Beth Israel Lahey Health
Beth Israel Deaconess Milton

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for Beth Israel Deaconess Hospital-Milton (BID Milton) is the culmination of a collaborative process that began in June 2024. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key stakeholders from throughout BID Milton's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging historically underserved populations.

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

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Introduction

Background

Beth Israel Deaconess Hospital–Milton is a community hospital for the southern metro Boston region. The hospital has 102 licensed inpatient beds with more than 950 employees and over 640 clinicians on active medical staff. With close ties to Beth Israel Deaconess Medical Center, one of the region's leading academic medical centers, BID Milton offers a full range of services, including orthopedics, urology, surgical services and digestive health.

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 2025 Community Health Needs Assessment (CHNA) 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 700 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, faith leaders, government officials, and community residents.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of BID 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 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 2022 and the report, along with the associated 2023-2025 IS, was approved by the BID Milton Board of Trustees on September 12, 2022. The 2022 CHNA report was posted on BID Milton's website before September 30, 2022 and, per federal compliance requirements, made available in paper copy without charge upon request.

The assessment and planning work for this current report was conducted between June 2024 and September 2025 and BID Milton's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 15, 2025.

Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within BID Milton's 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 Milton, Quincy, and Randolph, located to the south of the City of Boston. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban).

There is also diversity with respect to community needs. There are segments of the BID 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 the 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 most of its community benefits activities to improve the health status of those who face health disparities, experience poverty, or have been historically underserved. By prioritizing these cohorts, BID 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, datadriven, 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 thoughtful prioritization, planning, and reporting processes.

Special care was taken to include the voices of community residents who have been historically underserved such as those are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

The CHNA and IS development process was guided by the following principles: equity, accountability, community engagement, and impact.

Equity:

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

Accountability:

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

Community Engagement:

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

Impact:

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

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

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

In April of 2024, BILH hired JSI Research & Training Institute, Inc. (JSI), a public health research and consulting firm based in Boston, to assist BID 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 guidelines.

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

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

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

The involvement of BID Milton's staff in the CBAC promotes transparency and communication as well as ensures that there is a direct link between the hospital and many of the community's leading health and community-based organizations. The CBAC meets quarterly to support BID Milton's community benefits work and met five times during the course of the assessment. During these meetings, the CBAC provided invaluable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities.

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, BID Milton collected a wide range of quantitative data to characterize the communities in the hospital'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 analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment, including the BID 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 and 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 June 2024 and February 2025, BID Milton conducted 15 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving over 600 residents, and organized a community listening session. In total, the assessment process collected information from more than 700 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

15 interviews

with community leaders

693 survey respondents

5 focus groups

- Low-resource families
- Older adults in affordable housing
- Individuals living in affordable housing
- Haitian residents
- Public health professionals

Inventory of Community Resources

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

- Domestic violence
- Food assistance

- Housing
- Mental health and substance use
- Senior services
- Transportation

The resource inventory was compiled using information from existing resource inventories and partner lists from BID Milton. Community Benefits staff reviewed BID Milton's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which includes a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify available community resources in the CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

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

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

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

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

After the Board of Trustees formally approved the 2025 CHNA report and adopted 2026-2028 IS, these documents were posted on BID Milton's website, alongside the 2022 CHNA report and 2023-2025 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 the hospital's Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

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

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Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, other government officials, and community residents engaged in supporting the health and well-being of residents throughout BID 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 summary of interviews, focus groups, community listening session prioritization, and a databook that includes all of the quantitative data gathered for this assessment are included in Appendices A and B.

Community Characteristics

A description of the population's demographic characteristics and trends lays the foundation for understanding community needs and health status. This information is critical to recognizing health inequities and identifying communities and population segments that are disproportionately impacted by health issues and other social, economic, and systemic factors. This information is also critical to BID 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.

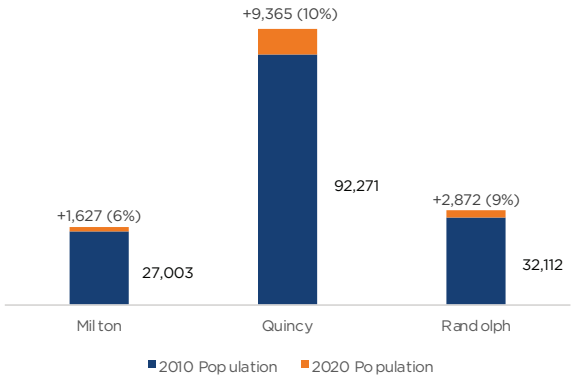
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the BID Milton CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were people of color, immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, non-English speakers, and individuals living with disabilities faced systemic challenges that limited their ability to access health care services. Some segments of the population were impacted by language and cultural barriers that limited access to appropriate services and posed challenges related to health literacy. These barriers also contributed to social isolation and may have lead to disparities in access and health outcomes.

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

Population Growth

Between 2010 and 2020, the population in BID 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



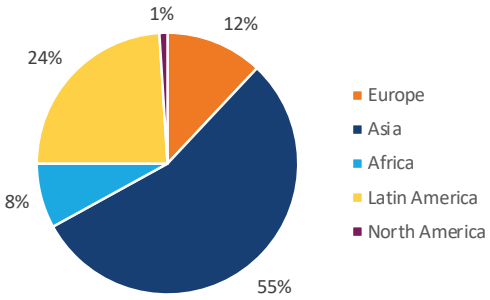
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

Nation of Origin

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

18% of the BID Milton CBSA population was foreign born.

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



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

Language

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

36% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

46% speak English less than "very well."

Source: US Census Bureau American Community Survey 2019-2023

Age

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

17%

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

18%

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

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

Gender Identity and Sexual Orientation

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

7%

of adults in Massachusetts identify as LGBTQIA+.

Source: Gallup/Wiliams, 2023

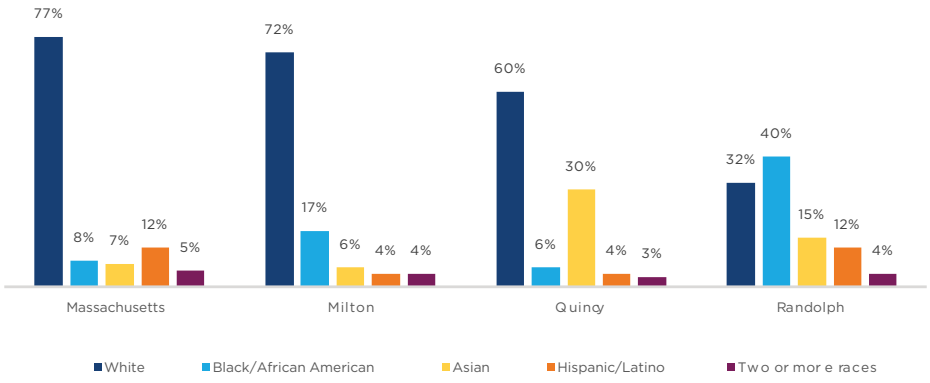
21% of LGBTQIA+ adults in Massachusetts are raising children

Source: Gallup/Williams, 2019

Race and Ethnicity

BID Milton's CBSA is diverse in terms of race and ethnicity. Milton and Randolph have higher percentages of residents who identify as Black or African American compared to the Commonwealth, and Quincy and Randolph have higher percentages of residents who identify as Asian.

Race/Ethnicity by Municipality, 2019-2023



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

Household Composition

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

26% of BID Milton CBSA 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, 2019-2023

Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." These conditions influence and define quality of life for many segments of the population in BID Milton's CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities, economic insecurity, access to care/navigation issues, and other important social factors.[8]

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

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

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

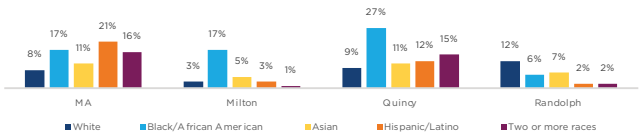
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

Economic Stability

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

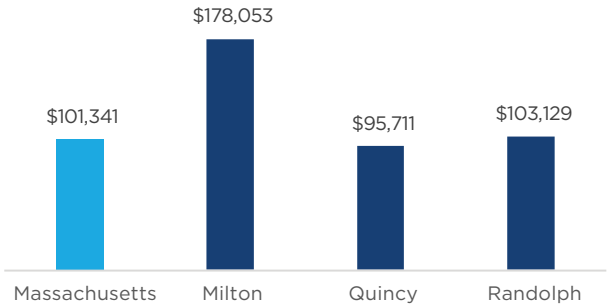
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains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

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



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

Median Household Income, 2019-2023

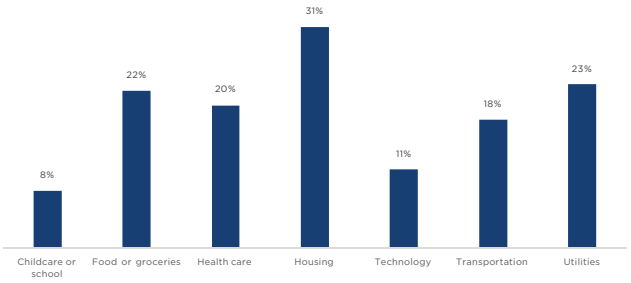


Source: US Census Bureau American Community Survey, 2019-2023

Across the BID 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 cumulative disadvantage over time.[12] Median household income is the total gross income before taxes, received within a one-year period by all members of a household. Median household income was lower than the Commonwealth overall in Quincy.

In the 2025 BID Milton Community Health Survey, survey respondents reported trouble paying for certain expenses in the past 12 months - especially related to housing, utilities, food or groceries, and health care.

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



Source: 2025 BID Milton Community Health Survey

"Social problems are synonymous with economic problems – not having enough and need[ing] to rely on government subsidies to survive. A lot of people give up. Take home pay is not enough to take home. We don't make enough to keep the head above water."

-Focus Group Participant

Education

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

90% of CBSA residents 25 years of age and older have a high school degree or higher.

49% of CBSA residents 25 years of age and older have a Bachelor's degree or higher.

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

Social Determinants of Health

Food Insecurity and Nutrition

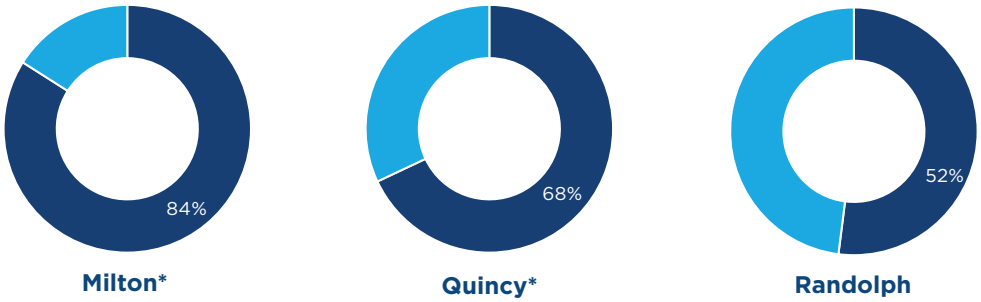
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

While it is important to have grocery stores placed throughout a community to promote access, there are other factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food, and cultural appropriateness of food offerings. Food pantries and community meal programs have evolved from providing temporary or emergency food assistance to providing ongoing support for individuals, families, older adults living on fixed incomes, and people living with disabilities and/or chronic health conditions.

14%

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

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



*Percentage shown is an average of the percentages across all zip codes in the municipality

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

Neighborhood and Built Environment

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

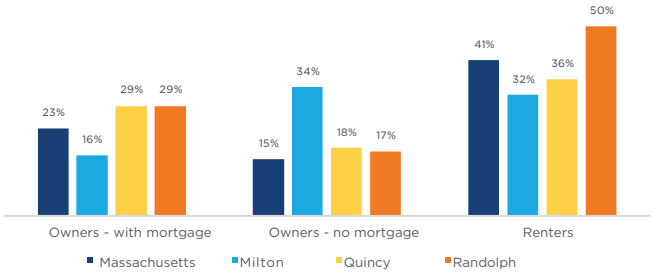
Housing

Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases, and poor mental health.[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.[15]

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

The percentage of owner-occupied housing units with housing costs in excess of 35% of household income was higher than the Commonwealth in all municipalities, with the exception of owner-occupied units with a mortgage in Milton. Among renters, percentages were higher than the Commonwealth in Randolph.

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



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

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

52% Community Health Survey respondents said "more affordable housing."

31% Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 BID Milton Community Health Survey

Transportation

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

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

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

26% of 2025 BID Milton Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 BID Milton Community Health Survey

12% of housing units in the BID Milton CBSA did not have an available vehicle.

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

Roads/Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety and increased mobility. Sidewalks allow more space for people to walk or bike, which increases physical activity and reduces the need for vehicles on the road. Respondents to the 2025 BID Milton Community Health Survey prioritized these improvements to the built environment.

33% of 2025 BID Milton Community Health Survey respondents identified a need for better roads.

43% of 2025 BID Milton Community Health Survey respondents identified a need for better side-walks and trails.

Source: 2025 BID Milton Community Health Survey

Systemic Factors

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

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of color, persons whose first language is not English, foreign-born individuals, individuals living with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment reinforced the challenges that residents throughout the BID Milton CBSA faced with respect to long wait-times, provider/workforce shortages, and service gaps which impacted people's ability to access services in a timely manner. This was true with respect to primary care, behavioral health, medical specialty care, and dental care services.

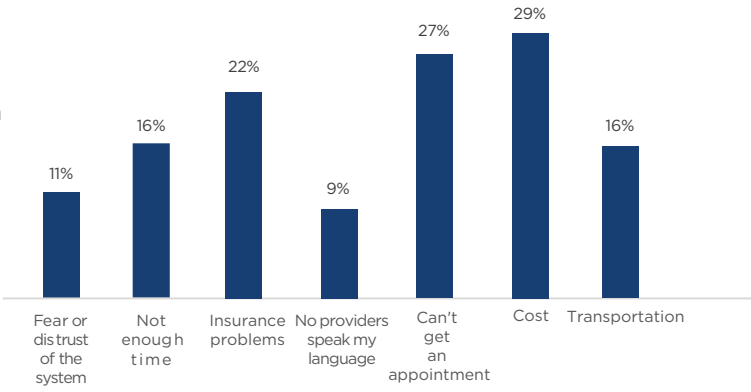
Interviewees, focus groups, and listening session participants also reflected on the high costs of care, including prescription medications, particularly for those who were uninsured or who had limited health insurance benefits. It can be challenging for low-resourced individuals and families to access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

Accessing and Navigating the Health Care System

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

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

What barriers keep you from getting needed health care?



Source: 2025 BID Milton Community Health Survey

Populations facing barriers and disparities

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

Community Connections and Information Sharing

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

"Everyone respects each other, and for the most part, work very well together. We [community organizations] can successfully come together in the name of public safety, health, and wellness. We're all focused on how our individual and collective efforts can affect the community. "

-Interviewee

Behavioral Factors

The nation, including the residents of Massachusetts and BID Milton's CBSA, faces a health crisis due to the increasing burden of chronic medical conditions.

Underlying these health conditions are a series of behavioral risk factors that are known to help prevent illness and are the early signs or contributors of the leading causes of death (e.g., heart disease, cancer, stroke and diabetes). The leading behavioral risk factors include an unhealthy diet, physical inactivity and tobacco, alcohol, and marijuana use.[17]

Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being and reduces the risk of illness and death due to the chronic conditions mentioned previously. When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use, and alcohol use. Those who participated in the assessment's community engagement activities were also asked to identify the health issues that they felt were most important. While these issues were ultimately not selected during the community's prioritization process, the information from the assessment supports the importance of incorporating these issues into BID 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.[18] Access to affordable healthy foods is essential to a healthy diet.

25% of BID Milton Community Health Survey respondents said they would like their community to have better access to healthy food.

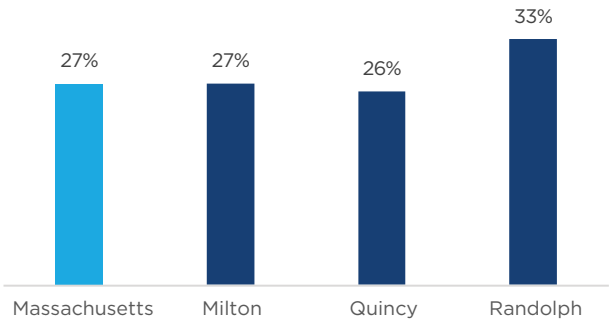
Source: 2025 BID Milton Community Health Survey

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 are Obese, 2022



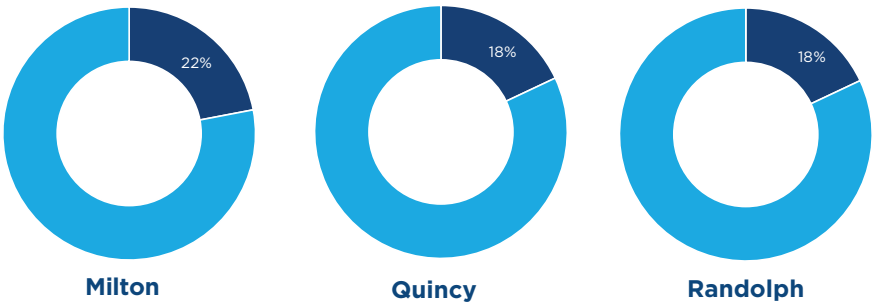
Source: CDC PLACES, 2022

Alcohol, Marijuana, and Tobacco Use

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

Clinical service providers reported linkages between substance use and mental health concerns, noting that individuals may use substances such as alcohol or marijuana as a way to cope with stress. Interviewees and focus group participants also identified vaping as a concern particularly affecting youth.

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC PLACES, 2022

Health Conditions

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

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

Given the limitations of the quantitative data, specifically that it was often out of date and not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, listening session, and the 2025 BID Milton Community Health Survey was of critical importance.

Mental Health

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

In addition to the overall burden and prevalence of mental health issues, residents also identified a need to address language and cultural barriers to behavioral health care, and recognized the impacts of trauma on immigrant, migrant, and refugee populations.

23% of Milton High School students reported feeling so sad or hopeless almost every day for two weeks or more, to the point that they stopped doing usual activities.

Source: Milton High School Youth Risk Behavior Survey, 2024

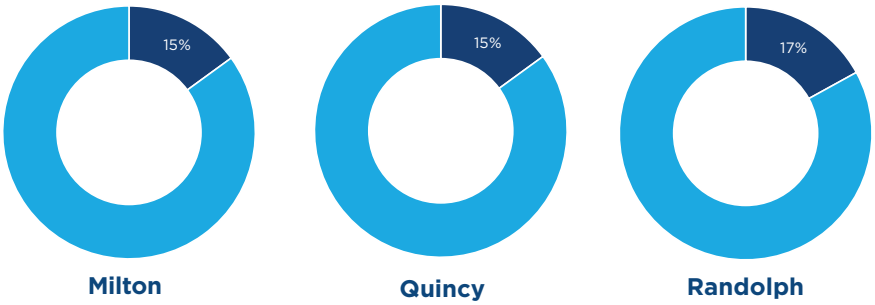
7% of Milton High School students reported having seriously considered suicide in the past 12 months.

Source: Milton High School Youth Risk Behavior Survey, 2024

50%

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

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



Source: CDC PLACES, 2022

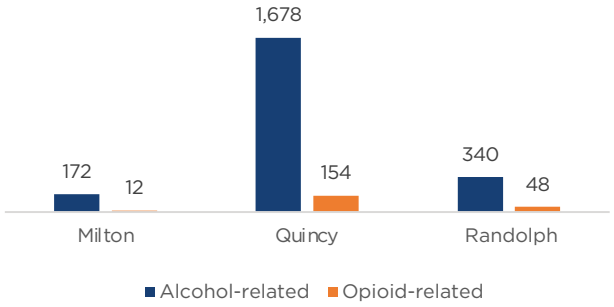
Health Conditions

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

Interviewees also reported that alcohol use was normalized, and that there were concerns of alcohol use among youth.

