Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for Northeast Hospital Corporation (NHC) is the culmination of a collaborative process that began in June 2024. Under a single license, NHC, referred to throughout this report as Beverly and Addison Gilbert Hospitals (BH/AGH), operates two acute care campuses - Beverly Hospital in Beverly, Massachusetts and Addison Gilbert Hospital in Gloucester, Massachusetts; an acute psychiatric inpatient satellite, BayRidge Hospital in Lynn, Massachusetts; and an outpatient facility, BILH Care Center-Danvers, in Danvers, Massachusetts. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key collaborators from throughout BH/AGH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

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

BH/AGH thanks the BH/AGH Community Benefits Advisory Committee and the residents who contributed to this process. Hundreds of residents throughout BH/AGH'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

Northeast Hospital Corporation (NHC) consists of multiple entities organized to serve the needs of those in its communities (referred to throughout this report as BH/AGH). With a consistently recognized reputation for high-quality care and safety, Beverly Hospital is home to centers of excellence in maternal-newborn health, cardiovascular services, orthopedics and general surgical services. There are 373 licensed inpatient beds across three campuses, with more than 2,500 employees and over 1,000 clinicians on active medical staff. Addison Gilbert Hospital is an acute care facility in Gloucester with specialties in emergency medicine, adult inpatient care, oncology services and ambulatory services. BayRidge Hospital is an inpatient psychiatric care facility in Lynn that offers high-quality mental health care, as well as substance use disorder treatment and partial-hospitalization and outpatient services.

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

This 2025 Community Health Needs Assessment (CHNA) report is an integral part of BH/AGH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BH/AGH provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This assessment, along with the associated prioritization and planning processes, also provides a critical opportunity for BH/AGH to engage the community and strengthen the community partnerships that are essential to BH/AGH's success now and in the future. The assessment engaged more than 2,200 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, government officials, and community residents.

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

Purpose

The CHNA is at the heart of BH/AGH's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the current and historical injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BH/AGH 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, BH/AGH completed its last assessment in the summer of 2022 and the report, along with the associated 2023-2025 IS, was approved by the BH/AGH Board of Trustees on September 8, 2022. The 2022 CHNA report was posted on BH/AGH'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 BH/AGH's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 11, 2025.

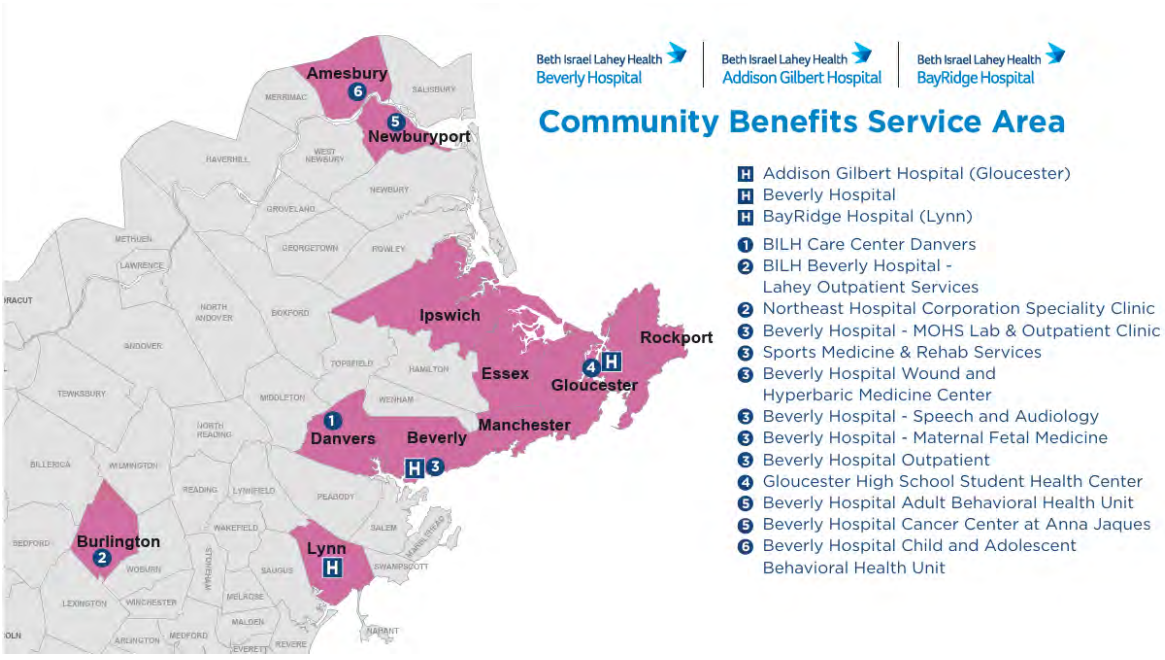
Definition of Community Served

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 BH/AGH's CBSA.

Understanding the geographic and demographic characteristics of BH/AGH's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

Description of Community Benefits Service Area

BH/AGH's CBSA includes the eleven municipalities of Amesbury, Beverly, Burlington, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester-by-the-Sea (MBTS), Newburyport, and Rockport in Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs. There are segments of the BH/AGH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes.



BH/AGH is committed to promoting health, enhancing access, and delivering the best care to all who live 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. BH/AGH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

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

BH/AGH CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns where BH/AGH operate licensed facilities. BH/AGH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. While BH/AGH operates licensed facilities in Burlington, Newburyport and Amesbury these service locations are in other BILH hospitals' CBSAs. The Town of Burlington is located within Lahey Hospital and Medical Center's (LHMC) CBSA, and the City of Newburyport and City of Amesbury are located within Anna Jaques Hospital's (AJH) CBSA. As a result, the community benefits activities for these municipalities have been delegated to LHMC and AJH. This helps to ensure that activities are properly coordinated and address the identified needs.

Assessment Approach & Methods

Approach

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

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

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

Equity:

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

Accountability:

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

Community Engagement:

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

Impact:

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

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

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

In April of 2024, BILH hired JSI Research & Training Institute, Inc. (JSI), a public health research and consulting firm based in Boston, to assist BH/AGH and other BILH hospitals to conduct the CHNA. BH/AGH worked with JSI to ensure that the final BH/AGH CHNA engaged the necessary community constituents, incorporated comprehensive quantitative information for all communities in its CBSA, and fulfilled federal and Commonwealth community benefits guidelines.

Methods

Oversight and Advisory Structures

The CBAC greatly informs BH/AGH's assessment and planning activities. BH/AGH'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 BH/AGH'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 BH/AGH'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, BH/AGH collected a wide range of quantitative data to characterize the communities in the hospital's CBSA. BH/AGH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was also tested for statistical significance whenever possible and 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 BH/AGH Community Health Survey, is included in Appendix B.

Community Engagement and Qualitative Data Collection

Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative and evidence-informed IS. Accordingly, BH/AGH applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, BH/AGH employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Between June 2024 and February 2025, BH/AGH conducted 18 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 2,000 residents, and organized a community listening session. In total, the assessment process collected information from more than 2,200 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

18 interviews

with community leaders

2,179 survey respondents

5 focus groups

- Homeless or recently housed
- Young mothers
- Low-resource fathers
- Adolescent girls
- Foreign-born residents engaged in English language programs

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 BH/AGH. Community Benefits staff reviewed BH/AGH's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which 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 BH/AGH 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 BH/AGH 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 BH/AGH's existing IS was augmented, revised, and tailored. When developing the IS, BH/AGH'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 BH/AGH'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 BH/AGH'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 BH/AGH's website, alongside the 2022 CHNA report and 2023-2025 IS, for easy viewing and download. As with all BH/AGH CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that 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 BH/AGH's CBSA. Findings are organized into the following areas:

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

Each section begins with a highlight of key findings. This introduction is followed by graphs and other data visuals. It is important to note that these five sections do not review all the findings collected during the assessment, rather they draw out the most significant drivers of health status and health disparities. A summary of interviews, focus groups, 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 BH/AGH's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status, and other characteristics.

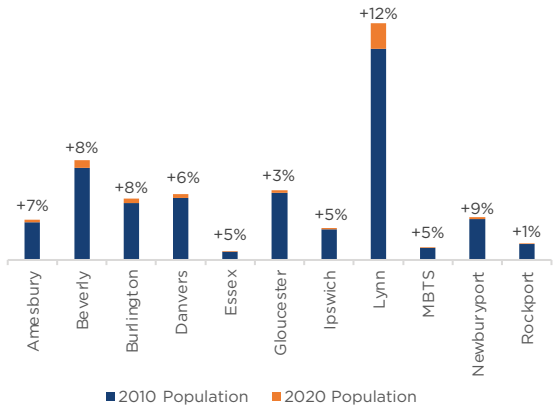
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the BH/AGH CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white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

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

Population Growth

Between 2010 and 2020, the population in BH/AGH's CBSA increased by 8%, from 296,206 to 319,444 people. Lynn saw the greatest percentage increase (12%) and Rockport saw the lowest (1%).

Population Changes by Municipality, 2010 to 2020



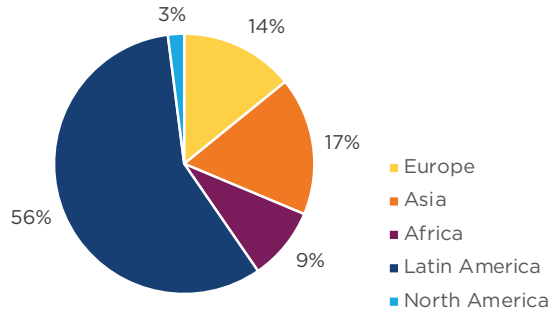
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

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]

19% of the BH/AGH 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]

25% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

45% speak English less than "very well."

Source: US Census Bureau American Community Survey 2019-2023

Age

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

19%

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

20%

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/Williams, 2023

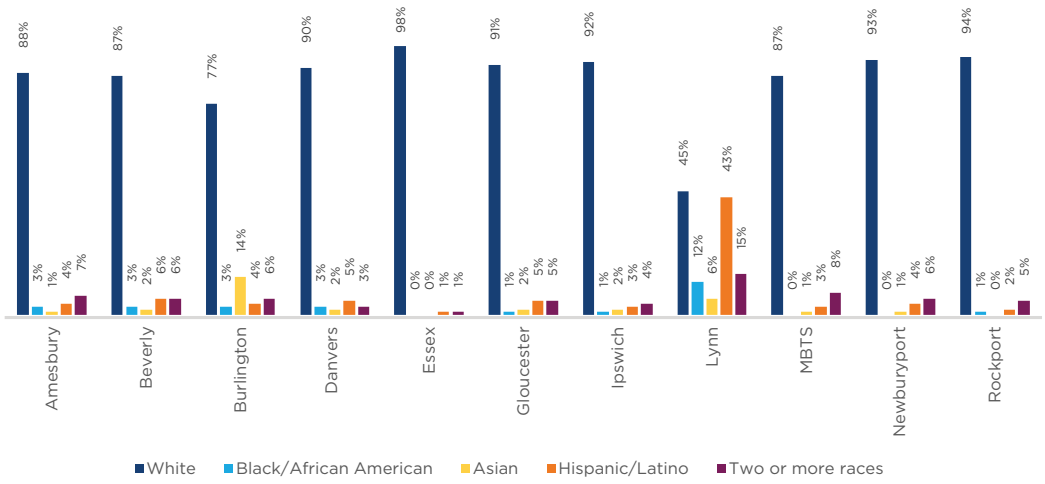
21% of LGBTQIA+ adults in Massachusetts are raising children

Source: Gallup/Williams, 2019

Race and Ethnicity

BH/AGH's CBSA is diverse. Compared to the Commonwealth overall, the percentage of residents who identify as Asian is significantly higher than the Commonwealth in Burlington; the percentage who identify as Hispanic/Latino or two or more races is significantly higher than the Commonwealth in Lynn.

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]

30% of BH/AGH CBSA households included one or more people under 18 years of age.

35% of BH/AGH 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 BH/AGH's CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. economic insecurity, access to care/navigation issues, and other important social factors.[8]

Information gathered through interviews, focus groups, the listening session, and the 2025 BH/AGH Community Health Survey reinforced that these issues impact 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 services.

Interviewees, focus groups, and listening session participants reported that housing costs were having a widespread impact across nearly all segments of the CBSA population. These effects were 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.

Lack of access to affordable healthy foods was identified as a challenge, especially for individuals and families under economic strain. Factors such as job loss, difficulty finding livable-wage employment, or reliance on inadequate fixed incomes all contribute to food insecurity, making it harder for people to afford healthy diets. Interviewees, focus group, and listening session participants emphasized that living costs continue to rise at a faster pace than wages, exacerbating the financial burden on households.

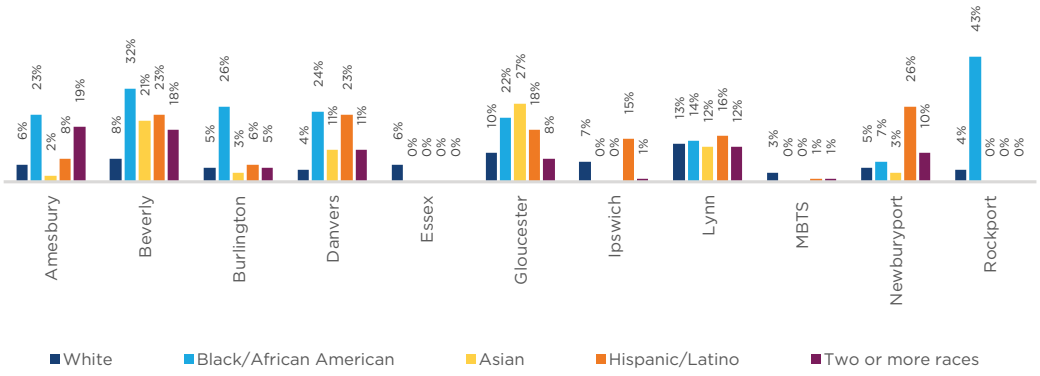
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

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.

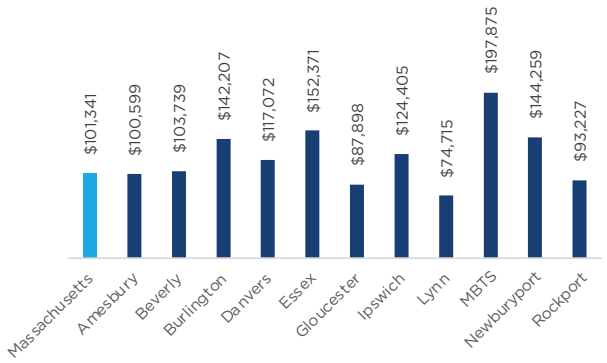
Percentage of Residents Living Below the Poverty Level, by Race/Ethnicity, 2019-2023



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

Across the BH/AGH CBSA, the percentage of individuals living below the poverty level tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of 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 in Amesbury, Gloucester, Lynn, and Rockport.

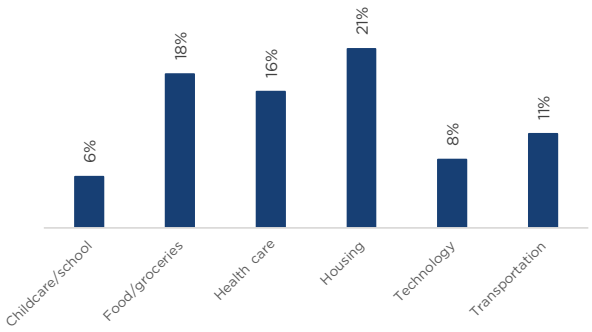
Median Household Income, 2019-2023



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

In the 2025 BH/AGH Community Health Survey, survey respondents reported trouble paying or certain expenses in the past 12 months. Costs associated with housing, health care, and food/groceries emerged as most problematic among survey respondents.

Percentage Who Had Trouble Paying for Expenses in the Past 12 Months, 2019-2023



Source: 2025 BH/AGH Community Health Survey

"We've seen an increase of over 100% in visits to the food bank between 2022 and 2024. This shows that people are still struggling to find food. We are starting to see folks that are having to make choices about whether to eat, pay for rent, and pay for other services."

-Interviewee

Education

Research shows that those with more education live longer, healthier lives. People 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.

43% 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

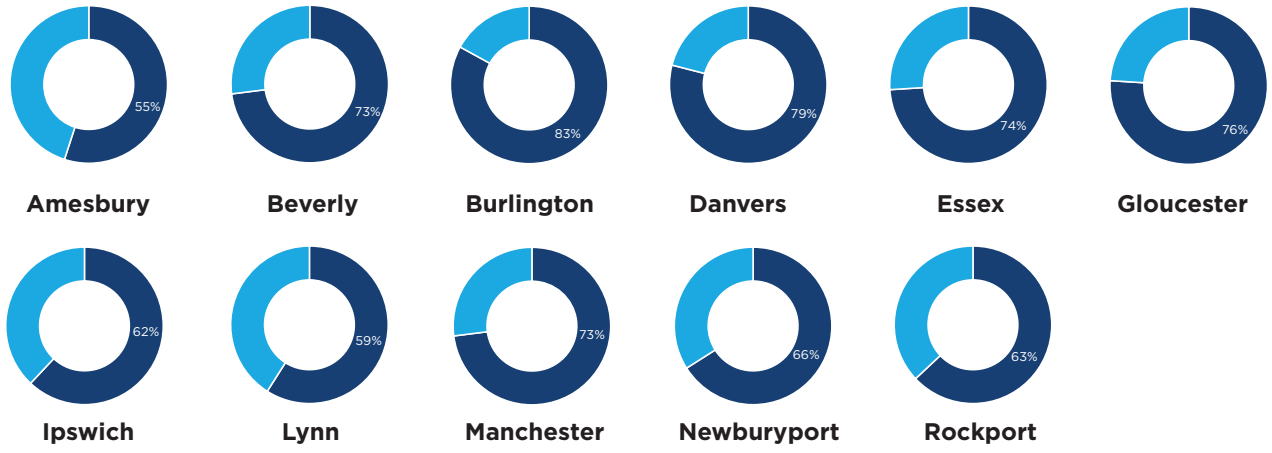
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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.

15%

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

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



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

Percentages shown for each municipality represent an average of percentages across all zip codes in a community.

Neighborhood and Built Environment

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

Housing

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

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

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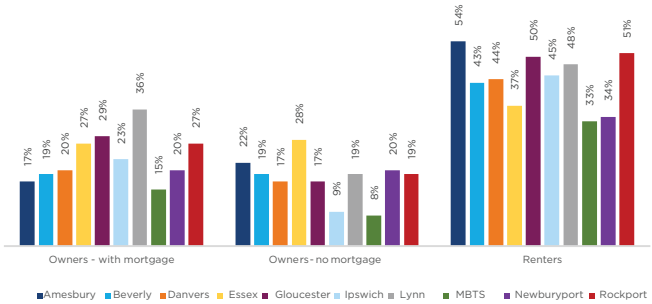
The percentage owner-occupied housing units (with and without a mortgage) with housing costs in excess of 35% of household income was higher than the Commonwealth in Essex, Gloucester, Lynn, and Rockport. Among renters, percentages were higher than the Commonwealth in all municipalities except Essex, Manchester, and Newburyport.

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,

57% of 2025 BH/AGH Community Health Survey respondents said "more affordable housing."

21% of 2025 BH/AGH Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 BH/AGH 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 BH/AGH Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 BH/AGH Community Health Survey

10% of housing units in the BH/AGH 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 BH/AGH Community Health Survey prioritized these improvements to the built environment.

34% of 2025 BH/AGH Community Health Survey respondents identified a need for better roads.

39% of 2025 BH/AGH Community Health Survey respondents identified a need for better side-walks and trails.

Source: 2025 BH/AGH Community Health Survey

Systemic Factors

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

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of of color, persons whose first language is not English, foreign-born individuals, individuals living with disabilities, and older adults.

Findings from the assessment reinforced the challenges that residents throughout the BH/AGH CBSA faced with respect to long wait-times, language and cultural barriers, and navigating a complex health care system. This was true with respect to primary care, behavioral health, and medical specialty care.

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.

Accessing and Navigating the Health Care System

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

> "Access to primary care is especially problematic. A lot of PCPs [primary care physicians] are leaving the profession. People are experiencing long waits. It's hard to get appointments for kids, too - especially for those on MassHealth. A lot of pediatricians aren't taking MassHealth, or the're putting people on wait lists."
>
> -Interviewee

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 BH/AGH CBSA were the strong community-based organizations and task forces that worked to meet the needs of CBSA residents. However, interviewees, focus groups, and listening session participants reported that community-based organizations 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.

"Organizations in this area are very collaborative. We're close enough that if we feel we need something, we can just make a call. Relationships are good and strong because many of our organizations have been working together for a long time."

-Interviewee

Behavioral Factors

The nation, including the residents of Massachusetts and BH/AGH'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. The information from the assessment supports the importance of incorporating these issues into BH/AGH's IS.

Nutrition

Adults who eat a healthy diet have increased life expectancy and decreased risk of chronic diseases and obesity; children require a healthy diet to grow and develop properly.[18] Access to affordable healthy foods is essential to a healthy diet.

17% of 2025 BH/AGH Community Health Survey participants would like their community to have better access to healthy food.

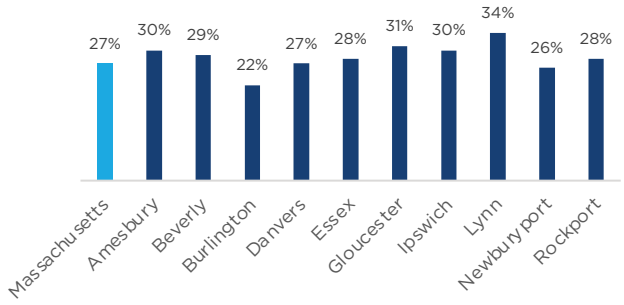
Source: 2025 BH/AGH Community Health Survey

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the BH/AGH 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 all CBSA municipalities except Burlington, Danvers, and Newburyport. Data was unavailable for Manchester-by-the-Sea.

Percentage of Adults Who are Obese, 2022



Data unavailable for Manchester-by-the-Sea

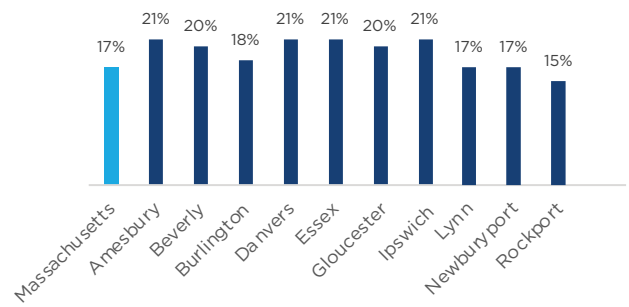
Source: CDC PLACES, 2022

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



Data unavailable for Manchester-by-the-Sea

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 BH/AGH's CBSA.

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

Given the limitations of the quantitative data, specifically that it was often out of date and was not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, listening session, and the 2025 BH/AGH 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.

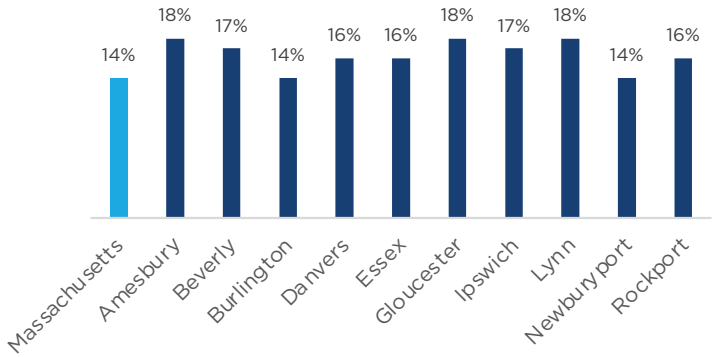
In addition to the overall burden and prevalence of mental health issues residents also identified a need for more behavioral health providers and treatment options, including inpatient and outpatient services and specialty care. Interviewees, focus groups, and listening session participants also reflected on the need to support individuals in navigating care options within the behavioral health system.

