY17 to FY19	2%	0%	-30%	38%
FY19 ED Volume rate per 100,000	102	22	91	318
Change in ED Volume Rate FY17 to FY19	11%	-33%	3%	30%
Infections				
FY19 Inpatient Discharges rate per 100,000	1,534	1,331	1,433	1,869
Change in Inpatient Discharge Rate FY17 to FY19	2%	-1%	0%	2%
FY19 ED Volume rate per 100,000	5,547	3,132	4,212	6,913
Change in ED Volume Rate FY17 to FY19	-6%	-3%	-9%	-14%
Injuries				
FY19 Inpatient Discharges rate per 100,000	1,103	622	906	1,534
Change in Inpatient Discharge Rate FY17 to FY19	5%	10%	0%	34%
FY19 ED Volume rate per 100,000	7,762	5,260	6,948	10,529
Change in ED Volume Rate FY17 to FY19	-4%	-3%	-2%	-3%
Poisonings				
FY19 Inpatient Discharges rate per 100,000	189	76	210	196
Change in Inpatient Discharge Rate FY17 to FY19	-7%	17%	-12%	4%
FY19 ED Volume rate per 100,000	693	360	731	743
Change in ED Volume Rate FY17 to FY19	-8%	-20%	-22%	-3%
Pneumonia/Influenza				
FY19 Inpatient Discharges rate per 100,000	286	316	250	351
Change in Inpatient Discharge Rate FY17 to FY19	8%	107%	3%	19%
FY19 ED Volume rate per 100,000	588	524	532	1,004
Change in ED Volume Rate FY17 to FY19	27%	26%	49%	34%
Sexually Transmitted Diseases				
FY19 Inpatient Discharges rate per 100,000	80	55	83	114
Change in Inpatient Discharge Rate FY17 to FY19	-9%	-55%	3%	-7%
FY19 ED Volume rate per 100,000	262	142	204	718
Change in ED Volume Rate FY17 to FY19	15%	-24%	10%	6%
Tuberculosis				
FY19 Inpatient Discharges rate per 100,000	9	0	5	0
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	-50%	-100%

FY19 ED Volume rate per 100,000	5	0	5	16
Change in ED Volume Rate FY17 to FY19	0%	0%	-60%	100%
Other				
Dementia and Cognitive Disorders				
FY19 Inpatient Discharges rate per 100,000	177	120	164	253
Change in Inpatient Discharge Rate FY17 to FY19	9%	-8%	13%	-6%
FY19 ED Volume rate per 100,000	201	131	204	237
Change in ED Volume Rate FY17 to FY19	-11%	-14%	-1%	-15%
Mental Health				
FY19 Inpatient Discharges rate per 100,000	4,382	2,139	3,454	4,048
Change in Inpatient Discharge Rate FY17 to FY19	5%	2%	6%	19%
FY19 ED Volume rate per 100,000	7,907	2,532	6,752	6,260
Change in ED Volume Rate FY17 to FY19	16%	-3%	19%	1%
Parkinsons and Movement Disorders				
FY19 Inpatient Discharges rate per 100,000	41	33	35	57
Change in Inpatient Discharge Rate FY17 to FY19	-2%	50%	8%	75%
FY19 ED Volume rate per 100,000	95	120	83	57
Change in ED Volume Rate FY17 to FY19	-4%	450%	3%	-53%
Substance Use Disorders				
FY19 Inpatient Discharges rate per 100,000	2,012	666	1,667	1,992
Change in Inpatient Discharge Rate FY17 to FY19	-2%	3%	-4%	13%
FY19 ED Volume rate per 100,000	8,347	2,052	7,588	5,803
Change in ED Volume Rate FY17 to FY19	0%	-46%	1%	-29%
Complication of Medical Care				
FY19 Inpatient Discharges rate per 100,000	2,698	3,001	3,140	2,987
Change in Inpatient Discharge Rate FY17 to FY19	5%	-7%	1%	-1%
FY19 ED Volume rate per 100,000	582	273	379	571
Change in ED Volume Rate FY17 to FY19	14%	-11%	-13%	11%

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Milton

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

		BID Milton Community Benefits Service Area		
	MA	Milton	Quincy	Randolph
All Cause				
FY19 Inpatient Discharges (all cause) rate per 100,000	9,762	7,263	10,658	12,660
Change in Inpatient Discharge Rate FY17 to FY19	0%	13%	4%	0%
FY19 ED Volume (all cause) rate per 100,000	24,003	15,765	26,611	33,424
Change in ED Volume Rate FY17 to FY19	2%	-13%	11%	3%
Cancer				
Breast Cancer				
FY19 Inpatient Discharges rate per 100,000	258	195	193	304
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-26%	-35%	22%
FY19 ED Volume rate per 100,000	195	250	251	477
Change in ED Volume Rate FY17 to FY19	18%	-31%	8%	-4%
Colorectal Cancer				
FY19 Inpatient Discharges rate per 100,000	116	83	104	163
Change in Inpatient Discharge Rate FY17 to FY19	0%	-50%	-46%	-32%
FY19 ED Volume rate per 100,000	27	0	58	65
Change in ED Volume Rate FY17 to FY19	12%	-100%	150%	100%
GYN Cancer				
FY19 Inpatient Discharges rate per 100,000	182	83	185	347
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-57%	-6%	0%
FY19 ED Volume rate per 100,000	82	56	42	163
Change in ED Volume Rate FY17 to FY19	21%	-20%	-31%	-35%
Lung Cancer				
FY19 Inpatient Discharges rate per 100,000	358	292	440	282
Change in Inpatient Discharge Rate FY17 to FY19	5%	-40%	-6%	-48%
FY19 ED Volume rate per 100,000	97	83	127	76
Change in ED Volume Rate FY17 to FY19	21%	100%	-21%	17%
Prostate Cancer				
FY19 Inpatient Discharges rate per 100,000	133	223	108	141
Change in Inpatient Discharge Rate FY17 to FY19	-5%	23%	17%	-13%
FY19 ED Volume rate per 100,000	60	139	69	98
Change in ED Volume Rate FY17 to FY19	30%	25%	38%	0%
Other Cancer				
FY19 Inpatient Discharges rate per 100,000	1,984	1,670	2,441	2,821
Change in Inpatient Discharge Rate FY17 to FY19	3%	-18%	8%	4%
FY19 ED Volume rate per 100,000	597	543	586	846
Change in ED Volume Rate FY17 to FY19	27%	5%	43%	5%
Chronic Disease				
Asthma				
FY19 Inpatient Discharges rate per 100,000	1,051	821	925	1,334
Change in Inpatient Discharge Rate FY17 to FY19	-17%	26%	-13%	-5%
FY19 ED Volume rate per 100,000	1,944	1,503	1,616	3,113
Change in ED Volume Rate FY17 to FY19	0%	-24%	9%	-2%
Congestive Heart Failure				
FY19 Inpatient Discharges rate per 100,000	1,292	724	1,307	1,736
Change in Inpatient Discharge Rate FY17 to FY19	10%	4%	25%	-8%
FY19 ED Volume rate per 100,000	396	264	389	499
Change in ED Volume Rate FY17 to FY19	41%	58%	36%	-23%
COPD and Lung Disease				
FY19 Inpatient Discharges rate per 100,000	1,994	807	2,306	2,105
Change in Inpatient Discharge Rate FY17 to FY19	1%	16%	5%	-15%
FY19 ED Volume rate per 100,000	1,388	404	1,770	1,595
Change in ED Volume Rate FY17 to FY19	10%	12%	27%	0%
Diabetes Mellitus				
FY19 Inpatient Discharges rate per 100,000	2,808	1,531	2,587	4,253
Change in Inpatient Discharge Rate FY17 to FY19	3%	24%	8%	-1%
FY19 ED Volume rate per 100,000	4,109	2,449	3,767	7,149
Change in ED Volume Rate FY17 to FY19	10%	24%	40%	12%
Heart Disease				
FY19 Inpatient Discharges rate per 100,000	3,609	2,602	3,540	4,491
Change in Inpatient Discharge Rate FY17 to FY19	4%	4%	3%	-5%
FY19 ED Volume rate per 100,000	1,448	821	1,300	1,345
Change in ED Volume Rate FY17 to FY19	17%	-23%	0%	-2%
Hypertension				
FY19 Inpatient Discharges rate per 100,000	4,045	2,908	4,215	5,717
Change in Inpatient Discharge Rate FY17 to FY19	-2%	26%	2%	5%