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

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



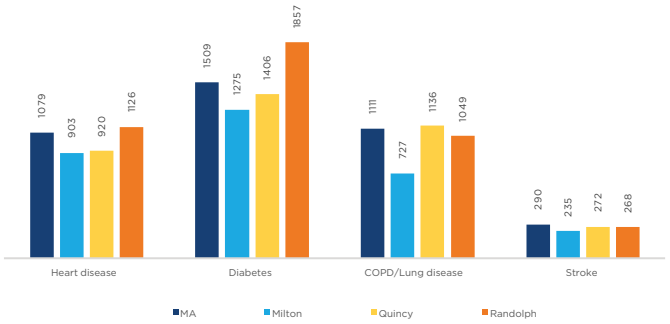
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

Chronic and Complex Conditions

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

Looking across four of the more common chronic/complex conditions, inpatient discharge rates among adults 65 years of age and older consistently lower than the Commonwealth overall in Milton, and similar or higher than the Commonwealth in Quincy and Randolph.

Inpatient Discharge Rates (per 100,000) for Chronic/Complex Conditions Among Those 65 Years of Age and Older, 2024



Source: Center for Health Information and Analysis, 2024

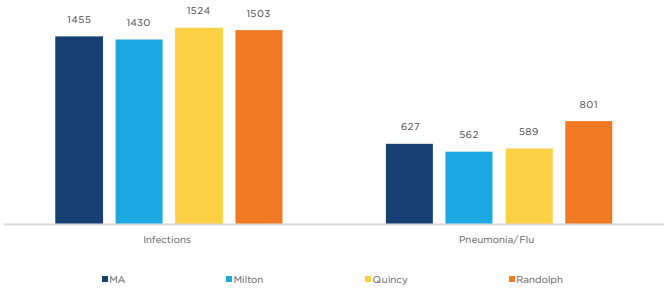
Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability and even death - as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees or participants at the listening session and focus groups,

it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

Data from the Center for Health Information and Analysis indicated that older adults in Quincy and Randolph had higher rates of infections compared to the Commonwealth overall, and Randolph had higher rates of pneumonia/flu.

Inpatient Discharge Rates (per 100,000) Among Those 65 and Older, 2024



Source: Center for Health Information and Analysis, 2024

Priorities

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

Massachusetts Community Health Priorities

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

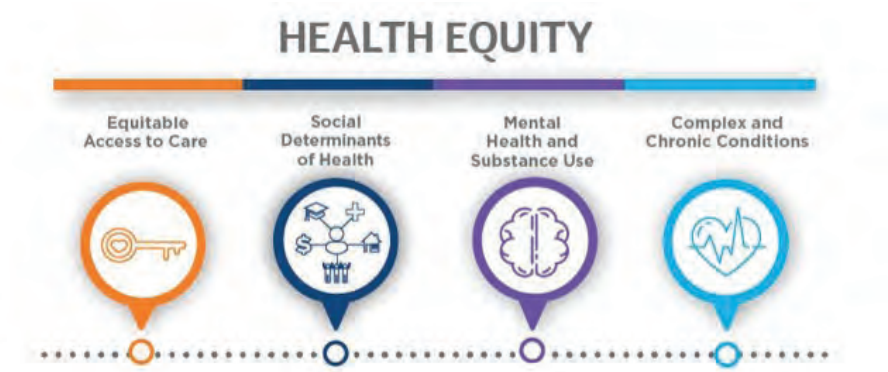
Community Health Priorities and Priority Cohorts

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

BID Milton Community Health Needs Assessment: Priority Cohorts

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

BID Milton Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BID Milton

It is important to note that there are 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, strengthening the built environment (i.e., improving roads/sidewalks) was identified as community needs but were not included in BID Milton's IS. While this issue is important, BID Milton's CBAC and senior leadership team decided that this issue was 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 this issue. BID Milton remains open and willing to work with community residents, other hospitals, and other public and private partners to address this issue, 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, transportation, economic insecurity, access to healthy and affordable food, language and cultural barriers, navigating a complex health care system, health insurance and cost barriers, long wait times, depression, anxiety, stress, youth mental health, social isolation among older adults, substance use, conditions associated with aging, diabetes, community-based prevention and education, and caregiver support.

Implementation Strategy

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

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

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

Community Benefits Resources

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

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

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

SOCIAL DETERMINANTS OF HEALTH

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

Strategies to address the priority:

- Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.
- Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.
- Support programs and activities that foster social connections, strengthen community cohesion and resilience.
- Support community/regional programs and partnerships to enhance access to affordable and safe transportation.
- Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations and community residents.
- Advocate for and support policies and systems that address social determinants of health.

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

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

Evaluation of Impact of 2023-2025 Implementation Strategy

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

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

Priority Area	Summary of Accomplishments and Outcomes
Social Determinants of Health	BID Milton addressed social determinants by funding programs for housing stability, food access, transportation, and community engagement. The hospital awarded grants for emergency domestic violence support, early childhood development, rental assistance, and nutrition programs—resulting in stable housing for dozens of individuals and improved food security for older adults and food pantry clients. Workforce development grants helped young adults with disabilities build skills and secure jobs. Investments in transportation included vouchers and funding for non-medical ride services, and hospital staff participated in regional coalitions advocating for system-level policy change.
Equitable Access to Care	BID Milton expanded equitable access by offering over 12,000 interpreter sessions in 57 languages. Financial counselors helped over 500 individuals gain health insurance, while more than 3,000 new patients were served at local primary care practices. Workforce development initiatives included ESOL, career advising, job placement, and a CPTech pipeline program, with BID Milton participating in multiple trainings. Efforts to support economic mobility included hospital-sponsored education and partnerships to promote career advancements.
Mental Health and Substance Use	The hospital supported youth resilience and coping skills through trauma-informed curricula, Botvin Life Skills training, and community grants to local school districts. Mental Health First Aid training expanded dramatically from 49 to 380 participants between FY23 and FY24. BID Milton also partnered with multi-sector coalitions like the Milton Coalition and Building Up Youth to advance mental health and substance use prevention. Treatment access improved through recovery coaches, the Collaborative Care model, and prescription take-back initiatives. In FY24 alone, 436 patients were screened for substance use, resulting in 172 treatment referrals.
Complex and Chronic Conditions	BID Milton advanced chronic disease prevention and management through screening, education, and support programs. Lung cancer screenings rose from 786 to 917, and diabetes self-management classes maintained strong participation and behavioral impact. Older adults benefited from increased palliative care consults, meditation, and music therapy sessions aimed at reducing isolation. Programs like Matter of Balance and free gym memberships promoted physical activity and reduced fall risk. These efforts reflect a commitment to equitable, coordinated care for at-risk populations and those managing complex or chronic health conditions.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: 2026-2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

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

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

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

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

Are there any questions before we begin?

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

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

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

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

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

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

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

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

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

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

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

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

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

Interviewees

- Marli Cassli, MPH, MS, Commissioner of Public Health, City of Quincy
- Caroline Kinsella, BSN, RN, RS, Health Director/Public Health Nurse, and Anne Grossman, MSW, LICSW, Community Health Social Worker, Town of Milton
- Peggy Montlouis, Community Health Educator, and Gerard Cody, Public Health Commissioner, Town of Randolph
- Peter Forman, President and CEO, South Shore Chamber of Commerce
- Janice Sullivan, MPH, Chief of Strategy and Communications, Aspire Health Alliance
- Cynthia Sierra, CEO, Manet Community Health Center
- Jennifer Herring, Assistant Director for Special Education and Student Services, Randolph Public Schools
- Richard Ash, City Councilor, City of Quincy; President, Quincy Pride
- Donna Shecrallah, Director of Area Agency on Aging, South Shore Elder Services
- Rachel Lee, MPH, RD, LDN, Project Manager - Diabetes and Health Equity, QARI and Dr. Tamn Nguyen, Professor, Boston College
- Sandy Bouchard, Food Pantry Director, Germantown Neighborhood Center, Hale Family YMCA
- Noreen Dolan, Fund Manager, Milton Residents' Fund
- Anna Erdei, Senior Vice President of Outpatient Services, Bay State Community Services
- Margaret Carels, Director, Milton Coalition
- Taylor Desanty, MSW, LICSW, Housing Resource Center Director, Father Bills & MainSpring

Community Health Priority Areas

Social Determinants of Health

- Transportation
    - Many families are unable to purchase a car due to costs; without a car it is difficult to access care and leave the house.
    - The RIDE program is not reliable and ride share apps are expensive
    - Transportation is a critical issue for older individuals in the community
- Food Insecurity
    - The cost of food is very high at the smaller community grocery stores; those without reliable transportation can't travel to cheaper supermarkets
    - Lack of education on nutrition and how to make healthy meals on a low budget
    - Community food pantries, farms, and grocery store donations help fill the need
- Housing
    - Home maintenance is challenging and expensive, especially for older adults. There are few rental units in the area and their prices are always increasing.
    - Lack of resources for individuals facing eviction and overall lack of affordable housing
    - High costs of utilities; some organizations provide additional funds for families who receive shutoff notices
    - Shelters often do not accept individuals with high medical needs
- Economic Insecurity
    - Need for more education on financial literacy, budgeting, and financial planning

    - Cost of higher education is increasing and is a burden for many parents
    - Need for higher wages and compensation for healthcare workers, especially in schools
    - Need for additional job training opportunities and access to professional supports
- Community Safety and Inclusivity
    - Youth violence and underage drinking at community parks is a challenge
    - Increase of used needles left in community parks
    - Some interviewees felt the Milton community was not welcoming of low-income people

Access to Care

- Need for additional community programming and outreach from the hospital (free screenings, education on blood pressure, flu clinics, etc.)
    - Community outreach needs to include culturally competent messages and be accessible in multiple languages
- System Navigation
    - Need for additional support and education on how to navigate the healthcare system including insurance access, re-enrollments, and care referrals
    - Expansion of the Peer Recovery Specialist model may help provide navigation support
- Provider Availability
    - Lack of providers who accept MassHealth, especially for mental health care
    - Lack of providers who are trained and specialize in treating substance use disorders
    - Lack of providers who are able to provide culturally competent care in multiple languages
- Some health needs, like hearing aids or fake teeth, are not covered by insurance, because they are viewed as cometic, but would greatly improve quality of life
- Many individuals only go to the doctor when they are seriously ill or hurt; lack of preventative care
- The high price of prescription medication is a barrier to care

Mental Health and Substance Use

- Mental Health
    - Isolation and loneliness in individuals who are homebound and older adults
    - Caregiver support
    - Anxiety, depression
    - Youth mental health
        - Academic pressure
        - Social Media
    - Impact of trauma
- Substance Use
    - Alcohol
    - Need for additional support groups for sober individuals and people in recovery
    - Youth vaping and nicotine use
    - Addressing community and provider stigma
- Post-COVID there is a higher demand for therapy and mental health care; currently not enough providers to meet the need
- Support for substance use prevention is low; most of the parent and community engagement is reactionary

Chronic and Complex Conditions

- Many individuals do not have the time to attend classes to learn about managing their chronic conditions or to learn about medication management
- Diabetes, tuberculosis, cancer, heart disease, and dementia are common conditions in the area

Priority Populations

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

- Interviewees also identified concerns for new parents, pregnant people, and individuals with substance use disorder

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout the service area communities, but communication between organizations can be challenging
    - Specific organizations identified as critical resources: Council on Aging, Greater Boston Food Bank, Brookwood Farm, Father Bill's, Foxborough Partnership Program, Asian Diabetes Clinic (AADI), Mass Hire, Baystate Services, Quincy Community Action Programs, QCARE
- Schools, food banks, shelters, religious organizations, emergency services, legal resources were common partnerships across interviews
- Interviewees highlighted wanting to have more collaboration with Boston-based organizations
- Language and lack of translation services is a barrier to community outreach and intervention

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

BID Milton
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Haitian Immigrants/Refugees
Location: Randolph, MA
Date, time: 9/24/2024
Facilitator: JSI, Nesly Metayer
Approximate number of participants: 15

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Exercise a lot. I am not too healthy; I do not have the best health. You should keep your body sharp and do a lot of exercise. Depending on the type of work that you do, you may be concerned about your safety at work if you are not fit.
    ii. I eat lots of legumes, fruits, and vegetables, which keep my body healthy
    iii. I walk a lot and drink lots of water
    iv. Our family exercises a lot
    v. I run a lot and don't do other exercises
    vi. I lived with my wife and kids in Haiti. There was a lot of insecurity back home, which caused me to have high blood pressure. I took medication for it. When I moved to the US, it was the opposite, I no longer took the medication. I don't watch my sodium intake, but I feel more stable. So the condition was related to the stress in my county back home. My family and I walk a lot in the park. We go out, we don't sit in the house a lot.
    vii. I am retired and keep myself active. I have been walking everyday for the past 20 years. My friends and I (8 of us in total) started a walking group and most of them have passed now; I am the only one left. I eat anything and everything, but in small quantities.
    viii. If you eat something bad and you don't feel well; you should stop eating it. I always keep active inside the house and try to avoid stress. I always talk with my household members by joking around and telling stories.
    ix. I watch what I eat; I avoid canned foods. I play a lot of sports, because a family member died of cancer.
    x. Reducing stress and eating well. My body is always in good shape. If I did not have God, I don't know where I would be.
    xi. I laugh a lot by telling jokes

b. **What stops you from being as physically healthy as you'd like to be?**
    i. When I was in Haiti, I used to do a lot of exercises, but when I moved here I stopped. I don't have the equipment here to exercise.
    ii. Finding and having a decent job
    iii. Stressful situations will cause many illnesses
    iv. Stress can stop you from being physically healthy; eating bad food can also cause bad health

Question 2

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?**
    a. I always manage my stress. I don't stress over things that I cannot change. I change my mindframe to accept things the way that they are.
    b. I sew a lot. I try not to leave any empty time to overthink. I do lots of coloring, puzzles, and crafts for church. I am happy on Sundays, because I enjoy the company of my grandchildren. When they come over, I tell them the histories of Haiti. I sing and listen to religious songs.
    c. I keep my mind busy. I laugh and tell jokes.
    d. Currently, I have low mental health. I go up to the hills to pray and I sing a lot when I am inside the house. I believe in God. I feel strong spiritually but not mentally. "Only God knows"
    e. I used to listen to music and pray a lot while I was cleaning. Although I do all of these things, I don't feel mentally strong.
    f. It is important to stay positive and not take anything personally.
    g. I pray a lot to be healthy
b. **What stops you from being as mentally healthy as you'd like to be?**
    a. I feel stress from the way I am living and I am also worried about my only daughter who has special needs. This situation is impacting my mental health. I have high blood pressure and I am stressed.
    b. The change in countries and moving away from my children impacts my mental health. I pray for my health and that I find a job here in the US.
    c. Hopelessness
    d. Stress and physical pain in my stomach (which may be related to my stress)
    e. Language barriers. When I cannot communicate it causes a lot of stress. I always feel that people are laughing and judging me because I do not speak English well.
    f. I am unable to adapt well to the new physical environment

Question 3

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

- **a. What social factors are most problematic in your community?**
    - a. Transportation
    - b. Housing
        - i. Housing for me and my daughter who is disabled is challenging. Where I currently stay is not comfortable for her.
        - ii. In the US, you can't stay at someone's house forever and it is even more difficult if you have a child with you. I am always crying, because I don't have my own place to stay.
        - iii. There was no warm welcome from my immediate family when I moved here to the US.
        - iv. Housing costs are getting higher and higher every year, which puts a burden on my pocket.
    - c. Economic insecurity and challenges finding employment
    - d. Accessing healthcare
- **b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?**
    - a. Lack of unity in the Haitian community
    - b. Language barriers
    - c. Lack of school programs for adults

Question 4

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

- **a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    - a. I am not aware of many local resources except for the IFSI, which is located in Boston, MA
    - b. They charge so much money to provide resources
    - c. The Randolph Intergenerational Community Center providers volunteer opportunities to help with ESL/conversational classes
- **b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    - a. ESL resources
    - b. Services to help people find jobs

Question 5

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

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

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

- Once we adapt ourselves to the system, speak the language, and find a job, then we will be okay
- I would like to see more resources around helping us find a job
- It is difficult to navigate the MassHealth system. I called to make an appointment and they took my number then said they would call me back but they never did.

BID Milton
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Low-Resourced Families
Location: Quincy Community Action Program
Date, time: 10/18/2024
Facilitator: JSI and QCAP
Approximate number of participants: 14

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Yoga
    ii. Sleep
    iii. Go for walks
    iv. Go to the gym
    v. Take vitamins
    vi. Drink herbal tea and eat warm soup
    vii. Eat honey
    viii. Go to the doctor

b. **What stops you from being as physically healthy as you'd like to be?**
    i. It is a struggle to stay healthy after having kids
    ii. I do not have enough time
    iii. I have neck and back pain from not moving enough
    iv. Eating fast or frozen food because it is quick and cheap
    v. Gym memberships are expensive
        1. I would like to learn more about insurance plans that pay for gym memberships
    vi. I want to find information and resources on how to be healthier

Question 2

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?**
    a. Talk to friends and chat with the "girls"
    b. Go to a monthly brunch with friends

c. Praying; using religion as an outlet
d. Exercise
e. Go on vacation and take day trips
f. When my kids see me happy, they are happy. When they see me mad, they are mad or sad
g. Mood is very important
h. I write things down to try and keep organized
i. Being able to speak about your problems keeps you mentally healthy
    i. Sharing feelings
    ii. Not talking about things leaders to depression, anxiety, and other things
j. Therapy
k. Trying to be appreciative of what you have is important. Practice self-reflection, health introspection, gratitude, and remember to step back
l. I am morning person and try to do things in the morning to work around the barrier of not having time

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

a. It gets harder as an adult to find and keep friends with how busy life is
b. Cost is a huge financial barrier
    i. Self-care activities and therapy can be a lot of money
c. There is no time to pause and refresh after coming home from work. I am dealing with kids and responsibilities
d. Denial of your situation; you need to accept when something is wrong
e. We always forget about ourselves as we focus mostly on the kids

Question 3

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

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

a. Housing
    i. Affordable housing is a big issue
    ii. I am looking at apartments and it is a nightmare
    iii. I am on the waitlist and haven't heard about assistance
    iv. Rent is far too expensive
    v. The high cost of housing is a huge issue
b. I have an autistic daughter and it is okay to find care
c. Food is too expensive, especially if you are trying to buy healthier options
    i. We need cheaper food options. We need a Market Basket and less Whole Foods
d. It is hard to find resources in general. A lot of people don't know that things exist or where to go to get help.
    i. We need more social workers

e. Transportation is a barrier for a lot of people. Public transportation can be hard to rely on; if you don't have a car or if your car is bad, it can be tough
f. Internet can be a barrier; some people don't have it

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

a. People who are receiving assistance or public housing; everything is harder
b. If you don't speak the language, everything is tremendously harder

Question 4

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

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

a. QCAP
b. Interfaith
c. Baystate Community Services and the Quincy Family Resource Center
d. Local libraries
e. Local clinics and hospitals
f. YMCA
g. The town of Weymouth itself, especially the Teen and Family Center
h. Local churches
    i. Granite City Church

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

a. We need more language services and ESOL classes in general (especially online options)
    i. The waitlists are very long
b. More mental health services, especially in-person therapy
c. Treatment (mobile) for substance use
d. More resources for affordable housing and housing in general
e. More information on political figures in general and their impact on local political decisions
f. More psychiatrists and therapists in general, especially providers who assist in immediate and long-term trauma situations
g. I would like to have a hospital back, not just an urgent care
h. Affordable childcare; there are very long waiting lists for the childcare facilities that are more affordable
i. We need more youth and young-adult centered substance use treatment. We also need more education in general for this population on substance use disorders, vaping, and marijuana

Question 5

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

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

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

- Getting healthcare in general; we need more help with navigation services
- Domestic violence and child/parent violence resources