38% of Beverly High School students reported feeling significant depression at some point in the past 12 months.
2022 Beverly High School Youth Risk Behavior Survey

32% of 2025 BH/AGH Community Health Survey respondents reported that mental health care in the community does not meet people's needs.
Source: 2019 Profiles of Student Life - Attitudes and Behaviors, Search Institute

55%
of 2025 BH/AGH 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



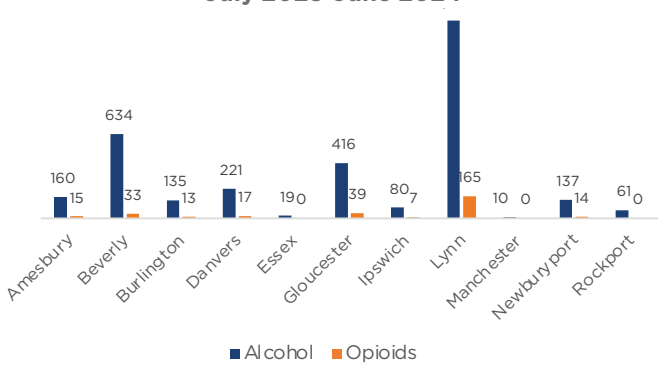
Data unavailable for Manchester-by-the-Sea
Source: CDC PLACES, 2022

Health Conditions

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

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 Lynn.

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



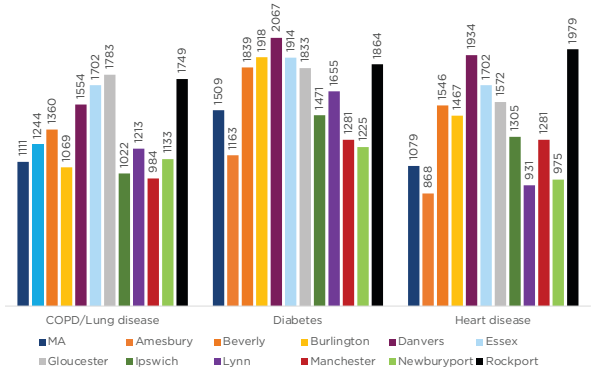
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

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 were consistently higher than the Commonwealth in Beverly, Danvers, Essex, Gloucester, and Rockport.

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

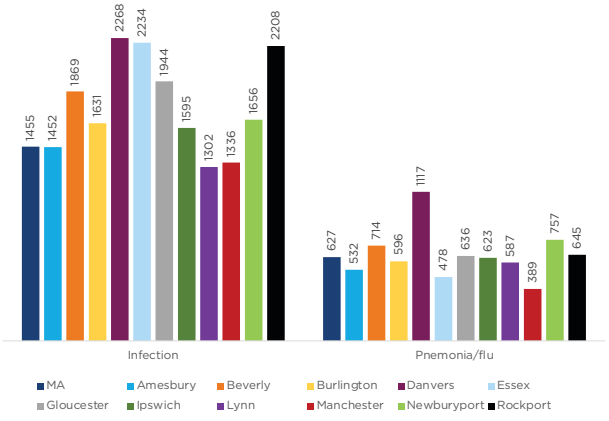


Source: Center for Health Information and Analysis, 2024

Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability and even death - as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees or participants at the listening session and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality. Data from the Center for Health Information and Analysis indicated that older adults in Beverly, Danvers, Gloucester, Newburyport, and Rockport had higher inpatient discharge rates for infections and pneumonia/flu compared to the Commonwealth.

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, BH/AGH'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 BH/AGH's IS. This prioritization process helps to ensure that BH/AGH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying 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)*

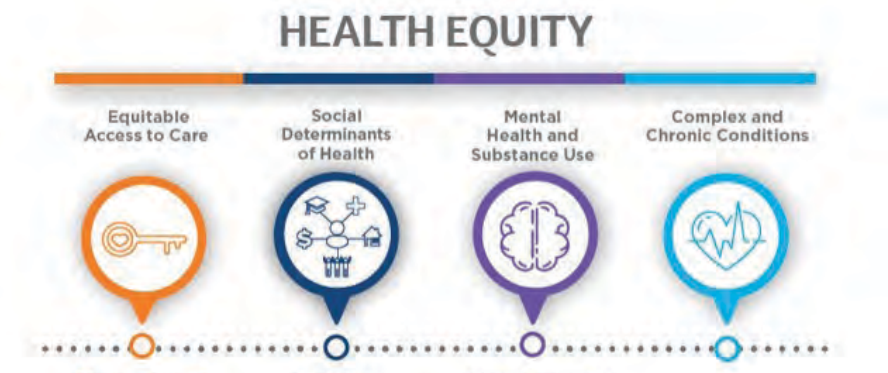
Community Health Priorities and Priority Cohorts

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

BH/AGH Community Health Needs Assessment: Priority Cohorts

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

BH/AGH Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BH/AGH

It is important to note that there are community health needs that were identified by BH/AGH's assessment that were not prioritized for investment or included in BH/AGH's IS. Specifically, improving the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in BH/AGH's IS. While these issues are important, BH/AGH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, BH/AGH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. BH/AGH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in BH/AGH's IS

The issues that were identified in the BH/AGH CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, transportation, economic insecurity, access to affordable childcare, language and cultural barriers to services, long wait times, navigating the health care system, health insurance and cost barriers, youth mental health, depression/anxiety/stress, substance use, lack of behavioral health providers, social isolation among older adults, youth substance use, behavioral health education and prevention, community-based chronic disease education and screenings, conditions associated with aging, maternal health, and chronic disease (e.g., cardiovascular disease, diabetes, cancer).

Implementation Strategy

BH/AGH'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 BH/AGH's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed BH/AGH to develop its 2026-2028 IS.

Included below, organized by priority area, are the core elements of BH/AGH'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 BH/AGH 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

BH/AGH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BH/AGH and/or its partners to improve the health of those living in its CBSA. BH/AGH 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, BH/AGH 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, BH/AGH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. BH/AGH is committed to assessing information and updating the plan as needed.

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

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

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

Strategies to address the priority:

- 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 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.
- Advocate for and support policies and systems that address social determinants of health.

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

- Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with chronic and complex conditions and/or their caregivers.
- Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.
- 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, BH/AGH evaluated its current IS. This process allowed BH/AGH to better understand the effectiveness of it's community benefits programming and to identify which programs should or should not continue. Moving forward with the 2026-2028 IS, BIDMC and all BILH hospitals will review community benefits programs through an objective, consistent process.

For the 2023-2025 IS process, BH/AGH 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. BH/AGH 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	BH/AGH addressed social determinants through investments in housing, food access, and policy advocacy. The Welcome Home Program helped chronically homeless individuals secure and maintain stable housing, while the CASA program assisted over 1,700 households in applying for affordable or elder housing. Food insecurity efforts included medically tailored groceries, nutrition workshops, and weekly mobile markets for older adults, with over 5,000 encounters in Beverly. Across programs, a high percentage of participants reported improved dietary habits. The hospital also advocated for nine state policies supporting root-cause social determinants.
Equitable Access to Care	BH/AGH expanded access to care through financial counseling, SHINE services, school-based health, and pharmacy support programs. Over 7,900 residents received help enrolling in Medicaid and other benefits in FY23, with 1,053 patients enrolled in FY24. The SHINE program provided nearly 2,000 consultations to Medicare beneficiaries. The Gloucester School-Based Health Center engaged over 3,500 student visits and delivered hundreds of food orders to students and families. Interpreter services grew significantly, with over 354,000 encounters in FY24. The hospital also supported workforce development, offering career counseling, ESOL classes, and support for 350 adult learners through community partnerships like Wellspring House.
Mental Health and Substance Use	BH/AGH strengthened behavioral health services through integrated care, counseling, education, and recovery support. The Collaborative Care Model was implemented in 11 sites, reaching over 1,400 patients. Outpatient mental health sessions exceeded 1,400 in FY24, and, across the BILH system, 380 individuals were trained in Mental Health First Aid. Programs like Rendever VR and the Nurturing Parents Program supported older adults and families, while the Moms Do Care initiative assisted over 90 women with substance use and parenting support. The Teach to Reach program trained recovery coaches, and BILH Behavioral Services delivered over 40,000 counseling sessions. Medication disposal and coalition participation rounded out a comprehensive prevention and treatment approach.
Complex and Chronic Conditions	BH/AGH improved chronic condition management through screening, navigation, and health promotion. Breast cancer risk assessments more than doubled from FY23 to FY24, identifying thousands of women at high risk. Oncology Nurse Navigators supported over 1,600 patients with treatment and survivorship resources. The hospital funded free Enhance Fitness classes, which helped participants, many economically disadvantaged, maintain or improve overall health and physical function. These programs collectively strengthened prevention, care coordination, and community-based support for individuals at risk for or managing complex and 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: FY2026-FY2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

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

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

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

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

Are there any questions before we begin?

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

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

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

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

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

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

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

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

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

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

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

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

Beverly Hospital/Addison Gilbert Hospital
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Beverly Municipal Leaders
- Sue Gabriel, Executive Director, Beverly Bootstraps
- Julie LaFontaine, President and CEO, The Open Door
- Maggie Brennan, President and CEO, North Shore Community Health
- Danvers Municipal Leaders
- Lynn Municipal Leaders
- Valerie Parker Callahan, Senior Director of Population Health, Greater Lynn Senior Services
- Agnes Misigah, Director of Housing, Policy, and Practice, Centerboard
- Brenda Rodriguez, CEO, Lynn Community Health Center
- Rockport Municipal Leaders
- Chris Lovasco, President and COE, YMCA of the North Shore
- Renata Ivnitskaya, Director of Residential Nursing, Northeast Arc
- Birgitta Damon, CEO, LEO, Inc.
- Susan Coviello, Executive Director, North Shore Health Project
- Manchester-by-the-Sea Municipal Leaders
- Gloucester Municipal Leaders
- Mayor Greg Verga, Mayor of Gloucester

Community Health Priority Areas

Social Determinants of Health

- Housing was consistently identified as a top concern by interviewees
    - Without stable housing, it is difficult to access medical services and manage treatment or medications
    - Lack of available, affordable, and new housing stock; this is made more competitive with the increase of people moving to the area
    - Rising housing costs is especially impactful for aging populations with fixed incomes
    - Rise in temporary housing, like hotels, to meet housing needs
        - Few beds and space in housing shelters, which may require sobriety
    - The housing that is available is poor quality and can be unsafe
- Food Insecurity was identified as the second biggest concern by interviewees
    - The region has a large WIC program that helps provide additional food resources
    - Community food banks assist many individuals in accessing healthy food
    - In general, food is not affordable, especially in smaller corner stores
    - Lack of knowledge on nutrition, food storage, and the relationship between diet and health
- Economic Insecurity
    - “Starting to see folks are making choices of whether to eat or pay for rent, services”
    - Cost burden of childcare
    - Wages are often too low to meet the cost of living

- Transportation
    - Lack of parking at health centers leads to delays and missed appointments
    - Transit is a major challenge, especially in accessing food resources and for older adults
    - Public transportation between towns is limited; making it difficult for residents to get to the hospital or medical care in other areas
- Workforce
    - Lack of sustainability and understaffing of health centers has lead to loss of services

Access to Care

- Lack of primary care providers and appointments to meet the need
    - Providers are leaving the profession
    - Long wait times
- Need for additional in-person and community-based services, not just individual treatment
- Lack of dental services available after COVID-19
- Insurance Challenges
    - Many pediatricians do not accept MassHealth or have long wait lists
    - Undocumented individuals are unable to receive care in most spaces
    - Lack of counselors to assist with MassHealth re-enrollment
    - Many individuals are underinsured or uninsured
- Co-pays are a financial barrier for many individuals
- Need for more resources and focus toward prevention
- Need for additional emergency care and maternal health care outside of the main hospital
- Language/Cultural Access
    - Challenge to assist non-English speakers with insurance, forms, and administrative paperwork
    - Assumptions of non-English speakers and newcomers based on perceptions and prejudices by providers
    - Ensuring translation services for a wide array of populations (Spanish, Portuguese, Albanian, Haitian Creole, etc.)
- Need for additional case management and healthcare navigation supports
    - Current reliance on self-advocacy
    - Need for social workers in the health department to assist in accessing public programs

Mental Health and Substance Use

- Lack of providers for pediatric and youth mental health (prescribers, therapists, etc.)
    - Limited resources are available outside of schools
- Stigma related to substance use limits care access and community support
    - Need for more prevention and education related to mental wellness in additional to clinical diagnoses
- Expanding knowledge and access of Narcan and Naloxone while incorporating harm reduction frameworks
- Substance Misuse
    - Cocaine
    - Youth vaping, marijuana, nicotine, and alcohol
    - Generational impact of substance misuse on families
- Mental Health

    - Depression
    - Anxiety
    - Impact of COVID-19 on communities
    - Impact of social media
    - Youth mental health
    - Older adult mental health
- Some communities, like Danvers, have had success directing individuals to mental health clinicians rather than jails
- Lack of mental health staff during hospital intake has led to hostility toward patients with mental health needs, especially if they are brought in by emergency services

Chronic and Complex Conditions

- Lack of continuous care; delays in screenings and patients are without follow-up care
    - Past community screening events have been successful
- Hypertension, high blood pressure, diabetes, and obesity are common chronic conditions in the community
- Food insecurity and poor nutrition contributes to chronic health conditions

Priority Populations

- Agreement across interviewees that the following populations should continue to be the priority, as they face the most significant barriers to care and services:
    - Youth
    - Older Adults
    - Racially/ethnically/linguistically diverse (including immigrants and refugees – primarily those that have newly arrived)
    - Low-resourced/low-income populations
- Interviewees also identified concerns for individuals living with disabilities (including children and family members/caretakers), individuals who are underinsured or uninsured, and LGBTQIA + populations

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout these communities including: Kids Weekend Food Program, Beverly Task Force, Beverly Bootstraps, Phoenix Food Hub, Greater Lynn Senior Services, Lynn Community Health Center, Continuum of Care, Systems of Care, Lynn Housing Authority, Open Door, North Shore Community Development Association, Centerboard, Danvers Cares Coalitions, Resilient Danvers, Danvers Cares, YMCA, Anchor Bay Church, Get Healthy Beverly Coalition, Regional Youth Prevention Network, Council on Aging, New Mothers group, Haverhill Mayor's Hope Task Force, Pathways for Children, North Shore Health Project
- Willingness to partner across organizations especially within the same town
- Schools, health departments, shelters, food pantries, religious groups, police departments are common collaborators across towns
- Need for more grants and financial resources, especially for multi-year initiatives

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

Northeast Hospital Corporation (BH-AGH)
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Connecting Young Moms
Location: Zoom
Date, time: 10/1/2024
Facilitator: JSI and Connecting Young Moms
Approximate number of participants: 9

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Walk everywhere
    ii. Go outside in the fresh air
    iii. Play at the park
    iv. Take classes at the YMCA
    v. Go to the gym
    vi. Push my toddler in her stroller
    vii. Practice healthy eating habits, like drinking green juice
    viii. Weight lifting and doing exercises with my baby
    ix. Doing cheerleading activities with my niece
    x. Taking multivitamins like Vitamin D and evergreen supplements
    xi. Doing a skin care routine
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Lack of motivation
    ii. Lack of time
    iii. Financial challenges
    iv. Challenge to reset eating habits after pregnancy

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. Take breaks throughout the day
    b. Practice self care at the end of the day
    c. Do my nails

d. Make my bed every morning
e. Try to get dressed and do my hair
f. Watch a show to decompress
    i. I rewatch shows at night. I like to know what to expect; it helps me to step away from reality.
g. Therapy
h. Take my medications regularly
i. Spend time outside
j. Listen to music as a distraction
k. Keep my room neat and organized
l. Write in a journal
m. Spend time alone and have my own space
n. Clean

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

a. Trying to secure a therapist is hard
    i. It is difficult to take the first step to find a therapist
b. Lack of time for therapy, especially as the default parent
c. I get distracted from taking the first step
d. There is so much focus on the baby as a priority and not myself
e. I get in my own way. The lack of motivation and the anxiety prevent action
f. I feel socially awkward
g. The wait lists for therapy are so long that you get accustomed to how you are feeling

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. Lack of Social Connection
    i. I feel socially awkward with strangers so I do not like to go out
    ii. I feel socially awkward and it makes me feel disconnected and drained by outside activities
    iii. I find it difficult when people ask me about my pregnancy and my baby
    iv. I hate having to interact with people in the community
    v. Social interactions are uncomfortable
b. Housing is a big struggle in my community
    i. Housing is so hard and it should not be. I was told I was disqualified and that I need to appeal.
    ii. Housing is confusing
    iii. Affordable housing is often only found in communities where you do not want to raise your children. I am looking for clean parks and low crime areas.
    iv. There is very little low-income housing available.

v. Housing costs are very expensive; it feels like that will prevent me from ever saving enough money or getting ahead.

c. Domestic Violence is hard; you have to endure so much to get housing.
d. Many people cannot afford to live in Ipswich, many move due to the high cost of living.
e. I am not able to go out due to high everyday expenses
f. Transportation is an issue; my community does not have any buses
    i. There is no public transportation access.

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?

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. Parks within walking distance
b. Backyard growers program
c. Connecting Young Mothers group
d. Wellspring assistance
e. Community offerings and activities
f. Farms
g. The library - Beverly library
h. The birth to 3 program in Ipswich has free play groups and a walking club
i. Lynn Healthy Families program and events
j. Open Door is very welcoming and they deliver. There are lots of healthy choices and online ordering makes the service more accessible.
k. Health Quarters clinic
l. Having a pediatrician that is open 365 days a year is helpful
m. North Shore Mall has family activities
n. Mom groups
o. Local Buy Nothing community

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

a. Lack of access to therapy
b. I wish there were better resources through DTA. I would prefer for services to be in-person; it is more challenging to deal with housing and RAFT virtually
    i. Not having in-person help with housing delays you
c. Difficulty accessing a primary care provider and MassHealth
d. Resources if you have lost insurance
e. It feels like people do not care about me because I am on MassHealth
f. I am not eligible for wisdom teeth removal because I am on MassHealth

g. There is a complicated process to get MassHealth coverage
    i. There is a learning curve to MassHealth
h. Urgent Care sent me to the emergency room since I did not have insurance
i. My child was marked as deceased, then my insurance was cancelled.
j. It is difficult to access durable medical equipment for a medically complex child.
k. Incompetent doctors
l. Prescriber issues - doctors have too many patients
m. Long waits to access a primary care provider or specialist

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?

No response

Northeast Hospital Corporation (BH-AGH)
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Young women in Lynn
Location: Girls, Inc.
Date, time: 10/7/2024
Facilitator: JSI and Girls Inc.
Approximate number of participants: 12

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. Doing my nails
    ii. Drinking water
    iii. Walking everywhere
    iv. My family encourages me to play sports
    v. Eating healthy
    vi. Getting enough sleep and exercise
    vii. PE class in school
    viii. Going outside in the fresh air
    ix. Communicating with others

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Sitting in school all day is rough
    ii. Laziness and lack of motivation
    iii. Staying in my room
    iv. Poor mental health
        1. Feelings of isolation after Covid
    v. Homework
    vi. Not eating enough or overeating
        1. Eating late at night
        2. Eating when bored
    vii. Lack of healthy food options at school
    viii. Family challenges
    ix. Cultural challenges
    x. Illness
    xi. Periods and menstruation
    xii. Birth Control

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. Ignore my feelings
b. Practice self-awareness
c. Go to therapy
d. Get support from my boyfriend
e. Read
f. Do things that I enjoy
g. Spend time with friends
h. Listen to music
i. Write
j. Ask for help
k. Make art
l. Take time alone
m. Meditate
n. Go for a walk
o. Surround myself with the right people

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

a. School
b. Social Media
    i. TikTok
c. Boys and romantic challenges
d. People in general
e. Family challenges
f. Stress from politics
g. Overthinking
h. Drama
i. Mental Illness
j. Financial and job stress

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. Homelessness
b. Drugs/Substance abuse

c. Teen pregnancy
d. Accessing geriatric care
e. Feeling ignored

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. Specific Communities
    i. Students
    ii. Low-income families
    iii. Veterans
    iv. Single parents
    v. Immigrants
b. Specific Barriers
    i. Gender inequality
    ii. Status
    iii. Age
    iv. Immigration Status Race
    v. Government requirements/approval

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. Teen community health center
b. Girls Inc.
c. Eliot
d. Food pantries
e. My Brother's Table
f. Centerboard Resource Center
g. Libraries
h. Fundraisers
i. Recovery Exchange
j. Healthy Streets
k. Community Closet
l. Doctors' offices
m. Resource Center

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

a. Free period products should be available in more places
b. Resources for soap, clean water, and new clothing

c. Lack of advertising of resources
d. Lack of activities and places for teens to hang out
e. Parks are dirty
f. More advertising for mental health resources
g. More parks

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?

- School staff doesn't listen - we would like someone to listen to us and actually do something about it
    - Quality of teachers
    - Teachers make us not want to go to school
- Not enough support for seniors who want to apply for college
    - Need support on which classes to take to get into college
- Need more support to help people get jobs
- Need more information on financing college

Northeast Hospital Corporation (BH-AGH)
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Low-resource fathers
Location: Zoom
Date, time: 11/6/2024
Facilitator: JSI with Pathways 4 Children
Approximate number of participants: 9

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. Mostly walking, taking the dog for a walk or pushing babies in the stroller
    ii. Every now and then I try to go to a fitness class at the YMCA
    iii. Walking is big; I walk it with family, especially in the evening
    iv. We do a lot of outdoor activities, I am like visiting local parks and going on bike rides
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Demand on time; I have young kids and animals, so it can be hard
    ii. Having free time, it is hard to want to engage after work
    iii. Combining work with physical activities can be time consuming especially as a dad like me who has a full time job

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. Trying to be mindful and engage with things that I like
    b. Reading; it takes mind off things
    c. I try and think positive all of the time
    d. We cultivated the habits of eating together and this has fostered communication among us, after a long time away we get to have the opportunity to sit together and I believe this has helped us mentally
    e. Prioritize building a happy relationship with my family

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

a. I have never really thought about it or know what I could do to improve my mental health
b. Time is definitely a barrier
c. I would say time constraints again, it doesn't always work that we are able to sit together, sometimes we are just tired

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. Food prices are difficult for everyone, especially access to healthy foods
b. Housing prices are high; affordable housing is difficult to find
c. Money and wages are big drivers
d. There are programs out there, but folks don't know about them
    i. Limited knowledge and awareness of resources

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. There are limited resources for language supports for non-English speakers

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. Use Action Inc. is a local housing resource in the Gloucester area
b. I have used the YMCA and the library
c. The Open Door is another good place
d. My church has helped me before in terms of sorting my house; mentally they have been helpful too

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

a. We absolutely need more mental health care and psychiatrists
b. More dental options
c. More support groups; I wish to see more support groups for people struggling with mental health issues

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?

No

Northeast Hospital Corporation (BH-AGH)
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Homeless and/or Recently Housed
Location: Action Inc. Emergency Shelter
Date, time: 11/7/2024
Facilitator: JSI
Approximate number of participants: 11

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Walk
    ii. Swim
    iii. Bicycle in the area
    iv. Ride my scooter around in the area
    v. Go to the YMCA
    vi. Go to Wingersheek Beach
    vii. Go to the Senior Center

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Depression; when you stop taking care of yourself you start to withdraw from society and stop activities like going on walks
    ii. Low economic and financial status
    iii. Struggling with different disabilities
    iv. Injuries
    v. Feeling lazy

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. Attend group functions
    b. Being around family
    c. Exercise
    d. Taking my medications
    e. Have a good support network

f. Have community with friends, coworkers, and family
g. Go to Action Inc.