FY19 ED Volume rate per 100,000	7,878	6,011	7,438	14,222
Change in ED Volume Rate FY17 to FY19	10%	-3%	36%	17%
Liver Disease				
FY19 Inpatient Discharges rate per 100,000	1,562	1,211	1,913	1,345
Change in Inpatient Discharge Rate FY17 to FY19	5%	58%	15%	-22%
FY19 ED Volume rate per 100,000	404	139	413	217
Change in ED Volume Rate FY17 to FY19	19%	-17%	16%	-26%
Obesity				
FY19 Inpatient Discharges rate per 100,000	2,410	1,489	2,179	3,352
Change in Inpatient Discharge Rate FY17 to FY19	5%	39%	-6%	8%
FY19 ED Volume rate per 100,000	675	264	455	738
Change in ED Volume Rate FY17 to FY19	17%	-30%	55%	-9%
Stroke and Other Neurovascular Diseases				
FY19 Inpatient Discharges rate per 100,000	443	376	490	683
Change in Inpatient Discharge Rate FY17 to FY19	2%	80%	20%	9%
FY19 ED Volume rate per 100,000	119	153	104	184
Change in ED Volume Rate FY17 to FY19	6%	120%	8%	13%
Injuries and Infections				
Allergy				
FY19 Inpatient Discharges rate per 100,000	1,314	654	1,049	1,117
Change in Inpatient Discharge Rate FY17 to FY19	20%	12%	-22%	-1%
FY19 ED Volume rate per 100,000	4,000	1,280	2,830	2,647
Change in ED Volume Rate FY17 to FY19	59%	53%	36%	110%
Hepatitis				
FY19 Inpatient Discharges rate per 100,000	492	111	760	325
Change in Inpatient Discharge Rate FY17 to FY19	-19%	-20%	-12%	-41%
FY19 ED Volume rate per 100,000	211	0	320	119
Change in ED Volume Rate FY17 to FY19	-11%	-100%	-20%	-27%
HIV Infection				
FY19 Inpatient Discharges rate per 100,000	157	56	208	282
Change in Inpatient Discharge Rate FY17 to FY19	-7%	100%	17%	0%
FY19 ED Volume rate per 100,000	236	153	413	488
Change in ED Volume Rate FY17 to FY19	-3%	38%	55%	13%
Infections				
FY19 Inpatient Discharges rate per 100,000	3,824	3,339	4,458	5,663
Change in Inpatient Discharge Rate FY17 to FY19	3%	21%	8%	2%
FY19 ED Volume rate per 100,000	3,618	2,685	3,540	4,676
Change in ED Volume Rate FY17 to FY19	-4%	-24%	-6%	0%
Injuries				
FY19 Inpatient Discharges rate per 100,000	3,425	2,658	3,937	4,361
Change in Inpatient Discharge Rate FY17 to FY19	6%	43%	9%	3%
FY19 ED Volume rate per 100,000	7,959	5,621	9,285	11,857
Change in ED Volume Rate FY17 to FY19	-2%	-21%	12%	14%
Poisonings				
FY19 Inpatient Discharges rate per 100,000	232	97	320	239
Change in Inpatient Discharge Rate FY17 to FY19	-7%	17%	2%	-8%
FY19 ED Volume rate per 100,000	395	181	424	412
Change in ED Volume Rate FY17 to FY19	5%	-13%	-18%	-16%
Pneumonia/Influenza				
FY19 Inpatient Discharges rate per 100,000	1,135	807	1,300	1,389
Change in Inpatient Discharge Rate FY17 to FY19	8%	45%	13%	-18%
FY19 ED Volume rate per 100,000	555	473	702	933
Change in ED Volume Rate FY17 to FY19	11%	0%	43%	10%
Sexually Transmitted Diseases				
FY19 Inpatient Discharges rate per 100,000	24	42	27	54
Change in Inpatient Discharge Rate FY17 to FY19	-3%	50%	40%	0%
FY19 ED Volume rate per 100,000	38	42	42	108
Change in ED Volume Rate FY17 to FY19	5%	0%	120%	0%
Tuberculosis				
FY19 Inpatient Discharges rate per 100,000	18	14	35	11
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	125%	0%
FY19 ED Volume rate per 100,000	6	0	12	0
Change in ED Volume Rate FY17 to FY19	7%	0%	0%	-100%
Other				
Dementia and Cognitive Disorders				
FY19 Inpatient Discharges rate per 100,000	868	877	964	1,269
Change in Inpatient Discharge Rate FY17 to FY19	10%	70%	39%	-2%
FY19 ED Volume rate per 100,000	325	348	332	315
Change in ED Volume Rate FY17 to FY19	-5%	108%	12%	-17%
Mental Health				
FY19 Inpatient Discharges rate per 100,000	7,268	3,604	7,558	7,203
Change in Inpatient Discharge Rate FY17 to FY19	4%	31%	3%	-8%
FY19 ED Volume rate per 100,000	6,209	1,350	7,623	4,686

Change in ED Volume Rate FY17 to FY19	17%	-22%	32%	-1%
Parkinsons and Movement Disorders				
FY19 Inpatient Discharges rate per 100,000	252	125	328	336
Change in Inpatient Discharge Rate FY17 to FY19	8%	-18%	33%	-16%
FY19 ED Volume rate per 100,000	185	195	231	228
Change in ED Volume Rate FY17 to FY19	5%	8%	40%	-5%
Substance Use Disorders				
FY19 Inpatient Discharges rate per 100,000	3,820	1,906	4,920	3,786
Change in Inpatient Discharge Rate FY17 to FY19	0%	32%	6%	-7%
FY19 ED Volume rate per 100,000	7,619	1,419	10,095	5,478
Change in ED Volume Rate FY17 to FY19	3%	-52%	20%	-32%
Complication of Medical Care				
FY19 Inpatient Discharges rate per 100,000	1,870	1,656	2,024	2,506
Change in Inpatient Discharge Rate FY17 to FY19	7%	9%	4%	-12%
FY19 ED Volume rate per 100,000	472	334	416	879
Change in ED Volume Rate FY17 to FY19	8%	-27%	-11%	7%

Community Health Needs Assessment - Beth Israel Deaconess Hospital - Milton

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

		BID Milton Community Benefits Service Area		
	MA	Milton	Quincy	Randolph
All Cause				
FY19 Inpatient Discharges (all cause) rate per 100,000	25,473	25,146	25,887	29,756
Change in Inpatient Discharge Rate FY17 to FY19	5%	10%	7%	12%
FY19 ED Volume (all cause) rate per 100,000	26,010	26,747	26,860	30,061
Change in ED Volume Rate FY17 to FY19	10%	-7%	10%	6%
Cancer				
Breast Cancer				
FY19 Inpatient Discharges rate per 100,000	1,253	1,656	1,303	1,407
Change in Inpatient Discharge Rate FY17 to FY19	6%	112%	33%	54%
FY19 ED Volume rate per 100,000	480	764	557	560
Change in ED Volume Rate FY17 to FY19	42%	-19%	51%	-39%
Colorectal Cancer				
FY19 Inpatient Discharges rate per 100,000	271	237	353	237
Change in Inpatient Discharge Rate FY17 to FY19	2%	-50%	2%	40%
FY19 ED Volume rate per 100,000	42	36	68	17
Change in ED Volume Rate FY17 to FY19	9%	-60%	33%	-50%
GYN Cancer				
FY19 Inpatient Discharges rate per 100,000	508	400	427	729
Change in Inpatient Discharge Rate FY17 to FY19	6%	-12%	-29%	19%
FY19 ED Volume rate per 100,000	145	218	210	237
Change in ED Volume Rate FY17 to FY19	47%	-60%	28%	100%
Lung Cancer				
FY19 Inpatient Discharges rate per 100,000	1,347	1,346	1,615	1,390
Change in Inpatient Discharge Rate FY17 to FY19	9%	85%	6%	9%
FY19 ED Volume rate per 100,000	282	309	410	288
Change in ED Volume Rate FY17 to FY19	26%	70%	9%	-6%
Prostate Cancer				
FY19 Inpatient Discharges rate per 100,000	1,270	1,492	1,081	1,373
Change in Inpatient Discharge Rate FY17 to FY19	6%	24%	3%	-9%
FY19 ED Volume rate per 100,000	434	819	375	627
Change in ED Volume Rate FY17 to FY19	36%	36%	-8%	-5%
Other Cancer				
FY19 Inpatient Discharges rate per 100,000	7,146	8,588	7,918	7,019
Change in Inpatient Discharge Rate FY17 to FY19	13%	31%	7%	8%
FY19 ED Volume rate per 100,000	1,519	1,856	1,701	1,306
Change in ED Volume Rate FY17 to FY19	33%	-16%	12%	-3%
Chronic Disease				
Asthma				
FY19 Inpatient Discharges rate per 100,000	1,596	1,128	1,047	1,814
Change in Inpatient Discharge Rate FY17 to FY19	-16%	-36%	-29%	-21%
FY19 ED Volume rate per 100,000	1,257	1,183	1,007	1,560
Change in ED Volume Rate FY17 to FY19	8%	-27%	-4%	-25%
Congestive Heart Failure				
FY19 Inpatient Discharges rate per 100,000	8,161	7,169	8,180	9,342
Change in Inpatient Discharge Rate FY17 to FY19	9%	13%	17%	14%
FY19 ED Volume rate per 100,000	1,705	1,274	1,490	1,594
Change in ED Volume Rate FY17 to FY19	34%	-29%	16%	-19%
COPD and Lung Disease				
FY19 Inpatient Discharges rate per 100,000	7,130	5,131	7,423	7,308
Change in Inpatient Discharge Rate FY17 to FY19	5%	11%	3%	8%
FY19 ED Volume rate per 100,000	2,422	1,674	2,867	2,085
Change in ED Volume Rate FY17 to FY19	18%	-26%	11%	-8%
Diabetes Mellitus				
FY19 Inpatient Discharges rate per 100,000	8,376	6,951	7,878	12,208
Change in Inpatient Discharge Rate FY17 to FY19	5%	9%	5%	7%
FY19 ED Volume rate per 100,000	5,867	5,222	5,307	8,783
Change in ED Volume Rate FY17 to FY19	18%	-10%	26%	1%
Heart Disease				
FY19 Inpatient Discharges rate per 100,000	18,344	15,575	17,042	18,600
Change in Inpatient Discharge Rate FY17 to FY19	6%	1%	10%	-1%
FY19 ED Volume rate per 100,000	3,975	2,675	3,538	3,188
Change in ED Volume Rate FY17 to FY19	16%	-43%	-1%	-34%
Hypertension				
FY19 Inpatient Discharges rate per 100,000	10,397	11,172	10,193	12,394