BID Milton
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Older Adults in Winter Valley Affordable Housing
Location: Winter Valley (Milton)
Date, time: 10/29/2024
Facilitator: JSI
Approximate number of participants: 15

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Walking - I try to come here and do physical activities. Very few people take advantage of the activities here.
    ii. Tai Chi
    iii. Exercise classes - yoga and cornhole are available but have poor participation. Unquity has exercise class events, but very few people attend.
    iv. Wii bowling

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Sometimes it's too hot or it's raining or it's too cold
    ii. Mobility issues affect motivation
    iii. The campus environment keeps people indoors and in their housing complexes
    iv. Lack of people. You start with a dozen people (at the activity), then it whittles down to 2-3 people
    v. Sometimes the activities are not at a time when I'm available. I know it is hard to meet everyone's needs, but if you did it sporadically at 10am or 3pm, so the time would work for different groups
    vi. Transportation to activities outside of the community is hard. Transportation can be expensive

Question 2

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

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

c. My monthly calendar
d. Reading
e. Playing Mexican dominos and other free games
f. Healing bowls
g. Crafts

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

a. One problem is that there is no access to a list of mental health doctors or counselors in the area. When you try to access services, they say that your insurance doesn't cover it
    i. That's a big problem
    ii. I found a program for the therapist and we all have to have access to that kind of program
    iii. We, as a group, need education. We also need help with coping skills. It is not healthy and it is not fair. If they don't want to be social, leave them alone; you can't force them
b. Language barriers
c. Mental health is a huge issue. It is a wonderful opportunity for the hospital to have people come out to the community and talk to us 1:1
d. Mental health access is getting scarcer and scarcer. Carney had 12 psychiatric beds and we only have two at the hospital. I don't think we have a social worker who will come out. We have to articulate that as a need.
e. People aren't sure what the resources are
f. People feel isolated and are happy to stay that way
g. There are not enough providers. Milton does not have a psycho-pharmacologist

Question 3

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

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

a. Access to healthy food
    i. The quality is bad at Meals on Wheels, but it will keep you alive
b. Transportation
    i. The RIDE is sometimes inconvenient
    ii. We have a driver here that runs between both buildings
    iii. I know of a couple of people that don't know how to use the Uber app. The Council on Aging had a class and people missed it.
    iv. Back in the day, Milton had two buses, Parkway East and Parkway West. A lot of towns, through the Council on Aging, have provided general transportation, but we don't have anything that corresponds to that. There should be a bus that would stop at the end of driveways.

v. My transportation options are limited to medical appointments. I haven't heard of transportation options for social activities or shopping trips.
    1. The RIDE has a flex program. In addition to helping with social connection, it costs you $3 to take a Lyft anywhere
vi. All of the new buildings should be built near public transportation; like in Milton it is the Mattapan area
    1. Unquity is accessible to public transportation
    2. Going to Milton hospital I was waiting a very long time - both when getting there and getting back

c. Knowledge of basic technology. This class has been offered at different times

Question 4

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

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?
    a. We have a good relationship with the Council on Aging; a lot of the residents go there.
    b. R3 (Right Place, Right Time, Right Care) through Hebrew Senior Life. I cannot say enough about it.
    c. Public libraries
    d. Churches that are outside of Milton that are very community oriented
    e. The Hyde Park YMCA. It would be nice if there was transportation there. I like the aqua aerobics class.
    f. Community Servings. They send frozen cooked food according to your dietary needs. It is the most wonderful service, because it is such a chore when you're tired all the time and don't have transportation. I am very grateful.
    g. Schools. Liz does a great job bringing in kids from Milton Academy and Milton High School.
    h. Funeral home
    i. Brookwood Farms. They will actually deliver. The Milton Board of Health has a program with them called Mass in Motion that is concerned about the wellbeing of Milton citizens
        i. The program looks at if people have access to food and if they are getting enough exercise. Lisa Courtney runs the Mass in Motion program

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?
    a. There is no major grocery in Milton. The stores that do exist don't accept food stamps

b. We need more urgent care facilities and health care facilities. The current wait times are too long.
c. We need more mental health services
d. We need more transportation options and we need to teach people how to use them

Question 5

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

Nothing additional

BID Milton
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals Living in Affordable Housing
Location: Quincy Harborview
Date, time: 11/12/2024
Facilitator: JSI
Approximate number of participants: 8

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. A lot of us try to cook at home instead of relying on fast food—it's cheaper and usually healthier, even if it's just simple meals with rice or frozen vegetables
    ii. The local food pantry, WIC, and SNAP are important. What's available at the housing facility is helpful.
    iii. Families talk about doing their best to keep kids active, but with the community center closed and parks not always feeling safe, options are limited—especially after dark.
    iv. When weather and safety allow, people try to walk in groups.
    v. The programs run by the public housing staff are huge—like organized walking groups, healthy cooking demos. When those are running, people show up.
    vi. We're doing our best with what's here—healthy food, safe places to move, and organized support make a big difference, but they're not always consistent or easy to access.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Safety is a big concern; people avoid going out after a certain time or avoid certain streets, which limits when and how they can be active outside.
        1. Safety is a major barrier—people say they don't feel comfortable doing stuff outside, avoid walking at night or in certain areas because of violence or drug activity.
    ii. The community center being closed makes a big difference—it used to be a safe place for kids and families to gather, exercise, and be part of healthy activities. Without it, there are fewer options.
    iii. Healthy food is expensive, especially fresh fruits and vegetables. Some people rely on food pantries or corner stores where choices are limited or not the healthiest.

iv. Stress and fatigue get in the way—working long hours, parenting without help, and dealing with financial strain leave little time or energy for working out or cooking full meals.
v. Lack of childcare makes it hard
vi. Chronic health conditions or pain make it difficult for some to exercise, especially without access to physical therapy or gentle fitness programs.
vii. People want to be healthy, but they feel stuck—without access to safe spaces, healthy food, or consistent programs, they're doing the best they can with limited options.

Question 2

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

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

a. Mental health is a big issue here, especially for the kids and teens. People talked about seeing more anxiety, depression, and even aggression in young people—but there aren't enough safe places or programs for them to open up or get help.
b. Older adults feel isolated—many live alone, don't have family nearby, or don't leave the apartment much. That isolation affects their mood and overall mental health.
c. Substance us—people shared concerns about drugs being easy to get, especially for youth, and how substance use is being used to cope with stress, boredom, or trauma. Some said they've lost neighbors or family to overdose.
d. Residents said they feel the stress of poverty every day—worrying about bills, rent, food, safety. That constant pressure takes a toll on mental health, especially when there's no break from it.
e. The lack of jobs and job training opportunities was mentioned often—not working or feeling stuck leads to people feeling unproductive, low, and disconnected. That sense of not having purpose adds to depression.
f. People said there's not enough access to mental health services—too few providers, long waits, no insurance coverage, or not knowing where to go. When help is available, it's often short-term or not culturally relevant.
g. There was a lot of talk about wanting more support groups—for parents, teens, people in recovery, or those dealing with stress or grief. People said they'd come if there was something regular, safe, and close to home.
h. Overall, people want to talk more about mental health—but they need real, consistent spaces to do that, and services that are accessible, local, and rooted in the community.

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

a. Access to care is a big issue—many people don't have insurance, or they have Medicaid but can't find providers who take it. Even when someone does take it, the wait is long, or they don't feel connected to the provider.
b. There aren't enough mental health professionals nearby, especially those who understand the community, culture, or speak Spanish. A lot of people give up after trying to find help and hitting walls.
c. The programs offered through housing are really helpful—they help people socialize, feel safe, and get connected to services—but they're not enough to meet the mental health needs of everyone here.
d. Winter is especially hard—when it's cold and dark, people stay inside more. That isolation builds up. Depression and loneliness gets worse, especially for older adults and those living alone.
e. People feel stuck—without jobs, opportunities, or a clear path forward. That constant stress and lack of purpose weighs on people's minds and shows up as depression, anxiety, or even anger.
f. There's a lot of unprocessed trauma—from violence, loss, or just years of living with instability. But most people never get a chance to talk about it in a safe space.
g. Despite all this, people want support. They just need it to be consistent, local, respectful, and easy to access—and they want more of the kind of community-based help that housing already provides.

Question 3

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

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

a. Affordable housing is a major concern—even though people are living in public housing now. They feel very lucky, but it's a huge issue..
b. Transportation is a barrier—not everyone has a car, and public transit is unreliable or doesn't go to where people need to be, like medical appointments, grocery stores, or jobs. This makes everything harder—from accessing health care to finding work.
    i. Transportation is a major issue—MBTA service is unreliable or doesn't go where people need to go, and not everyone qualifies for or can navigate The Ride or other paratransit services. Getting to appointments, job interviews, or grocery stores is a challenge.
c. Food access is limited—many rely on food pantries, WIC, or SNAP, but said it's hard to afford fresh and healthy foods. Nearby stores often don't have great options, and some people can't carry groceries far or don't feel safe walking.
d. Safety came up a lot—people said they don't feel comfortable being outside at certain times, especially after dark. Parents worry about letting their kids play outside, which limits opportunities for exercise and social connection.

e. Isolation is real—especially for older adults and people without close family. Some residents said they go days without seeing anyone or having a real conversation.
f. Lack of jobs and training opportunities—many want to work or get back into the workforce, but there aren't enough accessible, flexible jobs nearby. This affects mental health and overall stability.
g. Language and immigration status—for some families, language barriers and fear around documentation make it harder to access services or feel fully part of the community.
    i. Language access is still lacking, even in diverse cities like Boston and Quincy. Many resources are only in English, and interpreter services are not always available—or people don't know how to ask for them.
h. Long waitlists for services like mental health counseling, affordable childcare, job training, or housing transfers make people feel like they're stuck, even after doing everything "right" to sign up
i. Technology gaps and digital access create barriers, especially for older adults or those without smartphones, Wi-Fi, or digital literacy. Applications, appointments, and benefits are increasingly online, which shuts people out.
j. Lack of clear, up-to-date information—people often hear about programs only after it's too late or from a neighbor, not through official channels. Flyers and notices get missed, or the information is confusing.
k. Eligibility restrictions—people earn "just over the limit" for some programs but still struggle to afford food, rent, or care. Others are disqualified because of their immigration status or past involvement with systems

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

a. Older adults, especially in public or senior housing,
b. Teenagers and young adults struggling with mental health, peer pressure, and a lack of safe, free, or welcoming places to gather
c. Immigrant families and non-English speakers—especially in Quincy's Asian, Latino, and Cape Verdean communities. These groups face language barriers that make it harder to access housing supports, healthcare, job opportunities, or school-related services. Some rely on word-of-mouth because they don't trust or understand the system.
d. Single parents and families in subsidized housing often feel stretched thin
e. People with disabilities or chronic health issues face challenges with transportation, home modifications, and accessing care—especially when local clinics have long waits or don't accept MassHealth

Question 4

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

a. **Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    a. The programs run directly through the housing development were named first by many people—whether it's health screenings, youth programs, food distributions, or community navigators. These are trusted, easy to access, and close by.
    b. Community health centers like DotHouse, Mattapan Community Health, Manet Community Health in Quincy, and other neighborhood-based clinics are essential. People said they rely on these for primary care, mental health, and dental—especially for MassHealth coverage.
    c. Food pantries and food access programs like Project Bread, the Greater Boston Food Bank drop-offs, or local churches make a big difference. Some also mentioned school-based food distribution programs.
    d. Schools are an anchor for many families—people talked about trusting school staff, getting referrals to services through teachers or counselors, and relying on schools for meals, behavioral supports, and after-school programs when available.
    e. Parks and green spaces are important for health, especially for kids and older adults—but only if they feel safe and well-maintained. Some participants mentioned they don't always feel comfortable letting their kids play outside.
    f. Multi-service centers like ABCD, Boston Centers for Youth & Families, and Quincy Community Action Programs help people get connected to fuel assistance, housing support, childcare vouchers, and more. Some said they wouldn't know where to go without them.
    g. Faith-based organizations and churches were mentioned as both a source of emotional support and tangible help—like rides to appointments, food baskets, or a safe place to talk.
    h. Some people mentioned YMCA and Boys & Girls Clubs, especially for youth programming and summer activities, but access depends on cost and availability.

b. **What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. More mental health services—especially for youth and teens and those who are uninsured or Medicaid insured
    b. Affordable or free fitness programs for adults and families.
    c. Year-round programs for older adults. Seniors said that winter is especially lonely and isolating, and they want more consistent social and wellness activities without needing to travel far.
    d. Job training and employment support - People want to work, but they need help building skills and finding opportunities.
    e. More child and teen-focused programs—after-school programs,

f. Better access to fresh and affordable food—a weekly farmer's market, mobile grocery van
g. Translation services
h. Interpretation services
i. More consistent follow-up and case management—people often get referred to services and then never hear back. They want someone to check in and actually help them follow through.

Question 5

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

Nothing additional

BID Milton
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Milton Public Health Professionals
Location: Zoom
Date, time: 11/14/2024
Facilitator: JSI
Approximate number of participants: 9

Question 1

In the hospital's last assessment, they identified 4 community health priority areas - social determinants of health (including things like housing, transportation, economic struggles), access to care, mental health and substance use, and chronic and complex conditions.

- **a. When you think about the large categories of issues that people struggle with the most in your community, do these seem like the right priorities to you?**
    - a. Are mental health and substance use disorders the same?
    - b. The Milton community health needs assessment has just been completed
    - c. Access to care is less an issue in MIlton
    - d. Lots of chronic disease, but not complex conditions
    - e. Chronic diseases line up with the rest of the country, overweight and obesity rates. Cancer rates are important to note in comparison to the rest of the state and nation
    - f. Certainly social determinants of health are priorities, housing in particular
- **b. Would you add any additional priority areas?**
    - a. Asthma
    - b. Youth rates of ADHD are higher than the region but not the nation.
        - i. Youth alcohol
    - c. Cancer

Question 2

I'd like to ask you about the specific issues within each of these areas that are most relevant to your community.

- **a. In the area of Social Determinants of Health – what specific issues are most relevant to your community?**
    - a. Housing
        - i. The cost of housing and the importance of housing security
    - b. The hospital might be interested in additional focus on patients, including increasing ways people can move through the health system
    - c. The school system in Milton is very challenged by their ability to equitably think about and provide appropriate education among populations experiencing disparities

d. Social and racial segregation
    i. Data on young people of color experiencing bullying, racial profiling, and harassment
    ii. Poisonous political environment

b. In the area of Access to Care – what specific issues are most relevant to your community?

a. Residential segregation and civic engagement representation: employees, town government, boards
b. Navigation and understanding services related to immigration
c. The number of seniors is the fastest growing population in Milton

c. In the area of Mental Health and Substance Use – what specific issues are most relevant to your community?

a. Access to mental health services for youth and prevention resources
    i. BID lacks in providing mental health services in Milton
b. High rates of dementia in Milton

d. In the area of Complex and Chronic Conditions – what specific issues are most relevant to your community?

a. Cancer
b. Lots of people are dealing with heart disease due to lack of to physical activities
c. Asthma rates are higher than the country but not the state
d. We have an older population and high rates of obesity and social isolation which are linked to heart conditions, especially for people of color
    i. Lots of undiagnosed illness

Question 3

In the last assessment, the hospital also identified priority cohorts – or populations that face significant barriers to getting the care and services they need. The priority cohorts that were identified are youth, older adults, low-resourced populations, racially/ethnically/linguistically diverse populations, and individuals living with disabilities. When you think about the specific segments of the population in your community that face barriers, do these populations resonate with you?

e. Are there specific segments that I did not list that you would add for your community?

a. This is a comprehensive list.
b. LGBTQ+ kids
    i. Kids suffer mentally. They may be victims of bullying and afraid to go to school
    ii. Transgender youth. The families also need support, not just the kids.
        1. Includes a spectrum of identities
    iii. Families are very concerned about the impact of the national elections and what hospital administrators feel safe to talk about and address
c. People with disabilities
    i. Including children whose parents have dementia
    ii. Many parents who have kids with disabilities have trouble finding childcare
    iii. Issues related to arthritis of the neck and spine and its impact on activities of daily living

Question 4

I want to ask you about community assets and partnerships.

a. **What is the partnership environment in your community? Are organizations, collaboratives/task forces, municipal leadership, and individuals open to working with one another to address community issues?**
    a. **Are there specific collaboratives that are particularly strong?**
b. **Are there specific organizations that you think of as the "backbone" of your community – who work to get individuals the services and support that they need?**
    a. Partnership for a Healthy Milton is just getting off the ground and is looking to make a difference
    b. The Milton Coalition
    c. The Milton Health Department Substance Prevention Coalition
    d. Interfaith Clergy
    e. Affordable Inclusive Milton - affordable housing organization
    f. Celebrate Milton!
    g. Courageous Conversations
    h. Citizens for a Diverse Milton
    i. Milton Anti-Racist Coalition (MARC)
    j. Connect to Milton

Question 5

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

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

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

- Youth substance use; the use of Zyn nicotine pillow pouches is becoming prevalent
- Childhood adverse experiences, or childhood trauma
    - The number of girls who have been victimized
    - Youth who mention they live with substance use in their home.
- So many different groups collect data; there should be a more systematic way to share

Community Listening Sessions

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

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

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

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

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

Goals:

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

EVENT AGENDA

- Orientation to meeting/Zoom (JSI): 5 minutes
- Welcome and overview of assessment process (BILH): 5 minutes
- Presentation of Key Themes from Data Collection (JSI): 15 minutes
- Breakout Groups (Community Facilitators + Notetakers): ~50 minutes
- Next steps and closing statements (BILH): 1-2 minutes

BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

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

Participants will be asked to:

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

ROLE OF COMMUNITY FACILITATOR

Establish ground rules

Initiate and guide discussion

Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

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

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

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

LET'S REVIEW.

REMEMBER: YOU HAVE SUPPORT.

YOUR NEXT STEPS

Be sure to register for your Listening Session (both in-person and virtual). For Zoom meetings, registration is required to join and you will be sent your link to join the meeting after you register

Plan to arrive at the meeting 30 minutes prior to start time

Look for an email with your Breakout Discussion Guide 2 days prior to the event

CHARACTERISTICS OF A GOOD FACILITATOR

Impartial

Active listener

Authentic

Patient

Enthusiastic

INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish group agreements

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

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Consider accessibility

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

THANK YOU!