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

a. Depression
b. Isolation
c. Addiction
d. Not having a job
e. Not being able to see those I care about
f. Transportation challenges
g. I have a wheelchair and only get 12 rides a year. The limited number of rides prevents me from being physically healthy; I need more than 12
h. There is too much red tape; I need transportation to get from medical facility to medical facility
    i. It should be simple for the patient to be picked up and go places
i. I have gone to the emergency room because it is easier than getting to regular appointments
j. Years ago there was a 20-bed treatment facility in Gloucester; now it is gone
k. I noticed that when Lahey took over, there are now less services in the area
l. We need more medical staff

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. There are limited places for people who are homeless to go
    i. Weekends are worse; people get stuck outside
    ii. Many places are only open from 9:00am - 4:30pm on weekdays
    iii. There are not as many places for people to go in the morning
    iv. People will be in the shelter for 6+ months
    v. There are limited shelter beds; they can only bring so many people in and a lot of folks have nowhere to go
b. Transportation is tough
c. The area is very expensive
d. It is hard to find an apartment
    i. You need to have money for the first and last month's rent; have good credit; and not have a criminal record
    ii. There is a long waitlist for low-income housing
    iii. Housing is the biggest issue everywhere
    iv. Young people can't buy homes
    v. The process to buy a home takes too long
e. Getting insurance is tough
f. Stigma around addiction

g. Dual diagnoses of mental health and substance use in the community
    i. Mental Health - depression, anxiety, PTSD, bipolar disorder
    ii. Substance Use - fentanyl, crack, meth, opioids

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 with language barriers
b. People with disabilities

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. Action Inc.
b. Methadone Clinic
c. Gray Center
d. One Stop
e. Core
f. Elliot
g. 12-step groups

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

a. Better medical transportation
b. A place to go that is always warm and dry
c. More job opportunities; there are not enough jobs in Gloucester; I have to look in Boston and in Salem because there are slim pickings here
d. More volunteer opportunities that could help me stay out of the cold
e. A place to do activities
f. Overall more outreach and opportunities

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?

- The bedside manner isn't good at the hospital
- The wait is too long at the emergency room
- There is stigma against people who are homeless
- I recently had to go to a check-in at an appointment. I have a hearing disability, and didn't feel like I was seen or heard. It wasn't a good feeling being treated differently; I just want better care and respect towards patients. It was frustrating.
- This is not an ADA-friendly community
- There are more help and resources in Massachusetts than in Florida

Northeast Hospital Corporation (BH-AGH)
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals in an English as Second or Other Language (ESOL) Course
Location: Action Inc.
Date, time: 11/12/2024
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. Most people focus on healthy eating, getting better sleep, and regular exercise.
    ii. Popular activities include sports, going to the gym, swimming, jogging, biking, and walking.
        1. Common sports in the area include soccer, football, swimming, aerobics, and dancing.
    iii. Meditation is also practiced by some individuals.
    iv. Social activities like group meetings and community volunteering are helpful.
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Most people said that mental stress, overthinking, and financial worries (like rent and bills) make it difficult to focus on health.
    ii. Long working hours and lack of time prevent exercise.
    iii. Illness and family conflicts can disrupt health routines.
    iv. Disabilities or physical limitations can hinder participation in sports.
    v. Cost of gym memberships, such as those for the YMCA, is a barrier for some.
    vi. Mental health struggles can also prevent people from staying active.

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. This group uses various strategies to manage stress and overthinking, including medication, yoga, and dancing.

b. Spending time outdoors at parks like Stage Fort Park, swimming, and being near the ocean are also common ways to relax.
c. Engaging in physical health activities, cooking, cleaning, and personal care like makeup help with relaxation.
d. The group values social connections, spending time with loved ones, playing games like checkers, and celebrating events like parties.
e. A balanced lifestyle, including time for themselves and helping others, also supports mental well-being.

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

a. Financial stress
b. Being away from family
    i. Lack of time with loved ones
c. Family problems
d. Loneliness
e. Substance use

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. Language barriers
b. Loneliness
c. Immigration status
d. Transportation
e. Long wait times and limited access to services
f. Insufficient medical infrastructure
    i. Lack of access to modern hospitals and specialized care, like orthopedics
g. High housing costs
    i. Rent restrictions
    ii. Difficulty renting without a social security number

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. Immigrants and people with language barriers face difficulties accessing services, including job training and healthcare.
b. Older adults may face mobility issues and limited access to certain services.
c. People with mental health challenges face long waiting lists and difficulty finding treatment, which has been exacerbated in recent months.
d. Low-income individuals struggle with housing and job opportunities.

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. Action Inc. (education, utility assistance)
    b. Open Door (food access)
    c. The Senior Center (for older adults, though some feel more activities are needed)
    d. The Library (providing free internet, books, and coffee)
    e. YMCA (fitness and wellness programs)
    f. Parks and beaches (outdoor recreation options like walking and swimming)
    g. Schools (supportive for parents, though some have mixed feelings about the public school system)
    h. Local restaurants (such as those offering fresh seafood).
b. **What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. Job training programs and opportunities to earn certifications (e.g., cosmetics)
    b. More mental health treatment options, as there is a significant need, especially in the past nine months, with long waiting lists for services
    c. More social workers and resources for children with special needs
    d. More physical health facilities to address growing needs

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?

- Concerns about substance use, particularly with marijuana and some other drugs, which can affect the quality of life and cause issues like unpleasant building smells.
- There is also a need for more community events like Fiesta and soccer tournaments, as well as recreational resources like a movie theater, public jacuzzi, sauna, and more youth activities.
- Gloucester also needs public pools, public bathrooms near the beach, and more parking.
- Hospital-related concerns include the need for a maternity ward (delivery room), more specialized doctors, and additional primary care doctors in Gloucester.
- There are issues with the shelter system, specifically the lack of available beds and the difficulty of reserving space.
- Need for improved translation services to address language barriers (such as Moroccan Arabic and Egyptian Arabic).

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

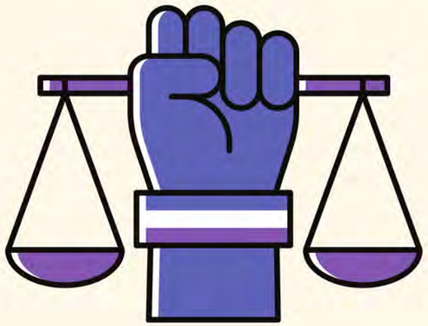
Be sure to register for your Listening Session (both in-person and virtual). For Zoom meetings, registration is required to join and you will be sent your link to join the meeting after you register

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."

Northeast Hospital Corporation
(Beverly Hospital and Addison Gilbert Hospital)
Community Listening Session

February 12, 2025 | 9:00-10:30pm

Beth Israel Lahey Health

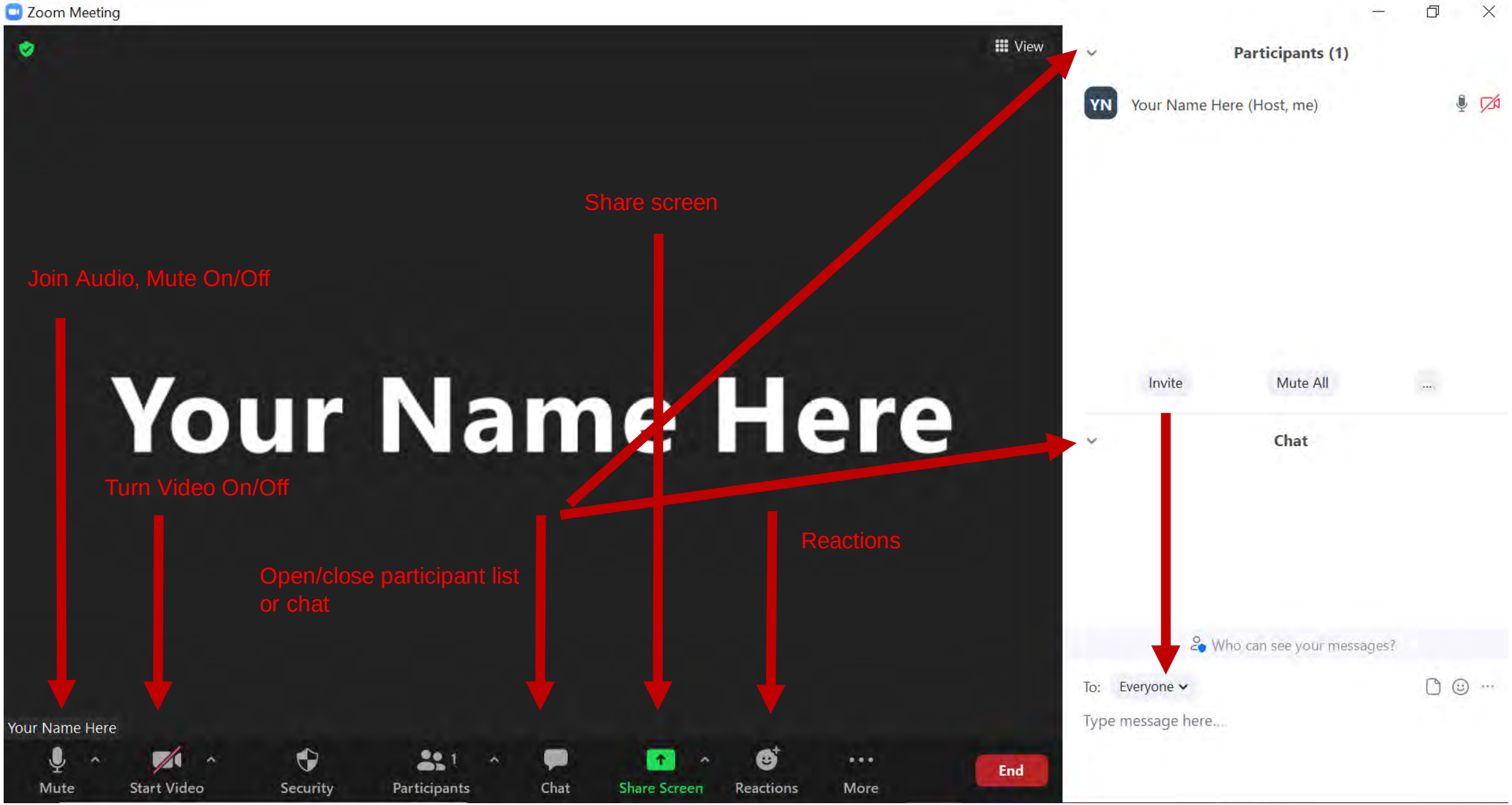
BH/AGH Community Listening Session

Join a language channel

1. Find **Interpretation** or **Language** icon on your Zoom toolbar

2. Choose your preferred language

3. Mute original audio to only hear the interpreted audio


Zoom Meeting
View
Participants (1)
YN
Your Name Here (Host, me)
Invite
Mute All
...
Chat
Who can see your messages?
To: Everyone
Type message here...
Your Name Here
Join Audio, Mute On/Off
Turn Video On/Off
Share screen
Open/close participant list or chat
Reactions
Your Name Here
Mute
Start Video
Security
Participants
1
Chat
Share Screen
Reactions
More
End

BH/AGH Hospital Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

BH/AGH Hospital Community Listening Session

Agenda

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

Assessment Purpose and Process

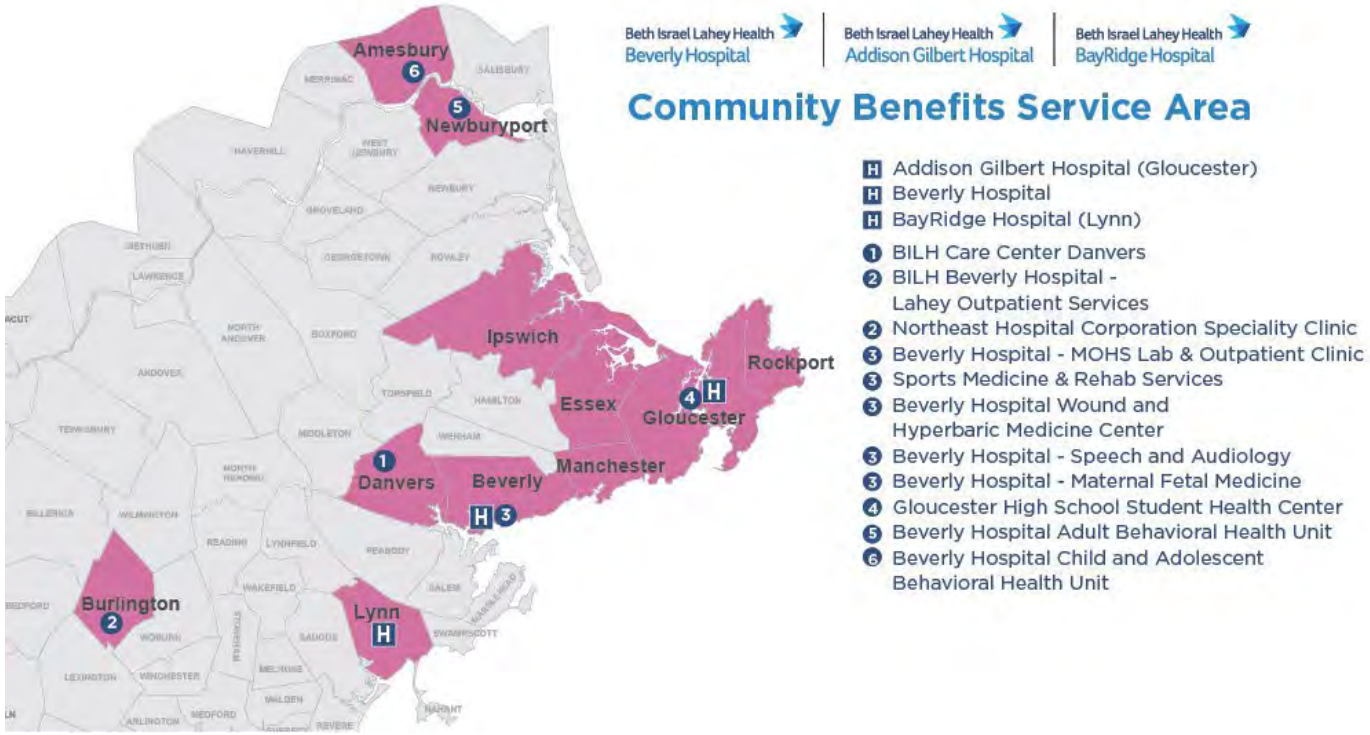
Assessment Purpose and Process

Purpose

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

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

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



Assessment Purpose and Process

FY25 BILH CHNA and Implementation Strategy Guiding Principles

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

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

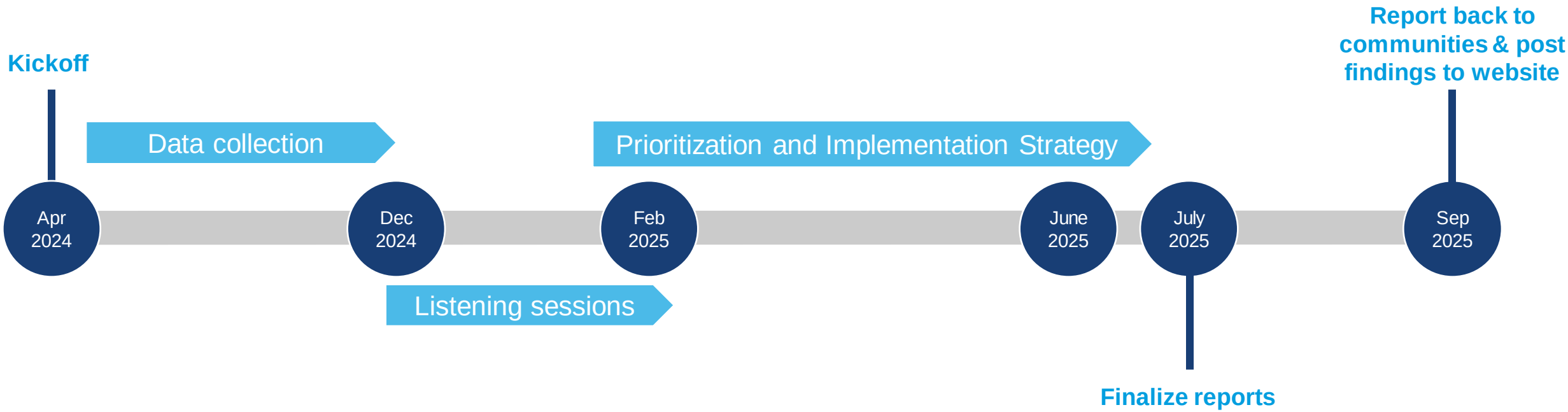
Engagement: Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, communities most impacted by inequities, and others

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

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

Assessment Purpose and Process

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 BH/AGH
- Present data for prioritization
- Identify opportunities for ***community-driven/led solutions and collaboration***

We want to hear from you.

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

Key Themes & Data Findings

FY25 CHNA Progress

Activities to date

Collection of secondary data, e.g.:

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

18 Interviews

2,179 BH/AGH FY25 Community Health Survey Respondents

5 Focus Groups

- Homeless or recently housed *(Action Inc.)*
- Young mothers (*Connecting Young Moms – BH/AGH Program)*
- Low-resourced fathers (*Pathways 4 Children*)
- Adolescent girls (*Girls Inc.*)
- Foreign-born residents engaged in ESOL programs *(Action Inc.)*

FY25 CHNA Progress

FY25 BH/AGH Community Health Survey Responses

2,179 responses

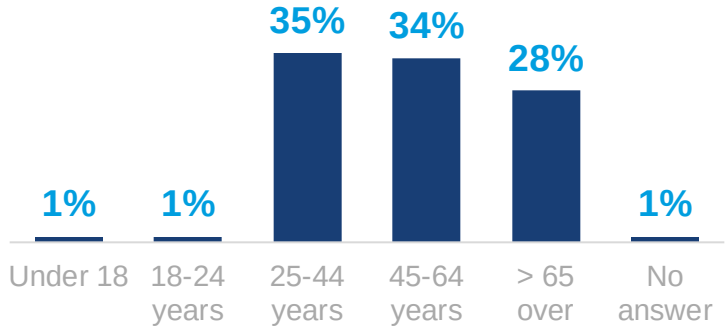
11% of respondents report a language other than English as the primary language spoken in their home

80% of the respondents are women

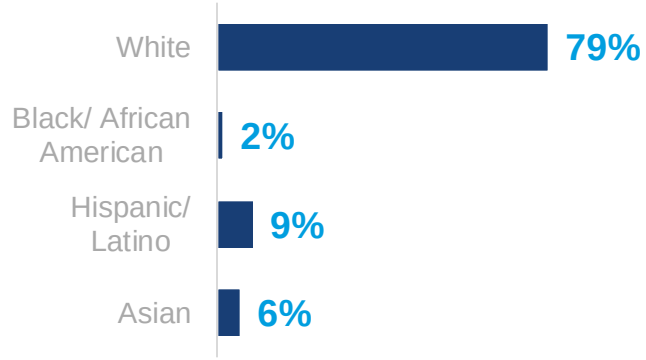
12% of the respondents identify as living with a disability

9% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning

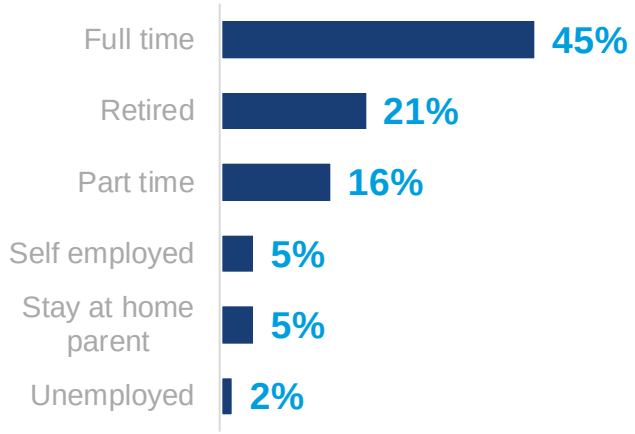
Age



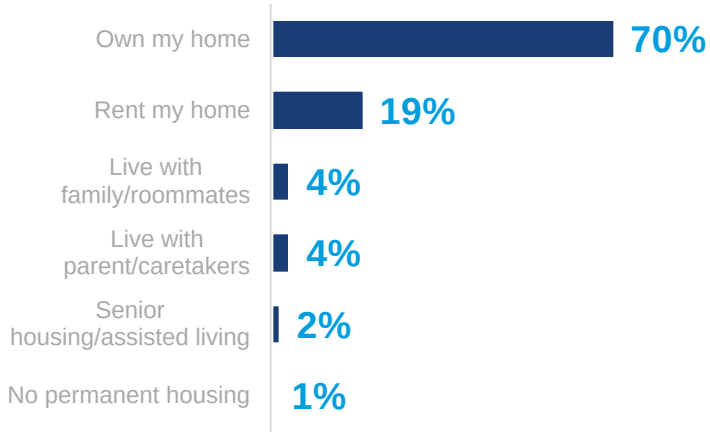
Race/Ethnicity



Employment (top responses)



Housing (top responses)



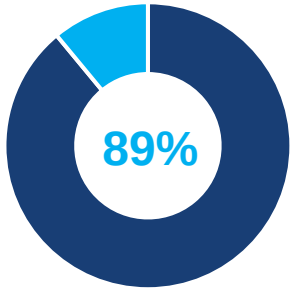
FY25 CHNA Progress

Community Benefits Service Area Strengths and Opportunities

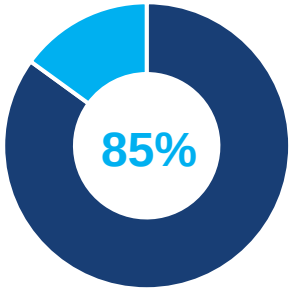
FROM INTERVIEWS & FOCUS GROUPS:

- Strong partnerships across organizations and sectors – may be opportunities to combine and streamline efforts to maximize impact and conserve resources
- Municipal leadership across communities is strong, engaged, and willing to partner with community organizations
- Organizations of all types are seeing high demand for services – explore opportunities for resource sharing

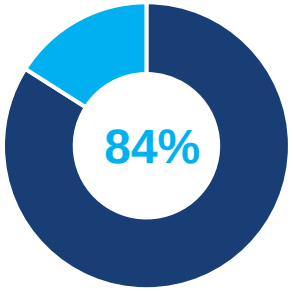
FROM FY25 BH-AGH COMMUNITY HEALTH SURVEY:



said they **feel like they belong** in their community



said they are **satisfied with quality of life in their community**



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

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 (affordability, displacement, homelessness)
- Food insecurity
- Transportation
- Economic insecurity and high cost of living
- Access to affordable childcare
- Language and cultural barriers to services

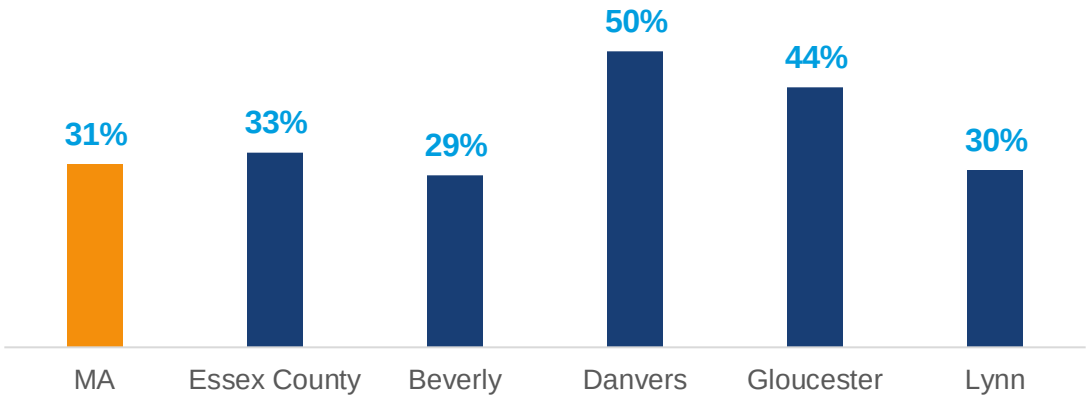
"We've seen an increase of over 100% in visits to the food bank between 2022 and 2024. This shows that people are still struggling to find food. We are starting to see folks that are having to make choices about whether to eat, pay for rent, and pay for other services."