Change in Inpatient Discharge Rate FY17 to FY19	-1%	2%	-1%	3%
FY19 ED Volume rate per 100,000	12,665	15,611	12,867	17,447
Change in ED Volume Rate FY17 to FY19	14%	-7%	18%	10%
Liver Disease				
FY19 Inpatient Discharges rate per 100,000	1,956	1,583	2,304	2,475
Change in Inpatient Discharge Rate FY17 to FY19	16%	0%	31%	29%
FY19 ED Volume rate per 100,000	258	200	290	220
Change in ED Volume Rate FY17 to FY19	36%	-21%	50%	0%
Obesity				
FY19 Inpatient Discharges rate per 100,000	3,869	2,711	3,339	5,086
Change in Inpatient Discharge Rate FY17 to FY19	14%	19%	-5%	50%
FY19 ED Volume rate per 100,000	367	73	216	407
Change in ED Volume Rate FY17 to FY19	26%	-60%	90%	60%
Stroke and Other Neurovascular Diseases				
FY19 Inpatient Discharges rate per 100,000	2,064	1,929	1,849	2,425
Change in Inpatient Discharge Rate FY17 to FY19	5%	-4%	0%	-3%
FY19 ED Volume rate per 100,000	380	491	427	560
Change in ED Volume Rate FY17 to FY19	10%	0%	44%	-13%
Injuries and Infections				
Allergy				
FY19 Inpatient Discharges rate per 100,000	3,711	1,929	2,042	2,865
Change in Inpatient Discharge Rate FY17 to FY19	32%	80%	-18%	46%
FY19 ED Volume rate per 100,000	5,138	1,419	2,241	2,001
Change in ED Volume Rate FY17 to FY19	88%	152%	58%	269%
Hepatitis				
FY19 Inpatient Discharges rate per 100,000	273	146	472	644
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	-7%	27%
FY19 ED Volume rate per 100,000	70	0	102	34
Change in ED Volume Rate FY17 to FY19	36%	-100%	80%	-33%
HIV Infection				
FY19 Inpatient Discharges rate per 100,000	53	109	34	102
Change in Inpatient Discharge Rate FY17 to FY19	2%	500%	100%	200%
FY19 ED Volume rate per 100,000	47	127	63	68
Change in ED Volume Rate FY17 to FY19	34%	-22%	267%	-20%
Infections				
FY19 Inpatient Discharges rate per 100,000	12,591	13,137	13,419	16,480
Change in Inpatient Discharge Rate FY17 to FY19	6%	4%	-2%	14%
FY19 ED Volume rate per 100,000	4,213	4,585	4,266	4,374
Change in ED Volume Rate FY17 to FY19	3%	6%	4%	-6%
Injuries				
FY19 Inpatient Discharges rate per 100,000	11,877	11,463	11,661	11,292
Change in Inpatient Discharge Rate FY17 to FY19	15%	18%	15%	11%
FY19 ED Volume rate per 100,000	10,393	9,498	11,741	10,088
Change in ED Volume Rate FY17 to FY19	11%	-27%	11%	-14%
Poisonings				
FY19 Inpatient Discharges rate per 100,000	281	200	427	271
Change in Inpatient Discharge Rate FY17 to FY19	7%	-21%	27%	78%
FY19 ED Volume rate per 100,000	185	127	188	441
Change in ED Volume Rate FY17 to FY19	27%	-13%	106%	160%
Pneumonia/Influenza				
FY19 Inpatient Discharges rate per 100,000	4,188	3,475	4,295	5,036
Change in Inpatient Discharge Rate FY17 to FY19	0%	-7%	-4%	11%
FY19 ED Volume rate per 100,000	569	528	796	882
Change in ED Volume Rate FY17 to FY19	1%	-28%	31%	24%
Sexually Transmitted Diseases				
FY19 Inpatient Discharges rate per 100,000	30	73	51	85
Change in Inpatient Discharge Rate FY17 to FY19	9%	300%	50%	400%
FY19 ED Volume rate per 100,000	5	18	0	0
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	0%
Tuberculosis				
FY19 Inpatient Discharges rate per 100,000	52	36	125	119
Change in Inpatient Discharge Rate FY17 to FY19	-11%	-60%	16%	40%
FY19 ED Volume rate per 100,000	6	0	17	17
Change in ED Volume Rate FY17 to FY19	13%	-100%	200%	0%
Other				
Dementia and Cognitive Disorders				
FY19 Inpatient Discharges rate per 100,000	6,264	6,605	6,445	8,393
Change in Inpatient Discharge Rate FY17 to FY19	6%	3%	7%	18%
FY19 ED Volume rate per 100,000	2,053	2,020	2,457	2,052
Change in ED Volume Rate FY17 to FY19	11%	-19%	13%	12%
Mental Health				
FY19 Inpatient Discharges rate per 100,000	10,900	8,206	10,171	9,512

Change in Inpatient Discharge Rate FY17 to FY19	15%	18%	16%	19%
FY19 ED Volume rate per 100,000	3,500	1,510	3,094	1,763
Change in ED Volume Rate FY17 to FY19	35%	-7%	24%	14%
Parkinsons and Movement Disorders				
FY19 Inpatient Discharges rate per 100,000	1,523	1,346	1,411	1,831
Change in Inpatient Discharge Rate FY17 to FY19	10%	-15%	9%	44%
FY19 ED Volume rate per 100,000	602	782	739	441
Change in ED Volume Rate FY17 to FY19	11%	10%	33%	4%
Substance Use Disorders				
FY19 Inpatient Discharges rate per 100,000	2,956	1,947	3,720	2,950
Change in Inpatient Discharge Rate FY17 to FY19	13%	19%	28%	13%
FY19 ED Volume rate per 100,000	2,258	619	2,833	1,356
Change in ED Volume Rate FY17 to FY19	22%	-63%	30%	-34%
Complication of Medical Care				
FY19 Inpatient Discharges rate per 100,000	4,867	5,240	5,279	5,968
Change in Inpatient Discharge Rate FY17 to FY19	13%	25%	16%	18%
FY19 ED Volume rate per 100,000	835	1,019	785	933
Change in ED Volume Rate FY17 to FY19	9%	-8%	-14%	-18%

Notes:

Population counts: Sg2 Claritas Demographic Data, 2021.

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

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

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

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

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

Community Health Survey

- BID Milton Community Health Survey
- Survey output
- Survey Distribution Channels

Beth Israel Lahey Health

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

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

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

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

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

Time in Community

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

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

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

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

Your Community

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

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

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

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

Social + Cultural Environment

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

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

Natural + Built Environment

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

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

Economic + Educational Environment

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

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

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

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

Health + Access to care

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

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

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

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

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

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

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

_____

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

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

Experiences with Discrimination

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

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

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

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

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

_____

_____

_____

About You

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

17. What is your age?

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

18. What is your current gender identity?

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

19. What is your sexual orientation?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First Name and Email or Phone:

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

Email:

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

Next
Back
Done

BID Milton Community Health Survey Output

Response Counts

Completion Rate:	**100%**	
	Complete	513

Totals: 513

1. Select a language.

Value	Percent	Responses
Take the survey in English	79.8%	406
参加简体中文调查	18.9%	96
參加繁體中文調查	1.0%	5
Tham gia khảo sát bằng tiếng Việt	0.4%	2

Totals: 509

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

Response
02186
02368
02169
02170
02171

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

Value	Percent	Responses
Less than 1 year	1.4%	7
1-5 years	14.4%	73
6-10 years	20.1%	102
Over 10 years but not all my life	51.2%	260
I have lived here all my life	9.4%	48
I used to live here, but not anymore	1.4%	7
I have never lived here	2.2%	11

Totals: 508

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

Value	Percent	Responses
Less than 1 year	4.6%	23
1-5 years	16.1%	81
6-10 years	16.5%	83
Over 10 years	20.7%	104
I do not work here	42.1%	212

Totals: 503

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
I feel like I belong in my community. Count Row %	8 1.6%	28 5.6%	276 55.4%	168 33.7%	18 3.6%	498
Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.) Count Row %	7 1.4%	44 8.8%	277 55.5%	158 31.7%	13 2.6%	499
My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play) Count Row %	13 2.6%	58 11.7%	235 47.4%	147 29.6%	43 8.7%	496
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 %	16 3.2%	66 13.1%	259 51.3%	142 28.1%	22 4.4%	505
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). Count Row %	12 2.4%	42 8.3%	271 53.7%	151 29.9%	29 5.7%	505
Totals Total Responses						505

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

Value	Percent	Responses
Better access to good jobs	18.8%	95
Better access to health care	23.6%	119
Better access to healthy food	21.2%	107
Better access to internet	13.3%	67
Better access to public transportation	27.1%	137
Better parks and recreation	19.2%	97
Better roads	32.3%	163
Better schools	30.7%	155
Better sidewalks and trails	24.4%	123
Cleaner environment	23.2%	117
Lower crime and violence	25.0%	126
More affordable childcare	14.3%	72
More affordable housing	35.8%	181
More arts and cultural events	24.6%	124
More effective city services (like water, trash, fire department, and police)	10.3%	52
More inclusion for diverse members of the community	21.8%	110
Stronger community leadership	15.0%	76
Stronger sense of community	14.3%	72
Other	5.1%	26

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
There are people and/or organizations in my community that support me during times of stress and need. Count Row %	14 2.8%	56 11.1%	272 54.0%	91 18.1%	71 14.1%	504
I believe that all residents, including myself, can make the community a better place to live. Count Row %	6 1.2%	4 0.8%	267 52.8%	217 42.9%	12 2.4%	506
During COVID-19, information I need to stay healthy and safe has been readily available in my community. Count Row %	12 2.3%	20 3.9%	234 45.8%	224 43.8%	21 4.1%	511
During COVID-19, resources I need to stay healthy and safe have been readily available in my community. Count Row %	11 2.2%	26 5.1%	236 46.5%	209 41.2%	25 4.9%	507
Totals Total Responses						511

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

	True	Somewhat True	Not At All True	Don't Know	Responses
My community feels safe. Count Row %	289 56.3%	201 39.2%	17 3.3%	6 1.2%	513
People like me have access to safe, clean parks and open spaces. Count Row %	322 63.6%	157 31.0%	16 3.2%	11 2.2%	506
People like me have access to reliable transportation. Count Row %	274 54.3%	168 33.3%	46 9.1%	17 3.4%	505
People like me have housing that is safe and good quality. Count Row %	332 65.5%	137 27.0%	21 4.1%	17 3.4%	507
The air in my community is healthy to breathe. Count Row %	319 62.7%	158 31.0%	12 2.4%	20 3.9%	509
The water in my community is safe to drink. Count Row %	259 50.8%	156 30.6%	69 13.5%	26 5.1%	510
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards. Count Row %	185 36.5%	141 27.8%	36 7.1%	145 28.6%	507
During extreme heat, people like me have access to options for staying cool. Count Row %	274 54.0%	116 22.9%	39 7.7%	78 15.4%	507
Totals Total Responses					513

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

	True	Somewhat True	Not At All True	Don't Know	Responses
People like me have access to good local jobs with living wages and benefits. Count Row %	180 36.2%	163 32.8%	56 11.3%	98 19.7%	497
People like me have access to local investment opportunities, such as owning homes or businesses. Count Row %	213 42.8%	171 34.3%	55 11.0%	59 11.8%	498
Housing in my community is affordable for people with different income levels. Count Row %	101 20.0%	172 34.1%	184 36.5%	47 9.3%	504
People like me have access to affordable childcare services. Count Row %	84 17.1%	144 29.3%	60 12.2%	204 41.5%	492
People like me have access to good education for their children. Count Row %	213 43.4%	154 31.4%	43 8.8%	81 16.5%	491
Totals Total Responses					504

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

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Responses
The built, economic, and educational environments in my community are impacted by **systemic racism.** This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row %	59 11.7%	106 20.9%	134 26.5%	159 31.4%	48 9.5%	506
The built, economic, and educational environments in my community are impacted by **individual racism.** This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row %	47 9.3%	94 18.6%	165 32.7%	168 33.3%	31 6.1%	505
Totals Total Responses						506

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

	True	Somewhat True	Not at all True	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	271 54.0%	154 30.7%	38 7.6%	39 7.8%	502
Health care in my community meets the mental health needs of people like me. Count Row %	162 32.3%	138 27.5%	77 15.4%	124 24.8%	501
Totals Total Responses					502