Feel free to send in any questions to Madison

madison_maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

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

Ground rules and introductions (5 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Area 2: Access to Care (12 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wrap up (1 minute)

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

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Beth Israel Deaconess Hospital-Milton Community Listening Session

February 24, 2025 | 12:00-1:30pm

Beth Israel Lahey Health

BID Milton Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Beth Israel Deaconess Milton

BID Milton Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
12:00-12:05pm	Zoom orientation and Welcome	JSI
12:05-12:10	Overview of assessment purpose, process, and guiding principles	Laureane Marquez, Community Benefits & Community Relations Manager, BID Milton
12:10-12:25	Presentation of preliminary themes and data findings	JSI
12:25-12:30	Transition to Breakout Groups	JSI
12:30-1:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
1:25-1:30	Wrap up and Next Steps	Laureane Marquez

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Assessment Purpose and Process

Beth Israel Lahey Health

Assessment Purpose and Process

Purpose

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

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

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

Beth Israel Lahey Health
Beth Israel Deaconess Milton

Community Benefits Service Area

- H Beth Israel Deaconess Hospital-Milton
- 1 Beth Israel Deaconess - Milton Radiology at Quincy

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

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

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

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

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

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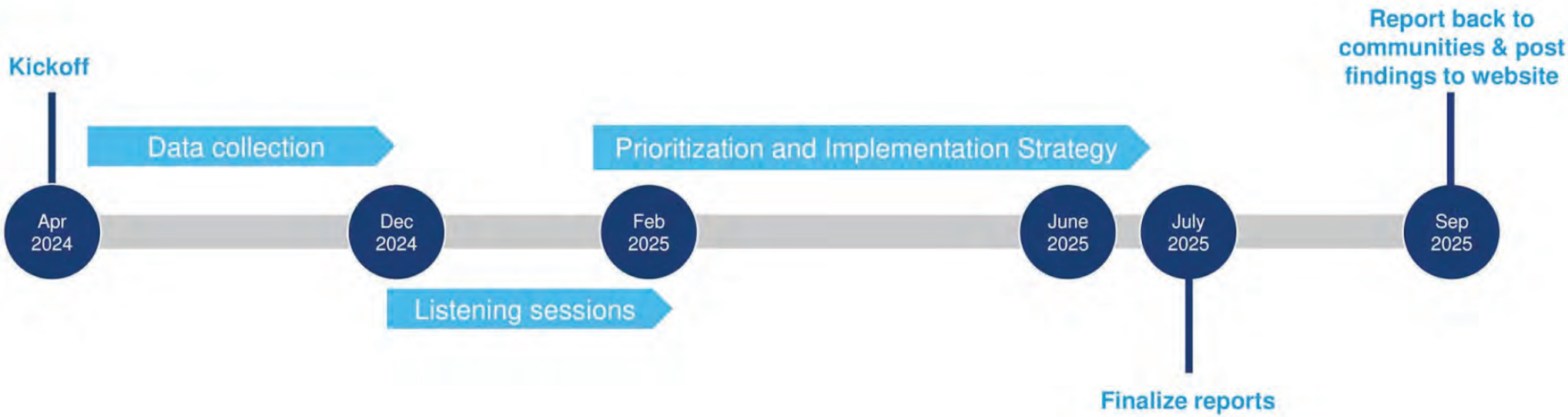
Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process

Meeting goals

Goals:

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

We want to hear from you.
Please be open to sharing when we get to Breakout Sessions

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Key Themes & Data Findings

Beth Israel Lahey Health

FY25 CHNA Progress

Activities to date

Collection of secondary data, e.g.:

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

15 Interviews

693 FY25 BID Milton Community Health Survey Respondents

5 Focus Groups

- *Low-resourced families (QCAP)*
- *Older adults in affordable housing (Winter Valley)*
- *Haitian residents (Evangelical Baptist Church)*
- *Individuals in affordable housing (Harborview - Quincy)*
- *Public health professionals (Milton)*

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FY25 CHNA Progress

FY25 BID Milton Community Health Survey Responses

693 responses

(Represents a 35% increase from 513 responses in FY22)

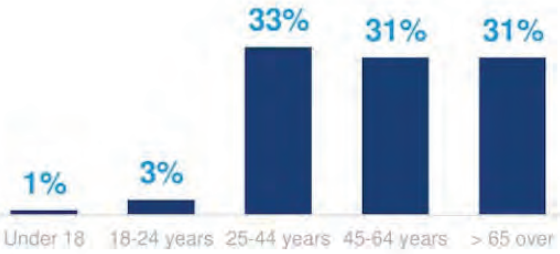
26% of respondents report a language other than English as the primary language spoken in their home **(up from 10% in FY22)**

77% of the respondents are women **(up from 76% in FY22)**

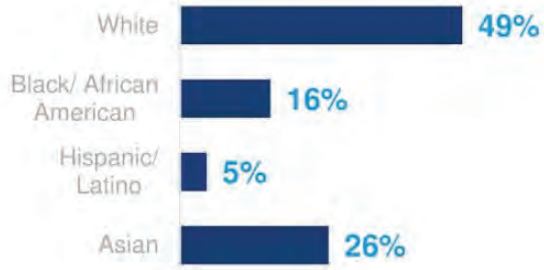
18% of the respondents identify as having a disability **(up from 12% in FY22)**

11% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(up from 5% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 172 in FY25 compared to 104 in FY22
- **Hispanic respondents:** 5% in FY25 compared to 3% in FY22
- **Asian respondents:** 26% in FY25 compared to 10% in FY22
- **Black/African American respondents:** 16% in FY25 compared to 14% in FY22

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FY25 CHNA Progress

Community Benefits Service Area Strengths

FROM INTERVIEWS & FOCUS GROUPS:

- Many community organizations have been collaborating cross-sectors for many years
- Several organizations that are focused on addressing the needs of historically underserved populations, including language and cultural groups and those who are homeless/unstably housed

FROM FY25 BID MILTON COMMUNITY HEALTH SURVEY:

said they **feel like they belong** in their community **(up from 89% in FY22)**

said they are **satisfied with quality of life in their community (down from 87% in FY22)**

said their community **feels safe (down from 96% in FY22)**

Beth Israel Lahey Health
Beth Israel Deaconess Milton

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FY25 CHNA Progress

Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

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

FY25 CHNA Progress
Social Determinants of Health

Primary concerns:

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

"Milton does not have its own big grocery store, and what we do have is very expensive. The cost of food is very high for many families. Not all families have transportation to get to the supermarkets that are nearby." – ***Interviewee***

When asked what they'd like to improve in their community, **52%** of FY25 Community Health Survey respondents reported more **affordable housing** (#1 response) **(up from 36% in FY22)**

22% of FY25 Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

When asked what they'd like to improve in their community, **26%** of FY25 Community Health Survey respondents reported **better access to public transportation** **(down from 27% in FY22)**

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FY25 CHNA Progress

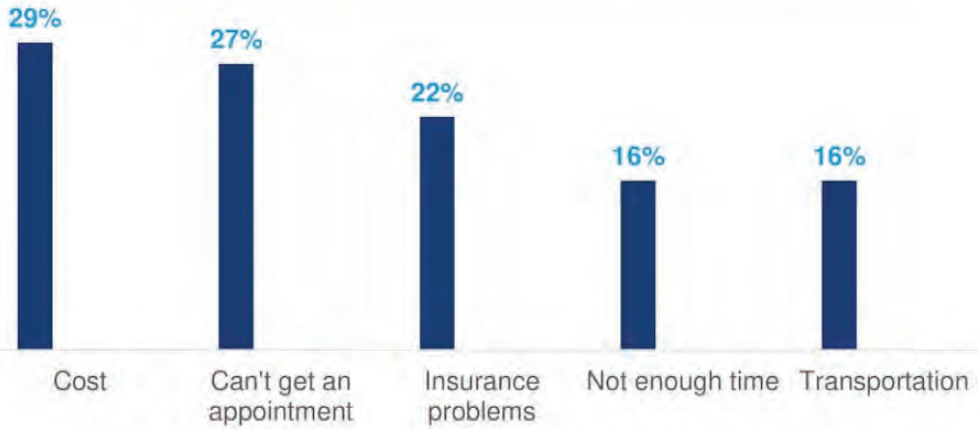
Preliminary Themes: Equitable Access to Care

Primary concerns:

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

What barriers keep you from getting needed health care?

(Top 5 responses from FY25 BID Milton Community Health Surveys)



27% of FY25 Community Health Survey respondents said health care in the community does not meet physical health needs

"We need a lot of help getting the right staff – staff with the cultural knowledge and language skills appropriate to serve our diverse communities. It is a huge challenge." - ***Interviewee***

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FY25 CHNA Progress

Preliminary Themes: Mental Health and Substance Use

Primary Concerns:

- Depression, anxiety, and stress
- Youth mental health
- Social isolation among older adults
- Cultural and language barriers to care
- Trauma among migrants, new immigrants, and refugees
- Substance use (specifically opioids)

"I am less concerned about substance use than I was in years past. Opioids and other substances are still an issue, and I don't want to minimize that. But we have seen efforts, like more education and recovery walks, that have humanized the issue and worked to reduce stigma. It has helped bring out more resources for support and treatment."
-Interviewee

AMONG FY25 BID MILTON COMMUNITY HEALTH SURVEY RESPONDENTS:

50% identified mental health as a heath issue that matters most in their community (#1 response)

31% reported that mental health care in the community does not meet people's needs

FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

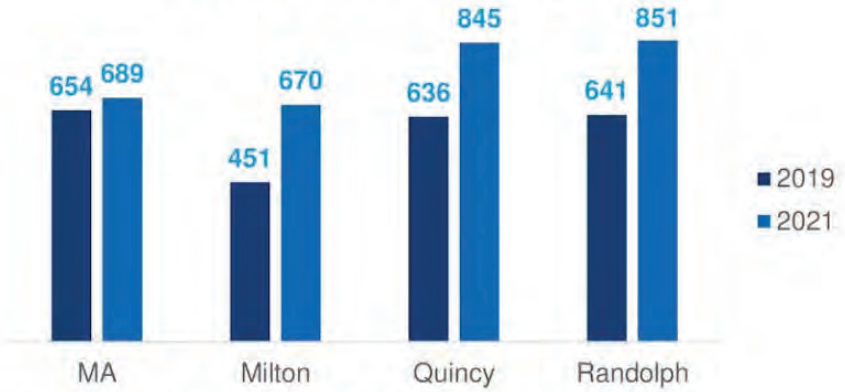
Primary Concerns:

- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Diabetes
- Community-based prevention and education
- Caregiver support

AMONG FY25 BID MILTON COMMUNITY HEALTH SURVEY RESPONDENTS:

42% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community

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



Data Source: MDPH, Massachusetts Deaths, 2019, 2021

"Diabetes and other chronic conditions are a huge issue in the Asian community, but they're an issue for everyone too. We see rising rates of cancer and heart disease. But there is data that shows that the rates of diabetes among the Asian population is exploding." ***-Interviewee***

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Instructions

11

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Breakout Sessions

Beth Israel Lahey Health

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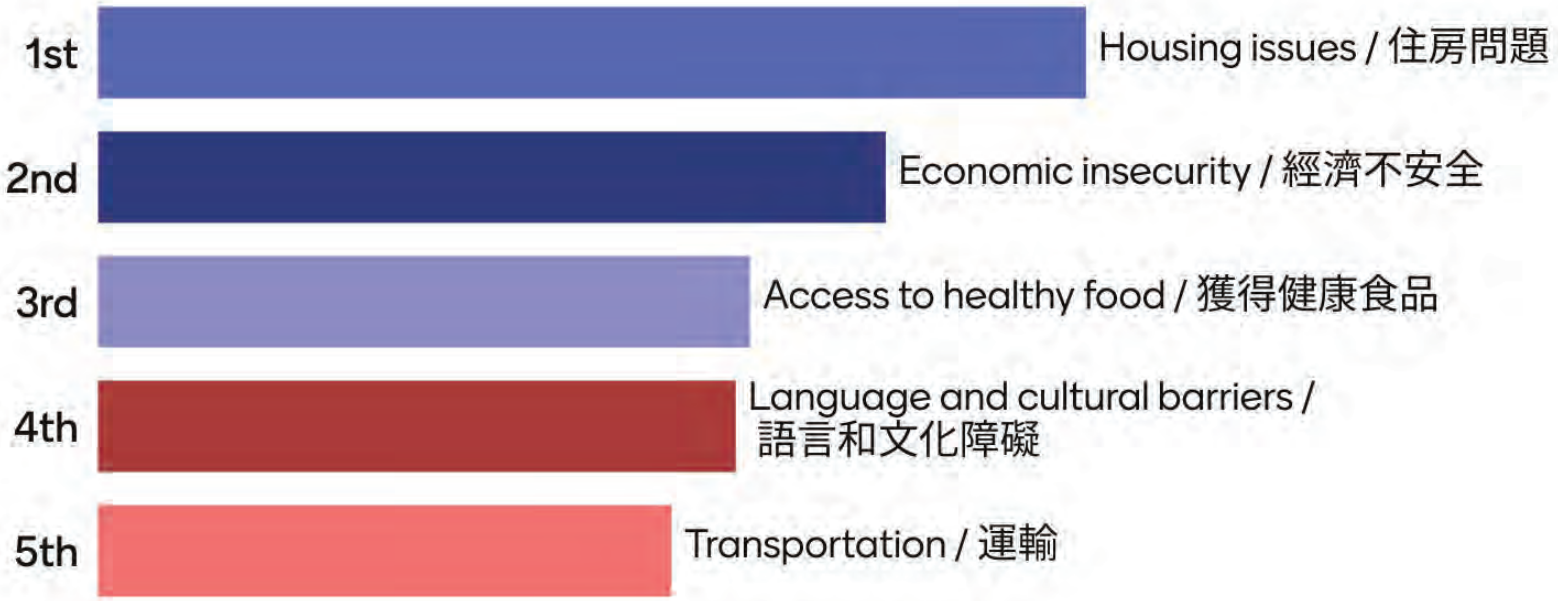
Social Determinants: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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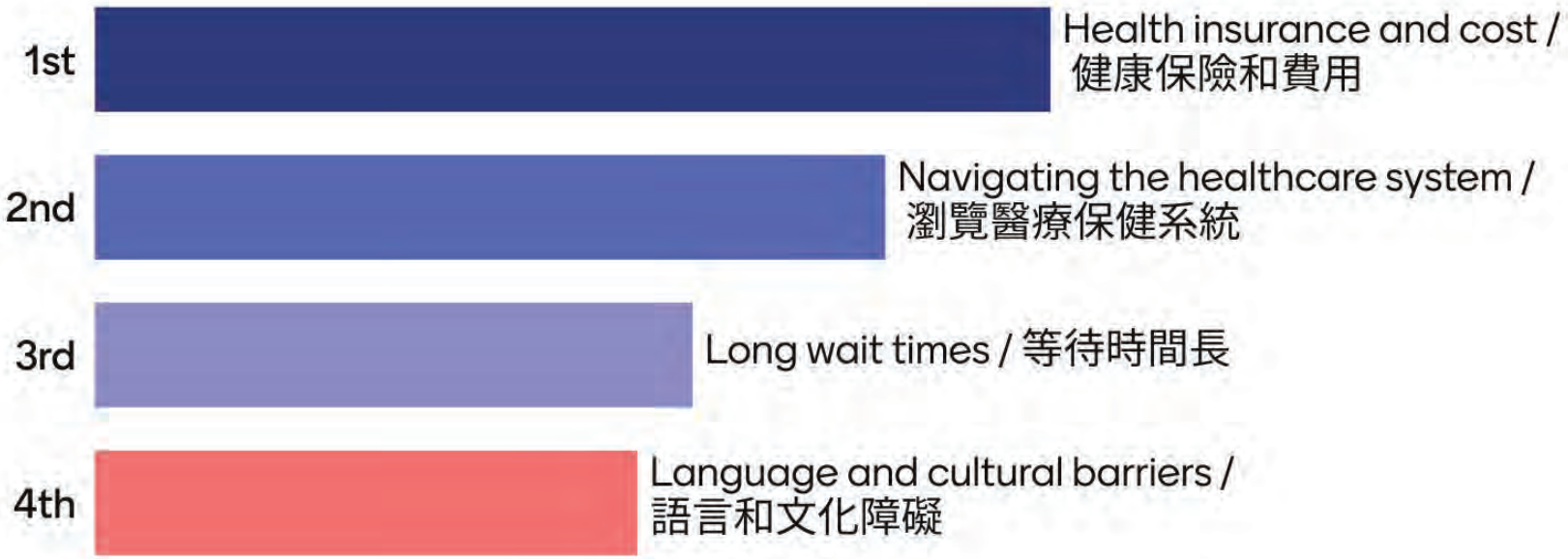
Access to care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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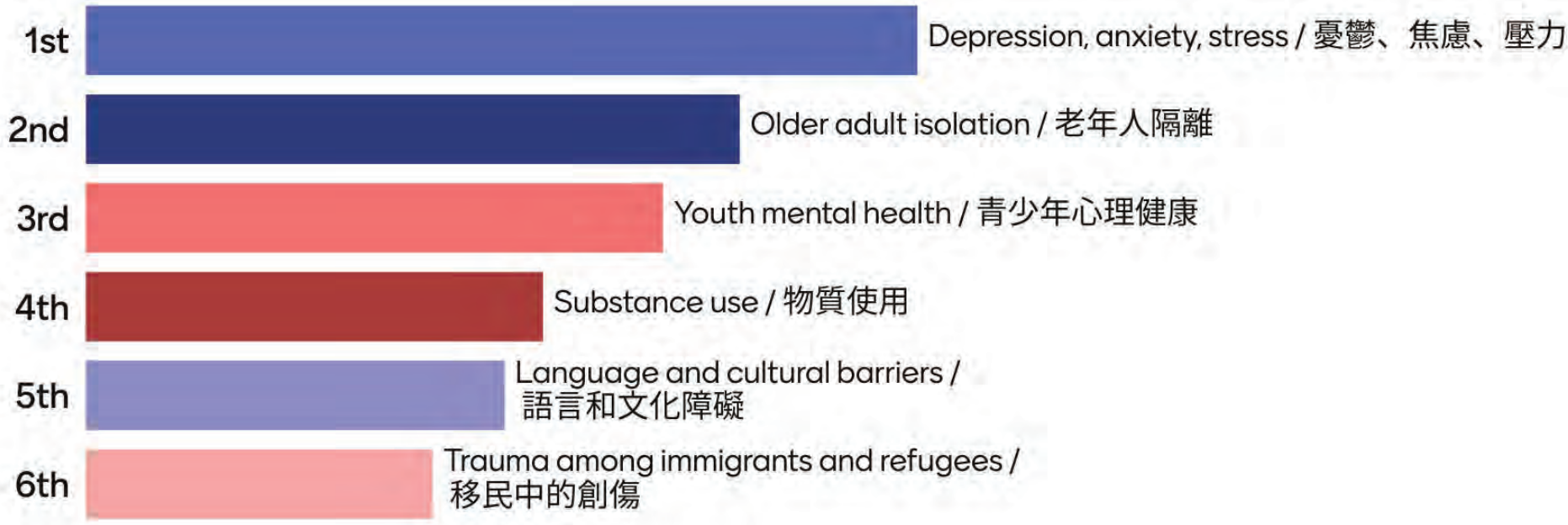
Mentimeter

Mental health and substance use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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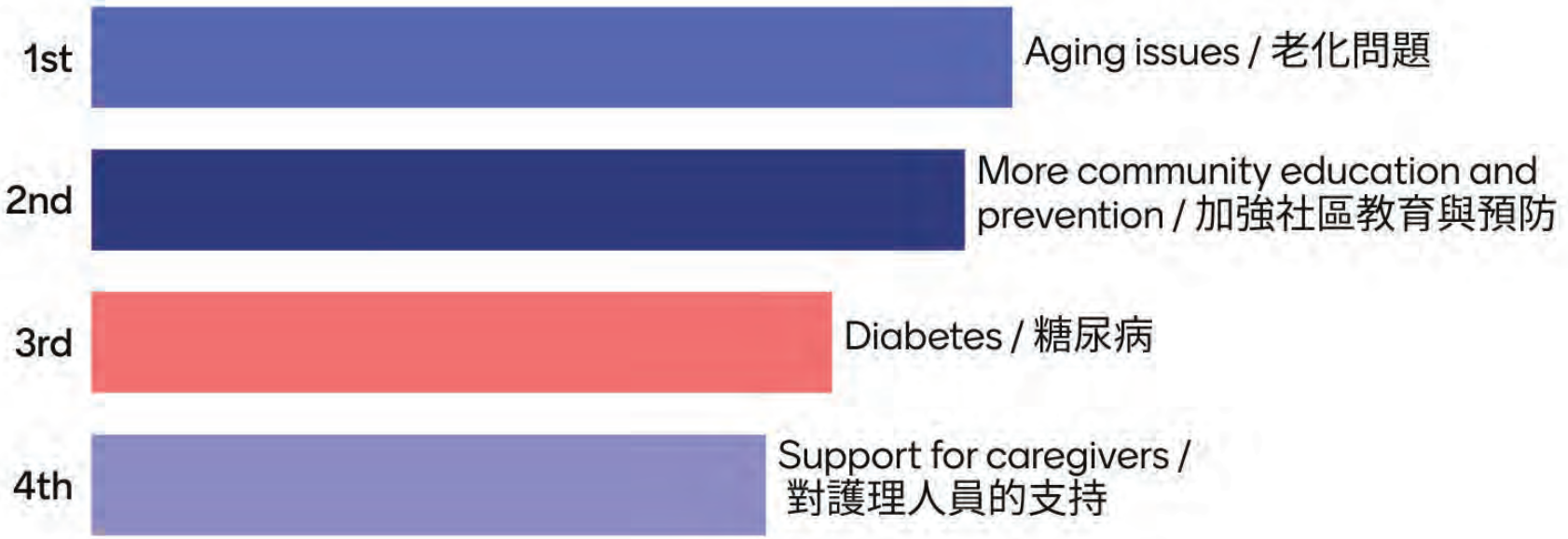
Chronic and complex conditions: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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Reconvene