– Interviewee

When asked what they'd like to improve in their community, **57%** of FY255 Community Health Survey respondents reported **more affordable housing** (#1 response) **[up from 54% in FY22]**

18% of FY25 Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

Percent of Adults Reporting They Make 'Just Enough Money' Each Month to Pay Bills (2023)



Data Source: MA CHES, 2023 (note that data is not available for all communities)

FY25 CHNA Progress

Preliminary Themes: Equitable Access to Care

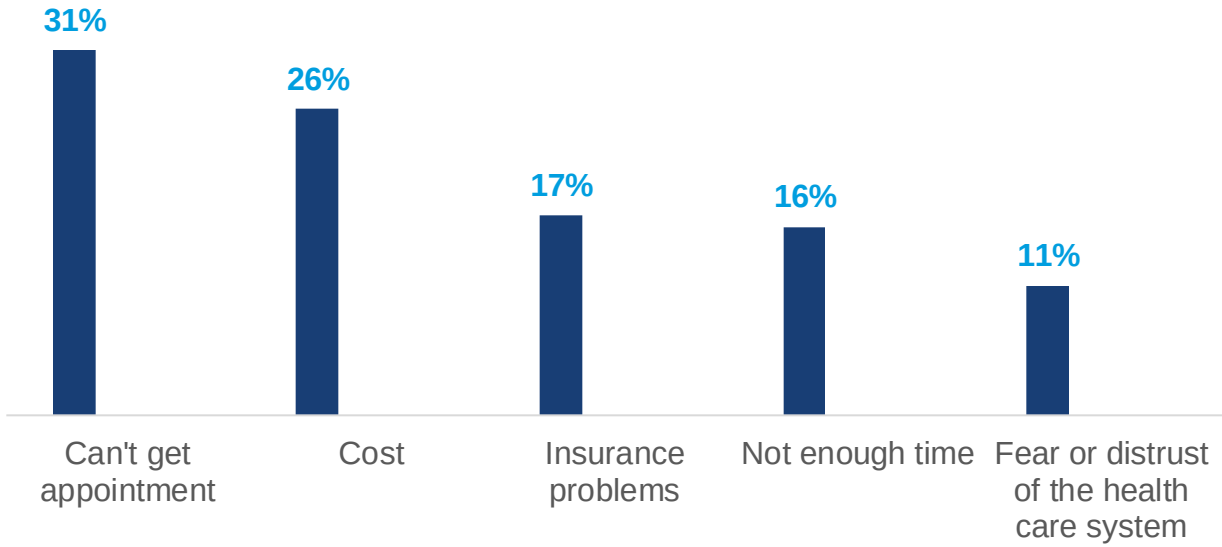
Primary concerns:

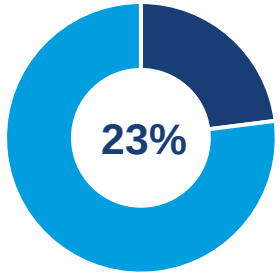
- Long wait times for primary care and behavioral health care (acknowledging that workforce was identified as an issue among providers)
- Navigating a complex health care system
- Health insurance and cost barriers
- Language and cultural barriers to care

"Access to primary care is especially problematic. A lot of PCPs are leaving the profession. People are experiencing long waits. It's hard to get appointments for kids too – especially for those on MassHealth. A lot of pediatricians aren't taking MassHealth, or they're putting people on wait lists." - ***Interviewee***

What barriers keep you from getting needed health care?

(Top 5 responses from FY25 BH-AGH Community Health Survey)





23% of FY25 BH-AGH Community Health Survey respondents reported that health care in their community does not meet people's physical health needs

FY25 CHNA Progress

Preliminary Themes: Mental Health and Substance Use

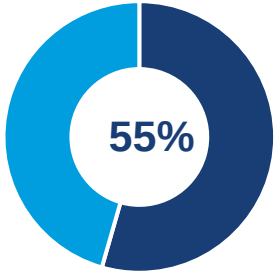
Primary Concerns:

- Youth mental health
- Depression, anxiety, and stress
- Substance use (opioids, alcohol, marijuana)
- Lack of behavioral health providers
- Social isolation and mental health issues among older adults
- Youth substance use (marijuana, nicotine)
- Need for more prevention and education

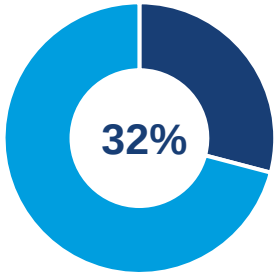
Gloucester's recent Needs Assessment found that compared to the state average, the City has:

- 72% **more** hospitalizations for substance use disorder
- 49% **more** individuals admitted to BSAS services
- 46% **more** alcohol-related ER visits
- 32% **more** alcohol-related deaths
- 14% **more** opioid-related deaths

AMONG FY25 BH-AGH COMMUNITY HEALTH SURVEY RESPONDENTS:



55% identified mental health as a heath issue that matters most in their community (#1 response)



32% reported that mental health care in the community does not meet people's needs

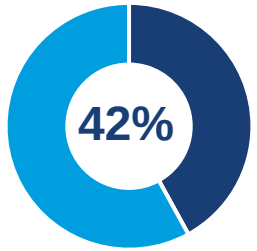
FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

Primary Concerns:

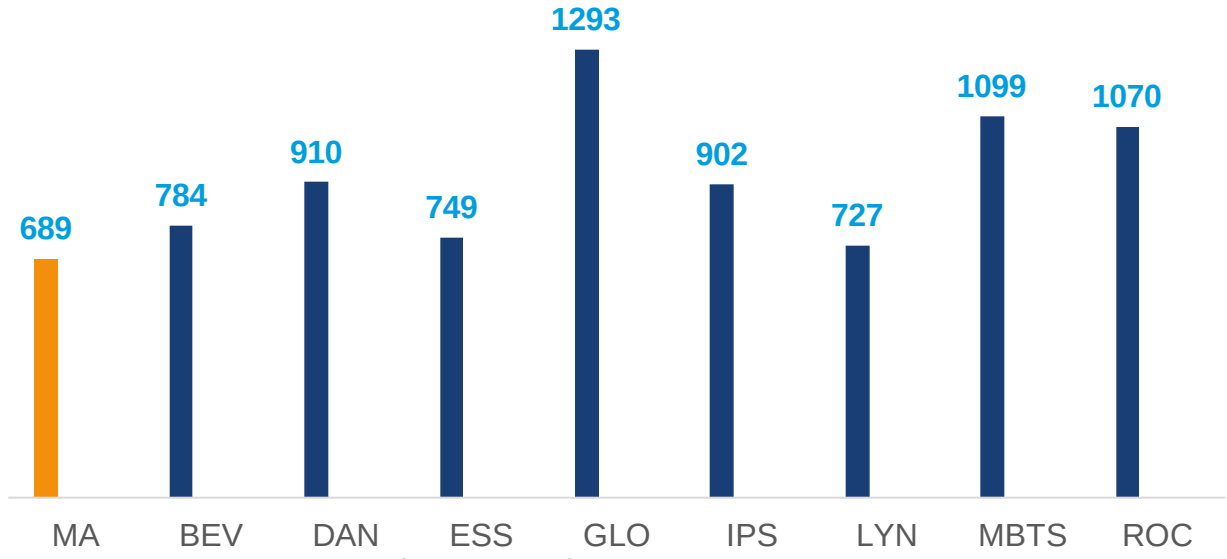
- Cardiovascular disease
- Desire for more community-based education and screenings (e.g., at housing complexes, councils on aging, libraries, schools)
- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Diabetes
- Cancer

AMONG FY25 BH-AGH 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, 2021 (rates per 100,000)



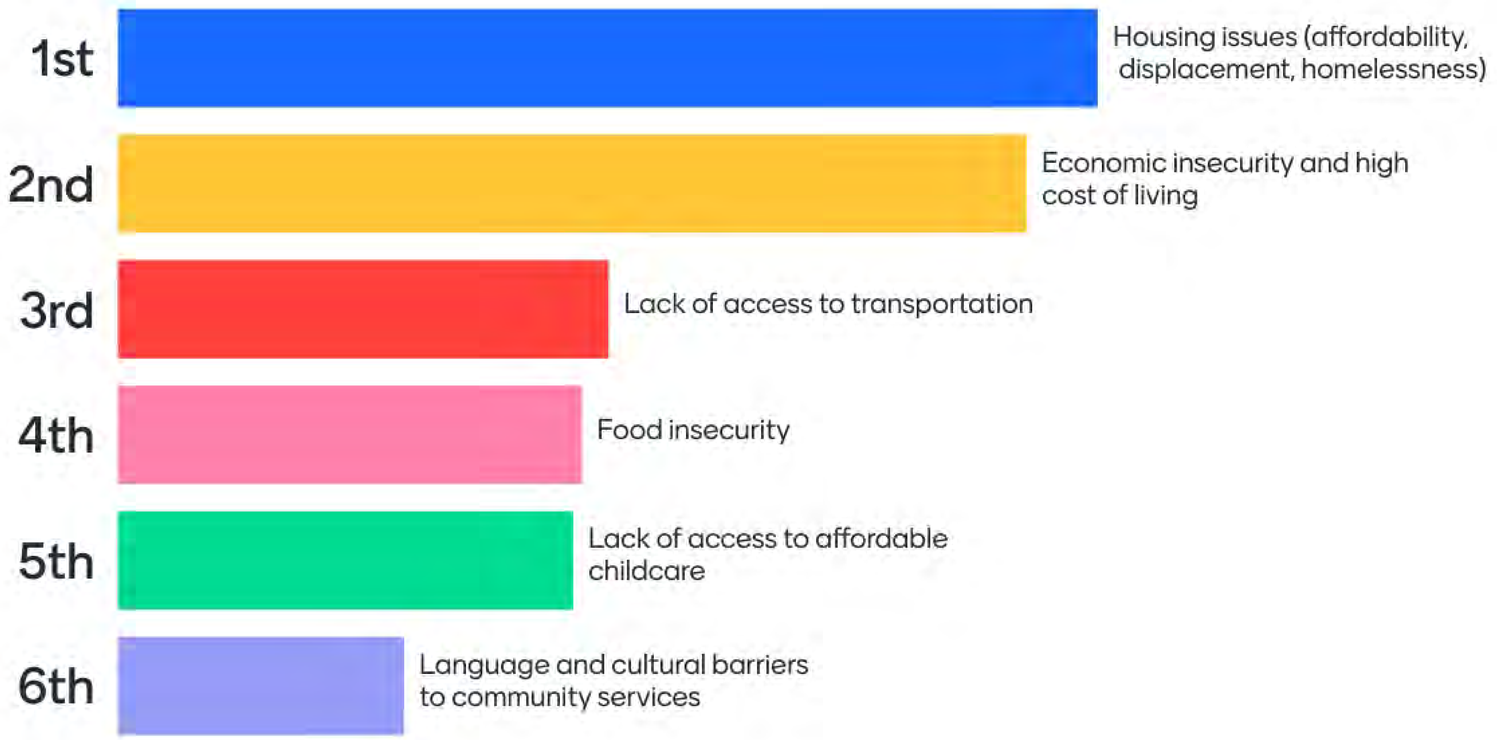
Data Source: MDPH, Massachusetts Deaths, 2021

"Health happens IN the community. We need preventative resources in the community to aid in clinical support."

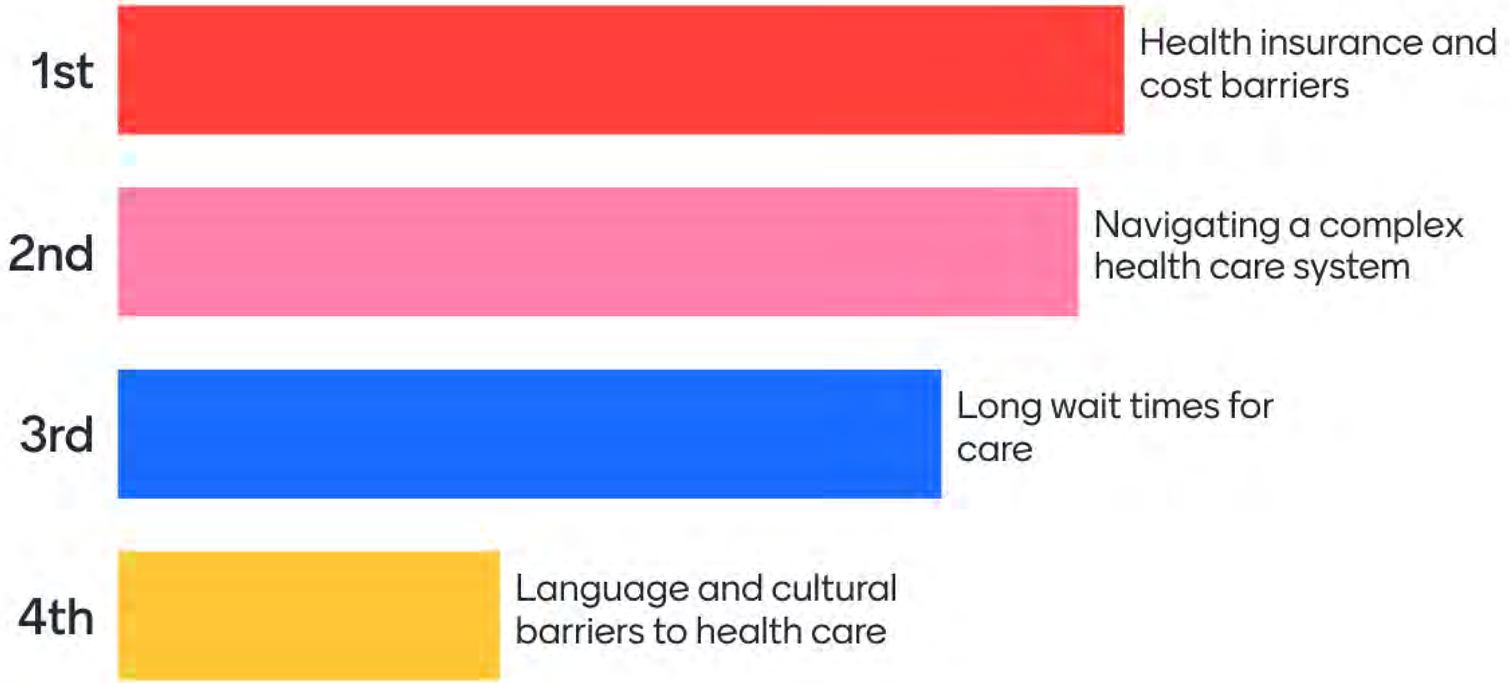
-Interviewee

Breakout Sessions

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



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



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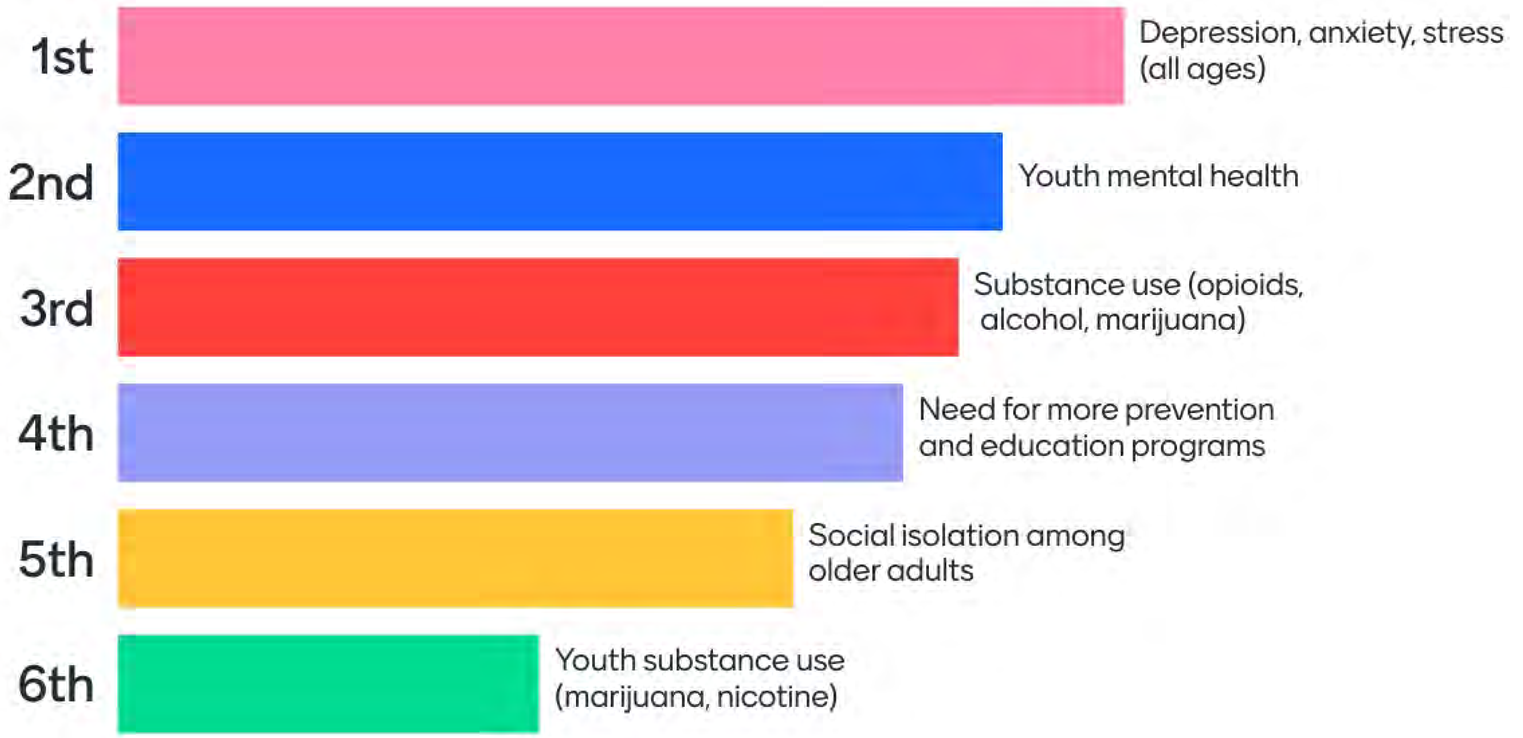
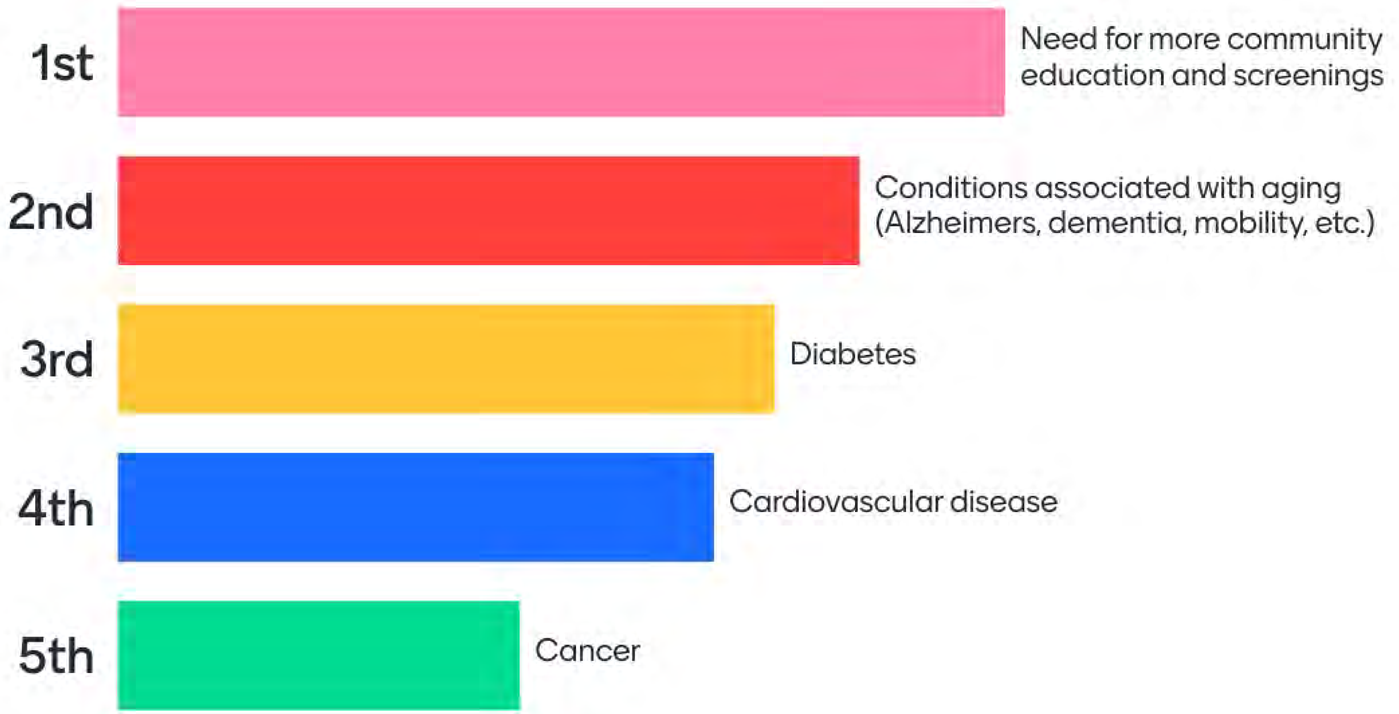
Mental Health and Substance Use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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



Reconvene

Wrap-up
BH/AGH Hospital Community Benefits

Marylou Hardy
Manager, Community Benefits & Community Relations
Northeast Hospital Corporation
Marylou.hardy@bilh.org

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

Community Benefits Annual Meeting in September (More info TBD)

Thank you!