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

	I needed this type of care and was able to access it.	I needed this type of care but was not able to access it.	I did not need this type of care.	Responses
Routine medical care Count Row %	436 86.3%	26 5.1%	43 8.5%	505
Dental (mouth) care Count Row %	416 82.9%	33 6.6%	53 10.6%	502
Mental health care Count Row %	116 23.5%	61 12.4%	316 64.1%	493
Reproductive health care Count Row %	114 23.2%	24 4.9%	353 71.9%	491
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	48 9.7%	29 5.9%	417 84.4%	494
Treatment for a substance use disorder Count Row %	56 11.3%	20 4.0%	418 84.6%	494
Vision care Count Row %	352 70.1%	40 8.0%	110 21.9%	502
Medication for a chronic illness Count Row %	223 44.7%	19 3.8%	257 51.5%	499
Totals Total Responses				505

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

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed	Responses
Routine medical care	80	12	11	55	5	1	50	214
Count	37.4%	5.6%	5.1%	25.7%	2.3%	0.5%	23.4%	
Row %								
Dental care	58	29	6	64	2	2	45	206
Count	28.2%	14.1%	2.9%	31.1%	1.0%	1.0%	21.8%	
Row %								
Mental health care	38	41	5	23	14	4	72	197
Count	19.3%	20.8%	2.5%	11.7%	7.1%	2.0%	36.5%	
Row %								
Reproductive health care	23	11	7	54	2	5	59	161
Count	14.3%	6.8%	4.3%	33.5%	1.2%	3.1%	36.6%	
Row %								
Emergency care for a mental health crisis, including suicidal thoughts	29	34	7	19	9	2	67	167
Count	17.4%	20.4%	4.2%	11.4%	5.4%	1.2%	40.1%	
Row %								
Treatment for a substance use disorder	18	14	5	53	6	1	59	156
Count	11.5%	9.0%	3.2%	34.0%	3.8%	0.6%	37.8%	
Row %								
Vision care	42	15	7	56	3	3	53	179
Count	23.5%	8.4%	3.9%	31.3%	1.7%	1.7%	29.6%	
Row %								
Medication for a chronic illness	23	41	5	29	7	2	54	161
Count	14.3%	25.5%	3.1%	18.0%	4.3%	1.2%	33.5%	
Row %								

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed	Responses
Totals								
Total Responses								214

ResponseID	Response
10986	时间安排对不上，要等的时间较长
11008	暂不需要
11178	我不需要
11203	I go to Boston doctors perception is care is bettter
11319	Reproductive = insurance wouldn't work with me / Mental health crisis = kept me in the ER when I needed a bed in a psychiatric facility
11370	These were not valid response. Limited mental health workers was the only concern
11797	No providers available for new patients
12353	Did not need it

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

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Responses
Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row %	84 17.0%	103 20.8%	150 30.3%	128 25.9%	30 6.1%	495
Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row %	76 15.5%	110 22.5%	175 35.8%	116 23.7%	12 2.5%	489
Totals Total Responses						495

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

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Responses
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise. Count Row %	354 78.0%	66 14.5%	25 5.5%	6 1.3%	1 0.2%	2 0.4%	454
You are unfairly stopped, searched, questioned, threatened, or abused by the police. Count Row %	403 84.5%	43 9.0%	20 4.2%	10 2.1%	1 0.2%	0 0.0%	477
You receive worse service than other people at stores, restaurants, or service providers. Count Row %	324 67.8%	70 14.6%	62 13.0%	17 3.6%	5 1.0%	0 0.0%	478
Landlords or realtors refused to rent or sell you an apartment or house. Count Row %	401 86.4%	35 7.5%	18 3.9%	6 1.3%	4 0.9%	0 0.0%	464
Healthcare providers treat you with less respect or provide worse services to you compared to other people. Count Row %	370 78.7%	55 11.7%	36 7.7%	7 1.5%	2 0.4%	0 0.0%	470
Totals Total Responses							478

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

Value	Percent	Responses
Ableism (discrimination on the basis of disability)	5.5%	6
Ageism (discrimination on the basis of age)	17.3%	19
Discrimination based on income or education level	10.9%	12
Discrimination based on the basis of weight or body size	9.1%	10
Homophobia (discrimination against gay, lesbian, bisexual, or queer people)	9.1%	10
Racism (discrimination on the basis of racial or ethnic group identity)	52.7%	58
Sexism (discrimination on the basis of sex)	16.4%	18
Transphobia (discrimination against transgender or gender non-binary people)	10.0%	11
Xenophobia (discrimination against people born in another country)	20.0%	22
Don't know	9.1%	10
Prefer not to answer	1.8%	2

20. What is your age?

Value	Percent	Responses
Under 18	1.4%	7
18-24	2.7%	14
25-44	30.8%	157
45-64	29.6%	151
65-74	18.4%	94
75-84	10.8%	55
85 and over	4.7%	24
Prefer not to answer	1.6%	8

Totals: 510

21. What is your current gender identity?

Value	Percent	Responses
Genderqueer or gender non-conforming	0.2%	1
Man	24.1%	121
Woman	75.5%	380
Prefer to self-describe:	0.2%	1

Totals: 503

22. What is your sexual orientation?

Value	Percent	Responses
Bisexual	3.2%	16
Gay or lesbian	1.8%	9
Straight/heterosexual	88.0%	440
Prefer to self-describe:	0.4%	2
Prefer not to answer	6.6%	33

Totals: 500

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

Value	Percent	Responses
American Indian or Alaska Native	5.5%	28
Asian	9.9%	50
Black or African American	13.8%	70
Hispanic/Latino	3.4%	17
Native Hawaiian or Other Pacific Islander	0.4%	2
White	60.7%	307
Not listed above/Other:	2.2%	11
Prefer not to answer	6.3%	32

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

Value	Percent	Responses
African American	10.3%	48
American	50.0%	233
Caribbean Islander (specify):	3.2%	15
Chinese	8.4%	39
European (specify):	18.7%	87
Other (specify):	4.9%	23
Unknown/Not specified	3.0%	14
African (specify):	0.6%	3
Brazilian	0.2%	1
Cape Verdean	0.9%	4
Colombian	0.2%	1
Cuban	0.4%	2
Dominican	0.6%	3
Guatemalan	0.2%	1
Haitian	1.7%	8
Indian	0.4%	2
Korean	0.2%	1
Middle Eastern (specify):	0.9%	4
Portuguese	1.7%	8
Puerto Rican	1.3%	6
Russian	0.4%	2
Vietnamese	1.7%	8

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

Value	Percent	Responses
Armenian	2.4%	12
Cape Verdean Creole	0.2%	1
Chinese (including Mandarin and Cantonese)	7.5%	38
English	89.2%	453
Haitian Creole	1.4%	7
Portuguese	0.6%	3
Spanish	1.8%	9
Vietnamese	1.4%	7
Other (specify):	0.2%	1
Prefer not to answer	1.2%	6

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

Value	Percent	Responses
Grades 1 through 8	2.2%	11
Grades 9 through 11/ Some high school	3.1%	16
Grade 12/Completed high school or GED	8.1%	41
Some college, Associates Degree, or Technical Degree	22.8%	116
Bachelor's Degree	29.1%	148
Any post graduate studies	32.8%	167
Prefer not to answer	2.0%	10

Totals: 509

27. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	45.9%	232
Employed part-time (Less than 40 hours per week)	12.5%	63
Self-employed (Full- or part-time)	4.4%	22
A stay at home parent	1.0%	5
A student (Full- or part-time)	2.4%	12
Unemployed	1.4%	7
Unable to work for health reasons	2.0%	10
Retired	28.3%	143
Other (specify):	1.2%	6
Prefer not to answer	1.0%	5

Totals: 505

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

Value	Percent	Responses
Less than one year	0.2%	1
1 to 3 years	1.6%	8
4 to 6 years	6.3%	32
More than 6 years, but not my whole life	16.4%	83
I have always lived in the United States	74.0%	375
Prefer not to answer	1.6%	8

Totals: 507

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

Value	Percent	Responses
Never served in the military	91.7%	463
On active duty now (in any branch)	0.4%	2
On active duty in the past, but not now (includes retirement from any branch)	5.5%	28
Prefer not to answer	2.4%	12

Totals: 505

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

Value	Percent	Responses
Yes	11.7%	58
No	83.3%	414
Prefer not to answer	5.0%	25

Totals: 497

31. How would you describe your current housing situation?

Value	Percent	Responses
I rent my home	18.4%	93
I own my home	69.2%	350
I am staying with another household	4.3%	22
I am experiencing homelessness or staying in a shelter	0.4%	2
Other (specify):	4.9%	25
Prefer not to answer	2.8%	14

Totals: 506

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

Value	Percent	Responses
Yes	28.4%	143
No	69.8%	351
Prefer not to answer	1.8%	9

Totals: 503

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

Value	Percent	Responses
0-3 years	23.9%	34
4-5 years	20.4%	29
6-10 years	40.1%	57
11-14 years	26.8%	38
15-17 years	25.4%	36

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

Value	Percent	Responses
My neighborhood or building	63.0%	301
Faith community (such as a church, mosque, temple, or faith-based organization)	30.3%	145
School community (such as a college or education program that you attend, or a school that you child attends)	23.8%	114
Work community (such as your place of employment, or a professional association)	45.0%	215
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)	17.8%	85
A shared interest group (such as a club, sports team, political group, or advocacy group)	32.8%	157
Another city or town where I do not live	14.9%	71
Other (Feel free to share):	3.3%	16

Beth Israel Lahey Health

Survey Distribution Channels: Global View Communications

Engaging with Diverse Communities

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

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

Our Approach

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

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

Channels

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

1. Print

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

A. El Mundo – Spanish Translation

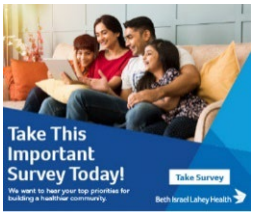
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

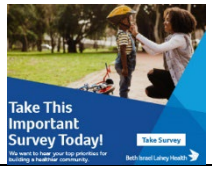
D. Bay State Banner – Black/African American, Cape Verdean/English

E. Chelsea Record – Hispanic/English

F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



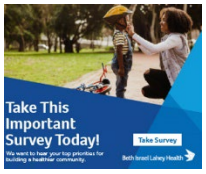
For the printed newspapers the publish dates are as follows:

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

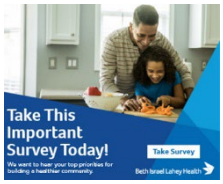
2. Digital Advertising

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

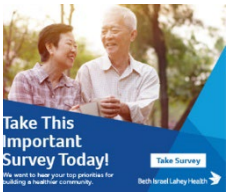
A. African American/Black, Haitian, Cape Verdean