Beth Israel Lahey Health

Next Steps

Laureane Marquez

Community Benefits and Community Relations Manager || BID Milton

laureane_marquez@bidmilton.org

Community Health and Community Benefits Information:

https://bidmilton.org/about/community-benefits-needs

Community Benefits Annual Meeting in September (date TBD)

Appendix B:
Data Book

Secondary Data

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
Population						US Census Bureau, American Community Survey 2019-2023
Total population	6992395	724540	28481	101361	34683	
Male	48.9%	48.5%	47.4%	50.2%	50.0%	
Female	51.1%	51.5%	52.6%	49.8%	50.0%	
Age Distribution						US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.2%	4.4%	4.8%	3.9%	
5 to 9 years	5.2%	5.5%	7.9%	3.7%	4.6%	
10 to 14 years	5.7%	6.1%	8.0%	4.2%	6.3%	
15 to 19 years	6.5%	6.4%	9.8%	3.9%	5.6%	
20 to 24 years	6.8%	6.1%	5.9%	5.8%	6.7%	
25 to 34 years	14.1%	12.9%	7.1%	20.5%	15.3%	
35 to 44 years	12.9%	13.2%	14.0%	15.4%	12.6%	
45 to 54 years	12.6%	13.3%	13.2%	11.3%	12.7%	
55 to 59 years	7.0%	7.3%	8.4%	6.0%	7.4%	
60 to 64 years	6.8%	6.7%	5.4%	6.6%	7.5%	
65 to 74 years	10.3%	10.0%	9.3%	10.5%	10.3%	
75 to 84 years	4.9%	4.9%	4.8%	4.8%	4.4%	
85 years and over	2.2%	2.4%	1.8%	2.5%	2.7%	
Under 18 years of age	19.6%	20.7%	25.7%	15.0%	18.3%	
Over 65 years of age	17.5%	17.4%	15.9%	17.7%	17.5%	
Race/Ethnicity						US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.7%	71.4%	71.7%	55.6%	29.5%	
Black or African American alone (%)	7.0%	7.2%	14.5%	6.4%	41.9%	
American Indian and Alaska Native (%) alone	0.2%	0.1%	0.2%	0.2%	0.0%	
Asian alone (%)	7.1%	12.1%	6.3%	29.2%	13.0%	

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.1%	0.0%	
Some Other Race alone (%)	5.4%	2.3%	1.2%	2.2%	7.3%	
Two or More Races (%)	9.5%	6.8%	6.1%	6.3%	8.4%	
Hispanic or Latino of Any Race (%)	12.9%	5.5%	3.5%	5.8%	13.2%	
Foreign-born						US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	138,392	4,002	33,180	12,513	
Naturalized U.S. citizen	54.5%	60.1%	62.8%	55.1%	72.3%	
Not a U.S. citizen	45.5%	39.9%	37.2%	44.9%	27.7%	
Region of birth: Europe	18.1%	20.0%	18.9%	13.0%	5.0%	
Region of birth: Asia	30.5%	47.6%	20.9%	66.3%	26.4%	
Region of birth: Africa	9.5%	7.3%	5.4%	9.1%	9.1%	
Region of birth: Oceania	0.3%	0.3%	1.6%	0.1%	0.0%	
Region of birth: Latin America	39.4%	22.8%	51.5%	11.1%	58.7%	
Region of birth: Northern America	2.2%	2.0%	1.6%	0.4%	0.7%	
Language						US Census Bureau, American Community Survey 2019-2023
English only	75.2%	77.0%	82.9%	61.7%	54.7%	
Language other than English	24.8%	23.0%	17.1%	38.3%	45.3%	
Speak English less than "very well"	9.7%	8.4%	3.8%	19.8%	17.3%	
Spanish	9.6%	3.5%	2.3%	3.5%	10.1%	
Speak English less than "very well"	4.1%	0.9%	0.3%	0.8%	3.0%	
Other Indo-European languages	9.2%	9.0%	10.7%	8.2%	21.0%	
Speak English less than "very well"	3.2%	2.8%	2.4%	2.9%	7.3%	
Asian and Pacific Islander languages	4.4%	8.6%	3.8%	24.3%	11.8%	
Speak English less than "very well"	1.9%	4.3%	1.1%	15.4%	7.0%	
Other languages	1.6%	1.9%	0.4%	2.2%	2.3%	

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
Speak English less than "very well"	0.4%	0.4%	0.0%	0.8%	0.1%	
Employment						US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	4.9%	3.7%	7.1%	7.9%	
Unemployment rate by race/ethnicity						
White alone	4.5%	4.6%	4.0%	6.5%	10.1%	
Black or African American alone	7.9%	8.0%	2.9%	17.6%	7.0%	
American Indian and Alaska Native alone	6.9%	16.0%	-	48.6%	-	
Asian alone	4.0%	4.1%	0.4%	6.1%	4.3%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	-	0.0%	-	
Some other race alone	8.0%	6.1%	6.5%	8.0%	15.3%	
Two or more races	7.9%	6.2%	3.8%	3.8%	4.6%	
Hispanic or Latino origin (of any race)	8.1%	5.5%	1.8%	5.8%	8.3%	
Unemployment rate by educational attainment						
Less than high school graduate	9.1%	7.5%	0.0%	8.6%	8.3%	
High school graduate (includes equivalency)	6.4%	7.1%	3.2%	13.6%	10.0%	
Some college or associate's degree	5.2%	5.1%	1.0%	8.8%	4.0%	
Bachelor's degree or higher	2.7%	2.6%	1.7%	2.8%	3.2%	
Income and Poverty						US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	126,497	178,053	95,711	103,129	
Population living below the federal poverty line in the last 12 months						
Individuals	10.0%	6.6%	4.7%	11.4%	7.4%	
Families	6.6%	4.7%	2.3%	6.6%	8.8%	
Individuals under 18 years of age	11.8%	5.8%	1.8%	15.4%	7.0%	
Individuals over 65 years of age	10.2%	8.7%	9.2%	14.3%	11.4%	
Female head of household, no spouse	19.1%	14.9%	2.3%	22.1%	9.2%	

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
White alone	7.6%	5.6%	2.5%	9.1%	11.8%	
Black or African American alone	17.1%	11.7%	17.4%	27.2%	6.4%	
American Indian and Alaska Native alone	19.1%	11.1%	0.0%	29.0%	-	
Asian alone	11.0%	8.1%	4.7%	11.2%	6.6%	
Native Hawaiian and Other Pacific Islander alone	21.7%	40.9%	0.0%	0.0%	-	
Some other race alone	20.1%	12.3%	6.5%	15.7%	2.3%	
Two or more races	15.7%	7.4%	0.5%	15.0%	2.4%	
Hispanic or Latino origin (of any race)	20.6%	9.4%	2.7%	12.2%	1.9%	
Less than high school graduate	24.4%	19.5%	14.4%	23.7%	14.4%	
High school graduate (includes equivalency)	12.7%	10.4%	23.0%	12.5%	8.8%	
Some college, associate's degree	9.2%	8.2%	4.9%	9.6%	9.6%	
Bachelor's degree or higher	4.0%	3.2%	2.1%	6.2%	2.7%	
With Social Security	29.8%	28.6%	28.0%	27.3%	29.2%	
With retirement income	22.9%	22.7%	23.8%	19.0%	22.5%	
With Supplemental Security Income	5.6%	3.8%	3.8%	4.9%	8.5%	
With cash public assistance income	3.5%	2.5%	1.4%	3.7%	5.2%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.7%	4.9%	13.8%	21.6%	
Housing						US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	95.9%	97.2%	94.5%	96.7%	
Owner-occupied	62.6%	68.5%	84.7%	45.0%	69.5%	
Renter-occupied	37.4%	31.5%	15.3%	55.0%	30.5%	
Lacking complete plumbing facilities	0.3%	0.3%	0.0%	0.7%	0.1%	
Lacking complete kitchen facilities	0.8%	0.7%	0.0%	1.1%	0.0%	
No telephone service available	0.8%	0.5%	0.0%	0.4%	0.9%	
Monthly housing costs <35% of total household income						

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
Among owner-occupied units with a mortgage	22.7%	21.6%	15.9%	29.3%	28.9%	
Among owner-occupied units without a mortgage	15.4%	16.9%	34.4%	18.0%	16.7%	
Among occupied units paying rent	41.3%	40.7%	31.5%	36.1%	50.1%	
Access to Technology						US Census Bureau, American Community Survey 2019-2023
Among households						
Has smartphone	89.2%	90.7%	93.0%	90.2%	88.6%	
Has desktop or laptop	83.2%	87.7%	92.8%	83.2%	84.0%	
With a computer	95.1%	96.5%	97.9%	95.8%	95.5%	
With a broadband Internet subscription	91.8%	94.2%	97.4%	94.0%	92.9%	
Transportation						US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	59.0%	56.0%	53.0%	66.5%	
Car, truck, or van -- carpooled	6.9%	5.6%	3.8%	6.7%	6.3%	
Public transportation (excluding taxicab)	7.0%	9.5%	8.8%	17.7%	8.8%	
Walked	4.2%	3.2%	2.5%	2.6%	0.6%	
Other means	2.5%	2.1%	3.2%	2.0%	4.1%	
Worked from home	16.7%	20.6%	25.6%	18.1%	13.6%	
Mean travel time to work (minutes)	29.3	32.9	32.1	34.2	37.4	
Vehicles available among occupied housing units						
No vehicles available	11.8%	8.9%	4.9%	14.2%	9.1%	
1 vehicle available	35.8%	35.4%	27.2%	48.3%	35.2%	
2 vehicles available	35.8%	39.1%	49.7%	30.0%	35.6%	
3 or more vehicles available	16.6%	16.6%	18.2%	7.5%	20.1%	
Education						US Census Bureau, American Community Survey 2019-2023

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
Educational attainment of adults 25 years and older						
Less than 9th grade	4.2%	3.0%	2.2%	5.9%	6.9%	
9th to 12th grade, no diploma	4.4%	2.7%	2.1%	4.1%	5.3%	
High school graduate (includes equivalency)	22.8%	17.4%	12.7%	20.6%	25.1%	
Some college, no degree	14.4%	12.4%	6.9%	13.6%	16.0%	
Associate's degree	7.5%	7.0%	5.6%	7.2%	11.9%	
Bachelor's degree	25.3%	30.0%	33.3%	28.0%	22.6%	
Graduate or professional degree	21.4%	27.7%	37.1%	20.7%	12.1%	
High school graduate or higher	91.4%	94.4%	95.7%	90.0%	87.8%	
Bachelor's degree or higher	46.6%	57.6%	70.4%	48.6%	34.7%	
Educational attainment by race/ethnicity						
White alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	94.6%	97.0%	98.3%	96.6%	94.2%	
Bachelor's degree or higher	49.4%	59.3%	76.6%	51.2%	33.4%	
Black alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	87.1%	90.0%	90.7%	93.1%	88.3%	
Bachelor's degree or higher	30.7%	39.4%	48.3%	41.8%	36.8%	
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	75.2%	78.6%	31.6%	78.6%	-	
Bachelor's degree or higher	24.4%	41.8%	31.6%	42.3%	-	
Asian alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	84.2%	83.0%	75.0%	69.6%	
Bachelor's degree or higher	64.0%	61.0%	67.1%	44.0%	29.2%	
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	65.9%	0.0%	100.0%	-	
Bachelor's degree or higher	40.0%	44.5%	0.0%	100.0%	-	

			Areas of Interest			
	Massachusetts	Norfolk County	Milton	Quincy	Randolph	
Demographics						Source
Some other race alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	71.6%	81.9%	91.4%	89.9%	89.9%	
Bachelor's degree or higher	20.0%	40.3%	62.5%	46.1%	34.5%	
Two or more races	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	80.6%	92.3%	95.6%	94.6%	92.2%	
Bachelor's degree or higher	33.6%	57.3%	58.5%	52.9%	41.8%	
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	73.4%	90.0%	92.2%	91.6%	93.6%	
Bachelor's degree or higher	23.3%	53.2%	67.4%	53.1%	40.5%	
Health insurance coverage among civilian noninstitutionalized population (%)						US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	98.1%	99.1%	96.5%	96.2%	
With private health insurance	73.8%	82.0%	87.9%	72.0%	67.5%	
With public coverage	37.1%	29.1%	22.4%	37.2%	40.2%	
No health insurance coverage	2.6%	1.9%	0.9%	3.5%	3.8%	
Disability						US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	9.7%	7.4%	11.0%	12.8%	
Under 18 with a disability	4.9%	3.6%	3.3%	4.6%	4.7%	
18-64	9.4%	6.9%	3.9%	7.5%	9.1%	
65+	30.2%	27.3%	27.2%	29.7%	35.1%	

Health Status

			Areas of Interest			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Access to Care						
Ratio of population to primary care physicians	103.5	125.7	125.7	125.7	125.7	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.1	145.3	145.2	145.2	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	16.4	0.0	57.1	8.6	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health						
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	13.8	Data unavailable	No data	13.1	16.3	
Mortality rate (crude rate per 100,000)	900.2	871.1				CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	233.2				Massachusetts Death Report, 2021
Risk Factors						
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	2.2	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.1	3.3	8.9	11.3	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	35.7	30.9	5.5	27.6	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	No data	25.5	32.7	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	No data	25.4	29.7	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	No data	32.3	31.1	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	No data	20.5	23.2	BRFSS, 2022
Chronic Conditions						
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	No data	10.5	12.3	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	No data	9.1	10.8	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	No data	4.8	5.4	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	No data	5.3	5.5	BRFSS, 2022

			Areas of Interest			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Stroke among adults (%), age-adjusted	3.6	Data unavailable	No data	2.6	3.1	BRFSS, 2022
Cancer						
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	No data	83.1	84.6	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	No data	60.5	61.2	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)						
All sites	449.4	462.7	463.6	462.9	462.0	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	56.3	56.6	56.2	57.3	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	117.7	115.8	117.8	117.5	State Cancer Profiles, 2016-2020
Communicable and Infectious Disease						
STI infection cases (per 100,000)						
Chlamydia	385.8	358.2	264.0	264.0	264.0	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	6.9	6.9	6.9	6.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	64.0	64.0	64.0	64.0	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	234.1	234.1	234.1	234.1	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	1.7	1.7	1.7	1.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19						
Percent of Adults Fully Vaccinated	78.1	87.8	85.8	85.8	85.8	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	3.8	3.8	3.8	3.8	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	
Substance Use						
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	No data	10.9	13.4	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	Data unavailable	No data	18.1	17.6	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	26.0	26.0	26.0	26.0	CDC- National Vital Statistics System, 2016-2020

			Areas of Interest			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Male Drug Overdose Mortality Rate (per 100,000)	48.3	38.5				
Female Drug Overdose Mortality Rate (per 100,000)	17.6	14.2				
Substance-related deaths (Age-adjusted rate per 100k)						
Any substance	61.9	40.3	19.1	67.2	57.9	
Opioid-related deaths	33.7	21.8	*	36.8	41.3	
Alcohol-related deaths	29.1	18.6	*	35.1	15.8	
Stimulant-related deaths	23.0	13.6	*	25.2	26.7	
Substance-related ER visits (age-adjusted rate per 100K)						
Any substance-related ER visits	1605.7	1182.2	838.2	1979.1	1315.7	
Opioid-related ER visits	169.3	89.8	33.7	147.1	137.0	
Opioid-related EMS Incidents	248.8	138.6	87.3	298.1	114.3	
Alcohol-related ER visits	1235.6	929.9	655.4	1652.3	973.5	
Stimulant-related ER visits	15.7	9.9	*	14.6	19.5	
Substance Addiction Services						
Individuals admitted to BSAS services (crude rate per 100k)	588.4	352.4	178.1	701.5	474.5	
Number of BSAS providers		88.0	0.0	26.0	4.0	
Number of clients of BSAS services (residents)		1540.0	31.0	477.0	109.0	
Avg. distance to BSAS provider (miles)	17.0	19.0	17.0	15.0	20.0	
Buprenorphine RX's filled	9982.0	7796.8	2927.0	12414.9	7552.0	
Individuals who received buprenorphine RX's		668.1	275.9	1244.6	691.7	
Naloxone kits received		16008.0	67.0	4460.0	244.0	
Naloxone kids: Opioid deaths Ratio		55.0	*	78.0	14.0	
Fentanyl test strips received		21900.0	0.0	3800.0	0.0	
Environmental Health						
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	55.9	81.0	80.2	91.2	Population in Neighborhoods Meeting Environmental Justice Health Criteria , Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead screening %	68.0		79.0	75.0	63.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage

			Areas of Interest			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
						of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6		7.7	11.0	4.1	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0		81.0	68.0	69.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		22.8	21.1	52.0	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9		7.9	8.6	12.6	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	7.0	NS	NS	NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3				EPA - National Air Toxics Assessment, 2018
Mental Health						
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	41.2	41.2	41.2	41.2	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	No data	19.7	19.5	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	No data	31.5	33.8	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	No data	24.8	28.4	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	No data	14.9	16.9	Behavioral Risk Factor Surveillance System, 2022
Adults Age 18+ with depression (crude %)	20.9	19.2	19.6	19.9	19.0	Behavioral Risk Factor Surveillance System, 2021
Adults age 18 and older who reported 14 or more days of poor mental health in the past 30 days (crude %)	14.7	13.1	13.1	14.7	15.3	Behavioral Risk Factor Surveillance System, 2021
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.1	0.1	0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021

			Areas of Interest			
	MA	Norfolk County	Milton	Quincy	Randolph	Source
Maternal and Child Health/Reproductive Health						
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	6.9	6.9	6.9	County Health Rankings, 2016-2022
Safety/Crime						
Property Crimes Offenses (#)						Massachusetts Crime Statistics, 2023
Burglary	10028.0		16.0	201.0	49.0	
Larceny-theft	60647.0		117.0	858.0	298.0	
Motor vehicle theft	7224.0		7.0	93.0	50.0	
Arson	377.0		0.0	7.0	0.0	
Crimes Against Persons Offenses (#)						
Murder/non-negligent manslaughter	162.0		0.0	2.0	2.0	
Sex offenses	4365.0		0.0	44.0	9.0	
Assaults	72086.0		42.0	1112.0	298.0	
Human trafficking	0.0		0.0	0.0	3.0	
Hate Crimes Offenses (#)						
Race/Ethnicity/Ancestry Bias	222.0			9.0		
Religious Bias	88.0			2.0		
Sexual Orientation Bias	80.0			2.0		
Gender Identity Bias	22.0			0.0		
Gender Bias	2.0			0.0		
Disability Bias	0.0			0.0		

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

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

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

			MASSACHUSETTS		Norfolk	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Housing	Current living situation	No steady place	1908	1.30%	*	*
		Worried about losing	1908	2.60%	163	3.70%
		Steady place	1908	95.10%	163	95.70%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	155	15.50%
Basic Needs	Food insecurity, past month	Never	1963	87.80%	164	93.90%
		Sometimes	1963	9.90%	164	4.30%
		A lot	1963	2.30%	*	*
Basic Needs	Current internet access	No internet	1938	1.30%	*	*
		Does not work well	1938	6.60%	*	*
		Works well	1938	92.20%	164	98.20%
Neighborhood	Able to get where you need to go	Somewhat or strongly disagree	1864	2.50%	*	*
		Somewhat agree	1864	14.60%	160	6.30%
		Strongly agree	1864	82.80%	160	93.10%
Neighborhood	Experienced neighborhood violence, lifetime	Never	1833	65.00%	159	79.20%
		Rarely	1833	22.80%	159	16.40%
		Somewhat often	1833	8.50%	159	3.80%
		Very often	1833	3.70%	*	*
Safety & Support	Have someone to talk to if needed help	No	1739	3.90%	*	*
		Yes, adult in home	1739	80.50%	152	86.80%
		Yes, adult outside home	1739	37.30%	152	35.50%
		Yes, friend or non-adult family	1739	43.00%	152	39.50%
	Feel safe with my family/caregivers	Not at all	1768	1.00%	*	*