Appendix B:
Data Book

Secondary Data

Demographics

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
Demographics								
Population								US Census Bureau, American Community Survey 2019-2023
Total population	6992395	807258	1622896	17277	42408	26223	27924	
Male	48.9%	48.6%	49.4%	48.8%	47.8%	48.20%	45.7%	
Female	51.1%	51.4%	50.6%	51.2%	52.2%	51.8%	54.3%	
Age Distribution								US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.4%	5.1%	4.9%	5.7%	4.8%	4.4%	
5 to 9 years	5.2%	5.6%	5.4%	4.4%	4.3%	6.5%	4.1%	
10 to 14 years	5.7%	6.2%	5.6%	6.5%	6.3%	4.9%	4.4%	
15 to 19 years	6.5%	6.4%	6.3%	5.3%	6.4%	4.0%	6.3%	
20 to 24 years	6.8%	6.2%	6.8%	3.2%	8.6%	5.7%	5.9%	
25 to 34 years	14.1%	12.5%	15.1%	12.9%	12.3%	10.3%	11.6%	
35 to 44 years	12.9%	12.6%	13.8%	14.0%	12.6%	14.0%	13.0%	
45 to 54 years	12.6%	12.8%	12.8%	15.2%	10.3%	13.6%	12.0%	
55 to 59 years	7.0%	7.3%	6.8%	8.4%	7.1%	7.9%	8.6%	
60 to 64 years	6.8%	7.0%	6.2%	7.2%	7.7%	7.0%	7.5%	
65 to 74 years	10.3%	10.7%	9.3%	11.3%	10.6%	10.8%	11.5%	
75 to 84 years	4.9%	5.0%	4.6%	4.9%	4.9%	6.8%	7.3%	
85 years and over	2.2%	2.4%	2.1%	1.8%	3.1%	4.0%	3.4%	
Under 18 years of age	19.6%	21.0%	19.6%	19.0%	19.1%	17.9%	16.9%	
Over 65 years of age	17.5%	18.0%	16.0%	18.0%	18.6%	21.5%	22.2%	
Race/Ethnicity								US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.70%	70.3%	69.0%	87.7%	87.4%	76.5%	90.2%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
Black or African American alone (%)	7.0%	4.1%	5.0%	3.3%	2.7%	2.5%	2.7%	
American Indian and Alaska Native (%) alone	0.2%	0.3%	0.2%	0.0%	0.2%	0.0%	0.1%	
Asian alone (%)	7.1%	3.5%	13.2%	1.1%	2.3%	13.5%	1.9%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	
Some Other Race alone (%)	5.4%	12.1%	4.2%	1.4%	1.7%	1.5%	1.8%	
Two or More Races (%)	9.5%	9.7%	8.4%	6.5%	5.6%	5.9%	3.2%	
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	3.8%	5.7%	4.3%	5.1%	
Foreign-born								US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	151,560	366,954	1,523	4,095	4,790	2,489	
Naturalized U.S. citizen	54.5%	56.4%	51.0%	53.4%	56.1%	59.8%	65.5%	
Not a U.S. citizen	45.5%	43.6%	49.0%	46.6%	43.9%	40.2%	34.5%	
Region of birth: Europe	18.1%	13.4%	16.9%	26.0%	29.0%	18.8%	21.1%	
Region of birth: Asia	30.5%	14.5%	42.9%	20.2%	18.2%	61.5%	23.9%	
Region of birth: Africa	9.5%	5.5%	7.6%	23.8%	11.2%	6.2%	5.8%	
Region of birth: Oceania	0.3%	0.2%	0.5%	0.9%	3.1%	2.2%	0.0%	
Region of birth: Latin America	39.4%	64.4%	29.7%	13.1%	34.5%	8.4%	44.3%	
Region of birth: Northern America	2.2%	2.0%	2.4%	16.0%	4.1%	3.0%	4.9%	
Language								US Census Bureau, American Community Survey 2019-2023
English only	75.2%	71.6%	71.7%	91.7%	88.1%	80.5%	88.6%	
Language other than English	24.8%	28.4%	28.3%	8.3%	11.9%	19.5%	11.4%	
Speak English less than "very well"	9.7%	12.2%	9.9%	2.9%	4.2%	4.7%	3.8%	
Spanish	9.6%	18.8%	6.4%	2.3%	3.0%	2.3%	3.7%	

Key

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Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
Speak English less than "very well"	4.1%	8.8%	2.4%	1.0%	0.8%	0.8%	1.2%	
Other Indo-European languages	9.2%	6.4%	12.2%	3.1%	6.2%	9.5%	5.5%	
Speak English less than "very well"	3.2%	2.2%	4.1%	1.2%	2.3%	1.9%	1.8%	
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	0.5%	1.1%	6.0%	1.2%	
Speak English less than "very well"	1.9%	0.9%	2.9%	0.1%	0.3%	1.8%	0.4%	
Other languages	1.6%	1.2%	2.0%	2.4%	1.6%	1.8%	1.0%	
Speak English less than "very well"	0.4%	0.4%	0.5%	0.6%	0.8%	0.2%	0.4%	
Employment								US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	5.1%	4.2%	3.9%	3.6%	3.6%	5.7%	
Unemployment rate by race/ethnicity								
White alone	4.5%	4.3%	4.0%	3.5%	3.5%	3.5%	5.5%	
Black or African American alone	7.9%	4.6%	6.4%	0.0%	8.5%	0.3%	20.1%	
American Indian and Alaska Native alone	6.9%	1.8%	5.5%	-	0.0%	0.0%	0.0%	
Asian alone	4.0%	3.3%	3.5%	0.0%	7.2%	3.3%	4.1%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	10.9%	0.0%	-	0.0%	0.0%	
Some other race alone	8.0%	7.9%	6.4%	0.0%	4.9%	0.0%	9.7%	
Two or more races	7.9%	8.6%	5.4%	12.7%	0.9%	7.5%	1.0%	
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	0.0%	1.5%	7.3%	19.9%	
Unemployment rate by educational attainment								
Less than high school graduate	9.1%	10.0%	8.1%	0.0%	0.0%	0.0%	26.1%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
High school graduate (includes equivalency)	6.4%	5.3%	5.9%	8.4%	6.4%	6.5%	6.1%	
Some college or associate's degree	5.2%	4.8%	4.9%	2.7%	2.2%	5.6%	7.4%	
Bachelor's degree or higher	2.7%	3.1%	2.7%	2.1%	3.2%	1.2%	3.9%	
Income and Poverty								US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	99,431	126,779	100,599	103,739	142,207	117,072	
Population living below the federal poverty line in the last 12 months								
Individuals	10.0%	9.4%	7.5%	7.0%	9.9%	5.6%	5.2%	
Families	6.6%	4.4%	6.7%	3.1%	4.3%	2.0%	6.8%	
Individuals under 18 years of age	11.8%	12.1%	7.4%	7.9%	14.8%	4.9%	6.9%	
Individuals over 65 years of age	10.2%	10.8%	8.6%	7.5%	9.5%	9.2%	6.8%	
Female head of household, no spouse	19.1%	18.2%	15.4%	10.3%	28.2%	9.2%	9.1%	
White alone	7.6%	7.2%	6.0%	5.6%	8.1%	5.4%	4.1%	
Black or African American alone	17.1%	14.1%	15.4%	23.1%	31.5%	25.9%	23.6%	
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	0.0%	0.0%	0.0%	0.0%	
Asian alone	11.0%	9.3%	8.6%	2.1%	20.9%	2.9%	10.5%	
Native Hawaiian and Other Pacific Islander alone	21.7%	0.0%	4.7%	0.0%	-	0.0%	0.0%	
Some other race alone	20.1%	19.0%	14.2%	2.1%	31.5%	9.1%	21.9%	
Two or more races	15.7%	11.1%	10.5%	19.2%	18.1%	4.8%	11.0%	
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	8.4%	22.5%	6.2%	22.8%	
Less than high school graduate	24.4%	22.8%	20.4%	15.7%	28.6%	12.8%	20.6%	
High school graduate (includes equivalency)	12.7%	11.8%	12.1%	8.0%	14.5%	10.5%	6.4%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
Some college, associate's degree	9.2%	8.6%	8.2%	7.8%	11.4%	3.6%	4.3%	
Bachelor's degree or higher	4.0%	3.5%	3.4%	2.3%	3.4%	4.4%	2.8%	
With Social Security	29.8%	31.4%	25.8%	28.6%	32.6%	35.1%	35.1%	
With retirement income	22.9%	22.5%	20.9%	20.8%	23.5%	27.4%	29.5%	
With Supplemental Security Income	5.6%	5.8%	3.9%	4.8%	4.9%	2.7%	2.1%	
With cash public assistance income	3.5%	4.6%	2.8%	4.8%	3.9%	1.3%	2.2%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	16.0%	8.6%	9.7%	12.1%	4.5%	6.7%	
Housing								US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	94.9%	95.5%	96.4%	95.8%	95.5%	96.8%	
Owner-occupied	62.6%	64.0%	61.6%	68.3%	60.1%	74.6%	68.9%	
Renter-occupied	37.4%	36.0%	38.4%	31.7%	39.9%	25.4%	31.1%	
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.1%	0.4%	0.0%	0.2%	
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.3%	1.6%	1.3%	2.1%	
No telephone service available	0.8%	0.8%	0.6%	0.2%	0.7%	0.4%	2.6%	
Monthly housing costs <35% of total household income								
Among owner-occupied units with a mortgage	22.7%	24.6%	20.7%	17.3%	19.1%	23.8%	19.8%	
Among owner-occupied units without a mortgage	15.4%	16.6%	15.2%	21.6%	19.2%	11.6%	16.7%	
Among occupied units paying rent	41.3%	46.3%	37.4%	53.7%	43.2%	44.5%	44.2%	
Access to Technology								US Census Bureau, American Community Survey 2019-2023
Among households								
Has smartphone	89.2%	88.7%	91.5%	93.1%	85.8%	90.3%	86.4%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
Has desktop or laptop	83.2%	81.0%	88.4%	86.5%	81.1%	92.4%	84.9%	
With a computer	95.1%	94.8%	96.5%	97.5%	93.2%	96.2%	94.0%	
With a broadband Internet subscription	91.8%	91.4%	94.2%	93.8%	91.3%	95.7%	93.3%	
Transportation								US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	69.3%	56.0%	74.1%	62.2%	68.7%	73.4%	
Car, truck, or van -- carpooled	6.9%	7.0%	6.4%	6.3%	4.2%	7.0%	4.2%	
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	1.3%	7.1%	3.0%	2.6%	
Walked	4.2%	2.8%	4.2%	2.0%	5.1%	0.5%	2.0%	
Other means	2.5%	2.6%	3.2%	0.9%	2.4%	0.6%	0.3%	
Worked from home	16.7%	14.6%	22.2%	15.4%	19.0%	20.2%	17.5%	
Mean travel time to work (minutes)	29.3	28.9	30.0	30.6	29.8	28.0	28.0	
Vehicles available among occupied housing units								
No vehicles available	11.8%	9.6%	10.4%	6.1%	10.8%	3.1%	6.0%	
1 vehicle available	35.8%	34.6%	36.5%	36.7%	36.5%	30.0%	32.6%	
2 vehicles available	35.8%	37.4%	37.8%	42.5%	39.7%	45.3%	36.4%	
3 or more vehicles available	16.6%	18.4%	15.3%	14.7%	13.0%	21.6%	25.0%	
Education								US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	5.2%	3.3%	0.9%	1.0%	1.6%	1.9%	
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	3.8%	2.4%	1.9%	3.5%	
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	22.3%	20.9%	19.0%	22.5%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
Some college, no degree	14.4%	15.2%	11.2%	18.2%	13.3%	12.8%	16.3%	
Associate's degree	7.5%	8.2%	5.7%	12.4%	10.1%	6.5%	9.0%	
Bachelor's degree	25.3%	24.9%	28.8%	26.6%	32.4%	32.5%	29.5%	
Graduate or professional degree	21.4%	17.5%	30.2%	15.9%	20.0%	25.7%	17.3%	
High school graduate or higher	91.4%	90.1%	93.4%	95.3%	96.6%	96.5%	94.5%	
Bachelor's degree or higher	46.6%	42.3%	59.0%	42.5%	52.3%	58.2%	46.8%	
Educational attainment by race/ethnicity								
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	94.6%	94.7%	96.0%	96.2%	97.1%	97.3%	95.0%	
Bachelor's degree or higher	49.4%	47.7%	60.9%	43.1%	53.9%	54.6%	46.9%	
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	87.1%	85.3%	89.6%	79.8%	96.8%	93.9%	92.1%	
Bachelor's degree or higher	30.7%	31.0%	40.0%	29.1%	28.8%	60.3%	50.0%	
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	75.2%	85.2%	69.1%	100.0%	100.0%	100.0%	100.0%	
Bachelor's degree or higher	24.4%	19.7%	31.3%	0.0%	38.2%	100.0%	0.0%	
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	83.9%	90.3%	91.4%	84.8%	94.2%	76.1%	
Bachelor's degree or higher	64.0%	55.0%	71.3%	70.4%	63.4%	83.4%	57.1%	
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	100.0%	98.5%	100.0%	-	100.0%	-	
Bachelor's degree or higher	40.0%	95.2%	20.9%	0.0%	-	0.0%	-	
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Amesbury - Danvers

				Areas of Interest				
	Massachusetts	**Essex County**	**Middlesex County**	**Amesbury**	**Beverly**	**Burlington**	**Danvers**	**Source**
High school graduate or higher	71.6%	67.5%	73.6%	78.0%	88.3%	75.4%	97.6%	
Bachelor's degree or higher	20.0%	12.9%	27.1%	7.1%	14.4%	46.3%	55.1%	
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	80.6%	81.1%	85.6%	93.3%	93.5%	95.2%	88.9%	
Bachelor's degree or higher	33.6%	29.6%	46.1%	41.0%	36.2%	47.4%	32.7%	
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	73.4%	71.1%	77.6%	87.6%	94.9%	79.5%	84.8%	
Bachelor's degree or higher	23.3%	16.9%	34.9%	36.6%	20.1%	49.3%	57.4%	
Health insurance coverage among civilian noninstitutionalized population (%)								US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	97.2%	97.6%	97.3%	97.5%	97.1%	98.6%	
With private health insurance	73.8%	71.0%	80.0%	78.2%	80.1%	82.5%	83.7%	
With public coverage	37.1%	39.9%	29.9%	33.7%	32.6%	27.9%	33.8%	
No health insurance coverage	2.6%	2.8%	2.4%	2.7%	2.5%	2.9%	1.4%	
Disability								US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	12.1%	9.8%	12.5%	11.2%	9.3%	12.6%	
Under 18 with a disability	4.9%	5.0%	4.1%	6.3%	4.2%	4.9%	5.5%	
18-64	9.4%	9.1%	7.1%	9.8%	8.3%	5.9%	8.3%	
65+	30.2%	31.0%	27.9%	29.3%	28.7%	22.6%	30.8%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Demographics									
Population									US Census Bureau, American Community Survey 2019-2023
Total population	6992395	807258	1622896	3680	29862	13820	100905	5368	
Male	48.9%	48.6%	49.4%	49.2%	49.0%	46.3%	50.1%	48.6%	
Female	51.1%	51.4%	50.6%	50.8%	51.0%	53.7%	49.9%	51.4%	
Age Distribution									US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.4%	5.1%	6.6%	5.5%	4.4%	6.6%	3.3%	
5 to 9 years	5.2%	5.6%	5.4%	3.9%	3.8%	4.4%	6.4%	3.5%	
10 to 14 years	5.7%	6.2%	5.6%	8.2%	3.7%	6.3%	6.5%	10.6%	
15 to 19 years	6.5%	6.4%	6.3%	7.8%	4.5%	5.8%	7.6%	6.3%	
20 to 24 years	6.8%	6.2%	6.8%	3.8%	5.6%	4.5%	6.8%	2.5%	
25 to 34 years	14.1%	12.5%	15.1%	9.4%	10.1%	10.5%	13.7%	7.2%	
35 to 44 years	12.9%	12.6%	13.8%	11.8%	11.2%	11.5%	14.2%	7.6%	
45 to 54 years	12.6%	12.8%	12.8%	18.4%	10.7%	15.7%	13.1%	15.6%	
55 to 59 years	7.0%	7.3%	6.8%	8.7%	9.0%	7.8%	5.4%	8.3%	
60 to 64 years	6.8%	7.0%	6.2%	8.0%	10.5%	6.5%	5.8%	9.6%	
65 to 74 years	10.3%	10.7%	9.3%	8.5%	16.0%	13.3%	8.8%	15.1%	
75 to 84 years	4.9%	5.0%	4.6%	3.5%	7.2%	6.7%	3.4%	7.6%	
85 years and over	2.2%	2.4%	2.1%	1.5%	2.2%	2.6%	1.7%	2.8%	
Under 18 years of age	19.6%	21.0%	19.6%	25.2%	15.5%	19.0%	24.3%	23.2%	
Over 65 years of age	17.5%	18.0%	16.0%	13.5%	25.5%	22.6%	13.9%	25.5%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Race/Ethnicity									US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.70%	70.3%	69.0%	98.3%	90.5%	92.4%	44.6%	87.3%	
Black or African American alone (%)	7.0%	4.1%	5.0%	0.0%	1.2%	0.7%	12.1%	0.0%	
American Indian and Alaska Native (%) alone	0.2%	0.3%	0.2%	0.0%	0.1%	0.0%	0.6%	0.0%	
Asian alone (%)	7.1%	3.5%	13.2%	0.0%	1.6%	2.0%	6.0%	1.2%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	
Some Other Race alone (%)	5.4%	12.1%	4.2%	0.7%	2.0%	0.9%	21.8%	3.4%	
Two or More Races (%)	9.5%	9.7%	8.4%	1.0%	4.6%	4.0%	14.7%	8.1%	
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	0.9%	4.8%	3.1%	42.5%	3.3%	
Foreign-born									US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	151,560	366,954	106	2,888	702	36,056	300	
Naturalized U.S. citizen	54.5%	56.4%	51.0%	46.2%	44.4%	71.8%	52.8%	57.7%	
Not a U.S. citizen	45.5%	43.6%	49.0%	53.8%	55.6%	28.2%	47.2%	42.3%	
Region of birth: Europe	18.1%	13.4%	16.9%	63.2%	33.5%	29.3%	7.0%	57.0%	
Region of birth: Asia	30.5%	14.5%	42.9%	0.0%	11.3%	32.1%	10.8%	14.7%	
Region of birth: Africa	9.5%	5.5%	7.6%	0.0%	11.7%	0.1%	9.2%	0.0%	
Region of birth: Oceania	0.3%	0.2%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	
Region of birth: Latin America	39.4%	64.4%	29.7%	31.1%	37.0%	31.6%	72.3%	0.0%	
Region of birth: Northern America	2.2%	2.0%	2.4%	5.7%	6.5%	6.8%	0.7%	28.3%	
Language									US Census Bureau, American Community Survey 2019-2023

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
English only	75.2%	71.6%	71.7%	97.9%	88.4%	93.9%	48.7%	95.6%	
Language other than English	24.8%	28.4%	28.3%	2.1%	11.6%	6.1%	51.3%	4.4%	
Speak English less than "very well"	9.7%	12.2%	9.9%	0.8%	5.7%	2.0%	25.8%	0.2%	
Spanish	9.6%	18.8%	6.4%	0.3%	3.3%	2.1%	36.6%	1.1%	
Speak English less than "very well"	4.1%	8.8%	2.4%	0.0%	1.8%	0.8%	19.4%	0.2%	
Other Indo-European languages	9.2%	6.4%	12.2%	1.8%	6.6%	2.4%	8.4%	1.5%	
Speak English less than "very well"	3.2%	2.2%	4.1%	0.8%	3.0%	0.8%	3.8%	0.0%	
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	0.0%	0.6%	1.5%	3.9%	1.7%	
Speak English less than "very well"	1.9%	0.9%	2.9%	0.0%	0.2%	0.3%	2.2%	0.0%	
Other languages	1.6%	1.2%	2.0%	0.0%	1.0%	0.0%	2.3%	0.0%	
Speak English less than "very well"	0.4%	0.4%	0.5%	0.0%	0.7%	0.0%	0.5%	0.0%	
Employment									US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	5.1%	4.2%	1.0%	6.4%	2.8%	4.6%	8.9%	
Unemployment rate by race/ethnicity									
White alone	4.5%	4.3%	4.0%	1.1%	6.5%	1.8%	2.9%	9.9%	
Black or African American alone	7.9%	4.6%	6.4%	-	0.0%	98.1%	2.8%	-	
American Indian and Alaska Native alone	6.9%	1.8%	5.5%	-	0.0%	-	0.0%	-	
Asian alone	4.0%	3.3%	3.5%	-	0.0%	0.0%	3.2%	0.0%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	10.9%	-	-	-	0.0%	-	

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Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Some other race alone	8.0%	7.9%	6.4%	0.0%	8.0%	30.8%	6.9%	0.0%	
Two or more races	7.9%	8.6%	5.4%	0.0%	6.2%	2.5%	8.4%	1.0%	
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	0.0%	10.1%	21.3%	6.0%	2.4%	
Unemployment rate by educational attainment									
Less than high school graduate	9.1%	10.0%	8.1%	0.0%	7.6%	0.0%	8.2%	-	
High school graduate (includes equivalency)	6.4%	5.3%	5.9%	0.0%	6.2%	0.4%	4.2%	12.5%	
Some college or associate's degree	5.2%	4.8%	4.9%	3.2%	7.1%	6.2%	3.6%	4.7%	
Bachelor's degree or higher	2.7%	3.1%	2.7%	0.0%	3.7%	1.9%	2.4%	6.7%	
Income and Poverty									US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	99,431	126,779	152,371	87,898	124,405	74,715	197,875	
Population living below the federal poverty line in the last 12 months									
Individuals	10.0%	9.4%	7.5%	6.0%	10.6%	6.5%	13.7%	2.8%	
Families	6.6%	4.4%	6.7%	2.5%	7.0%	7.4%	3.6%	4.5%	
Individuals under 18 years of age	11.8%	12.1%	7.4%	10.3%	18.8%	6.7%	17.3%	0.0%	
Individuals over 65 years of age	10.2%	10.8%	8.6%	14.1%	8.5%	9.5%	20.2%	6.5%	
Female head of household, no spouse	19.1%	18.2%	15.4%	35.9%	22.1%	13.3%	19.5%	0.0%	
White alone	7.6%	7.2%	6.0%	6.1%	10.3%	6.8%	12.6%	3.2%	
Black or African American alone	17.1%	14.1%	15.4%	-	22.1%	0.0%	13.5%	-	
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	-	0.0%	-	26.0%	-	