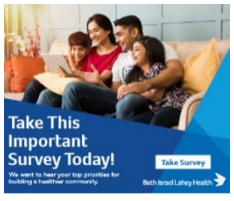
B. Hispanic



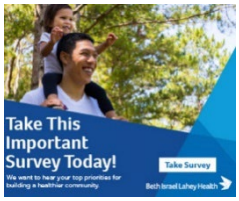
C. Chinese



D. Indian



E. Vietnamese



C. Precision Audio

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

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

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

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

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

BID Milton Survey Distribution Channels: Community Partners

Organization	Promotion other than flyers or print (e.g., Social Media, Newsletter, other Electronic Publication, etc.)	Contact Person/Name	Title (if Applicable)
A New Way Recovery Center		Warren Nicoli	Program Director
Aspire Health Alliance		Marian Girouard Spino	Chief System Integration & Quality Officer
Bay State Community Services	Social media	Ashley Stockwell	Program Director
Blue Hills Community Health Alliance (CHNA 20)	Social media	Ashley Stockwell	Program Director
City of Quincy		Marli Cassli,	Commissioner of Public Health
Domestic Violence Ended, Inc. (DOVE)		Sue Chandler	Executive Director
Enhance Asian Communities on Health (EACH)		Sara Tan	Executive Director
Equity and Justice for All Committee		Chris Hart/Patricia Lattimore	co-chairs, community members
Father Bill's & Mainspring House		Taylor DeSanty/Kimberly Skellet	Triage Directors
First Baptist Church		Rev. Baffour Nkrumah-Appiah	Senior Pastor
Fuller Village		Julia McMahon	Program Director
Interfaith Social Services		Rick Doane	Executive Director
Manet Community Health Center		Cynthia Sierra	CEO
May Institute		Matt Riley	Executive Director
Metropolitan Area Planning Council		Heidi Stucker	Senior Public Health Planner
Milton Board of Health		Caroline Kinsella	Director of Public Health
Milton Chamber of Commerce	presented at chamber meeting, chamber e-newsletter	Joel Paravechio	Chamber President
Milton Council on Aging	newsletter	Christine Stanton/ Katie O'Brien	Executive Director/Outreach Coordinator
Milton Early Childhood Alliance (MECA)	social media	Susan Dolan	Director
Milton Housing Authority		Brian Tatro	Executive Director, Milton Housing Authority
Milton Public Library	e-newsletter	Sally Lawler	Asst. Director
Milton Public Schools		James Jette	Superintendent, Miltoon Public Schools
Milton Substance Abuse Prevention Coalition	social media, e-newsletter	Stormy Leung/Margaret Carels	Co-directors, Milton Substance Abuse Prevention Coalition
Milton Youth Advocates for Change		Stormy Leung	Co-director, Milton Substance Abuse Prevention Coalition
N/A		Christine Tangishaka	community champion
N/A		Keith Wortzman	community member
NA		Laurie Stillman	community champion
Quincy Asian Resources, Inc. (QARI)	social media	Tina Ho/ Phil Chong	Integrated Service Lead Family and Community Service/CEO
Quincy Chambers of Commerce		Paula Pecevich	Creative & Marketing Director
Quincy Commission for Disabilities		Jeannette Kutash	community member
Quincy Community Action Programs (QCAP)		Kristen Schlapp	Chief Operating Officer
Quincy Diversity, Equity and Inclusion (DEI) Commission		Jeannette Kutash	community member
Quincy Family Resource Center		Melissa Harrison	Program Director
Quincy Housing Authority		Christine Cunningham	Family Resident Service Coordinator
Quincy LGBTQ Commission		Garret Nicols	Chair
Quincy Public Schools		Rita Bailey	Coordinator of Health Services
Randolph Chambers of Commerce	chamber e-newsletter	Jeannette Travaline	Executive Director
Randolph Community Partnerships		Susan Hearn	Executive Director
Randolph Community Wellness Plan	email	Heidi Stucker	Senior Public Health Planner
Randolph Educational Collaborative		Jean Brewster	Director
Randolph Intergenerational Center	town website/newsletter	Liz LaRosee/Keri Sullivan	Director of Library, Recreation, and Community Programs/Director of Elder Affairs Town of Randolph
Randolph Public Schools		Hanna Walsh	Director of Language Acquisition and World Languages
Signature Healthcare		Hilary Lovell	Manager Marketing, Provider & Community Relations
Simon Fireman Community		Stephanie Small	Executive Director
South Shore Elder Services	printed copies delivered w/Meals on Wheels participants	Betty Maxwell/Tim Carey	Director of Clinical Practice/Director of Program Development
South Shore YMCA		Katelyn Szafir	Executive Director
Southwest Community Food Center, QCAP		Melinda Alexander	Coordinator
Spring of Water Church		Karen Ricketts	Pastor
St. Bernadettes Parish (Randolph)		Denise Daley	Assistant
Town of Randolph		Michelle Tyler/Peggy Montlouis	Planner Town of Randolph/ Community Health Educator
United Parkway Methodist Church		Stephane Campbell	community member

Appendix C:
Resource Inventory

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

Beth Israel Deaconess Milton Community Resource List

Community Benefits Service Area includes: Milton, Quincy and Randolph

Health Issue	Organization	Brief Description	Address	Phone	Website
Statewide Resources	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	www.projectbread.org/get-help
	SafeLink	Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence.		877.785.2020	www.casamyrna.org/get-support/safelink
	SAMHSA's National Helpline	Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders.		800.662.HELP (4357)	www.samhsa.gov/find-help/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		800.273.8255	www.veteranscrisisline.net
Domestic Violence	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
Food Assistance	Friendly Food Pantry of Randolph	Provides food assistance to residents of Randolph.	1 Turner Ln Randolph	339.987.5577	
	Germantown Neighborhood Center Food Pantry	Provides food assistance to residents of Quincy.	366 Palmer St Quincy	617.376.1389	www.ssymca.org/germantown-neighborhood-center-food-pantry/

Beth Israel Deaconess Milton Community Resource List

Community Benefits Service Area includes: Milton, Quincy and Randolph

Health Issue	Organization	Brief Description	Address	Phone	Website
Food Assistance	Interfaith Social Services Food Pantry	Provides food assistance to residents of Braintree, Cohasset, Hingham, Holbrook, Hull, Milton, Quincy, Randolph, Scituate or Weymouth.	105 Adams St Quincy	617.773.6203	www.interfaithsocialservices.org
	Milton Community Food Pantry	Provides food assistance to residents of Milton.	158 Blue Hills Parkway Milton	617.696.0221	www.miltonfoodpantryma.org
	Salvation Army Quincy	Provides food assistance to residents of Quincy.	6 Baxter St Quincy	617.472.2345	www.SalvationArmyMA.org/Quincy
	Southwest Community Food Center	Provides food assistance to residents of Quincy.	1 Copeland St Quincy	617.471.0796	www.qcap.org/our-programs/food-nutrition
Housing Support	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
	Interfaith Social Services-Homesafe Program	Provides a wide range of social services for individuals and families in need of assistance.	105 Adams St Quincy	617.773.6203	www.interfaithsocialservices.org/homesafe
	Metro Housing Boston	Provides information and resources for low and moderate resource families and individuals.	1411 Tremont St Boston	617.859.0400	www.MetroHousingBoston.org
	Milton Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	65 Miller Ave Milton	617.698.2169	www.miltonhousingauthority.com
	Neighbor Works/Housing Solutions	Provides housing resource assistance.	422 Washington St Quincy	617.770.2227	www.nhsmass.org
	Quincy Community Action	Provides a wide range of social services for individuals and families in need of assistance.	1509 Hancock St 3rd Floor Quincy	617.657.5376	www.qcap.org/our-programs/housing-programs
	Quincy Housing Authority	Provides affordable, subsidized rental housing for low-resource residents in Quincy.	80 Clay St Quincy	617.847.4350	www.quincyha.com

Beth Israel Deaconess Milton Community Resource List

Community Benefits Service Area includes: Milton, Quincy and Randolph

Health Issue	Organization	Brief Description	Address	Phone	Website
Housing Support	Randolph Housing Authority	Provides affordable, subsidized rental housing for low-resource older adults and persons with disabilities.	One Decelle Dr Randolph	781.961.1400	www.randolphhousingauthority.org
Mental Health and Substance Use	Adcare	Provides comprehensive and individualized treatment programs for individuals, and families recovering from substance use disorders and co-occurring disorders.	1419 Hancock St Quincy	866.216.6445	www.adcare.com/locations/quincy
	Aspire Health Alliance	Provides early intervention, mental health treatment and recovery programs.	460 Quincy Ave Quincy	800.852.2844	www.aspirehealthalliance.org
	Bay State Community Services Quincy	Provides Child and Family Services, Outpatient Behavioral Health Counseling, Prevention Services, Restorative Justice Programs, Substance Use Recovery Services, Residential Treatment, Day Services, and Peer Recovery Support Services.	1120 Hancock St Quincy	617.471.8400	www.baystatecs.org
	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.nebhealth.org
	Boston Treatment Center	Provides inpatient detoxification and treatment service for men and women who need to be medically detoxified from alcohol, opiates and benzodiazepines.	784 Massachusetts Ave Boston	617.247.1001	www.nebhealth.org
	Gavin Foundation	Provides comprehensive adult, youth and community substance use education, prevention and treatment programs.	43 Old Colony Ave Quincy	617.845.5785	www.gavinfoundation.org
	Good Shepherd's Maria Droste Counseling	Provides professional mental-health counseling and holistic therapies.	1354 Hancock St Quincy	617.471.5686	www.mariadrostecounseling.com