			MASSACHUSETTS		Norfolk	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Safety & Support		Somewhat	1768	7.70%	155	4.50%
		Very much	1768	91.30%	155	94.80%
Safety & Support	Feel I belong at school	Not at all	1760	5.90%	*	*
		Somewhat	1760	29.10%	155	21.90%
		Very much	1760	65.00%	155	76.80%
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	*	*
		Somewhat	1745	17.10%	153	12.40%
		Very much	1745	80.50%	153	86.90%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	155	63.20%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	155	3.90%
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	155	20.00%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	155	10.30%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	155	5.80%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	155	9.70%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	155	68.40%
Safety & Support	Experienced intimate partner violencea	Ever	1589	13.10%	122	9.00%
		In past year	1567	7.80%	122	4.10%
Safety & Support	Experienced household violenceb	Ever	1536	14.20%	118	7.60%
		In past year	1519	5.50%	118	4.20%
Safety & Support	Experienced sexual violencec	Ever	1558	9.20%	121	6.60%
		In past year	1551	3.10%	*	*
Safety & Support	Experienced discrimination	Ever	1674	45.20%	152	35.50%
		In past year	1674	19.60%	152	15.80%
Employment	Worked for pay, past year	No	1652	51.50%	149	62.40%

			MASSACHUSETTS		Norfolk	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
		Yes, <10 hours per week	1652	18.10%	149	22.80%
		Yes, 11-19 hours per week	1652	13.30%	149	7.40%
		Yes, 20-34 hours per week	1652	10.30%	*	*
		Yes, >35 hours per week	1652	6.80%	149	4.70%
		None of these	1484	66.80%	142	77.50%
		Frequent absences	1484	7.60%	*	*
		Needed more support in school	1484	7.00%	142	3.50%
		Needed more support outside school	1484	6.30%	*	*
		Safety concerns	1484	5.10%	*	*
Education	Educational challenges, past year	Temperature in classroom	1484	18.50%	142	18.30%
		Never	1503	87.70%	143	93.00%
		Once or twice	1503	9.10%	143	6.30%
		Monthly	1503	1.60%	*	*
Education	Hurt or harrassed by school staff, past year	Daily	1503	1.60%	*	*
		College-preparation	1459	57.90%	142	64.10%
		Extracurricular activities	1459	74.40%	142	83.10%
		Guidance conselour	1459	58.80%	142	66.90%
Education	Helpful school resources provided	Programs to reduce bullying, violence, racism	1459	19.10%	142	19.00%
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	*	*
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	*	*
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	*	*
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	*	*

			MASSACHUSETTS		Norfolk	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those needing care)	Yes	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those needing care)	Yes	62	7.90%	*	*
Healthcare Access	ANY unmet heath care need, past year (among those needing any care)	Yes	857	10.30%	67	7.50%
Mental Health	Psychological distress, past month	Low	1376	22.10%	101	22.80%
		Medium	1376	33.00%	101	38.60%
		High	1376	18.40%	101	21.80%
		Very high	1376	26.60%	101	16.80%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	136	6.60%
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%	104	13.50%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	136	3.70%
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	134	8.20%
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	134	5.20%
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	134	7.50%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*

			MASSACHUSETTS		Norfolk	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	*	*
		Not sure	1445	5.70%	128	5.50%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%	70	21.40%
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%	70	7.10%
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%	70	22.90%
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%	70	20.00%
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%	70	21.40%
Emerging Issues	Unable to work due to weather, past 5 years1	Yes	767	7.60%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years1	Yes	767	33.30%	70	31.40%
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%	*	*

			MASSACHUSETTS		Norfolk	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%	70	48.60%
a6.1% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages. *b9.1% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.* *c8.2% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.* *d12.0% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.*						

Community Health Equity Survey (CHES) – Adult

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Housing	Current living situation	No steady place	14888	2.50%	1313	1.10%	*	*	*	*
		Worried about losing	14888	8.00%	1313	6.60%	130	6.90%	*	*
		Steady place	14888	89.30%	1313	92.10%	130	90.00%	48	87.50%
Housing	Issues in current housing2	Yes, at least one	11103	37.00%	1006	31.70%	97	33.00%	34	44.10%
Basic Needs	Trouble paying for childcare/school1	Yes	7486	4.60%	630	4.00%	58	8.60%	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food)1	Yes	7486	18.80%	630	11.70%	*	*	*	*
Basic Needs	Trouble paying for health care1	Yes	7486	15.00%	630	10.30%	58	8.60%	*	*
Basic Needs	Trouble paying for housing1	Yes	7486	19.40%	630	11.10%	58	20.70%	*	*
Basic Needs	Trouble paying for technology1	Yes	7486	8.40%	630	4.90%	58	8.60%	*	*
Basic Needs	Trouble paying for transportation1	Yes	7486	12.60%	630	7.60%	*	*	*	*
Basic Needs	Trouble paying for utilities1	Yes	7486	17.20%	630	9.40%	58	12.10%	*	*
Basic Needs	Trouble paying for ANY basic needs1	Yes	7486	35.20%	630	24.90%	58	29.30%	*	*
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	1317	13.40%	133	24.80%	49	16.30%
Basic Needs	End of month finances	Not enough money	13814	16.50%	1201	11.00%	121	14.00%	45	15.60%
		Just enough money	13814	31.10%	1201	28.10%	121	38.80%	45	42.20%
		Money left over	13814	52.40%	1201	60.90%	121	47.10%	45	42.20%
Basic Needs	Current internet access2	No internet	11425	3.00%	1030	0.90%	*	*	*	*
		Does not work well	11425	9.30%	1030	6.10%	99	9.10%	35	14.30%
		Works well	11425	87.70%	1030	93.00%	99	87.90%	35	85.70%
Neighborhood	Able to get where you need to go2	Somewhat or strongly disagree	11064	7.00%	968	4.90%	96	7.30%	*	*
		Somewhat agree	11064	22.00%	968	17.30%	96	20.80%	35	28.60%

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Strongly agree	11064	71.00%	968	77.90%	96	71.90%	35	62.90%
		Never	11008	58.60%	967	64.60%	97	50.50%	35	40.00%
	Experienced	Rarely	11008	28.90%	967	28.70%	97	36.10%	35	40.00%
	neighborhood	Somewhat often	11008	9.10%	967	5.50%	97	11.30%	*	*
Neighborhood	violence, lifetime2	Very often	11008	3.40%	967	1.10%	*	*	*	*
Safety &	Can count on	Yes	14393	80.60%	1285	84.10%	131	72.50%	47	72.30%
Support	someone for favors	Not sure	14393	6.50%	1285	5.60%	131	7.60%	47	14.90%
Safety &	Can count on someone to care for	Yes	14366	73.20%	1281	75.40%	130	70.80%	47	72.30%
Support	you if sick	Not sure	14366	10.20%	1281	9.90%	130	8.50%	47	10.60%
Safety &	Can count on	Yes	14325	64.60%	1281	73.00%	131	64.90%	47	55.30%
Support	someone to lend money	Not sure	14325	12.90%	1281	10.80%	131	16.00%	47	21.30%
Safety &	Can count on	Yes	14336	79.20%	1277	83.60%	131	74.80%	47	76.60%
Support	someone for support with family trouble	Not sure	14336	7.00%	1277	6.10%	131	9.90%	*	*
Safety &	Can count on	Yes	14247	62.30%	1266	66.70%	131	67.20%	46	54.30%
Support	someone to help find housing	Not sure	14247	16.30%	1266	16.40%	131	15.30%	46	19.60%
Safety &	Experienced intimate	Ever	13621	29.70%	1207	23.80%	120	23.30%	42	21.40%
Support	partner violence	In past year	13359	4.50%	1195	3.20%	*	*	*	*
Safety &	Experienced sexual	Ever	13628	21.00%	1211	18.10%	126	20.60%	45	11.10%
Support	violence	In past year	13593	1.40%	1210	0.40%	*	*	*	*
Safety &	Experienced	Ever	14130	55.20%	1256	57.60%	124	49.20%	46	58.70%
Support	discrimination	In past year	14130	18.00%	1256	16.80%	124	16.10%	46	21.70%
Employment	Have multiple jobs (among all workers)2	Yes	6896	20.90%	563	21.00%	49	24.50%	*	*
		At home only	9173	7.50%	771	10.00%	76	7.90%	*	*
	Location of work	Outside home only	9173	54.60%	771	43.70%	76	50.00%	*	*
Employment	(among all workers)	Both at home/outside home	9173	37.40%	771	46.00%	76	42.10%	*	*
	Paid sick leave at	Yes	6903	75.30%	564	74.30%	48	83.30%	*	*
Employment	work (among all workers)2	Not sure	6903	4.20%	564	4.40%	*	*	*	*

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Reported chronic condition 1	Yes	6821	65.20%	635	65.00%	68	58.80%	*	*
Healthcare Access	Unmet need for short-term illness care (among those who needed this care)2	Yes	3455	7.60%	331	6.00%	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care)2	Yes	1674	9.00%	152	4.60%	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	275	8.70%	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	40	27.50%	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	222	21.60%	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)2	Yes	998	7.00%	77	10.40%	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment	Yes	109	13.90%	*	*	*	*	*	*

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
	(among those who needed this care)2									
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	72	11.10%	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)2	Yes	6941	15.20%	635	13.70%	63	19.00%	*	*
Healthcare Access	Telehealth visit, past year1	One or more visit	6747	51.20%	636	56.10%	68	52.90%	*	*
		Offered, didn't have	6747	7.00%	636	6.90%	68	7.40%	*	*
		Not offered	6747	22.10%	636	20.80%	68	22.10%	*	*
		No healthcare visits	6747	20.30%	636	16.70%	68	17.60%	*	*
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	394	18.80%	42	14.30%	*	*
		Not sure	4184	3.80%	394	4.60%	*	*	*	*
Mental Health	Psychological distst	Low	13267	36.80%	1183	40.20%	116	47.40%	41	48.80%
		Medium	13267	32.00%	1183	35.20%	116	23.30%	41	22.00%
		High	13267	13.90%	1183	11.70%	116	12.90%	41	12.20%
		Very high	13267	17.30%	1183	12.80%	116	16.40%	41	17.10%

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
	r e s s , p a s t m o n t h									
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	906	9.70%	90	13.30%	*	*
Mental Health	Suicide ideation, past yearc	Yes	13036	7.40%	1168	4.70%	114	4.40%	*	*
Substance Use	Tobacco use, past month2	Yes	10305	14.10%	908	6.30%	87	9.20%	*	*
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	1209	52.10%	122	34.40%	42	38.10%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	1221	4.40%	123	4.90%	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	1224	5.00%	123	4.90%	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	1223	10.80%	122	9.00%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	1224	13.20%	123	10.60%	*	*
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	*	*	*	*

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/ Ketamine use, past year	Yes	13626	0.80%	1224	0.40%	*	*	*	*
Substance Use	Fentanyl use, pasy year	Yes	13626	0.60%	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	*	*	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	13626	0.60%	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	1224	1.30%	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	1224	0.70%	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	1224	1.10%	*	*	*	*
Emerging Issues	COVID-19 vaccinatination, past year1	Yes	6729	67.80%	636	78.50%	66	80.30%	*	*
		Not sure	6729	3.60%	636	2.50%	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)2	Yes	6196	22.00%	554	15.50%	49	22.40%	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies , past 5 years2	Yes	10422	37.40%	902	38.50%	86	29.10%	33	30.30%
Emerging Issues	Flooding in home or on street, past 5 years2	Yes	10422	11.00%	902	10.90%	86	7.00%	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years2	Yes	10422	32.20%	902	23.90%	86	16.30%	*	*

			MASSACHUSETTS		NORFOLK		Quincy		Randolph	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	Power outages, past 5 years2	Yes	10422	24.50%	902	20.40%	86	17.40%	33	15.20%
Emerging Issues	School cancellation due to weather, past 5 years2	Yes	10422	17.60%	902	15.20%	86	9.30%	*	*
Emerging Issues	Unable to work due to weather, past 5 years2	Yes	10422	14.80%	902	10.90%	86	15.10%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years2	Yes	10422	28.30%	902	24.50%	86	25.60%	33	18.20%
Emerging Issues	Other climate impact, past 5 years2	Yes	10422	1.70%	902	1.90%	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years2	Yes	10422	67.20%	902	63.30%	86	53.50%	33	39.40%

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

CHIA Ages 0-17

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
All Causes				
FY24 ED Volume (all cause) rate per 100,000	4923	3630	3387	5235
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1149	1264	1355
Allergy				
FY24 ED Volume rate per 100,000	293	253	199	253
FY24 Inpatient Discharges rate per 100,000	29	35	22	38
Asthma				
FY24 ED Volume rate per 100,000	347	312	269	563
FY24 Inpatient Discharges rate per 100,000	67	31	58	100
Attention Deficit Hyperactivity Disorder				
FY24 ED Volume rate per 100,000	77	87	62	94
FY24 Inpatient Discharges rate per 100,000	27	17	14	5
Complication of Medical Care				
FY24 ED Volume rate per 100,000	33	42	22	41
FY24 Inpatient Discharges rate per 100,000	49	49	25	26
Diabetes				
FY24 ED Volume rate per 100,000	21	3	18	23
FY24 Inpatient Discharges rate per 100,000	8	10	7	5
HIV/AIDS				
FY24 ED Volume rate per 100,000	0			
FY24 Inpatient Discharges rate per 100,000	0			
Infection				
FY24 ED Volume rate per 100,000	1314	755	1010	1500
FY24 Inpatient Discharges rate per 100,000	131	123	104	132
Injuries				
FY24 ED Volume rate per 100,000	922	1089	614	863
FY24 Inpatient Discharges rate per 100,000	49	35	27	32

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
Learning Disorders				
FY24 ED Volume rate per 100,000	22	35	32	58
FY24 Inpatient Discharges rate per 100,000	24	21	22	23
Mental Health				
FY24 ED Volume rate per 100,000	292	144	181	265
FY24 Inpatient Discharges rate per 100,000	75	63	53	14
Obesity				
FY24 ED Volume rate per 100,000	7		9	
FY24 Inpatient Discharges rate per 100,000	12	3	4	2
Pneumonia/Influenza				
FY24 ED Volume rate per 100,000	150	49	66	103
FY24 Inpatient Discharges rate per 100,000	32	24	30	32
Poisonings				
FY24 ED Volume rate per 100,000	59	28	28	79
FY24 Inpatient Discharges rate per 100,000	6	3	1	2
STIs				
FY24 ED Volume rate per 100,000	4		2	5
FY24 Inpatient Discharges rate per 100,000	1		0	
Substance Use				
FY24 ED Volume rate per 100,000	48	7	34	44
FY24 Inpatient Discharges rate per 100,000	11	3	7	
Age 0-17 Total	4923	3630	3387	5235

CHIA Ages 18-44

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
All Causes				
FY24 ED Volume (all cause) rate per 100,000	11106	5669	8974	13730
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	1444	2095	2582
Allergy				
FY24 ED Volume rate per 100,000	952	414	618	807
FY24 Inpatient Discharges rate per 100,000	206	98	162	224
Asthma				
FY24 ED Volume rate per 100,000	552	260	477	958
FY24 Inpatient Discharges rate per 100,000	266	126	175	291
Breast Cancer				
FY24 ED Volume rate per 100,000	7	7	6	5
FY24 Inpatient Discharges rate per 100,000	9	59	3	5
CHF				
FY24 ED Volume rate per 100,000	14	21	21	44
FY24 Inpatient Discharges rate per 100,000	50	52	38	117
Complication of Medical Care				
FY24 ED Volume rate per 100,000	120	80	91	123
FY24 Inpatient Discharges rate per 100,000	645	544	655	772
COPD and Lung Disease				
FY24 ED Volume rate per 100,000	30	10	11	14
FY24 Inpatient Discharges rate per 100,000	40	3	27	14
Diabetes				
FY24 ED Volume rate per 100,000	309	115	291	509
FY24 Inpatient Discharges rate per 100,000	173	73	194	253
GYN Cancer				
FY24 ED Volume rate per 100,000	2		1	5

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
FY24 Inpatient Discharges rate per 100,000	4	10		
Heart Disease				
FY24 ED Volume rate per 100,000	12	3	6	14
FY24 Inpatient Discharges rate per 100,000	56	31	36	64
Hepatitis				
FY24 ED Volume rate per 100,000	26	14	74	32
FY24 Inpatient Discharges rate per 100,000	70	7	88	61
HIV/AIDS				
FY24 ED Volume rate per 100,000	24		23	67
FY24 Inpatient Discharges rate per 100,000	14	3	22	38
Hypertension				
FY24 ED Volume rate per 100,000	447	270	424	680
FY24 Inpatient Discharges rate per 100,000	210	91	225	259
Infection				
FY24 ED Volume rate per 100,000	1595	808	1264	1895
FY24 Inpatient Discharges rate per 100,000	338	224	291	409
Injuries				
FY24 ED Volume rate per 100,000	1775	956	1315	2426
FY24 Inpatient Discharges rate per 100,000	237	84	224	312
Liver Disease				
FY24 ED Volume rate per 100,000	99	38	107	88
FY24 Inpatient Discharges rate per 100,000	191	108	208	226
Mental Health				
FY24 ED Volume rate per 100,000	1310	428	1363	1158
FY24 Inpatient Discharges rate per 100,000	834	421	790	778
Obesity				
FY24 ED Volume rate per 100,000	135	24	143	170
FY24 Inpatient Discharges rate per 100,000	324	108	196	412
Other Cancer				
FY24 ED Volume rate per 100,000	12	7	10	8

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
FY24 Inpatient Discharges rate per 100,000	23	31	27	29
Pneumonia/Influenza				
FY24 ED Volume rate per 100,000	122	66	75	168
FY24 Inpatient Discharges rate per 100,000	85	49	71	114
Poisonings				
FY24 ED Volume rate per 100,000	182	52	156	176
FY24 Inpatient Discharges rate per 100,000	33		29	35
Prostate Cancer				
FY24 ED Volume rate per 100,000	0			
FY24 Inpatient Discharges rate per 100,000	0			
STIs				
FY24 ED Volume rate per 100,000	77	28	59	206
FY24 Inpatient Discharges rate per 100,000	37	24	43	35
Stroke and Other Neurovascular Diseases				
FY24 ED Volume rate per 100,000	8	10	5	
FY24 Inpatient Discharges rate per 100,000	19	3	13	61
Substance Use				
FY24 ED Volume rate per 100,000	2079	481	1900	1556
FY24 Inpatient Discharges rate per 100,000	588	112	571	551
Tuberculosis				
FY24 ED Volume rate per 100,000	2		0	2
FY24 Inpatient Discharges rate per 100,000	8	21	23	2
Age 18-44 Total	11106	5669	8974	13730

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
All Causse				
FY24 ED Volume (all cause) rate per 100,000	6844	4797	5677	9311
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	1202	2183	2638
Allergy				
FY24 ED Volume rate per 100,000	797	397	487	719
FY24 Inpatient Discharges rate per 100,000	330	126	223	300
Asthma				
FY24 ED Volume rate per 100,000	299	161	245	406
FY24 Inpatient Discharges rate per 100,000	254	115	197	197
Breast Cancer				
FY24 ED Volume rate per 100,000	40	38	34	47
FY24 Inpatient Discharges rate per 100,000	57	59	55	38
CHF				
FY24 ED Volume rate per 100,000	78	31	85	103
FY24 Inpatient Discharges rate per 100,000	344	137	317	639
Complication of Medical Care				
FY24 ED Volume rate per 100,000	100	105	95	168
FY24 Inpatient Discharges rate per 100,000	428	242	431	548
COPD and Lung Disease				
FY24 ED Volume rate per 100,000	239	45	225	395
FY24 Inpatient Discharges rate per 100,000	415	98	400	421
Diabetes				
FY24 ED Volume rate per 100,000	759	411	612	1252
FY24 Inpatient Discharges rate per 100,000	688	253	608	978