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Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Asian alone	11.0%	9.3%	8.6%	-	26.5%	0.0%	12.0%	0.0%	
Native Hawaiian and Other Pacific Islander alone	21.7%	0.0%	4.7%	-	-	-	0.0%	-	
Some other race alone	20.1%	19.0%	14.2%	0.0%	15.2%	27.7%	17.3%	0.0%	
Two or more races	15.7%	11.1%	10.5%	0.0%	7.5%	0.7%	11.9%	0.5%	
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	0.0%	18.1%	15.1%	15.7%	1.1%	
Less than high school graduate	24.4%	22.8%	20.4%	0.0%	24.0%	1.9%	20.8%	37.2%	
High school graduate (includes equivalency)	12.7%	11.8%	12.1%	13.1%	12.7%	12.3%	14.7%	11.7%	
Some college, associate's degree	9.2%	8.6%	8.2%	10.3%	9.2%	6.9%	10.0%	4.0%	
Bachelor's degree or higher	4.0%	3.5%	3.4%	2.7%	4.2%	5.5%	6.9%	3.0%	
With Social Security	29.8%	31.4%	25.8%	21.5%	40.0%	34.3%	28.0%	37.3%	
With retirement income	22.9%	22.5%	20.9%	12.4%	24.7%	27.0%	15.9%	30.8%	
With Supplemental Security Income	5.6%	5.8%	3.9%	1.9%	4.9%	2.9%	8.6%	4.7%	
With cash public assistance income	3.5%	4.6%	2.8%	2.2%	2.9%	0.9%	4.9%	0.6%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	16.0%	8.6%	7.1%	12.0%	6.1%	28.9%	0.0%	
Housing									US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	94.9%	95.5%	86.4%	90.1%	91.8%	96.0%	97.0%	
Owner-occupied	62.6%	64.0%	61.6%	77.0%	63.3%	72.6%	50.4%	70.0%	
Renter-occupied	37.4%	36.0%	38.4%	23.0%	36.7%	27.4%	49.6%	30.0%	
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.0%	0.5%	0.8%	0.5%	0.0%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.0%	0.3%	0.3%	0.6%	0.0%	
No telephone service available	0.8%	0.8%	0.6%	0.0%	0.9%	0.0%	1.2%	0.0%	
Monthly housing costs <35% of total household income									
Among owner-occupied units with a mortgage	22.7%	24.6%	20.7%	26.5%	29.4%	23.2%	35.7%	15.2%	
Among owner-occupied units without a mortgage	15.4%	16.6%	15.2%	27.6%	17.0%	9.1%	19.3%	8.2%	
Among occupied units paying rent	41.3%	46.3%	37.4%	36.5%	49.8%	45.2%	47.6%	33.3%	
Access to Technology									US Census Bureau, American Community Survey 2019-2023
Among households									
Has smartphone	89.2%	88.7%	91.5%	95.5%	85.7%	92.4%	85.8%	96.8%	
Has desktop or laptop	83.2%	81.0%	88.4%	92.7%	76.7%	91.0%	71.7%	96.5%	
With a computer	95.1%	94.8%	96.5%	98.1%	93.4%	97.4%	92.8%	99.7%	
With a broadband Internet subscription	91.8%	91.4%	94.2%	97.8%	89.2%	95.8%	88.5%	99.1%	
Transportation									US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	69.3%	56.0%	63.7%	74.1%	74.4%	67.4%	51.1%	
Car, truck, or van -- carpooled	6.9%	7.0%	6.4%	7.0%	6.6%	2.0%	10.7%	4.8%	
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	0.4%	2.5%	3.1%	7.3%	9.3%	
Walked	4.2%	2.8%	4.2%	5.4%	4.8%	3.9%	2.4%	4.4%	
Other means	2.5%	2.6%	3.2%	1.0%	1.4%	0.4%	4.5%	0.0%	
Worked from home	16.7%	14.6%	22.2%	22.3%	10.7%	16.1%	7.6%	30.5%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Mean travel time to work (minutes)	29.3	28.9	30.0	23.8	26.0	28.3	31.3	30.7	
Vehicles available among occupied housing units									
No vehicles available	11.8%	9.6%	10.4%	1.2%	8.5%	6.7%	16.6%	0.0%	
1 vehicle available	35.8%	34.6%	36.5%	28.4%	40.5%	31.4%	39.7%	34.5%	
2 vehicles available	35.8%	37.4%	37.8%	45.8%	34.4%	36.9%	29.2%	46.2%	
3 or more vehicles available	16.6%	18.4%	15.3%	24.5%	16.6%	25.1%	14.6%	19.3%	
Education									US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older									
Less than 9th grade	4.2%	5.2%	3.3%	1.6%	2.4%	1.1%	12.9%	0.7%	
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	2.9%	3.7%	1.0%	8.7%	0.4%	
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	11.0%	28.2%	17.5%	31.4%	3.5%	
Some college, no degree	14.4%	15.2%	11.2%	8.7%	17.1%	15.8%	15.2%	7.6%	
Associate's degree	7.5%	8.2%	5.7%	7.1%	9.8%	7.2%	8.5%	3.8%	
Bachelor's degree	25.3%	24.9%	28.8%	40.1%	23.0%	32.7%	15.5%	47.5%	
Graduate or professional degree	21.4%	17.5%	30.2%	28.6%	15.8%	24.8%	7.8%	36.5%	
High school graduate or higher	91.4%	90.1%	93.4%	95.5%	93.9%	97.9%	78.4%	98.9%	
Bachelor's degree or higher	46.6%	42.3%	59.0%	68.7%	38.8%	57.5%	23.3%	84.0%	
Educational attainment by race/ethnicity									
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	94.6%	94.7%	96.0%	96.0%	94.4%	97.9%	88.9%	98.8%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
Bachelor's degree or higher	49.4%	47.7%	60.9%	69.3%	39.6%	57.0%	28.0%	84.3%	
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	87.1%	85.3%	89.6%	-	71.4%	100.0%	84.9%	-	
Bachelor's degree or higher	30.7%	31.0%	40.0%	-	23.2%	1.9%	26.4%	-	
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	75.2%	85.2%	69.1%	-	100.0%	-	75.7%	-	
Bachelor's degree or higher	24.4%	19.7%	31.3%	-	0.0%	-	9.5%	-	
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	83.9%	90.3%	-	100.0%	100.0%	63.0%	100.0%	
Bachelor's degree or higher	64.0%	55.0%	71.3%	-	41.4%	47.7%	22.9%	96.8%	
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	100.0%	98.5%	-	-	-	100.0%	-	
Bachelor's degree or higher	40.0%	95.2%	20.9%	-	-	-	100.0%	-	
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	71.6%	67.5%	73.6%	48.0%	70.1%	88.6%	57.1%	100.0%	
Bachelor's degree or higher	20.0%	12.9%	27.1%	20.0%	13.6%	42.9%	10.1%	100.0%	
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	80.6%	81.1%	85.6%	90.5%	89.3%	100.0%	71.1%	100.0%	
Bachelor's degree or higher	33.6%	29.6%	46.1%	52.4%	25.1%	95.3%	22.0%	69.7%	
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Essex – Manchester-by-the-Sea

				Areas of Interest					
	Massachusetts	**Essex County**	**Middlesex County**	**Essex**	**Gloucester**	**Ipswich**	**Lynn**	**Manchester-by-the-Sea**	**Source**
High school graduate or higher	73.4%	71.1%	77.6%	48.0%	70.4%	80.0%	60.4%	100.0%	
Bachelor's degree or higher	23.3%	16.9%	34.9%	20.0%	27.8%	57.3%	11.8%	98.2%	
Health insurance coverage among civilian noninstitutionalized population (%)									US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	97.2%	97.6%	97.4%	97.8%	98.5%	95.6%	98.0%	
With private health insurance	73.8%	71.0%	80.0%	87.4%	66.3%	82.4%	54.7%	87.5%	
With public coverage	37.1%	39.9%	29.9%	20.6%	47.2%	32.1%	51.6%	30.6%	
No health insurance coverage	2.6%	2.8%	2.4%	2.6%	2.2%	1.5%	4.4%	2.0%	
Disability									US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	12.1%	9.8%	8.1%	9.9%	8.3%	13.6%	6.1%	
Under 18 with a disability	4.9%	5.0%	4.1%	2.5%	0.7%	2.5%	6.5%	0.0%	
18-64	9.4%	9.1%	7.1%	6.1%	7.5%	5.2%	11.0%	4.5%	
65+	30.2%	31.0%	27.9%	27.8%	21.6%	21.2%	37.7%	14.9%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
Demographics						
Population						US Census Bureau, American Community Survey 2019-2023
Total population	6992395	807258	1622896	18444	6977	
Male	48.9%	48.6%	49.4%	44.3%	48.5%	
Female	51.1%	51.4%	50.6%	55.7%	51.5%	
Age Distribution						US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.4%	5.1%	3.4%	3.3%	
5 to 9 years	5.2%	5.6%	5.4%	6.8%	2.1%	
10 to 14 years	5.7%	6.2%	5.6%	8.9%	2.8%	
15 to 19 years	6.5%	6.4%	6.3%	4.2%	4.9%	
20 to 24 years	6.8%	6.2%	6.8%	2.9%	5.6%	
25 to 34 years	14.1%	12.5%	15.1%	9.6%	8.0%	
35 to 44 years	12.9%	12.6%	13.8%	10.9%	7.1%	
45 to 54 years	12.6%	12.8%	12.8%	12.2%	8.1%	
55 to 59 years	7.0%	7.3%	6.8%	8.1%	8.7%	
60 to 64 years	6.8%	7.0%	6.2%	10.0%	9.7%	
65 to 74 years	10.3%	10.7%	9.3%	13.1%	26.9%	
75 to 84 years	4.9%	5.0%	4.6%	6.5%	8.7%	
85 years and over	2.2%	2.4%	2.1%	3.3%	4.2%	
Under 18 years of age	19.6%	21.0%	19.6%	21.8%	11.7%	
Over 65 years of age	17.5%	18.0%	16.0%	22.9%	39.8%	
Race/Ethnicity						US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.70%	70.3%	69.0%	92.7%	94.4%	
Black or African American alone (%)	7.0%	4.1%	5.0%	0.4%	0.6%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
American Indian and Alaska Native (%) alone	0.2%	0.3%	0.2%	0.0%	0.1%	
Asian alone (%)	7.1%	3.5%	13.2%	0.7%	0.2%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	12.1%	4.2%	0.7%	0.1%	
Two or More Races (%)	9.5%	9.7%	8.4%	5.5%	4.6%	
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	4.0%	2.4%	
Foreign-born						US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	151,560	366,954	1,168	335	
Naturalized U.S. citizen	54.5%	56.4%	51.0%	59.5%	48.7%	
Not a U.S. citizen	45.5%	43.6%	49.0%	40.5%	51.3%	
Region of birth: Europe	18.1%	13.4%	16.9%	47.4%	40.6%	
Region of birth: Asia	30.5%	14.5%	42.9%	11.0%	7.5%	
Region of birth: Africa	9.5%	5.5%	7.6%	2.9%	0.0%	
Region of birth: Oceania	0.3%	0.2%	0.5%	3.3%	2.7%	
Region of birth: Latin America	39.4%	64.4%	29.7%	29.7%	40.6%	
Region of birth: Northern America	2.2%	2.0%	2.4%	5.7%	8.7%	
Language						US Census Bureau, American Community Survey 2019-2023
English only	75.2%	71.6%	71.7%	93.3%	95.8%	
Language other than English	24.8%	28.4%	28.3%	6.7%	4.2%	
Speak English less than "very well"	9.7%	12.2%	9.9%	1.8%	0.9%	
Spanish	9.6%	18.8%	6.4%	2.6%	1.2%	
Speak English less than "very well"	4.1%	8.8%	2.4%	0.6%	0.1%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
Other Indo-European languages	9.2%	6.4%	12.2%	3.6%	2.8%	
Speak English less than "very well"	3.2%	2.2%	4.1%	1.2%	0.8%	
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	0.2%	0.0%	
Speak English less than "very well"	1.9%	0.9%	2.9%	0.0%	0.0%	
Other languages	1.6%	1.2%	2.0%	0.3%	0.2%	
Speak English less than "very well"	0.4%	0.4%	0.5%	0.0%	0.0%	
Employment						US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	5.1%	4.2%	5.8%	9.1%	
Unemployment rate by race/ethnicity						
White alone	4.5%	4.3%	4.0%	5.5%	8.5%	
Black or African American alone	7.9%	4.6%	6.4%	0.0%	0.0%	
American Indian and Alaska Native alone	6.9%	1.8%	5.5%	-	-	
Asian alone	4.0%	3.3%	3.5%	0.0%	0.0%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	10.9%	-	-	
Some other race alone	8.0%	7.9%	6.4%	0.0%	0.0%	
Two or more races	7.9%	8.6%	5.4%	14.0%	22.2%	
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	13.3%	34.2%	
Unemployment rate by educational attainment						
Less than high school graduate	9.1%	10.0%	8.1%	8.2%	25.0%	

Key

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Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
High school graduate (includes equivalency)	6.4%	5.3%	5.9%	11.9%	0.0%	
Some college or associate's degree	5.2%	4.8%	4.9%	2.6%	3.2%	
Bachelor's degree or higher	2.7%	3.1%	2.7%	5.4%	12.5%	
Income and Poverty						US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	99,431	126,779	144,259	93,227	
Population living below the federal poverty line in the last 12 months						
Individuals	10.0%	9.4%	7.5%	5.1%	3.6%	
Families	6.6%	4.4%	6.7%	7.8%	5.1%	
Individuals under 18 years of age	11.8%	12.1%	7.4%	5.1%	0.0%	
Individuals over 65 years of age	10.2%	10.8%	8.6%	4.5%	3.0%	
Female head of household, no spouse	19.1%	18.2%	15.4%	10.0%	0.0%	
White alone	7.6%	7.2%	6.0%	4.7%	3.5%	
Black or African American alone	17.1%	14.1%	15.4%	6.8%	42.5%	
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	-	0.0%	
Asian alone	11.0%	9.3%	8.6%	3.1%	0.0%	
Native Hawaiian and Other Pacific Islander alone	21.7%	0.0%	4.7%	-	-	
Some other race alone	20.1%	19.0%	14.2%	18.0%	0.0%	
Two or more races	15.7%	11.1%	10.5%	9.9%	0.0%	
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	26.2%	0.0%	
Less than high school graduate	24.4%	22.8%	20.4%	17.2%	25.4%	

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Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
High school graduate (includes equivalency)	12.7%	11.8%	12.1%	12.9%	8.6%	
Some college, associate's degree	9.2%	8.6%	8.2%	8.1%	3.7%	
Bachelor's degree or higher	4.0%	3.5%	3.4%	2.9%	1.8%	
With Social Security	29.8%	31.4%	25.8%	33.4%	51.6%	
With retirement income	22.9%	22.5%	20.9%	30.4%	38.5%	
With Supplemental Security Income	5.6%	5.8%	3.9%	2.1%	2.2%	
With cash public assistance income	3.5%	4.6%	2.8%	2.1%	3.5%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	16.0%	8.6%	6.4%	5.2%	
Housing						US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	94.9%	95.5%	93.9%	77.1%	
Owner-occupied	62.6%	64.0%	61.6%	76.2%	69.2%	
Renter-occupied	37.4%	36.0%	38.4%	23.8%	30.8%	
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.0%	0.0%	
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.2%	0.2%	
No telephone service available	0.8%	0.8%	0.6%	0.0%	1.0%	
Monthly housing costs <35% of total household income						
Among owner-occupied units with a mortgage	22.7%	24.6%	20.7%	20.3%	27.1%	
Among owner-occupied units without a mortgage	15.4%	16.6%	15.2%	19.9%	18.9%	
Among occupied units paying rent	41.3%	46.3%	37.4%	34.1%	50.8%	

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Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
Access to Technology						US Census Bureau, American Community Survey 2019-2023
Among households						
Has smartphone	89.2%	88.7%	91.5%	89.5%	84.4%	
Has desktop or laptop	83.2%	81.0%	88.4%	87.6%	88.6%	
With a computer	95.1%	94.8%	96.5%	95.7%	94.9%	
With a broadband Internet subscription	91.8%	91.4%	94.2%	93.2%	91.1%	
Transportation						US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	69.3%	56.0%	63.1%	70.0%	
Car, truck, or van -- carpooled	6.9%	7.0%	6.4%	3.9%	2.6%	
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	3.0%	2.1%	
Walked	4.2%	2.8%	4.2%	4.6%	3.3%	
Other means	2.5%	2.6%	3.2%	1.8%	1.3%	
Worked from home	16.7%	14.6%	22.2%	23.6%	20.6%	
Mean travel time to work (minutes)	29.3	28.9	30.0	32.3	28.0	
Vehicles available among occupied housing units						
No vehicles available	11.8%	9.6%	10.4%	5.2%	5.9%	
1 vehicle available	35.8%	34.6%	36.5%	35.9%	39.7%	
2 vehicles available	35.8%	37.4%	37.8%	44.0%	40.9%	
3 or more vehicles available	16.6%	18.4%	15.3%	14.9%	13.6%	
Education						US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older						
Less than 9th grade	4.2%	5.2%	3.3%	0.8%	0.6%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	1.5%	3.9%	
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	11.9%	12.5%	
Some college, no degree	14.4%	15.2%	11.2%	13.4%	16.2%	
Associate's degree	7.5%	8.2%	5.7%	6.4%	9.5%	
Bachelor's degree	25.3%	24.9%	28.8%	37.5%	29.0%	
Graduate or professional degree	21.4%	17.5%	30.2%	28.4%	28.3%	
High school graduate or higher	91.4%	90.1%	93.4%	97.6%	95.5%	
Bachelor's degree or higher	46.6%	42.3%	59.0%	65.9%	57.2%	
Educational attainment by race/ethnicity						
White alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	94.6%	94.7%	96.0%	97.9%	95.7%	
Bachelor's degree or higher	49.4%	47.7%	60.9%	66.0%	58.1%	
Black alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	87.1%	85.3%	89.6%	90.4%	100.0%	
Bachelor's degree or higher	30.7%	31.0%	40.0%	9.6%	0.0%	
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	75.2%	85.2%	69.1%	-	100.0%	
Bachelor's degree or higher	24.4%	19.7%	31.3%	-	100.0%	
Asian alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	83.9%	90.3%	100.0%	100.0%	
Bachelor's degree or higher	64.0%	55.0%	71.3%	95.3%	100.0%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	100.0%	98.5%	-	-	
Bachelor's degree or higher	40.0%	95.2%	20.9%	-	-	
Some other race alone	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	71.6%	67.5%	73.6%	74.1%	100.0%	
Bachelor's degree or higher	20.0%	12.9%	27.1%	33.6%	100.0%	
Two or more races	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	80.6%	81.1%	85.6%	96.8%	88.4%	
Bachelor's degree or higher	33.6%	29.6%	46.1%	69.8%	33.8%	
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	73.4%	71.1%	77.6%	93.3%	85.0%	
Bachelor's degree or higher	23.3%	16.9%	34.9%	57.6%	30.8%	
Health insurance coverage among civilian noninstitutionalized population (%)						US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	97.2%	97.6%	99.1%	98.7%	
With private health insurance	73.8%	71.0%	80.0%	86.7%	79.5%	
With public coverage	37.1%	39.9%	29.9%	28.0%	48.1%	
No health insurance coverage	2.6%	2.8%	2.4%	0.9%	1.3%	
Disability						US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	12.1%	9.8%	10.6%	12.5%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

Demographics: Newburyport - Rockport

				Areas of Interest		
	Massachusetts	**Essex County**	**Middlesex County**	**Newburyport**	**Rockport**	**Source**
Under 18 with a disability	4.9%	5.0%	4.1%	2.6%	7.1%	
18-64	9.4%	9.1%	7.1%	7.0%	6.3%	
65+	30.2%	31.0%	27.9%	27.6%	21.7%	

Health Status

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
Access to Care											
Ratio of population to primary care physicians	103.5	73.3	128.3	73.3	73.3	128.3	73.3	73.3	73.3	73.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	151.7	145.3	151.8	151.9	145.2	152.1	152.6	151.9	151.0	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	26.9	18.0	23.0	37.5	11.4	135.3	0.0	23.6	7.3	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	Data unavailable	12.9	12.3	10.9	10.8	10.3	14.3	12.2	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	948.4	764.9								CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	291.1	188.0								Massachusetts Death Report, 2021
Risk Factors											
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	1.2	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.6	7.6	5.9	15.8	15.7	11.5	5.5	10.2	8.8	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	30.1	24.6	71.7	29.2	19.9	28.7	100.0	7.0	43.4	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	Data unavailable	29.9	29.2	21.5	27.3	27.8	30.6	29.6	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	Data unavailable	25.9	26.3	23.4	25.4	24.4	27	25.8	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	Data unavailable	30.4	30.6	29.8	30.3	30.1	30.8	30.7	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	Data unavailable	17.8	17.3	15.9	15.2	14.7	19.3	17.6	BRFSS, 2022
Chronic Conditions											

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	12.0	11.6	10.6	11.2	11.2	12.1	11.7	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	Data unavailable	7.6	7.4	7.1	6.8	6.5	8	7.3	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	5.6	5.1	4.3	4.5	4.2	6	5.2	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	Data unavailable	5.9	5.5	4.8	5.1	5.1	6.1	5.5	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	2.6	2.4	2.3	2.2	2.1	2.7	2.4	BRFSS, 2022
Cancer											
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	84.1	85.2	83.7	84.8	85.2	83.1	84.3	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	64.9	65.2	66.9	66.8	65.4	64.4	67.5	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)											
All sites	449.4	453.1	426.6	455.3	452.9	428.1	452.0	456.3	454.0	451.8	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	58.9	52.1	57.1	58.9	51.1	59.7	62.2	59.0	60.8	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	109.8	108.6	111.3	108.0	106.6	110.5	126.8	108.2	105.6	State Cancer Profiles, 2016-2020
Prevention and Screening											
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	Data unavailable	79.3	79.7	76.2	79.5	79.6	79.1	79.3	Behavioral Risk Factor Surveillance System, 2022
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	87.9	88.1	88	88.6	90.1	87.1	87.8	Behavioral Risk Factor Surveillance System, 2021
Communicable and Infectious Disease											

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
STI infection cases (per 100,000)											
Chlamydia	385.8	293.2	264.0	424.5	424.5	293.2	424.5	424.5	424.5	424.5	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphillis	10.6	6.7	9.8	6.7	6.7	9.9	6.7	6.7	6.7	6.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	90.7	84.2	118.0	90.7	84.2	90.7	90.7	90.7	90.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	289.6	288.2	289.6	289.6	288.2	289.6	289.6	289.6	289.6	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.9	2.7	2.9	2.9	2.7	2.9	2.9	2.9	2.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19											
Percent of Adults Fully Vaccinated	78.1	83.9	87.7	82.0	82.0	87.0	82.0	82.0	82.0	82.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.5	4.0	4.5	4.5	4.0	4.5	4.5	4.5	4.5	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use											
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	Data unavailable	11.6	10.6	8.9	9.2	9.5	12.6	11.8	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	Data unavailable	Data unavailable	20.8	20.1	18.4	21.2	21.1	20.2	20.9	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	39.3	22.2	39.3	39.3	22.2	39.3	No data	39.3	39.3	CDC- National Vital Statistics System, 2016-2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	59.8	32.6								MA BSAS, 2023
Female Drug Overdose Mortality Rate (per 100,000)	17.6	20.1	12.0								MA BSAS, 2023

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
Substance-related deaths (Age-adjusted rate per 100k)											
Any substance	61.9	59.8	41.1	54.2	38.0	41.0	56.2	*	69.8	55.8	MA BSAS, 2023
Opioid-related deaths	33.7	32.4	20.1	*	21.5	*	30.5	*	28.3	*	
Alchohol-related deaths	29.1	26.7	20.4	38.9	14.1	29.9	1.2	0.0	35.1	*	
Stimulant-related deaths	23.0	22.4	13.6	*	14.6	*	19.2	0.0	17.8	*	
Substance-related ER vists (age-adjusted rate per 100K)											
Any substance-related ER visits	1605.7	1421.3	1246.4	1197.5	1580.4	597.7	1120.1	888.9	2002.2	1011.1	MA BSAS, 2023
Opioid-related ER visits	169.3	144.9	102.9	78.0	75.5	29.5	96.7	*	123.5	48.1	
Opioid-related EMS Incidents	248.8	244.2	176.3	109.4	126.6	87.2	288.4	*	195.1	58.0	
Alchohol-related ER visits	1235.6	1059.7	962.1	957.8	1296.6	433.5	826.4	711.6	1598.9	744.1	
Stimulant-related ER visits	15.7	13.8	13.6	*	0.0	*	0.0	0.0	0.0	0.0	
Substance Addiction Services											
Individuals admitted to BSAS services (crude rate per 100k)	588.4	608.6	340.3	472.2	578.9	193.4	530.5	*	941.8	304.7	MA BSAS, 2023
Number of BSAS providers		140.0	201.0	3.0	8.0	1.0	13.0	0.0	10.0	0.0	
Number of clients of BSAS services (residents)		3092.0	3702.0	47.0	129.0	31.0	79.0	6.0	171.0	*	
Avg. distance to BSAS provider (miles)	17.0	18.0	17.0	26.0	17.0	20.0	16.0	24.0	24.0	23.0	
Buprenorphine RX's filled	9982.0	8521.4	6002.1	9628.0	7869.7	5774.0	9481.3	5006.8	18224.6	6652.2	
Individuals who received buprenophrine RX's		756.5	508.3	869.5	754.6	466.3	1538.1	435.4	1517.0	573.1	
Naloxone kits received		23764.0	35323.0	355.0	405.0	140.0	1935.0	20.0	949.0	45.0	
Naloxone kids: Opioid deaths Ratio		73.0	78.0	*	34.0	*	143.0	*	270.0	*	
Fentanyl test strips received		42200.0	50130.0	1000.0	1200.0	600.0	3000.0	100.0	3000.0	0.0	
Environmental Health											
Environmental Justice (%) (Centers for Disease Control	56.6	71.8	72.4	77.9	65.5	56.5	100.0	0.0	63.2	0.0	Population in Neighborhoods Meeting Environmental