Beth Israel Deaconess Milton Community Resource List

Community Benefits Service Area includes: Milton, Quincy and Randolph

Health Issue	Organization	Brief Description	Address	Phone	Website
Mental Health and Substance Use	Lamour Clinic	Provides behavioral health, therapeutic and community-based services for individuals, children, and families.	44 Diauto Dr Randolph	781.885.7252	www.lamourclinic.org
	Mass Bay Counseling	Provides psychological counseling, testing and psychotherapy to individuals, families, couples and businesses.	21 Thomas McGrath Highway Quincy	617.786.0137	www.massbaycounselingquincy.com
	New Directions Counseling Center	Provides counseling services for Individuals, Couples, Family, Group, Adults and Youth.	105 Adams St Quincy	617.773.6203 ext. 12	www.interfaithsocialservices.org/new-directions-counseling-center
	A New Way Recovery	Provides support, resources and encouragement for all paths of recovery.	85 Quincy Ave Ste B Quincy	617.302.3287	www.anewwayrecoveryctr.org
	Volunteers of America Massachusetts	Provides programs to low resource individuals throughout Eastern Massachusetts with programming for At-Risk Youth; Mental Health and Substance Abuse Services; and Veterans Services.	1419 Hancock St Quincy	617.770.9690	www.voamass.org
	William James Interface Helpline	Provides free, confidential, mental health and wellness referral service for residents of Milton.		1.888.244.6843	www.interface.williamjames.edu/community/milton
Senior Services	Milton Council on Aging	Provides services for older adults in Milton including fitness, education, social services, and recreation.	10 Walnut St Milton	617.898.4893	www.townofmilton.org/council-aging
	Quincy Council on Aging	Provides services for older adults in Quincy including fitness, education, social services, and recreation.	440 East Squantum St Quincy	617.376.1506	www.quincyma.gov/govt/depts/elder/default.htm
	Randolph Intergenerational Center/Randolph Council on Aging	Provides services for older adults in Randolph including fitness, education, social services, and recreation.	128 Pleasant St Randolph	781.961.0930	www.randolphicc.com

Beth Israel Deaconess Milton Community Resource List

Community Benefits Service Area includes: Milton, Quincy and Randolph

Health Issue	Organization	Brief Description	Address	Phone	Website
Senior Services	South Shore Elder Services	Provides a wide range of in-home services to low-resource older adults including Meals on Wheels.	350 Granite St Ste 2303 Braintree	781.848.3910	www.sselder.org
Transportation	MBTA	Provides transportation thru out Milton and surrounding communities.			www.mbta.com
	South Shore Community Action Council	Provides transportation assistance to older adults or people with disabilities or low resource residents throughout the South Shore area (including Milton, Quincy, Randolph) to medical appointments, day health programs, and education facilities.		508.747.7575	www.sscac.org
Additional Resources	Germantown Neighborhood Center	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	366 Palmer St Quincy	617.376.1384	www.ssymca.org/location/germantown-neighborhood-center
	Quincy Asian Resources	Provides culturally competent services, such as workforce development, adult education programs, youth development, and cultural events as well as information and referrals to public or other community organizations to Quincy and neighboring communities.	1509 Hancock St Quincy	617.472.2200	www.quincyasianresources.org
	South Shore YMCA Quincy	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	79 Coddington St Quincy	617.479.8500	www.ssymca.org/location/quincy

Appendix D:

Evaluation of 2020-2022 Implementation Strategy

BID Milton

Evaluation of 2020-2022 Implementation Strategy

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

Priority: Mental Health and Substance Use

Goal 1: Address stigma associated with mental health and substance use Issues			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions • Immigrants and non-English speakers	•Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health •Reduce the stigma associated with mental illness/ mental health and substance use/misuse, and addiction	•Organize Mental Health First Aid trainings in targeted community-based settings to raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use •Provide Community Health Grants to local departments of Health or other community-based partners to support evidence-based programs that promote mental health and substance use education and prevention •Organize Mental Health and Substance Use Support Groups for those with or recovering from mental health or substance use and their family/friends/caregivers to raise awareness, reduce stigma, educate, and promote coping/recovery	**Mental Health First Aid** A total of 20 community members were trained how to recognize the signs of someone struggling with mental illness, assist someone who might be in distress, and recognize and correct misconceptions about mental illness **Support for Milton Substance Abuse Prevention Coalition** Provide community education resources and increase awareness of substance use/misuse and healthy mental, emotional, and social health; During FY20, MSAPC hosted 'Milton Learns Together: WEBINAR WEDNESDAYS' a series of educational and skills-building webinars in May and June to support and reach Milton families during the COVID-19 pandemic. The series focused on a variety of different topics and hosted speakers with various expertise – all concerning mental health and substance use prevention. A total of 8 webinars were held that reached 132 community members. In FY21, 2 virtual presentations centered around youth transitions and ever-changing adjustments as a result of COVID-19, 100 community members attending virtually. Funding also provided for a 3-part training on youth engagement.

• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions • Immigrants and non-English speakers	•Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health •Reduce the stigma associated with mental illness/ mental health and substance use/misuse, and addiction	•Support Community-based Health Education Events with community partners to raise awareness, and educate on risk/protective factors, and services available in the community	**Botvin Life Skills** BID Milton provided funding in the amount of $10,000 (year 1) to Milton Public Schools to implement Botvin Life Skills health curriculum in all fifth-grade classrooms. The program helps kids think about and develop a variety of general life and drug resistance skills. In FY20, 204 students participated in the Botvin Life Skills Program; 92.2% of students reported learning something new about tobacco/vaping to help them deter use. 82.8% of students indicated learning a new coping skill to manage stress and anxiety; In FY21 out of 268 participating students, 87% indicated they had learned something new about tobacco/vaping use and its dangerous effects. 82% indicated they learned a new coping mechanism for stress and/or anxiety such as progressive relaxation or guided imagery. **Support Groups** In FY20, 159 hours of in-kind space needs were provided for Al-Anon, Alateen, CHADD, Overeaters' Anonymous, Alcoholics Anonymous, and New Moms. Due to COVID-19, space was not available in FY21.

Goal 2: Enhance access to mental health and substance use screening, assessment, and treatment services			
Population	Objectives	Activities	Progress, Outcomes, and Impact
•Youth •Adults •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers	•Promote cross-sector partnership, collaboration, and information sharing across the broad health system to address access to mental health and substance use services •Increase access to clinical and non-clinical support services for those with mental health and substance use issues, with an emphasis on priority populations •Increase access to Peer Support Groups for those with mental health and substance use and their family, friends, and caregivers •Reduce inappropriate use of ED and other acute care services •Increase access to screening, education, referral, and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and non-clinical settings, with an emphasis on priority populations •Increase access to insurance,	•Participate in task forces and coalitions to promote collaboration, share knowledge, and coordinate community health improvement activities •Support the Interface Mental Health Hotline, which provides education and referral services for those seeking mental health counseling services •Support efforts to develop Integrated Behavioral Health Services (mental health and substance use) in Primary Care and Other Specialty Care Settings (Impact Model) for those with or at-risk of mental health issues, including screening, assessment, and treatment •Explore Partnerships with Elder Service Providers to Promote Care Coordination and Reduce Isolation that reach out to and serve isolated older adults not currently engaged in Council on Aging activities •Explore partnerships with Local Health Departments, substance use providers, and BID-Milton departments to implement Peer Recovery Coach Programs geared to linking those with substance	Funded **Interface Hotline,** a behavioral health telephone referral service for Milton residents seeking help for themselves or others who may be struggling with mental health or substance misuse issues. The referral service is staffed by trained clinicians who conduct an assessment over the phone, and if applicable, provide a referral to a local provider. 107 residents use it; Primary presenting concerns were anxiety and depression and COVID-19. **Collaborative of Care** To increase access to behavioral health services in primary care setting: Provided services to 457 patients at 2 sites. **Recovery Coach Program** Implemented Peer Recovery Coach program with Gosnold Recovery Services. A peer recovery specialist is now embedded in the Emergency Department five days a week, eight hours each day. From November 2019-September 2020, 133 patients were screened, resulting in 89 patients being transferred to treatment. FY20 was first year of program. In FY21, 145 patients were seen by a Recovery Specialist in the Emergency department with 68% resulting in transfer to treatment. Treatment modalities include inpatient detox, medication assisted therapy, intensive outpatient programs or hospital transfer.

•Youth •Adults •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers	patient navigation support, and other enabling/ supportive services for those with mental health and substance use issues, with an emphasis on priority populations Increase access to peer recovery coaches for those with substance use/misuse issues •Reduce elder health isolation and depression •Provide support to Increase the number of practice settings with integrated behavioral health and primary care/specialty care services	use/misuse issues to peer recovery coaches who provide recovery, case management, and navigation support •Support efforts to develop a BID-Milton Bridge Program for those suffering from substance use disorder that screens, identifies, assesses, initiates treatment, and links participants to long-term SUD services in the community	**Reducing Burden of Behavioral Health** Reduce inappropriate ED use by embedding Aspire behavioral health clinician in BID Milton's Emergency Department to perform emergency psychiatric evaluations to prescreen patients for placement in an inpatient psychiatric unit and/or crisis stabilization unit; Clinician is on call 7 days/week-24hrs/day and is onsite 5 days/week.

Priority: Chronic and Complex Conditions and Their Risk Factors

Goal 1: Enhance Access to Health Education, Screening, Referral, and Chronic Disease Management Services in Clinical and Non-Clinical Settings			
Population	Objectives	Activities	Progress, Outcomes, and Impact
•Youth •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers	•Increase the number of people who are educated about chronic disease risk factors and protective behaviors •Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services for diabetes, hypertension, asthma, cancer, and other chronic/ complex conditions •Increase the number of people with chronic/complex conditions whose conditions are under control	•Participate in task forces and coalitions to promote collaboration, share knowledge, and coordinate community health improvement activities •Organize BID-Milton "Lecture Series" in community-based settings related to awareness, education, and the management of chronic and complex conditions •Provide Wellness, Fitness Education and Other events as part of comprehensive chronic disease management program •Provide evidence-based health education on risk/protective factors, and Self-Management Support Programs through partnerships with community-based organizations with an emphasis on Priority Population Segments •Support screening, education, and referral Programs in clinical and non-clinical settings that screen, educate, and refer patients in need of further assessment and chronic disease management supports	**Community Education Lectures & Workshops** In FY20 members of BID Milton's Medical Staff and employees conducted 8 lectures to 167 community members. Due to COVID, lectures did not take place in the spring at the hospital or Council on Aging; in FY21 Education was provided in a virtual setting with the Milton Council on Aging and Milton Public library. 6 programs were conducted reaching 57 community members. Topics included cancer, healthy eating, arthroscopic surgery, COVID-19/Flu, osteoarthritis and thyroid disorders. **EACH Diabetes Education** BID Milton provided a $5,000 grant to Enhance Asian Community on Health to implement and translate the Centers for Disease Control's "Prevent T-2: Diabetes Prevention" workshops in Chinese. Eight participants completed the course before course had to transition to virtual setting due to COVID. In FY21, five virtual Chronic Disease Self-Management Program workshops were conducted virtually with a total of 82 community members being engaged. **My Life, My Health: Diabetes Self-Management Education** Two 6-week workshops were held (October 2019 and January 2020) and 19 individuals successfully completed the My Life, My Health: Diabetes Self-Management course, with participants indicating an increase in knowledge learned to better manage

•Youth •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers	•Increase the number of people who are educated about chronic disease risk factors and protective behaviors •Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services for diabetes, hypertension, asthma, cancer, and other chronic/ complex conditions •Increase the number of people with chronic/complex conditions whose conditions are under control	•Provide Community Health Grants to community partners to support evidence-based programs that promote health education, screening, referral, and chronic disease management for priority populations	their diabetes. In FY21, due to COVID, only one workshop was able to take place, resulting in 10 community members taking the class with 80% indicating a change in behavior to better manage their diabetes. Seven participants were provided with free 3-month memberships to the YMCA to continue a healthy lifestyle. **Cancer Screenings** In FY20, BID Milton performed 307 scans for lung cancer. Due to COVID-19 pandemic, no patients were screened for skin or oral/neck/head cancer screenings. In FY21, due to COVID, skin and oral head and neck cancer screenings were not conducted. The lung cancer screening program performed 508 scans. **Blood Screening** In FY20 36 individuals were screened for cholesterol and blood chemistry indicators. Due to COIVD-19, program did not take place in FY21. **CPR** 24 people certified in CPR in FY20. Due to COIVD-19, program did not take place in FY21.