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
GYN Cancer				
FY24 ED Volume rate per 100,000	4	3	4	
FY24 Inpatient Discharges rate per 100,000	16	7	16	5
Heart Disease				
FY24 ED Volume rate per 100,000	37	24	39	50
FY24 Inpatient Discharges rate per 100,000	280	133	219	462
Hepatitis				
FY24 ED Volume rate per 100,000	23	17	42	17
FY24 Inpatient Discharges rate per 100,000	83	59	135	76
HIV/AIDS				
FY24 ED Volume rate per 100,000	34	28	59	44
FY24 Inpatient Discharges rate per 100,000	34	31	30	53
Hypertension				
FY24 ED Volume rate per 100,000	1377	1040	1218	2608
FY24 Inpatient Discharges rate per 100,000	918	481	851	1123
Infection				
FY24 ED Volume rate per 100,000	813	499	641	1025
FY24 Inpatient Discharges rate per 100,000	627	326	642	822
Injuries				
FY24 ED Volume rate per 100,000	1351	1019	1182	1842
FY24 Inpatient Discharges rate per 100,000	534	291	555	683
Liver Disease				
FY24 ED Volume rate per 100,000	113	49	101	73
FY24 Inpatient Discharges rate per 100,000	383	147	414	383
Mental Health				
FY24 ED Volume rate per 100,000	703	193	924	672
FY24 Inpatient Discharges rate per 100,000	1042	481	1059	1067
Obesity				
FY24 ED Volume rate per 100,000	138	35	132	112
FY24 Inpatient Discharges rate per 100,000	619	281	493	725

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
Other Cancer				
FY24 ED Volume rate per 100,000	30	21	16	23
FY24 Inpatient Discharges rate per 100,000	100	87	112	123
Pneumonia/Influenza				
FY24 ED Volume rate per 100,000	73	66	59	67
FY24 Inpatient Discharges rate per 100,000	228	98	261	288
Poisonings				
FY24 ED Volume rate per 100,000	82	35	75	82
FY24 Inpatient Discharges rate per 100,000	36	7	46	50
Prostate Cancer				
FY24 ED Volume rate per 100,000	12	14	15	8
FY24 Inpatient Discharges rate per 100,000	28	28	23	23
STIs				
FY24 ED Volume rate per 100,000	10	7	4	26
FY24 Inpatient Discharges rate per 100,000	6	10	3	17
Stroke and Other Neurovascular Diseases				
FY24 ED Volume rate per 100,000	24	21	23	23
FY24 Inpatient Discharges rate per 100,000	92	70	86	132
Substance Use				
FY24 ED Volume rate per 100,000	1492	284	1604	1361
FY24 Inpatient Discharges rate per 100,000	858	274	913	784
Tuberculosis				
FY24 ED Volume rate per 100,000	1		1	
FY24 Inpatient Discharges rate per 100,000	11	7	21	53
Age 45-64 Total	6844	4797	5677	9311

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
All Causes				
FY24 ED Volume (all cause) rate per 100,000	5485	5919	4688	5718
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	4224	4235	4465
Allergy				
FY24 ED Volume rate per 100,000	798	442	404	353
FY24 Inpatient Discharges rate per 100,000	671	326	465	509
Asthma				
FY24 ED Volume rate per 100,000	155	151	120	200
FY24 Inpatient Discharges rate per 100,000	314	249	218	297
Breast Cancer				
FY24 ED Volume rate per 100,000	69	45	91	73
FY24 Inpatient Discharges rate per 100,000	216	228	266	232
CHF				
FY24 ED Volume rate per 100,000	270	239	250	271
FY24 Inpatient Discharges rate per 100,000	1445	1170	1414	1515
Complication of Medical Care				
FY24 ED Volume rate per 100,000	158	154	117	135
FY24 Inpatient Discharges rate per 100,000	809	801	777	742
COPD and Lung Disease				
FY24 ED Volume rate per 100,000	350	249	367	277
FY24 Inpatient Discharges rate per 100,000	1111	727	1136	1049
Diabetes				

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
FY24 ED Volume rate per 100,000	860	868	815	1382
FY24 Inpatient Discharges rate per 100,000	1509	1275	1406	1857
GYN Cancer				
FY24 ED Volume rate per 100,000	7	3	3	11
FY24 Inpatient Discharges rate per 100,000	27	17	20	14
Heart Disease				
FY24 ED Volume rate per 100,000	90	105	77	76
FY24 Inpatient Discharges rate per 100,000	1079	903	920	1126
Hepatitis				
FY24 ED Volume rate per 100,000	7		12	5
FY24 Inpatient Discharges rate per 100,000	51	52	99	64
HIV/AIDS				
FY24 ED Volume rate per 100,000	7	24	6	20
FY24 Inpatient Discharges rate per 100,000	14	31	16	11
Hypertension				
FY24 ED Volume rate per 100,000	1774	2572	1869	2573
FY24 Inpatient Discharges rate per 100,000	1758	1687	1606	1795
Infection				
FY24 ED Volume rate per 100,000	718	780	625	707
FY24 Inpatient Discharges rate per 100,000	1455	1430	1524	1503
Injuries				
FY24 ED Volume rate per 100,000	1257	1356	1045	1158
FY24 Inpatient Discharges rate per 100,000	1365	1349	1336	1270
Liver Disease				
FY24 ED Volume rate per 100,000	65	17	43	50
FY24 Inpatient Discharges rate per 100,000	421	435	503	601
Mental Health				
FY24 ED Volume rate per 100,000	347	123	463	188
FY24 Inpatient Discharges rate per 100,000	1456	1247	1401	1199
Obesity				

	BID Milton Hospital Community Benefits Service Area			
	MA	Milton	Quincy	Randolph
FY24 ED Volume rate per 100,000	72	3	74	82
FY24 Inpatient Discharges rate per 100,000	764	488	570	763
Other Cancer				
FY24 ED Volume rate per 100,000	58	56	49	32
FY24 Inpatient Discharges rate per 100,000	285	203	294	256
Pneumonia/Influenza				
FY24 ED Volume rate per 100,000	79	98	76	79
FY24 Inpatient Discharges rate per 100,000	627	562	589	801
Poisonings				
FY24 ED Volume rate per 100,000	30	24	20	29
FY24 Inpatient Discharges rate per 100,000	44	38	53	26
Prostate Cancer				
FY24 ED Volume rate per 100,000	62	91	61	35
FY24 Inpatient Discharges rate per 100,000	221	189	162	182
STIs				
FY24 ED Volume rate per 100,000	1		0	
FY24 Inpatient Discharges rate per 100,000	7	3	3	8
Stroke and Other Neurovascular Diseases				
FY24 ED Volume rate per 100,000	63	70	41	44
FY24 Inpatient Discharges rate per 100,000	290	235	272	268
Substance Use				
FY24 ED Volume rate per 100,000	391	151	425	238
FY24 Inpatient Discharges rate per 100,000	552	404	640	397
Tuberculosis				
FY24 ED Volume rate per 100,000	1		3	2
FY24 Inpatient Discharges rate per 100,000	15	7	21	41
Age 65+ Total	5485	5919	4688	5718

Community Health Survey

- FY25 BID Milton Community Health Survey
  - Survey output

Beth Israel Lahey Health

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

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

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

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

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

Select a language

About Your Community

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

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

Zip code: _____

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

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

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

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

Beth Israel Lahey Health

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

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

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

Health and Access to care

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

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

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

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

Beth Israel Lahey Health

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

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

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

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

About You

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

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

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

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

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

11. What is your sexual orientation?

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

12. What is your current gender identity?

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

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

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

14. What is your age?

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

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

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

16. Are you currently:

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

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

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

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

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

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

May14, 2024

Beth Israel Lahey Health

Enter to Win a $100.00 Gift Card!

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

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

---

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

   First Name: _____

   Email: _____

   Daytime Phone #: _____

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

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

FY25 BILH CHNA Survey - BID Milton

Response Counts

Completion Rate:	**90.3%**		
	Complete		626
	Partial		67

Totals: 693

1. Select a language.

Value	Percent	Responses
Take the survey in English	74.9%	512
شارك في الاستطلاع باللغة العربية	0.1%	1
Faze es Piskiza na Kriolu di Kabu Verdi	0.1%	1
参加简体中文调查	15.6%	107
參加繁體中文調查	2.8%	19
Reponn sondaj la nan lang kreyòl ayisyen	2.9%	20
Participe da pesquisa em português	0.3%	2
Responda la encuesta en español	2.5%	17
Tham gia khảo sát bằng tiếng Việt	0.7%	5

Totals: 684

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

Value	Percent	Responses
I live in this community	90.1%	620
I work in this community	24.9%	171
Other, please specify:	2.8%	19

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

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
I feel like I belong in my community. Count Row %	246 35.9%	375 54.7%	35 5.1%	12 1.7%	18 2.6%	686
Overall, I am satisfied with the quality of life in my community. *(Think about health care, raising children, getting older, job opportunities, safety, and support.)* Count Row %	185 27.6%	380 56.7%	78 11.6%	8 1.2%	19 2.8%	670
My community is a good place to raise children. *(Think about things like schools, daycare, after-school programs, housing, and places to play)* Count Row %	203 30.2%	343 51.0%	60 8.9%	12 1.8%	55 8.2%	673
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 %	167 24.4%	346 50.6%	111 16.2%	21 3.1%	39 5.7%	684
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	173 25.4%	364 53.5%	105 15.4%	16 2.4%	22 3.2%	680
My community feels safe. Count Row %	181 26.3%	411 59.8%	70 10.2%	9 1.3%	16 2.3%	687

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	169 24.9%	378 55.7%	86 12.7%	14 2.1%	32 4.7%	679
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	99 14.6%	314 46.2%	84 12.4%	13 1.9%	169 24.9%	679
My community offers people options for staying cool during extreme heat. Count Row %	104 15.3%	311 45.7%	108 15.9%	11 1.6%	147 21.6%	681
My community has services that support people during times of stress and need. Count Row %	108 16.0%	335 49.6%	99 14.6%	18 2.7%	116 17.2%	676
I believe that all residents, including myself, can make the community a better place to live. Count Row %	248 36.6%	382 56.3%	21 3.1%	8 1.2%	19 2.8%	678
Totals Total Responses						687

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

Value	Percent	Responses
Better access to good jobs	22.9%	156
Better access to health care	33.9%	231
Better access to healthy food	24.5%	167
Better access to internet	15.3%	104
Better access to public transportation	26.4%	180
Better parks and recreation	17.3%	118
Better roads	32.9%	224
Better schools	21.9%	149
Better sidewalks and trails	23.8%	162
Cleaner environment	15.9%	108
Lower crime and violence	26.4%	180
More affordable childcare	24.4%	166
More affordable housing	51.8%	353
More arts and cultural events	16.4%	112
More effective city services (like water, trash, fire department, and police)	13.8%	94
More inclusion for diverse members of the community	20.4%	139

Value	Percent	Responses
Stronger community leadership	11.6%	79
Stronger sense of community	12.3%	84
Other, please specify:	4.4%	30

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	59 9.0%	117 17.8%	358 54.3%	90 13.7%	35 5.3%	659
Health care in my community meets the mental health needs of people like me. Count Row %	42 6.5%	156 24.3%	277 43.1%	56 8.7%	111 17.3%	642
Totals Total Responses						659

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

Value	Percent	Responses
A doctor's or nurse's office	66.2%	434
A public health clinic or community health center	22.1%	145
Urgent care provider	2.7%	18
A hospital emergency room	3.5%	23
No usual place	3.8%	25
Other, please specify:	1.7%	11

Totals: 656

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

Value	Percent	Responses
Fear or distrust of the health care system	11.0%	72
Not enough time	16.3%	107
Insurance problems	21.8%	143
No providers or staff speak my language	9.1%	60
Can’t get an appointment	26.8%	176
Cost	29.3%	192
Concern about COVID or other disease exposure	5.0%	33
Transportation	16.2%	106
Other, please specify:	6.7%	44
No barriers	30.6%	201

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

Value	Percent	Responses
Aging problems (like arthritis, falls, hearing/vision loss)	41.5%	267
Alcohol or drug misuse	28.5%	183
Asthma	5.8%	37
Cancer	20.2%	130
Child abuse/neglect	5.8%	37
Diabetes	17.3%	111
Domestic violence	8.1%	52
Environment (like air quality, traffic, noise)	25.8%	166
Heart disease and stroke	17.9%	115
Hunger/malnutrition	11.8%	76
Homelessness	22.2%	143
Housing	37.6%	242
Mental health (anxiety, depression, etc.)	50.1%	322
Obesity	13.2%	85
Poor diet/inactivity	15.4%	99
Poverty	12.0%	77

Value	Percent	Responses
Sexually transmitted infections (STIs)	3.6%	23
Smoking	8.6%	55
Suicide	5.3%	34
Trauma	7.2%	46
Underage drinking	10.3%	66
Vaping/E-cigarettes	8.2%	53
Violence	6.5%	42
Youth use of social media	17.7%	114
Infant death	1.1%	7
Rape/sexual assault	2.8%	18
Teenage pregnancy	2.6%	17

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

Value	Percent	Responses
12th grade or lower (no diploma)	6.5%	42
High school (including GED, vocational high school)	12.8%	82
Started college but not finished	10.0%	64
Vocational, trade, or technical program after high school	5.6%	36
Associate degree (for example, AA, AS)	9.5%	61
Bachelor's degree (for example, BA, BS, AB)	27.6%	177
Graduate degree (for example, master's, professional, doctorate)	24.0%	154
Prefer not to answer	4.0%	26

Totals: 642

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

Value	Percent	Responses
American Indian or Alaska Native	1.7%	11
Asian	25.8%	167
Black or African American	16.2%	105
Hispanic or Latine/a/o	5.1%	33
Middle Eastern or North African	0.5%	3
Native Hawaiian or Pacific Islander	0.3%	2
White	49.1%	318
Other, please specify:	2.3%	15
Not sure	0.2%	1
Prefer not to answer	4.0%	26

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	4.9%	31
Bisexual and/or Pansexual	2.5%	16
Gay or Lesbian	2.0%	13
Straight (Heterosexual)	79.0%	503
Queer	0.5%	3
Questioning/I am not sure of my sexuality	0.6%	4
I use a different term, please specify:	0.2%	1
I do not understand what this question is asking	2.4%	15
I prefer not to answer	8.0%	51

Totals: 637

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	77.1%	498
Male, Man	19.3%	125
Nonbinary, Genderqueer, not exclusively male or female	0.6%	4
Questioning/I am not sure of my gender identity	0.2%	1
I do not understand what this question is asking	0.3%	2
I prefer not to answer	2.5%	16

Totals: 646

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

Value	Percent	Responses
Childcare or school	8.3%	52
Food or groceries	22.2%	140
Formula or baby food	2.4%	15
Health care (appointments, medicine, insurance)	20.2%	127
Housing (rent, mortgage, taxes, insurance)	31.3%	197
Technology (computer, phone, internet)	11.0%	69
Transportation (car payment, gas, public transit)	17.9%	113
Utilities (electricity, water, gas)	22.9%	144
Other, please specify:	2.2%	14
None of the above	47.3%	298

14. What is your age?

Value	Percent	Responses
Under 18	0.9%	6
18-24	2.6%	17
25-44	33.1%	214
45-64	30.9%	200
65-74	17.9%	116
75-84	9.7%	63
85 and over	3.4%	22
Prefer not to answer	1.4%	9

Totals: 647

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

Value	Percent	Responses
Armenian	2.6%	17
Cape Verdean Creole	1.4%	9
Chinese (including Mandarin and Cantonese)	21.3%	137
English	72.2%	465
Haitian Creole	5.7%	37
Hindi	0.3%	2
Portuguese	1.1%	7
Russian	0.3%	2
Spanish	4.5%	29
Vietnamese	1.2%	8
Other, please specify:	2.0%	13
Prefer not to answer	2.0%	13

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	40.5%	261
Employed part-time (Less than 40 hours per week)	15.3%	99
Self-employed (Full- or part-time)	2.6%	17
A stay-at-home parent	4.7%	30
A student (Full- or part-time)	2.6%	17
Unemployed	4.7%	30
Unable to work for health reasons	3.4%	22
Retired	24.0%	155
Other, please specify:	0.6%	4
Prefer not to answer	1.6%	10

Totals: 645

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

Value	Percent	Responses
Yes	17.8%	113
No	77.7%	494
Prefer not to answer	4.6%	29

Totals: 636

18. I currently:

Value	Percent	Responses
Rent my home	29.3%	188
Own my home (with or without a mortgage)	46.9%	301
Live with parent or other caretakers who pay for my housing	5.1%	33
Live with family or roommates and share costs	5.5%	35
Live in a shelter, halfway house, or other temporary housing	0.6%	4
Live in senior housing or assisted living	10.3%	66
I do not currently have permanent housing	1.2%	8
Other	1.1%	7

Totals: 642

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

Value	Percent	Responses
I have always lived in the United States	61.5%	396
Less than one year	2.5%	16
1 to 3 years	4.0%	26
4 to 6 years	3.4%	22
More than 6 years, but not my whole life	27.0%	174
Prefer not to answer	1.6%	10

Totals: 644

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

Value	Percent	Responses
My neighborhood or building	51.0%	317
Faith community (such as a church, mosque, temple, or faith-based organization)	27.0%	168
School community (such as a college or education program that you attend or a school that your child attends)	17.4%	108
Work community (such as your place of employment or a professional association)	30.2%	188
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)	17.0%	106
A shared interest group (such as a club, sports team, political group, or advocacy group)	24.4%	152
Another city or town where I do not live	12.2%	76
Other, please feel free to share:	5.6%	35

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

Value	Percent	Responses
Yes	39.1%	157
No	60.9%	245

Totals: 402

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
	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 Aging & Independence	Provides access to the resources for older adults to live healthy in every community in the Commonwealth	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	Find Help	Provides resources for financial assistance, food pantries, medical care, and other free or reduced-cost help.			www.findhelp.org
	Mass 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 10th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-aging-independence
	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

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

Domestic Violence	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	Concord Baptist Food Pantry	Provides food assistance to residents of Milton.	180 Blue Hill Ave Milton	617.698.9300	www.cbcboston.org
	Friendly Food Pantry of Randolph	Provides food assistance to residents of Randolph.	1 Donald S McNeil Way Randolph	339.987.5577	www.friendlyfoodpantry.com
	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/
	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	easternusa.salvationarmy.org/massachusetts/quincy/
	Southwest Community Food Center	Provides food assistance to residents of Quincy.	18 Copeland St Quincy	617.471.0796	www.qcap.org/our-programs/food-nutrition
	Father Bill's & Mainspring	Provides shelter, job support and case management for people without housing.	39 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

Housing Support	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
	Office of Healthy Homes Quincy	Provides Lead Abatement, Housing Rehab, First Time Homebuyer and Aging in Place for residents of Quincy.		617.376.1428	www.officeofhealthyhomes.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
	Randolph Housing Authority	Provides affordable, subsidized rental housing for low-resource older adults and persons with disabilities.	1 Decelle Dr Randolph	781.961.1400	www.randolphha.com/Home.aspx
	South Shore Habitat for Humanity	Serves low to moderate income seniors, veterans, and families in 32 cities and towns south and southwest of Boston with critical home repairs and affordable housing.	77 Accord Park Dr D7 Norwell	781.337.7744	www.sshabitat.org
	Aspire Health Alliance	Provides early intervention, mental health treatment and recovery programs.	460 Quincy Ave Quincy	617.847.1950	www.aspirehealthalliance.org