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)											Justice Health Criteria , Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead screening %	68.0			63.0	68.0	70.0	80.0	69.0	81.0	75.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6			13.6	9.6	5.4	7.5	23.3	26.2	8.8	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			65.0	70.0	58.0	68.0	63.0	74.0	62.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6			17.3	27.6	8.7	10.18.3	NS	30.0	20.8	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9			4.4	4.7	10.1	8.4	4.4	8.1	6.8	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	8.1	5.5	NS	NS	0.0	NS	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	0.3								EPA - National Air Toxics Assessment, 2018
Mental Health											

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	57.4	36.9	57.4	57.4	36.9	57.4	57.4	57.4	57.4	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	25.6	24.6	22.9	23.9	24.2	25.7	25.1	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	34.3	33	33.2	33.4	31.7	33.9	33	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adusted	No data	Data unavailable	Data unavailable	21.7	20	23	20.5	17.7	21.2	19.8	Behavioral Risk Factor Surveillance System, 2023
Adults eperiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	17.6	16.7	14.3	15.5	15.7	18	17.4	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.1	0.0	0.2	0.0	0.1	0.0	0.0	0.4	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health											
Infant Mortality Rate (per 1,000 live births)	4.0	4.0	3.0	4.0	4.0	3.0	4.0	4.0	4.0	4.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	7.4	7.4	7.1	7.4	7.4	7.4	7.4	County Health Rankings, 2016-2022
Safety/Crime											
Property Crimes Offenses (#)											Massachusetts Crime Statistics, 2023
Burglary	10028.0			11.0	9.0	19.0	20.0	2.0	29.0	5.0	
Larceny-theft	60647.0			120.0	186.0	401.0	291.0	11.0	126.0	26.0	
Motor vehicle theft	7224.0			5.0	12.0	27.0	26.0	1.0	16.0	4.0	
Arson	377.0			2.0	0.0	3.0	0.0	0.0	4.0	0.0	
Crimes Against Persons Offenses (#)											
Murder/non-negligent manslaughter	162.0			0.0	0.0		0.0	0.0	0.0	0.0	
Sex offenses	4365.0			13.0	7.0	11.0	21.0	1.0	25.0	3.0	
Assaults	72086.0			117.0	87.0	118.0	192.0	14.0	296.0	22.0	

Health Status: Amesbury-Ipswich

				Areas of Interest							
	MA	Essex County	Middlesex County	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Source
Human trafficking	0.0			0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)											
Race/Ethnicity/Ancestry Bias	222.0			0.0			0.0			1.0	
Religious Bias	88.0			1.0			0.0			0.0	
Sexual Oreintation Bias	80.0			0.0			0.0			0.0	
Gender Identity Bias	22.0			0.0			1.0			0.0	
Gender Bias	2.0			0.0			0.0			0.0	
Disability Bias	0.0			0.0			0.0			0.0	

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	Essex County	Middlesex County	Lynn	Manchester-by-the-Sea	Newburyport	Rockport	Source
Access to Care								
Ratio of population to primary care physicians	103.5	73.3	128.3	73.3	73.3	73.3	73.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	151.7	145.3	151.8	153.6	151.9	151.5	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	26.9	18.0	71.1	18.5	10.9	0.0	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health								
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	13.8	Data unavailable	Data unavailable	21.8	no data	9.1	10.4	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	948.4	764.9					CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	291.1	188.0					Massachusetts Death Report, 2021
Risk Factors								
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	1.2	4.8	0.0	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.6	7.6	13.1	1.9	5.6	8.4	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	30.1	24.6	8.4	29.7	9.6	18.0	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adusted prevalence	27.2	Data unavailable	Data unavailable	34.3	no data	26.3	27.9	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	Data unavailable	30.6	no data	24.7	24.3	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	Data unavailable	32.1	no data	30.1	29.9	BRFSS, 2021

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	Essex County	Middlesex County	Lynn	Manchester-by-the-Sea	Newburyport	Rockport	Source
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	Data unavailable	27.7	no data	13.0	14.8	BRFSS, 2022
Chronic Conditions								
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	12	no data	11.0	11.4	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adusted	10.5	Data unavailable	Data unavailable	11.6	no data	6.3	6.7	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	6.6	no data	3.9	4.4	BRFSS, 2022
Coronary heart disease among adults (%), age-adusted	6.2	Data unavailable	Data unavailable	6.9	no data	4.8	5.1	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	3.5	no data	2.0	2.2	BRFSS, 2022
Cancer								
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	81.5	no data	85.5	84.7	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	58.1	no data	68.4	67.8	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)								
All sites	449.4	453.1	426.6	452.7	459.0	454.0	457.1	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	58.9	52.1	58.7	56.5	58.3	54.5	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	109.8	108.6	109.2	119.3	108.8	119.4	State Cancer Profiles, 2016-2020
Prevention and Screening								
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	Data unavailable	79.1	no data	80.2	79.8	Behavioral Risk Factor Surveillance System, 2022

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	**Essex County**	**Middlesex County**	**Lynn**	**Manchester -by-the-Sea**	**Newburyport**	**Rockport**	**Source**
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	85.5	no data	89.4	89.4	Behavioral Risk Factor Surveillance System, 2021
Communicable and Infectious Disease								
STI infection cases (per 100,000)								
Chlamydia	385.8	293.2	264.0	424.5	424.5	424.5	424.5	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphillis	10.6	6.7	9.8	6.7	6.7	6.7	6.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	90.7	84.2	90.7	90.7	90.7	90.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	289.6	288.2	289.6	289.6	289.6	289.6	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.9	2.7	2.9	2.9	2.9	2.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19								
Percent of Adults Fully Vaccinated	78.1	83.9	87.7	82.0	82.0	82.0	82.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.5	4.0	4.5	4.5	4.5	4.5	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use								
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	Data unavailable	14.2	no data	7.0	9.2	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	Data unavailable	Data unavailable	16.9	no data	21.2	21.2	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	39.3	22.2	39.3	39.3	39.3	39.3	CDC- National Vital Statistics System, 2016-2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	59.8	32.6					MA BSAS, 2023

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	Essex County	Middlesex County	Lynn	Manchester -by-the-Sea	Newburyport	Rockport	Source
Female Drug Overdose Mortality Rate (per 100,000)	17.6	20.1	12.0					MA BSAS, 2023
Substance-related deaths (Age-adjusted rate per 100k)								
Any substance	61.9	59.8	41.1	110.3	*	46.5	*	MA BSAS, 2023
Opioid-related deaths	33.7	32.4	20.1	67.4	0.0	*	*	
Alchohol-related deaths	29.1	26.7	20.4	39.7	*	26.5	*	
Stimulant-related deaths	23.0	22.4	13.6	46.0	0.0	*	0.0	
Substance-related ER vists (age-adjusted rate per 100K)								
Any substance-related ER visits	1605.7	1421.3	1246.4	2068.2	419.3	842.4	1132.6	MA BSAS, 2023
Opioid-related ER visits	169.3	144.9	102.9	212.2	0.0	61.7	*	
Opioid-related EMS Incidents	248.8	244.2	176.3	451.3	0.0	76.5	*	
Alchohol-related ER visits	1235.6	1059.7	962.1	1550.0	338.2	630.1	984.6	
Stimulant-related ER visits	15.7	13.8	13.6	10.7	0.0	*	*	
Substance Addiction Services								
Individuals admitted to BSAS services (crude rate per 100k)	588.4	608.6	340.3	1096.3	296.6	514.0	371.9	MA BSAS, 2023
Number of BSAS providers		140.0	201.0	30.0	0.0	0.0	0.0	
Number of clients of BSAS services (residents)		3092.0	3702.0	742.0	*	*	*	
Avg. distance to BSAS provider (miles)	17.0	18.0	17.0	14.0	1909.2	26.0	35.0	
Buprenorphine RX's filled	9982.0	8521.4	6002.1	13077.1	166.8	3411.9	5091.5	
Individuals who received buprenophrine RX's		756.5	508.3	1211.8	64.0	399.1	486.3	
Naloxone kits received		23764.0	35323.0	6145.0		48.0	144.0	
Naloxone kids: Opioid deaths Ratio		73.0	78.0	95.0	-	*	-	
Fentanyl test strips received		42200.0	50130.0	9200.0	300.0	1700.0	200.0	
Environmental Health								

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	Essex County	Middlesex County	Lynn	Manchester -by-the-Sea	Newburyport	Rockport	Source
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	71.8	72.4	94.7	0.0	61.8	58.3	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			73.0	57.0	61.0	69.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47 months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6			27.7	0.0	10.8	32.5	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	80.0	74.0	79.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6			38.6	NS	10.2	15.6	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9			9.6	8.5	5.4	NS	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	8.1	5.5	NS	0.0	0.0	NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	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	57.4	36.9	57.4	57.4	57.4	57.4	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	22.7	no data	23.5	24.5	Behavioral Risk Factor Surveillance System, 2022

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	**Essex County**	**Middlesex County**	**Lynn**	**Manchester -by-the-Sea**	**Newburyport**	**Rockport**	**Source**
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	36.8	no data	32.5	32.8	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adusted	No data	Data unavailable	Data unavailable	27.8	no data	19.0	19.1	Behavioral Risk Factor Surveillance System, 2023
Adults eperiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	18.4	no data	14.2	15.6	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.1	0.0	0.0	0.0	0.0	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health								
Infant Mortality Rate (per 1,000 live births)	4.0	4.0	3.0	4.0	4.0	4.0	4.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	7.4	7.4	7.4	7.4	County Health Rankings, 2016-2022
Safety/Crime								
Property Crimes Offenses (#)								Massachusetts Crime Statistics, 2023
Burglary	10028.0			163.0	1.0	5.0	1.0	
Larceny-theft	60647.0			958.0	27.0	80.0	7.0	
Motor vehicle theft	7224.0			178.0	1.0	11.0	0.0	
Arson	377.0			6.0	0.0	0.0	0.0	
Crimes Against Persons Offenses (#)								
Murder/non-negligent manslaughter	162.0			7.0	0.0	0.0	0.0	
Sex offenses	4365.0			93.0	0.0	16.0	1.0	
Assaults	72086.0			1896.0	2.0	74.0	21.0	
Human trafficking	0.0			0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)								
Race/Ethnicity/Ancestry Bias	222.0			6.0	1.0	1.0		

Health Status: Lynn - Rockport

				Areas of Interest				
	MA	Essex County	Middlesex County	Lynn	Manchester -by-the-Sea	Newburyport	Rockport	Source
Religious Bias	88.0			4.0	0.0	0.0		
Sexual Oreintation Bias	80.0			0.0	2.0	0.0		
Gender Identity Bias	22.0			0.0	0.0	0.0		
Gender Bias	2.0			0.0	0.0	0.0		
Disability Bias	0.0			0.0	0.0	0.0		

Community Health Equity Survey (CHES) – Youth

CHES – Youth
Data Notes:
Note 1: Sample sizes (N) and percentages are displayed below for each survey question. The percentages are weighted by statewide age, race and gender identity distributions. See data notes for more information.
Note 2: The CHES was not designed to be a representative survey of all MA residents and percentages displayed may not be representative of the state.

			MASSACHUSETTS	
Topic	**Question**	**Response**	**N**	**%**
Housing	Current living situation	No steady place	1908	1.30%
		Worried about losing	1908	2.60%
		Steady place	1908	95.10%
Housing	Issues in current housing	Yes, at least one	1830	24.50%
Basic Needs	Food insecurity, past month	Never	1963	87.80%
		Sometimes	1963	9.90%
		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%
Neighborhood	Able to get where you need to go	Somewhat or strongly disagree	1864	2.50%
		Somewhat agree	1864	14.60%
		Strongly agree	1864	82.80%
Neighborhood	Experienced neighborhood violence, lifetime	Never	1833	65.00%
		Rarely	1833	22.80%
		Somewhat often	1833	8.50%
		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%
		Yes, adult outside home	1739	37.30%
		Yes, friend or non-adult family	1739	43.00%
Safety & Support	Feel safe with my family/caregivers	Not at all	1768	1.00%
		Somewhat	1768	7.70%
		Very much	1768	91.30%
Safety & Support	Feel I belong at school	Not at all	1760	5.90%
		Somewhat	1760	29.10%
		Very much	1760	65.00%

			MASSACHUSETTS	
Topic	**Question**	**Response**	**N**	**%**
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%
		Somewhat	1745	17.10%
		Very much	1745	80.50%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%
Safety & Support	Experienced intimate partner violencea	Ever	1589	13.10%
		In past year	1567	7.80%
Safety & Support	Experienced household violenceb	Ever	1536	14.20%
		In past year	1519	5.50%
Safety & Support	Experienced sexual violencec	Ever	1558	9.20%
		In past year	1551	3.10%
Safety & Support	Experienced discrimination	Ever	1674	45.20%
		In past year	1674	19.60%
Employment	Worked for pay, past year	No	1652	51.50%
		Yes, <10 hours per week	1652	18.10%
		Yes, 11-19 hours per week	1652	13.30%
		Yes, 20-34 hours per week	1652	10.30%
		Yes, >35 hours per week	1652	6.80%
Education	Educational challenges, past year	None of these	1484	66.80%
		Frequent absences	1484	7.60%
		Needed more support in school	1484	7.00%
		Needed more support outside school	1484	6.30%
		Safety concerns	1484	5.10%

			MASSACHUSETTS	
Topic	**Question**	**Response**	**N**	**%**
		Temperature in classroom	1484	18.50%
Education	Hurt or harrassed by school staff, past year	Never	1503	87.70%
		Once or twice	1503	9.10%
		Monthly	1503	1.60%
		Daily	1503	1.60%
Education	Helpful school resources provided	College-preparation	1459	57.90%
		Extracurricular activities	1459	74.40%
		Guidance conselour	1459	58.80%
		Programs to reduce bullying, violence, etc.	1459	19.10%
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%
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%
Mental Health	Psychological distress, past month	Low	1376	22.10%
		Medium	1376	33.00%
		High	1376	18.40%

			MASSACHUSETTS	
Topic	**Question**	**Response**	**N**	**%**
		Very high	1376	26.60%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%
Substance Use	Tobacco use, past month	Yes	1499	8.00%
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%
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%
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%
Substance Use	Fentanyl use, past year	Yes	1487	0.60%
Substance Use	Heroin use, past year	Yes	1487	0.30%
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%
Substance Use	Psilocybin use, past year	Yes	1487	2.20%
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%
		Not sure	1445	5.70%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%

			MASSACHUSETTS	
Topic	**Question**	**Response**	**N**	**%**
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%
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%
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%
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		ESSEX		Beverly		Danvers		Gloucester		Lynn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	773	1.90%	*	*	*	*	*	*	116	4.30%
		Worried about losing	14888	8.00%	773	10.20%	61	11.50%	*	*	*	*	116	16.40%
Housing	Current living situation	Steady place	14888	89.30%	773	87.50%	61	88.50%	33	87.90%	33	87.90%	116	77.60%
Housing	Issues in current housing2	Yes, at least one	11103	37.00%	571	37.30%	48	39.60%	*	*	*	*	77	55.80%
Basic Needs	Trouble paying for childcare/school1	Yes	7486	4.60%	374	5.90%	*	*	*	*	*	*	61	8.20%
Basic Needs	Trouble paying for food or groceries (including formula or baby food)1	Yes	7486	18.80%	374	20.10%	*	*	*	*	*	*	61	31.10%
Basic Needs	Trouble paying for health care1	Yes	7486	15.00%	374	17.40%	*	*	*	*	*	*	61	9.80%
Basic Needs	Trouble paying for housing1	Yes	7486	19.40%	374	22.70%	*	*	*	*	*	*	61	29.50%
Basic Needs	Trouble paying for technology1	Yes	7486	8.40%	374	8.00%	*	*	*	*	*	*	61	11.50%
Basic Needs	Trouble paying for transportation1	Yes	7486	12.60%	374	14.20%	*	*	*	*	*	*	61	16.40%
Basic Needs	Trouble paying for utilities1	Yes	7486	17.20%	374	19.80%	*	*	*	*	*	*	61	36.10%
Basic Needs	Trouble paying for ANY basic needs1	Yes	7486	35.20%	374	43.60%	*	*	*	*	*	*	61	57.40%
Basic Needs	Applied for/received econimic assisstance	Yes	14928	20.30%	768	18.00%	61	13.10%	*	*	34	14.70%	114	39.50%
		Not enough money	13814	16.50%	703	18.90%	59	8.50%	*	*	*	*	102	30.40%
		Just enough money	13814	31.10%	703	32.70%	59	28.80%	30	50.00%	32	43.80%	102	30.40%
Basic Needs	End of month finances	Money left over	13814	52.40%	703	48.40%	59	62.70%	30	36.70%	32	43.80%	102	39.20%
		No internet	11425	3.00%	588	1.70%	*	*	*	*	*	*	80	6.30%
		Does not work well	11425	9.30%	588	9.00%	49	16.30%	*	*	*	*	80	11.30%
Basic Needs	Current internet access2	Works well	11425	87.70%	588	89.30%	49	81.60%	*	*	*	*	80	82.50%
		Somewhat or strongly disagree	11064	7.00%	572	5.90%	*	*	*	*	*	*	86	7.00%
		Somewhat agree	11064	22.00%	572	22.40%	41	12.20%	*	*	*	*	86	31.40%
Neighborhood	Able to get where you need to go2	Strongly agree	11064	71.00%	572	71.70%	41	82.90%	*	*	*	*	86	61.60%

			MASSACHUSETTS		ESSEX		Beverly		Danvers		Gloucester		Lynn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Neighborhood	Experienced neighborhood violence, lifetime2	Never	11008	58.60%	566	55.80%	41	63.40%	*	*	*	*	86	32.60%
		Rarely	11008	28.90%	566	29.20%	41	29.30%	*	*	*	*	86	24.40%
		Somewhat often	11008	9.10%	566	11.50%	*	*	*	*	*	*	86	30.20%
		Very often	11008	3.40%	566	3.50%	*	*	*	*	*	*	86	12.80%
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	734	78.10%	58	84.50%	31	83.90%	31	83.90%	109	63.30%
		Not sure	14393	6.50%	734	7.90%	*	*	*	*	*	*	109	8.30%
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	736	71.30%	58	79.30%	31	64.50%	31	74.20%	110	60.90%
		Not sure	14366	10.20%	736	10.90%	*	*	31	22.60%	*	*	110	9.10%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	735	60.50%	58	70.70%	31	67.70%	31	61.30%	109	42.20%
		Not sure	14325	12.90%	735	13.60%	58	12.10%	31	16.10%	*	*	109	14.70%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	730	78.60%	58	84.50%	31	87.10%	30	73.30%	110	70.00%
		Not sure	14336	7.00%	730	6.40%	*	*	*	*	*	*	110	7.30%
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	731	57.70%	58	58.60%	31	54.80%	31	71.00%	108	40.70%
		Not sure	14247	16.30%	731	17.60%	58	19.00%	31	25.80%	31	16.10%	108	21.30%
Safety & Support	Experienced intimate partner violence	Ever	13621	29.70%	693	34.20%	58	46.60%	*	*	31	29.00%	99	37.40%
		In past year	13359	4.50%	677	5.00%	*	*	*	*	*	*	95	6.30%
Safety & Support	Experienced sexual violence	Ever	13628	21.00%	697	23.70%	56	37.50%	30	20.00%	31	16.10%	103	19.40%
		In past year	13593	1.40%	695	1.20%	*	*	*	*	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	725	56.30%	58	63.80%	30	40.00%	31	29.00%	107	56.10%
		In past year	14130	18.00%	725	18.90%	58	13.80%	*	*	*	*	107	20.60%
Employment	Have multiple jobs (among all workers)2	Yes	6896	20.90%	388	21.60%	32	21.90%	*	*	*	*	58	34.50%
Employment	Location of work (among all workers)	At home only	9173	7.50%	527	5.30%	*	*	*	*	*	*	*	*
		Outside home only	9173	54.60%	527	56.50%	45	46.70%	*	*	*	*	73	56.20%
		Both at home/outside home	9173	37.40%	527	38.00%	45	44.40%	*	*	*	*	73	39.70%
Employment	Paid sick leave at work (among all workers)2	Yes	6903	75.30%	394	78.20%	33	97.00%	*	*	*	*	59	76.30%
		Not sure	6903	4.20%	394	4.10%	*	*	*	*	*	*	*	*
Healthcare Access	Reported chronic condition 1	Yes	6821	65.20%	365	60.50%	32	78.10%	*	*	*	*	49	44.90%
Healthcare Access	Unmet need for short-term illness care (among	Yes	3455	7.60%	171	9.90%	*	*	*	*	*	*	*	*

			MASSACHUSETTS		ESSEX		Beverly		Danvers		Gloucester		Lynn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
	those who needed this care)2													
Healthcare Access	Unmet need for injury care (among those who needed this care)2	Yes	1674	9.00%	88	10.20%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	154	9.10%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	129	20.90%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)2	Yes	998	7.00%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care)2	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	48	10.40%	*	*	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)2	Yes	6941	15.20%	360	15.80%	34	20.60%	*	*	*	*	47	17.00%
Healthcare Access	Telehealth visit, past year1	One or more visit	6747	51.20%	364	51.10%	33	63.60%	*	*	*	*	47	36.20%
		Offered, didn't have	6747	7.00%	364	5.20%	*	*	*	*	*	*	*	*
		Not offered	6747	22.10%	364	21.40%	33	15.20%	*	*	*	*	47	17.00%
		No healthcare visits	6747	20.30%	364	23.10%	*	*	*	*	*	*	47	40.40%
		Yes	4184	20.20%	237	19.80%	*	*	*	*	*	*	42	16.70%

			MASSACHUSETTS		ESSEX		Beverly		Danvers		Gloucester		Lynn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Child had unmet mental health care need (among parents)	Not sure	4184	3.80%	237	5.10%	*	*	*	*	*	*	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	689	33.50%	56	26.80%	*	*	*	*	98	23.50%
		Medium	13267	32.00%	689	32.50%	56	28.60%	*	*	*	*	98	37.80%
		High	13267	13.90%	689	14.70%	56	21.40%	*	*	*	*	98	16.30%
		Very high	13267	17.30%	689	19.30%	56	23.20%	*	*	*	*	98	22.40%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	524	13.70%	38	26.30%	*	*	*	*	74	17.60%
Mental Health	Suicide ideation, past year	Yes	13036	7.40%	674	6.20%	*	*	*	*	*	*	90	6.70%
Substance Use	Tobacco use, past month2	Yes	10305	14.10%	520	10.80%	39	15.40%	*	*	*	*	77	9.10%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	701	49.90%	54	53.70%	*	*	30	43.30%	102	35.30%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	707	6.40%	55	12.70%	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	707	7.10%	55	12.70%	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	707	9.90%	55	14.50%	*	*	31	16.10%	102	7.80%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	707	14.30%	55	18.20%	*	*	31	25.80%	102	10.80%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	707	0.80%	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	*	*	*	*	*	*	*	*	*	*
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%	707	1.30%	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	707	1.60%	*	*	*	*	*	*	*	*