Goal 2: Reduce the prevalence of vaping/tobacco use			
Population	Objectives	Activities	Progress, Outcomes, and Impact
•Youth •Adults •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions	•Increase the number of people who quit smoking cigarettes, vaping, or using e-cigarettes •Increase access to tobacco, vaping/e-cigarette cessation programs	•Organize, facilitate, or support Smoking Cessation Programs geared to reducing tobacco, vaping and e-cigarette use	**Reducing Vaping and Tobacco Use** Grant funding was provided to Quincy Public Schools to implement vaping prevention education to all 10th grade students in Quincy School District. Fourteen students who were deemed at-risk (caught vaping on school grounds) completed intervention workshops. To educate parents on the dangers of vaping, two parent presentations were held. In FY21, 204 students were presented with the vaping curriculum. During post-assessments 97% of students reported learning new information such as health risks, peer influence and pressure, media use and tactics and vaping withdrawal. **Nicotine Anonymous support group** held weekly at hospital from October 2019- February 2020 by suspended due to COVID-19 pandemic.

Priority: Social Determinants and Access to Care

Goal 1: Enhance access to care and reduce the impact of social determinants			
Population	Objectives	Activities	Progress, Outcomes, and Impact
•Youth •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers	•Increase partnerships and collaboration with social service and other community-based organizations •Increase access to culturally appropriate and responsive care •Increase educational opportunities related to the importance and impact of social determinants •Decrease the number of people who struggle with financial insecurity/rent insecurity •Increase access to low cost healthy foods with an emphasis on priority population segments •Increase access to affordable, safe transportation options with an emphasis on	•Community Benefit and other Hospital staff participate in coalition and other Community Meetings to promote collaboration, share knowledge, and coordinate community health improvement activities •Provide Community Health Grants to community partners to support evidence-based programs that address social determinants and access to care (e.g., Quincy Community Action Program) •Organize Fresh Truck Outings Program to provide fresh, locally-grown produce to low to moderate income, underserved populations •Support the Blessings in a Backpack Program in school-based settings to promote food access and nutrition exercise for low to moderate income families •Support the Grocery Shopping Tours Program to provide nutrition education and food access to low- and moderate-income populations living in public housing, Councils on Aging, and other community venues	**Certified Application Counselors** In FY20, BID Milton's Certified Application Counselors assisted 262 community members, filed 220 applications, and successfully enrolled 70 individuals in Mass Health, 22 individuals in Commonwealth Care, and assisted 23 people in acquiring free care. In FY21, BID Milton's CACs assisted 223 community members and successfully enrolled 112 individuals in Mass Health, 66 individuals in Commonwealth Care, and assisted 45 people in applying for the Health Safety Net. **Culturally Responsive Care-Interpreter Services** In FY20, Interpreters provided a total of 4,905 face-to-face and phone encounters in 42 languages. In addition, hospital purchased a total of 10 video remote interpreting devices to better assist limited English proficiency patients when in-person interpretation was not available. In FY21, Total face-to-face plus phone encounters conducted by interpreters increased 28% vs FY20 to 6,890 conducted in 51 languages. An additional 5 Video remote interpreting devices were purchased to increase access to an interpreter when in-person interpreter not available. **Rental Assistance/Eviction Prevention Grant** In FY20, a $15,000 grant to Quincy Community Action Program. Direct rental assistance was provided to 16 at-risk households preventing eviction/homelessness for 31 individuals. In FY21, an additional $15,000 was

•Youth •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers	priority population segments •Increase the number of people assisted with insurance and other public program enrollment, and patient navigation •Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports •Ensure access to preventive measures, testing, screening and treatment for those at-risk or exposed to COVID-19 and mitigate the impacts of the pandemic on the social determinants of health.	•Organize Wellness and Nutrition Education events in partnership with community partners targeting older adults, low to moderate income individuals and families, and those at-risk of chronic disease •Enhance access to healthy food for older adults and low to moderate income individuals and families •Provide Enrollment Counseling/ Assistance and Patient Navigation Support Services to uninsured or underinsured residents to enhance access to care •Provide Linguistically and Culturally Appropriate Health Education and Care Management Support though targeted community events for those with or identified as at-risk of chronic/ complex conditions with an emphasis on priority populations •Explore Transportation Access Partnerships with regional transportation partners and other community partners to enhance access to affordable, safe, accessible transportation options	awarded to this program. Direct rental assistance averaging $844 was provided to 15 at-risk households, preventing 34 individuals from homelessness. **Blessings in a Backpack** In FY19, BID Milton began a partnership with the national organization Blessings in Backpack to assist the Randolph Public Schools with providing supplemental food to elementary aged children on the weekends. In FY20, 50 children participated. During the COVID-19 pandemic, BID Milton worked with the schools to distribute more food to these children as the school transitioned to a remote learning environment. In September of 2020, BID Milton contributed an additional $5,000 to be put toward the 2020-21 school year. In FY21, weekend food packs were provided to 65 children. **Transportation Initiatives** BID Milton employee is an active member of the Blue Hills Regional Coordinating Council (BHRCC) and in FY20 provided $5,000 in grant funding to continue to collaborative efforts that enhance access to affordable transportation options. In FY21, $5,000 in grant funding was provided to continue to collaborative efforts that enhance access to affordable transportation options. Action plan was completed in August 2021 and outlines 6 overall strategies and over 25 actions to address transportation equity in the region. In FY20, Free taxi vouchers totaling $3,523 were provided to patients with no access to transportation for medical care. In

•Youth •Older Adults •Low to Moderate Income Populations •Individuals with Chronic/ Complex Conditions •Immigrants and non-English speakers			FY21, Free taxi vouchers totaling $2,623 were provided to patients. **Community Education** BID Milton registered dietitians provided free grocery shopping tours at Milton's Fruit Center Marketplace. Dietitians led participants through the grocery store and discussed healthy food options, how to read nutrition labels and provided healthy recipe options. Each participant also received $20 gift cards for use in purchasing groceries at the Fruit Center. Eight participants signed up for the tour held in November of 2019. Due to COVID, tours scheduled in Spring of 2020 were cancelled. **Initiatives around COVID-19** Provided one-time grant funding to Academic Public Health Volunteer Corps' Health Equity Initiatives in Randolph. Funding in the amount of $2,415 assisted in translating and directing messaging around COVID-19 to reach the Haitian population within the Randolph community via radio and internet-based social media. **Primary Care Access** In FY21, seven new primary care/family practitioners were recruited to the hospital's medical staff to increase access to healthcare in Quincy and the surrounding area. **Food Distribution** *Snack Pack Distribution for South Shore Elders* 1,500 snack packs were distributed to identified in-need seniors of the Meals on Wheels Program.

			Grab N Go Chinese Lunch Box Program Funding from BID Milton supported the lunch program with Asian American Service Association to prepare culturally appropriate Chinese style lunches for seniors during COVID-19; 600 culturally appropriate grab-n-go meals were distributed

Goal 2: Promote independence and "Aging in Place"			
Population	Objectives	Activities	Progress, Outcomes, and Impact
Older Adults	•Reduce fear of falling •Reduce Falls •Increase activity levels •Reduce preventable Emergency Department and inpatient visits •Increase the number of older adults living independently in their homes	•Support Safety at Home Program for older adults to promote aging in place and reduce falls •Organize Matter of Balance workshops for priority populations	**Community Education:** *Yoga* To increase activity levels, BID Milton offered yoga classes to the community in January of 2020. With the onset of COVID, only 7 classes were held with 10 community members. In FY21, suspended due to COVID. *AARP* 12 Seniors completed the AARP Driver Safety Course in fall of FY20. In FY21, suspended due to COVID.

Appendix E:
2023-2025 Implementation Strategy

Beth Israel Lahey Health
Beth Israel Deaconess Milton

FY23-FY25
Implementation Strategy

Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Hospital-Milton (BID Milton) is a 100-bed acute care hospital with a complete complement of inpatient and outpatient health services, 24-hour emergency services, and more than 450 physicians on staff. BID Milton also includes Beth Israel Deaconess Milton Radiology at BILH Quincy Urgent Care Center. BID Milton's mission is to improve the health of the community by providing exceptional, personalized healthcare with dignity, compassion, and respect.

The assessment and planning work for this Community Health Needs Assessment (CHNA) report was conducted between September 2021 and September 2022. In conducting this assessment and planning process, it would be difficult to overstate BID Milton's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BID Milton'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 a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

BID Milton collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). The hospital also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs of specific communities. The data were tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Between October 2021 and February 2022, BID Milton conducted 19 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 500 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. Accordingly, using an interactive, anonymous polling software, BID Milton's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts
that they believed should be the focus of BIDM's IS. This prioritization process helps to ensure that BID Milton maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

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

BID Milton'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:

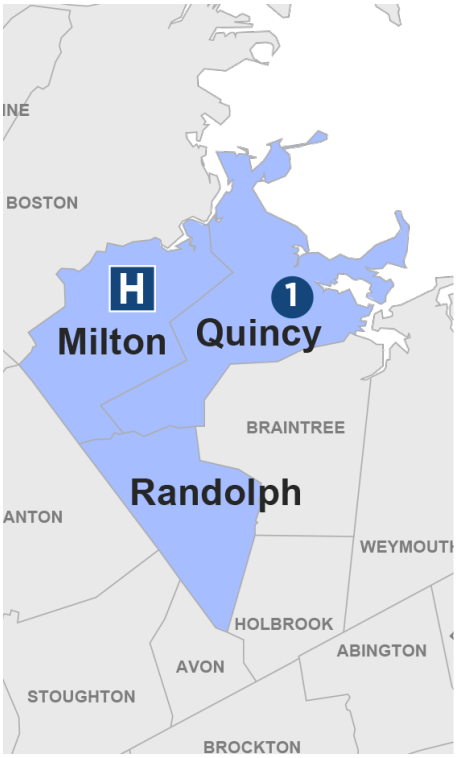
- Address the prioritized community health needs and/or populations in the hospital's Community Benefits Service Area (CBSA).
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential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

Community Benefits Service Area

BID Milton's CBSA includes the three of Milton, Quincy, and Randolph located south of the City of Boston. Collectively, 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 and suburban). There is also diversity with respect to community needs. There are segments of BID Milton'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 Milton 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 Milton is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

BID Milton's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within the CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses 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 Milton is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.