Mental Health and Substance Use	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.bilhbehavioral.org
	Dana Behavioral Health	Provides psychology, psychiatry, and medication management.	21 Thomas McGrath Highway Ste 202 Quincy	617.786.0137	www.danabehavioralhealth.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 Ste 209 Quincy	617.471.5686	www.mariadrostecounseling.com
	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
	Metis Psychological Associates, LLC	Provide in-person and telehealth services in Individual and Group Psychotherapy, Couples and Marital Therapy, Psychological Testing and Evaluation, and Psychiatric Medication Evaluation and Management. Provide services in several core clinical areas. Consultation to public and private agencies, and educational institutions.	490 North Main St Ste 2 Randolph	781.963.1200	www.metispsych.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
	New Life Counseling and Wellness	Multicultural organization that promotes the well-being of individuals, children, youths and families through high quality mental health and social services that are culturally competent such as counseling, support groups, advocacy, and education.	400 North Main St Randolph	781.986.4800	www.newlifecounselingcenter.org
	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 Ste 202 Quincy	617.770.9690	www.voamass.org/our-services/outpatient-behavioral-health/
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/594/Council-on-Aging
	Quincy Council on Aging/Kennedy Center	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 Elder Services	Provides services for older adults in Randolph including fitness, education, social services, and recreation.	128 Pleasant St Randolph	781.961.0930	www.randolphicc.com/elder-affairs
	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

Additional Resources	Asian American Service Association	Provides recreation, wellness classes and activities and family services for Asian seniors and families with children under age 11 in Quincy and surrounding communities	550 Hancock St Quincy	617.471.9354	www.aasa-ma.org
	Boston Chinatown Neighborhood Center	Provides a broad range of innovative programs and services centered around education, workforce development, family support, and arts and culture	1458 Hancock St 3rd Fl Ste 306 Quincy	617.770.0091	www.bcnc.net
	Hale Family YMCA	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/halefamilyymca
	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.qariusa.org
	Randolph Intergenerational Community Center	Provides quality and enriching fitness, sports, educational, cultural and intergenerational experiences. Programs and services are designed with a focus on the diverse physical, social, and emotional needs of the residents of Randolph.	128 Pleasant St Randolph	781.961.0930	www.randolphicc.com

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

Beth Israel Deaconess Hospital-Milton

Evaluation of 2023-2025 Implementation Strategy

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

Priority: Equitable Access to Care

Goal:			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Racially, ethnically, & linguistically diverse populations ● Individuals with disabilities ● Low-resourced populations	Promote equitable care, health equity, health literacy for patients, especially those who face cultural and linguistic barriers.	● Interpreter Services	● Number of face-to-face and phone encounters performed by Interpreter Services o FY23: 9,169 encounters in 57 languages o FY24: 12, 064 encounters in 57 languages
● Low-resourced populations	Promote access to health care, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.	● Financial counselors ● Primary Care Support	● Number of people assisted by financial counselors and enrolled in health insurance (FY23: 520; FY24: 124, with 1,098 utilizing the Health Safety Net) ● Number of new patients in Milton, Quincy and Randolph primary care offices (FY23: 3,159; FY24: 2,248)

● Individuals with disabilities ● Racially, ethnically, & linguistically diverse populations ● Low-resourced populations	Provide and promote career support services and career mobility programs to hospital employees.	● CPTech Pipeline Program (in development) ● Career and academic advising ● Hospital-sponsored community college courses ● Hospital-sponsored English Speakers of Other Languages (ESOL) classes	● Number of Workforce Development events and presentations conducted with community partners o FY23: 67 o FY24: 33 ● Number of pipeline programs offered at BID Milton (FY23: 2; FY24: 2) ● Number of employees that successfully completed Central Sterile Tech Processing Pipeline Program (CPTech) and hired (FY23: 2; FY24: 0) ● Number of employees that accessed career and academic advising sessions (FY23: 46) ● Number of employees enrolled in hospital-sponsored college courses (FY23: 4) ● Number of employees enrolled in ESOL classes at BID Milton (FY23: 1: FY24: 82 across BILH) ● Number of job seekers referred to BILH o FY23: 225 o FY24: 412 ● Number of job seekers hired across BILH o FY23: 70 o FY24:111

			● Number of community college students who applied as certified nursing assistants and hired FY23: 9; FY24: Grant ended, program not offered) ● Number of people trained (FY23: 89 community members trained across BILH - Patient Care Technician or Nursing Assistant (30), Pharmacy Tech (16), Perioperative LPN (3), Medical Assistant (21) and Behavioral Health roles (4) and 15 were enrolled into the Associate Degree Nursing Residency program – BID Milton participated in these trainings; FY24: Trainees not placed)

Priority: Social Determinants of Health

Goal: Enhance the built, social, and economic environment where people live, work, play, and learn in order to improve health and quality-of-life outcomes.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Youth • Older adults • Low-resourced populations • Racially, ethnically, & linguistically diverse populations • Individuals with disabilities	Provide support for impactful programs and community initiatives that address issues associated with the social determinants of health.	• Emergency Flex Funding for Domestic Violence Survivors • Provide an opportunity for grant funding to community	• Amount of community grant dollars for emergency flex funding awarded to DOVE for domestic violence survivors o FY23: $5,000 o FY24: $5,000 • Number of people served o FY23: 5 o FY24: 5 • Number of clients provided with additional wrap around services o FY23: 5 o FY24: 5 • Amount of community grant funding awarded to address social determinant of health (FY23: $5,000 one-time grant to install National Fitness Court to address built environment) • Amount of community grant funding awarded to Milton Early Childhood Alliance to address social determinants of health o FY23: $5,000 o FY24: $5,000

			● Children enrolled in Milton Early Childhood Alliance program o FY23: 26, FY24: 27
● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations ● Older adults	Support programs that stabilize or create access to affordable housing.	● Rental Assistance/Eviction Prevention Community Grants	● Amount of community grant funding awarded to Quincy Community Action Programs for

			rental assistance and eviction prevention o FY23: $15,000 o FY24: $15,000 ● Number of individuals prevented from experiencing homelessness by providing rental assistance o FY23: 15 households for a total of 25 individuals received an average of $900 o FY24: 15 households for a total of 31 individuals received an average of $923) and percent of families receiving referrals who then engaged with one or more area resources services ▪ FY23:86% ▪ FY24:100%

● Youth ● Older adults ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	● 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 community	● Amount of produce supplied to food pantries o FY23: 420 lbs o FY24: 420 lbs ● Number of meals distributed to older adults o FY23: 500 o FY24: 500 ● Number of nutrition consultations performed o FY23: 25 o FY24: 30 ● Number of communal learning events o FY23: 2 cooking demonstrations o FY24: 7 ● BID Milton'sCommunity Health Initiative - Randolph's Friendly Food Pantry was directly awarded $20,603 in FY23 to immediately improve logistics and operations and expand access to residents in Randolph

● Youth and young adults ● Individuals with disabilities ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	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.	● Internship programs in multiple departments: Nursing, Radiology, Pharmacy etc ● High School Internship Program ● Healthcare scholarships ● Provide an opportunity for grant funding to community	● Amount of community grant funding awarded to the May Institute to implement workforce development initiatives for youth and young adults with disabilities in o FY23 $10,0000 o FY24: $10,000 o Number of students participating ▪ FY23: 50 ▪ FY24: 30 ● Percentage of students with increased improvement in social and technical skills o FY23: N/A, program started late in reporting year o FY24: 100% with 2 students earning employment in the community ● Number of college students completing internships o FY23: 4 o FY24: 5 o Number of hours completed ▪ FY23: 560 ▪ FY24: 2,100 o Number of students hired for positions

			▪ FY23: 2 ▪ FY24: 1 ● Number of students participating in high school internship program o FY23: 4 o FY24: 4 o Number of hours completed ▪ FY23: 200 ▪ FY24: 271 ● Number of job shadowing and volunteer hours provided at the hospital by area teenagers o FY23: 500 hours o FY24: 453 hours ● Number and amount of health care scholarships provided o FY23: $500 scholarship provided to 1 student o FY24: $500 scholarship provided to 1 student

● Youth ● Older adults ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.	● Member of Blue Hills Regional Coordinating Council, provided previous grant funding for assessment phase	● Amount of community grant funding awarded to South Shore Elder Services to address non-medical transportation needs for older adults (Baseline(FY23): $6,000, Year 1(FY24): $6,000) o Number of rides provided: (Baseline(FY23): Data not yet available Year 1(FY24): 610 round-trip rides for 181 individuals) ● Amount of transportation vouchers provided (Baseline(FY23): $6,414; Year 1(FY23): $10,242)

● Youth ● Older adults ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.	● Member of Randolph Community Wellness Coalition ● Member of Mass in Motion Regional Food Policy Council	● BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for bills that supported access to services to address the root causes of poor health outcomes for all Massachusetts residents (Baseline(FY23): Data not yet available; Year 1(FY24): 9).

Priority: Mental Health and Substance Use

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Youth ● Racially, ethnically, & linguistically diverse populations	Support impactful programs that promote healthy development, support children, youth, and their families, and increase their resilience, coping and prevention skills.	● Trauma informed schools grant ● Getting the Teens Out Grant ● Provide an opportunity for grant funding to community	● Getting the Teens out Program: o FY23: Number of program/groups held: 12 o Number of participants #116 o FY24: 4 Parent workshops o 90 participants ● Number of staff trained to implement Trauma Informed Schools classroom curriculum o FY23:12 o FY24: 18 ● Number of 5th grade students participating in Botvin Life Skills training o FY23: 164 o FY24: 368 ● Change in knowledge, behavior or skills o FY23: 80% reported increased learning and stress coping mechanisms o FY24: 77% reported increased learning and stress coping mechanisms ● Amount of grant funding awarded to Milton Public Schools to implement resilience and mental health programs

			○ FY23: $12,500 ○ FY24: $12,500 ● In FY24 grant funding provided by BILH to Quincy Public Schools for development and implementation of community behavioral health navigator program
● Youth ● Older adults ● Racially, ethnically, & linguistically diverse populations	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.	● Mental Health First Aid ● Behavioral Health/Cognitive Behavioral Therapy (CBT) Classes	● 28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies. ● Number of community members trained in Mental Health First Aid ○ FY23: 49 ○ FY24: 380

			• Number of CBT classes
			  o FY23: Classes not offered
			  o FY24:classes not offered

• Racially, ethnically, & linguistically diverse populations
• Low-resourced populations
• Youth
	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.	• Milton Coalition
		• Building Up Youth: Regional Partnership on Health and Wellness
			• FY23: 4 regional trainings and 6 open houses
			• FY24: 5 regional trainings and 6 open houses
			• More than 3,000 residents reached through events in FY23 and FY24
			• Amount of grant funding awarded to the Milton Coalition (formerly Milton Substance Abuse Prevention Coalition)
			  o FY23: $15,000
			  o FY24: $15,000
			• Number of sectors represented on coalition
			  o FY23: 14
			  o FY24: 14
			• Number of additional youth members recruited
			  o FY23: 5
			  o FY24: 4
			• Number of bills BILH Government Affairs advocated for, directly or through the state hospital association or community coalitions, to support access to mental health and substance use services for all Massachusetts residents (Baseline(FY23): Data not yet available; Year 1(FY24): 8)

• Racially, ethnically, &	Provide access to high-quality and culturally and linguistically appropriate	• BILH Collaborative Care	• Number of patients served by behavioral health clinicians embedded into primary care practices (FY23: 336, FY24: 462)

linguistically diverse populations ● Low-resourced populations	mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	● Medication Assisted Treatment (MAT) ● Recovery coaches ● Prescription take-back kiosk (in development)	● Number of patients screened and transferred to treatment by recovery coaches o FY23: 418 screened, 200 transferred to treatment o FY24: 436 screened, 172 transferred to treatment ● Number of patients receiving emergency psychiatric evaluations for placement in an inpatient psychiatric unit and/or crisis stabilization unit o FY23: 571 ● Number of patients served by behavioral health clinicians embedded into primary care practices o FY23: 336 ● Amount of discarded prescription medications collected o FY23: 23 pounds o FY24: 79 pounds

Priority: Complex and Chronic Conditions

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Older adults ● Low-resourced populations ● Racially, ethnically, & linguistically diverse populations	Address barriers to timely cancer and chronic disease screenings and follow-up care through culturally appropriate navigation and innovative programs.	● Lung Cancer Screening	● Number of patients screened for lung cancer o FY23: 786 o FY24: 917
● Older adults ● Racially, ethnically, & linguistically diverse populations	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.	● Diabetes Self-Management Courses ● Matter of Balance Classes	● Number of community members enrolled in diabetes self-management courses o FY23: 8 o FY24:6 ● Percentage of participants reporting a change in behavior to better manage their diabetes o FY23: 80% o FY24: 80% ● Number of participants provided with free 3-month gym memberships to continue healthy lifestyle o FY23: 2 o FY24: N/A ● Number of community members enrolled in Matter of Balance classes o FY23: 8

			○ FY24: N/A course offered but not completed until FY25 ● Percentage of participants reporting a decreased fear of falling and increased physical activity levels ○ FY23: 70% ○ FY24: N/A course offered but not completed until FY25) ● Number of participants provided with free 3-month gym memberships to continue a healthy lifestyle ○ FY23: 6 ○ FY24: N/A
● Older adults	Ensure older adults have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.	● Palliative care ● Meditation classes	● Number of palliative care consults performed ○ FY23:108 ○ FY24:189) ● Number of programs conducted to address social isolation in older adults ○ FY23: 22 meditation classes and 14 music therapy classes ○ FY24: 16 music therapy classes and 6 community luncheons ● Number of participants ○ FY23: 15-20 participants in each class ○ FY24:10-15 participants in each class, 120 people for luncheons

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Beth Israel Deaconess Milton

FY26-FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Hospital–Milton (BID Milton) is a community hospital for the southern metro Boston region. The hospital has 102 licensed inpatient beds with more than 950 employees and over 640 clinicians on active medical staff. With close ties to Beth Israel Deaconess Medical Center, one of the region's leading academic medical centers, BID Milton offers a full range of services, including orthopedics, urology, surgical services and digestive health.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. It would be difficult to overstate BID 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 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 with limited resources, individuals who speak a language other than English, 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). BID Milton also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk and crafting a collaborative, evidence-informed Implementation Strategy (IS.). Between June 2024 and February 2025, BID Milton conducted 15 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving over 600 600 residents, and organized a community listening session. In total, the assessment process collected information from more than 700 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 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.

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 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 municipalities of Milton, Quincy, and Randolph, located to the south of the City of Boston. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs. There are segments of BID 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 populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, 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.

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 Living with Disabilities

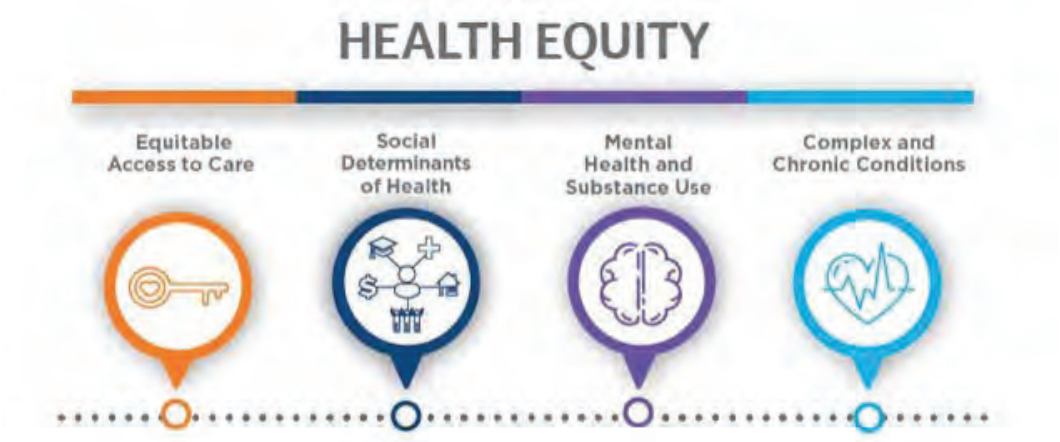
Community Health Needs Not Prioritized by BID Milton

It is important to note that there are 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, strengthening the built environment (i.e., improving roads/sidewalks) was identified as community needs but were not included in BID Milton's IS. While this issue is important, BID Milton's CBAC and senior leadership team decided that this issue was 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 this issue. BID Milton remains open and willing to work with community residents, other hospitals, and other public and private partners to address this issue, 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, transportation, economic insecurity, access to healthy and affordable food, language and cultural barriers, navigating a complex health care system, health insurance and cost barriers, long wait times, depression, anxiety, stress, youth mental health, social isolation among older adults, substance use, conditions associated with aging, diabetes, community-based prevention and education, and caregiver support.

BID Milton Community Health Priority Areas



Implementation Strategy Details

Priority: Equitable Access to Care

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations • Older adults • Individuals living with disabilities	• Health insurance eligibility and enrollment assistance activities • Financial counseling activities • Programs and activities to support culturally/ linguistically competent care and interpreter services • Expanded primary care and medical specialty care services for Medicaid-covered, insured, and underinsured populations	• # of sessions conducted • # of patients assisted • # of encounters (in person, VRI, telephone) • # of languages provided • # of practices providing primary care • # of new patients served • # of new providers added	• BILH clinical service providers • Hospital-based activities
Advocate for and support policies and systems that improve access to care.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-activities

Priority: Social Determinants of Health

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

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 stability.

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• All priority populations	• Food access, nutrition support, and education programs and activities	• Pounds of food distributed • # of people served	• Private, non-profit, and health-related agencies
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• Low-resourced populations • Older adults • Individuals living with disabilities	• Housing assistance, navigation, and resident support activities • Community investment and affordable housing initiatives	• # of families and individuals prevented from homelessness • Amount of rental assistance provided • % of people referred to additional services	• Housing support and community development agencies

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations and community residents.	• All priority populations	• Career advancement and mobility programs Youth employment and internship programs	• # of students or people reached • # of hours • # of student participants in each internship • # of hours provided by students • # of students hired for positions at hospital • # of preceptor staff hours • # of employee participants • # hired • # of programs/ classes held • # who obtained employment at BILH	• Local primary and secondary schools • Vocational schools • Hospital-based activities
Support programs and activities that foster social connections and strengthen community cohesion and resilience.	• Older adults	• Community connection and social engagement activities	• # of volunteers • # of hours	• Older adult services agencies
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation	• Older adults • Low-resourced populations • Individuals living with disabilities	• Transportation and ride share assistance programs	• # of rides provided • # of people served	• Older adult services agencies
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

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

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• All priority populations	• Health education, awareness, and wellness activities for children and youth • Medication disposal programs	• # of people served • # of referrals • Lbs of medication disposed of	• Hospital-based activities • Local primary and secondary schools
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Programs and activities with community health workers, recovery coaches, and peer support workers • Crisis intervention and early response programs and activities • Expand access to mental health and substance use services for individuals and families • Primary care and behavioral health integration and collaborative care programs • Health education, awareness, and wellness activities for all ages • Participation in community coalitions	• # of people served • # of referrals made • # of classes, trainings, and activities • # of clinical practices supported • # of community meetings attended • Increased knowledge about how to support someone experiencing mental health challenges	• Clinical health service providers • Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Chronic and Complex Conditions

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	• Low-resourced populations • Older adults • Racially, ethnically, and linguistically diverse populations • Individuals living with disabilities	• Chronic disease management, treatment, and self-care support programs • Chronic disease, fitness, nutrition, and healthy living programs • Speakers Bureau programs • Cancer screening programs	• # of people served • # of classes, activities, classes organized	• Private, non-profit, health-related agencies
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

General Regulatory Information

Contact Person:	Laureane Marquez, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was adopted by authorized governing body:	September 15, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 15, 2025
Date written plan was required to be adopted:	February 15, 2026
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 12, 2022
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