Beth Israel Lahey Health
Beth Israel Deaconess Milton

Community Benefits Service Area

H Beth Israel Deaconess Hospital-Milton

1 Beth Israel Deaconess Milton Radiology at BILH Quincy Urgent Care Center

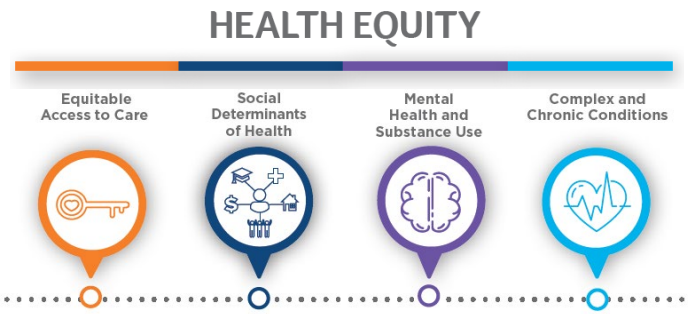
Prioritized Community Health Needs and Cohorts

BID Milton 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 Milton Priority Cohorts

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

BID Milton Community Health Priority Areas



Community Health Needs Not Prioritized by BID Milton

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

The issues that were identified in the BID Milton CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, transportation, economic insecurity, navigating SDOH resources, build capacity of workforce, navigation of healthcare access barriers, information and resource sharing, cost and insurance barriers, mental health, stress, anxiety, depression, isolation, mental health stigma, culturally appropriate/competent health and community services, linguistic access/barriers to community resources/services, treatment programs that include/address mental health and co-occurring substance use/misuse issues, substance use outreach/education/prevention, caregiver support, and alcohol use prevention/treatment.

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.

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote equitable care, health equity, and health literacy for patients, especially those who face cultural and linguistic barriers.	• Racially, ethnically, & linguistically diverse populations • Individuals with disabilities • Low-resourced populations	• Interpreter Services	• # of face-to-face encounters • # of languages used • # of phone encounters	• Interpreter Services Department	Not Applicable
Promote access to health care, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.	Low-resourced populations	• Financial counselors • Primary Care Support	• # of people enrolled in health insurance • # of patients	• BID Milton Financial Counselors • BILH Primary Care	Social Determinants of Health

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide and promote career support services and career mobility programs to hospital employees.	• Individuals with disabilities • Racially, ethnically, & linguistically diverse populations • Low-resourced populations	• CPTech Pipeline Program (in development) • Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes	• # of employees successfully enrolled in program • # of employees who were hire and/ or promoted	• Quincy Asian Resources, Inc. (QARI) • BILH Workforce Development	Social Determinants of Health

Priority: Social Determinants of Health

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide support for impactful programs and community initiatives that address issues associated with the social determinants of health.	• Youth • Older adults • Low-resourced populations • Racially, ethnically, & linguistically diverse populations • Individuals with disabilities	• Emergency Flex Funding for Domestic Violence Survivors • Provide an opportunity for grant funding to community	• # of children enrolled in programs • # of clients served • Additional clients enrolled in wrap-around services	• Domestic Violence Ended, Inc. (DOVE) • Milton Early Childhood Alliance (MECA)	• Violence • Education
Support programs that stabilize or create access to affordable housing.	• Low-resourced populations • Racially, ethnically, & linguistically diverse populations • Older adults	• Rental Assistance/ Eviction Prevention Community Grants	• # of clients served and their demographics • # amount of assistance provided • # of clients who were stabilized in housing • # of clients enrolled in additional services (SNAP, etc)	• Quincy Community Action Programs (QCAP) • Father Bills & Mainspring • Interfaith Social Services	Not Applicable

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	• Youth • Older adults • Low-resourced populations • Racially, ethnically, & linguistically diverse populations	• Community-Supported Agriculture (CSA) Shares to food pantries • Nutritional Supports for Seniors in Affordable Housing • Community Table Events • Provide an opportunity for grant funding to the community	• # of students served • # amount of food distributed • # of programs conducted • # of participants served • Change in learning pre/post assessments if applicable	• Local Schools • Randolph Inter-generational Center • Food Pantries • Simon Fireman Community • Milton Council on Aging	Chronic and Complex Conditions
Increase mentorship, training, and employment opportunities to increase employment and earnings and increase financial security for youth, young adults, and adults residing in the communities.	• Youth and young adults • Individuals with disabilities • Low-resourced populations • Racially, ethnically, & linguistically diverse populations	• Internship programs in multiple departments: Nursing, Radiology, Pharmacy, etc. • High School Internship Program • Healthcare scholarships • Provide an opportunity for grant funding to the community	• # of participants/ students and their demographics • # of job shadowing hours • # of hours of job training • Increased job skills	• Local schools • Curry College • Quincy Community Action Programs (QCAP) • Quincy Asian Resources, Inc. (QARI)	Not Applicable
Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.	• Youth • Older adults • Low-resourced populations • Racially, ethnically, & linguistically diverse populations	• Member of Blue Hills Regional Coordinating Council, provided previous grant funding for assessment phase	• # of partners/sectors • # of initiatives • # of policy or system changes • Amount of resources obtained	• Blue Hills Regional Coordinating Council	Not Applicable

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.	• Youth • Older adults • Low-resourced populations • Racially, Ethnically, & Linguistically Diverse Populations	• Member of Randolph Community Wellness Coalition • Member of Mass in Motion Regional Food Policy Council	• # of partners/sectors • # of initiatives • # of policy or system changes • Amount of resources obtained	Randolph Community Wellness Committee	Food insecurity

Priority: Mental Health and Substance Use

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

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

Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health and economic insecurity. Interviewees, focus group, and listening session participants also reported that alcohol use is normalized, and use is prevalent among both adults and youth.

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support impactful programs that promote healthy development, support children, youth, and their families, and increase their resilience, coping and prevention skills.	• Youth • Racially, ethnically, & linguistically diverse Populations	• Trauma informed schools grant • Getting the Teens Out Grant • Provide an opportunity for grant funding to community	• # of staff trained • # of programs conducted • # of participants • # of parent workshops • Pre-post assessments: learn new skill to cope w/ stress/anxiety • Change in knowledge or behavior	• Milton Public Schools • Milton Youth Advocates for Change • Randolph Youth Collaborative • Quincy Family Resource Center • Quincy Asian Resources, Inc. (QARI)	Not Applicable
Build the capacity of community members to understand the importance of mental health and substance use, and reduce negative stereotypes, bias, and stigma around mental illness and substance use disorders.	• Youth • Older adults • Racially, ethnically, & linguistically diverse populations	• Mental Health First Aid™ • Behavioral Health/ Cognitive Behavioral Therapy (CBT) Classes	• # of classes conducted • # of trainers trained • # of community residents trained • Increased skills • Increased confidence in ability to use skills	• Randolph Youth Collaborative • Milton Coalition • Aspire Health Alliance • Interfaith Social Services • Enhance Asian Communities on Health (EACH) • Milton Council on Aging	Not Applicable

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to increase resiliency, reduce youth substance use, and prevent opioid overdoses and deaths.	• Racially, ethnically, & linguistically diverse populations • Low resourced populations • Youth	• Milton Coalition • Building Up Youth: Regional Partnership on Health and Wellness	• # of partners/ sectors • # of initiatives • # of policy or system changes • Amount of resources obtained • # of programs sponsored • # of people in attendance	• Milton Coalition • Milton Board of Health • Building Up Youth: Regional Partnership on Health and Wellness Coalition	Not Applicable
Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	• Racially, ethnically, & linguistically diverse populations • Low resourced populations	• BILH Collaborative Care • Medical Assisted Treatment (MAT) • Recovery coaches • Prescription take-back kiosk (in development)	• # of patients assisted • # of providers • # of consults • # of people referred to treatment • # of pounds collected	• BILH Behavioral Health • Gosnold Behavioral Health	Not Applicable

Priority: Chronic and Complex Conditions

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Address barriers to timely cancer and chronic disease screenings and follow-up care through culturally appropriate navigation and innovative programs.	• Older adults • Low resourced populations • Racially, ethnically, & linguistically diverse Populations	Lung Cancer Screening	• # of patients screened • Reduced time between finding and treatment	• Enhance Asian Communities on Health (EACH) • Medical Staff	• Equitable • Access to Care
Provide preventative health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.	• Older adults • Racially, ethnically, & linguistically diverse populations	• Diabetes Self-Management Courses • Matter of Balance Classes	• # of participants enrolled in self-management classes • Change in behavior scores • # of people provided with YMCA memberships • # of new providers added that address chronic disease	• South Shore YMCA • Enhance Asian Communities on Health (EACH)	• Aging in place • Equitable Access to Care
Ensure older adults have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.	Older adults	• Palliative care • Meditation classes	• # of consults • # of Re-admissions • # of educational programs conducted • Reduced isolation	• Milton Council on Aging • South Shore Elder Services	• Aging place • Equitable Access to Care • Mental Health

General Regulatory Information

Contact Person:	Laureane Marquez, Manager of Community Benefits and Community Relations
Date of written plan:	June 30, 2022
Date written plan was adopted by authorized governing body:	September 12, 2022
Date written plan was required to be adopted	February 15, 2023
Authorized governing body that adopted the written plan:	Beth Israel Deaconess Hospital-Milton Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 5, 2019
Name and EIN of hospital organization operating hospital facility:	Beth Israel Deaconess Hospital-Milton 04-2103604
Address of hospital organization:	199 Reedsdale Road, Milton, MA 02186

Beth Israel Lahey Health

Beth Israel Deaconess Milton

bidmilton.org