			MASSACHUSETTS		ESSEX		Beverly		Danvers		Gloucester		Lynn	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	707	2.30%	*	*	*	*	*	*	*	*
Emerging Issues	COVID-19 vaccinatination, past year1	Yes	6729	67.80%	360	61.10%	34	58.80%	*	*	*	*	48	56.30%
		Not sure	6729	3.60%	360	5.00%	*	*	*	*	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)2	Yes	6196	22.00%	335	30.10%	*	*	*	*	*	*	42	33.30%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years2	Yes	10422	37.40%	523	39.00%	40	42.50%	*	*	*	*	75	41.30%
Emerging Issues	Flooding in home or on street, past 5 years2	Yes	10422	11.00%	523	9.40%	*	*	*	*	*	*	75	6.70%
Emerging Issues	More ticks or mosquitoes, past 5 years2	Yes	10422	32.20%	523	24.10%	40	20.00%	*	*	*	*	75	13.30%
Emerging Issues	Power outages, past 5 years2	Yes	10422	24.50%	523	19.70%	40	20.00%	*	*	*	*	75	10.70%
Emerging Issues	School cancellation due to weather, past 5 years2	Yes	10422	17.60%	523	14.70%	40	20.00%	*	*	*	*	75	17.30%
Emerging Issues	Unable to work due to weather, past 5 years2	Yes	10422	14.80%	523	13.40%	*	*	*	*	*	*	75	14.70%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years2	Yes	10422	28.30%	523	24.50%	40	25.00%	*	*	*	*	75	33.30%
Emerging Issues	Other climate impact, past 5 years2	Yes	10422	1.70%	523	1.90%	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years2	Yes	10422	67.20%	523	65.60%	40	75.00%	*	*	*	*	75	58.70%

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

CHIA Ages 0-17

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
All Causes												
FY24 ED Volume (all cause) rate per 100,000	4923	3651	4031	3148	3647	5797	4461	2864	9240	2543	2827	1993
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1255	1433	1417	1343	2393	1139	1152	2178	724	844	501
Allergy												
FY24 ED Volume rate per 100,000	293	306	502	416	465	372	620	326	1145	389	245	272
FY24 Inpatient Discharges rate per 100,000	29	11	18	30	21		16	21	47	18	5	28
Asthma												
FY24 ED Volume rate per 100,000	347	266	320	187	272	319	408	210	484	167	207	215
FY24 Inpatient Discharges rate per 100,000	67	40	77	106	121	212	60	94	103		16	28
Attention Deficit Hyperactivity Disorder												
FY24 ED Volume rate per 100,000	77	11	94	49	111	159	140	21	29	37	16	129
FY24 Inpatient Discharges rate per 100,000	27	28	44	30	68	106	46	36	55	18	43	86
Complication of Medical Care												
FY24 ED Volume rate per 100,000	33	28	40	45	32		23	21	54	55	5	28
FY24 Inpatient Discharges rate per 100,000	49	23	25	22	35		13	7	63		70	14
Diabetes												
FY24 ED Volume rate per 100,000	21		23	7	32	53	13		30	18	10	14
FY24 Inpatient Discharges rate per 100,000	8		7	7	7			7	9		16	
HIV/AIDS												
FY24 ED Volume rate per 100,000	0											
FY24 Inpatient Discharges rate per 100,000	0											

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
Infection												
FY24 ED Volume rate per 100,000	1314	949	1266	748	1164	1914	1431	855	3875	612	588	458
FY24 Inpatient Discharges rate per 100,000	131	115	101	95	100	106	120	101	193	37	70	43
Injuries												
FY24 ED Volume rate per 100,000	922	729	961	756	874	1542	1059	710	1238	872	664	788
FY24 Inpatient Discharges rate per 100,000	49	28	30	19	46		46	36	51	37	16	43
Learning Disorders												
FY24 ED Volume rate per 100,000	22	5	4	19	14		23		29			14
FY24 Inpatient Discharges rate per 100,000	24	11	16	22	60		16	14	39			
Mental Health												
FY24 ED Volume rate per 100,000	292	231	381	213	283	1010	496	239	255	222	174	473
FY24 Inpatient Discharges rate per 100,000	75	121	94	64	125	638	117	137	155	37	87	172
Obesity												
FY24 ED Volume rate per 100,000	7		4		7		16		5			
FY24 Inpatient Discharges rate per 100,000	12		11	7	17	159	6	7	28			14
Pneumonia/Influenza												
FY24 ED Volume rate per 100,000	150	69	148	103	164	106	160	65	386	55	136	28
FY24 Inpatient Discharges rate per 100,000	32	5	35	26	75	53	33	14	53	18	16	
Poisonings												
FY24 ED Volume rate per 100,000	59	11	89	38	85	106	60	21	466		16	71
FY24 Inpatient Discharges rate per 100,000	6	5		3	7			7	7			
STIs												
FY24 ED Volume rate per 100,000	4				3				6			

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 Inpatient Discharges rate per 100,000	1								1			
Substance Use												
FY24 ED Volume rate per 100,000	48	34	51	11	53	53	154	65	53	18	38	86
FY24 Inpatient Discharges rate per 100,000	11	34	7		17	53	36	43	22		5	
Age 0-17 Total	4923	3651	4031	3148	3647	5797	4461	2864	9240	2543	2827	1993

CHIA Ages 18-44

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
All Causes												
FY24 ED Volume (all cause) rate per 100,000	11106	7292	8490	6939	7441	9042	9694	5757	14499	2989	5687	4374
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	1967	2426	2059	1888	2872	2111	1580	3435	965	1220	975
Allergy												
FY24 ED Volume rate per 100,000	952	1510	2277	1532	2178	3031	2812	1508	3301	724	904	1089
FY24 Inpatient Discharges rate per 100,000	206	109	174	126	182	212	127	94	255	18	65	14
Asthma												
FY24 ED Volume rate per 100,000	552	804	646	152	437	319	1367	478	283	185	457	559
FY24 Inpatient Discharges rate per 100,000	266	138	330	175	250	265	335	246	402	167	81	114
Breast Cancer												
FY24 ED Volume rate per 100,000	7	5	2		7	53	16	29	3			
FY24 Inpatient Discharges rate per 100,000	9	11	7	3	35		13		3		5	
CHF												
FY24 ED Volume rate per 100,000	14	23	11				6	21	11		5	
FY24 Inpatient Discharges rate per 100,000	50	5	42	15	32		10	50	73			
Complication of Medical Care												
FY24 ED Volume rate per 100,000	120	75	80	84	60	106	103	65	163	37	38	71
FY24 Inpatient Discharges rate per 100,000	645	555	575	691	498	1010	496	500	996	278	354	229
COPD and Lung Disease												
FY24 ED Volume rate per 100,000	30	34	30	11	10	53	120		11	18	5	43
FY24 Inpatient Discharges rate per 100,000	40	11	28	11	25	53	36	21	40	18	21	
Diabetes												

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 ED Volume rate per 100,000	309	243	308	171	247	265	536	145	495	92	152	100
FY24 Inpatient Discharges rate per 100,000	173	98	141	141	154		191	116	333	18	21	71
GYN Cancer												
FY24 ED Volume rate per 100,000	2		2						0			
FY24 Inpatient Discharges rate per 100,000	4		4		7			14	8			
Heart Disease												
FY24 ED Volume rate per 100,000	12	17	28		10	53	36	14	5	18		
FY24 Inpatient Discharges rate per 100,000	56	5	70	61	28	53	53	21	79		5	14
Hepatitis												
FY24 ED Volume rate per 100,000	26		23	7	21		70	14	9		16	14
FY24 Inpatient Discharges rate per 100,000	70	46	80	26	46	53	73	43	150		38	
HIV/AIDS												
FY24 ED Volume rate per 100,000	24		4	7	3		10		14	18		
FY24 Inpatient Discharges rate per 100,000	14	11	14	7			3	7	24			
Hypertension												
FY24 ED Volume rate per 100,000	447	329	490	103	358	585	874	275	475	74	239	315
FY24 Inpatient Discharges rate per 100,000	210	150	193	129	143	159	224	123	348		49	57
Infection												
FY24 ED Volume rate per 100,000	1595	1082	1240	886	981	1170	1532	884	2035	482	958	702
FY24 Inpatient Discharges rate per 100,000	338	266	315	248	240	319	305	239	549	148	163	143
Injuries												
FY24 ED Volume rate per 100,000	1775	1001	1461	1058	1135	1755	1666	1109	2186	612	773	932

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 Inpatient Discharges rate per 100,000	237	156	233	198	218	265	231	217	273	55	125	129
Liver Disease												
FY24 ED Volume rate per 100,000	99	40	176	22	157	53	328	79	183		16	86
FY24 Inpatient Discharges rate per 100,000	191	167	209	145	164	159	274	101	334	18	81	114
Mental Health												
FY24 ED Volume rate per 100,000	1310	781	1761	638	1049	1117	2799	1290	1174	575	621	1348
FY24 Inpatient Discharges rate per 100,000	834	810	1124	527	773	1223	945	688	1292	297	457	487
Obesity												
FY24 ED Volume rate per 100,000	135	5	214	11	128	53	449	108	68	55	16	243
FY24 Inpatient Discharges rate per 100,000	324	318	363	198	297	478	348	239	570	74	87	129
Other Cancer												
FY24 ED Volume rate per 100,000	12			3	10		40	7	2			
FY24 Inpatient Discharges rate per 100,000	23	23	14	15	28	53	26	7	15		5	86
Pneumonia/Influenza												
FY24 ED Volume rate per 100,000	122	98	89	68	75	53	127	50	197	37	70	100
FY24 Inpatient Discharges rate per 100,000	85	28	68	84	60	106	60	65	133		27	14
Poisonings												
FY24 ED Volume rate per 100,000	182	214	205	95	96	212	227	116	290	74	87	43
FY24 Inpatient Discharges rate per 100,000	33	28	42	30	32	106	53	72	47		10	28
Prostate Cancer												
FY24 ED Volume rate per 100,000	0											
FY24 Inpatient Discharges rate per 100,000	0								0			
STIs												

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 ED Volume rate per 100,000	77	17	35	38	21	53	3	14	83		5	
FY24 Inpatient Discharges rate per 100,000	37	34	44	11	14		13	14	47	18	5	
Stroke and Other Neurovascular Diseases												
FY24 ED Volume rate per 100,000	8		14	3	7		6		7		5	
FY24 Inpatient Discharges rate per 100,000	19	5	16	22	10		6		18	18	5	
Substance Use												
FY24 ED Volume rate per 100,000	2079	1533	2133	1001	1300	1861	3134	1334	2919	482	1067	1434
FY24 Inpatient Discharges rate per 100,000	588	590	794	347	462	638	844	384	926	204	288	444
Tuberculosis												
FY24 ED Volume rate per 100,000	2			3					0			
FY24 Inpatient Discharges rate per 100,000	8		2	3	3				23			
Age 18-44 Total	11106	7292	8490	6939	7441	9042	9694	5757	14499	2989	5687	4374

CHIA– Ages 45-64

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
All Causes												
FY24 ED Volume (all cause) rate per 100,000	6844	6672	6000	4868	5385	7925	8139	4372	6957	3731	5780	4775
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	2083	2437	1830	2450	2287	2929	2001	2782	1188	1656	1950
Allergy												
FY24 ED Volume rate per 100,000	797	1655	2074	1769	2067	2978	3007	1442	2611	946	1258	1979
FY24 Inpatient Discharges rate per 100,000	330	127	209	233	315	319	308	232	365	74	179	243
Asthma												
FY24 ED Volume rate per 100,000	299	619	313	106	193	585	720	239	138	241	359	229
FY24 Inpatient Discharges rate per 100,000	254	219	323	252	297	159	362	166	424	167	141	200
Breast Cancer												
FY24 ED Volume rate per 100,000	40	5	21	22	39	53	124	36	12	55	21	43
FY24 Inpatient Discharges rate per 100,000	57	75	75	49	32	53	80	58	49	55	59	71
CHF												
FY24 ED Volume rate per 100,000	78	52	99	15	46	106	147	94	119		76	100
FY24 Inpatient Discharges rate per 100,000	344	318	384	256	444	319	355	210	556	55	130	315
Complication of Medical Care												
FY24 ED Volume rate per 100,000	100	86	94	145	150	53	83	43	101	55	70	129
FY24 Inpatient Discharges rate per 100,000	428	451	476	416	505	319	533	442	512	185	321	286
COPD and Lung Disease												
FY24 ED Volume rate per 100,000	239	254	285	15	164	106	714	174	91	18	81	272
FY24 Inpatient Discharges rate per 100,000	415	416	518	187	480	159	596	297	653	74	217	415

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
Diabetes												
FY24 ED Volume rate per 100,000	759	665	855	481	616	585	1076	507	1135	111	730	430
FY24 Inpatient Discharges rate per 100,000	688	561	712	504	777	319	781	413	1109	129	392	415
GYN Cancer												
FY24 ED Volume rate per 100,000	4					53					5	
FY24 Inpatient Discharges rate per 100,000	16	5	4	45	28	53	13	21	10		5	14
Heart Disease												
FY24 ED Volume rate per 100,000	37	46	66	19	42	106	157	29	11	204	10	129
FY24 Inpatient Discharges rate per 100,000	280	266	285	286	336	159	375	253	350	111	163	200
Hepatitis												
FY24 ED Volume rate per 100,000	23		28	3	3		63	14	5			
FY24 Inpatient Discharges rate per 100,000	83	34	47	26	32		90	50	155	18	59	14
HIV/AIDS												
FY24 ED Volume rate per 100,000	34	23	4	3	17		40	7	13			
FY24 Inpatient Discharges rate per 100,000	34	17	7	11	25		73		39			
Hypertension												
FY24 ED Volume rate per 100,000	1377	1429	1442	393	974	1648	2541	1051	1158	575	1127	1462
FY24 Inpatient Discharges rate per 100,000	918	798	936	737	981	1063	1233	804	1181	482	539	688
Infection												
FY24 ED Volume rate per 100,000	813	908	818	473	630	904	1045	514	795	538	648	616
FY24 Inpatient Discharges rate per 100,000	627	619	662	485	673	425	740	478	835	259	528	401
Injuries												
FY24 ED Volume rate per 100,000	1351	1261	1416	985	1232	2180	2024	928	1337	965	1035	1276

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 Inpatient Discharges rate per 100,000	534	486	662	462	713	585	851	420	645	315	359	544
Liver Disease												
FY24 ED Volume rate per 100,000	113	28	245	53	204	638	522	232	120	92	49	401
FY24 Inpatient Discharges rate per 100,000	383	376	459	317	376	265	610	297	496	129	283	301
Mental Health												
FY24 ED Volume rate per 100,000	703	538	1126	301	680	1010	2232	659	559	556	294	1190
FY24 Inpatient Discharges rate per 100,000	1042	1099	1376	699	1200	744	1307	920	1656	389	659	731
Obesity												
FY24 ED Volume rate per 100,000	138	46	214	22	146	372	697	123	46	148	16	286
FY24 Inpatient Discharges rate per 100,000	619	393	634	420	727	425	653	369	918	92	294	372
Other Cancer												
FY24 ED Volume rate per 100,000	30	11	28	11	21		130	14	11	37	10	57
FY24 Inpatient Discharges rate per 100,000	100	69	75	126	42		140	58	94	55	114	43
Pneumonia/Influenza												
FY24 ED Volume rate per 100,000	73	52	56	49	35	106	60	14	67		76	14
FY24 Inpatient Discharges rate per 100,000	228	196	221	164	272	106	261	188	304	37	185	43
Poisonings												
FY24 ED Volume rate per 100,000	82	69	89	38	68	212	90	50	93	18	81	43
FY24 Inpatient Discharges rate per 100,000	36	28	37	30	57		63	29	76		27	28
Prostate Cancer												
FY24 ED Volume rate per 100,000	12		21	3	10		23	7		18	5	
FY24 Inpatient Discharges rate per 100,000	28		33	11	35	53	40	29	31	55	21	43
STIs												

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 ED Volume rate per 100,000	10		2		3		10	7	7			
FY24 Inpatient Discharges rate per 100,000	6		4		7		10		7	18		14
Stroke and Other Neurovascular Diseases												
FY24 ED Volume rate per 100,000	24	17	33	30	39	53	80	36	19	37	10	14
FY24 Inpatient Discharges rate per 100,000	92	63	63	68	46	106	93	123	105	55	54	71
Substance Use												
FY24 ED Volume rate per 100,000	1492	1423	1591	657	985	1223	2950	935	1830	334	811	1032
FY24 Inpatient Discharges rate per 100,000	858	891	1016	512	809	531	1263	826	1203	204	522	645
Tuberculosis												
FY24 ED Volume rate per 100,000	1											
FY24 Inpatient Discharges rate per 100,000	11		7	7	3		10		22			
Age 45-64 Total	6844	6672	6000	4868	5385	7925	8139	4372	6957	3731	5780	4775

CHIA– Ages 65+

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
All Causes												
FY24 ED Volume (all cause) rate per 100,000	5485	5341	5684	5785	6836	9148	8286	5945	3648	5124	8035	9063
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	4056	5623	5510	6839	9308	6362	5474	3789	4734	5093	7270
Allergy												
FY24 ED Volume rate per 100,000	798	1371	1985	2663	2826	2978	2802	2269	1917	1485	2151	3714
FY24 Inpatient Discharges rate per 100,000	671	358	551	691	702	904	680	464	513	389	490	1003
Asthma												
FY24 ED Volume rate per 100,000	155	266	238	26	154	159	439	152	41	167	348	788
FY24 Inpatient Discharges rate per 100,000	314	196	495	389	483	638	442	464	356	352	234	602
Breast Cancer												
FY24 ED Volume rate per 100,000	69	11	113	11	75	53	271	94	10	129	10	286
FY24 Inpatient Discharges rate per 100,000	216	115	261	343	333	1117	288	333	140	594	315	659
CHF												
FY24 ED Volume rate per 100,000	270	208	358	114	483	531	576	261	178	408	392	803
FY24 Inpatient Discharges rate per 100,000	1445	1093	1900	1750	2346	2180	1656	1312	1473	1336	1193	2423
Complication of Medical Care												
FY24 ED Volume rate per 100,000	158	98	226	183	257	372	288	116	117	148	294	200
FY24 Inpatient Discharges rate per 100,000	809	833	1195	1230	1189	1648	1230	1058	703	1058	887	1448
COPD and Lung Disease												
FY24 ED Volume rate per 100,000	350	561	483	80	444	1170	1300	232	70	241	506	774

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 Inpatient Discharges rate per 100,000	1111	1244	1360	1069	1554	1702	1783	1022	1213	984	1133	1749
Diabetes												
FY24 ED Volume rate per 100,000	860	873	957	733	1071	1010	1609	739	773	594	877	1061
FY24 Inpatient Discharges rate per 100,000	1509	1163	1839	1918	2067	1914	1833	1471	1655	1281	1225	1864
GYN Cancer												
FY24 ED Volume rate per 100,000	7		4	3	10		26	7	0	18		
FY24 Inpatient Discharges rate per 100,000	27	23	30	30	21	53	56	29	11		43	100
Heart Disease												
FY24 ED Volume rate per 100,000	90	17	226	45	154	372	432	145	22	389	43	372
FY24 Inpatient Discharges rate per 100,000	1079	868	1546	1467	1934	1702	1572	1305	931	1281	975	1979
Hepatitis												
FY24 ED Volume rate per 100,000	7		7	3			80					
FY24 Inpatient Discharges rate per 100,000	51	17	28	30	46		70	58	98	18	10	28
HIV/AIDS												
FY24 ED Volume rate per 100,000	7		4	3			6	7	2			
FY24 Inpatient Discharges rate per 100,000	14		9				20		11			14
Hypertension												
FY24 ED Volume rate per 100,000	1774	2239	2107	512	2006	3563	3848	1994	905	1652	3432	3872
FY24 Inpatient Discharges rate per 100,000	1758	1689	2173	2166	2439	4308	2601	2342	1341	2172	2200	2667
Infection												
FY24 ED Volume rate per 100,000	718	810	742	726	834	1063	1123	739	377	631	969	1175
FY24 Inpatient Discharges rate per 100,000	1455	1452	1869	1631	2268	2234	1944	1595	1302	1336	1656	2208
Injuries												

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 ED Volume rate per 100,000	1257	1047	1711	1253	2121	2925	2725	1885	713	1800	1743	3112
FY24 Inpatient Discharges rate per 100,000	1365	1238	1959	1734	2543	3617	2081	2037	1387	1875	1579	2538
Liver Disease												
FY24 ED Volume rate per 100,000	65	17	160	42	161	319	398	116	38	185	59	258
FY24 Inpatient Discharges rate per 100,000	421	312	502	401	505	904	653	551	444	427	310	717
Mental Health												
FY24 ED Volume rate per 100,000	347	243	761	129	659	1382	1920	558	122	686	386	1462
FY24 Inpatient Discharges rate per 100,000	1456	1290	2147	1658	2508	3031	2286	1747	1668	1281	1514	2265
Obesity												
FY24 ED Volume rate per 100,000	72	5	183	22	111	478	432	94	13	111		444
FY24 Inpatient Discharges rate per 100,000	764	584	900	565	1028	1276	938	594	913	464	419	1104
Other Cancer												
FY24 ED Volume rate per 100,000	58	11	77	19	71	265	288	72	7	92	16	530
FY24 Inpatient Discharges rate per 100,000	285	243	353	405	390	319	529	406	230	278	365	674
Pneumonia/Influenza												
FY24 ED Volume rate per 100,000	79	57	68	99	118	53	113	72	42	37	114	143
FY24 Inpatient Discharges rate per 100,000	627	532	714	596	1117	478	636	623	587	389	757	645
Poisonings												
FY24 ED Volume rate per 100,000	30	23	30	53	60	53	77	29	20	18	21	86
FY24 Inpatient Discharges rate per 100,000	44	34	80	68	57		110	101	43	92	32	129
Prostate Cancer												
FY24 ED Volume rate per 100,000	62	5	101	26	78	212	187	79	8	111	27	272

	BH/AGH Community Benefits Service Area											
	MA	Amesbury	Beverly	Burlington	Danvers	Essex	Gloucester	Ipswich	Lynn	Manchester	Newburyport	Rockport
FY24 Inpatient Discharges rate per 100,000	221	104	268	278	397	585	385	304	185	464	266	344
STIs												
FY24 ED Volume rate per 100,000	1	5	2	3	3							
FY24 Inpatient Discharges rate per 100,000	7	11	9	7	3		3	7	9			28
Stroke and Other Neurovascular Diseases												
FY24 ED Volume rate per 100,000	63	52	299	68	372	425	328	377	28	129	65	401
FY24 Inpatient Discharges rate per 100,000	290	306	304	408	419	425	398	384	236	167	261	473
Substance Use												
FY24 ED Volume rate per 100,000	391	329	471	221	451	744	1146	522	459	259	375	587
FY24 Inpatient Discharges rate per 100,000	552	526	848	439	720	1542	1159	616	617	519	517	688
Tuberculosis												
FY24 ED Volume rate per 100,000	1		2				3		0			
FY24 Inpatient Discharges rate per 100,000	15		14	38	10	53	20	7	34		16	
Age 65+ Total	5485	5341	5684	5785	6839	9308	8286	5945	3789	5124	8035	9063

Community Health Survey

- 2025 BH/AGH 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: _____

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
☐ Prefer not to answer
☐ Other (specify_____)

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 - BHAGH

Response Counts

Completion Rate:	**89.3%**		
	Complete		1,944
	Partial		232

Totals: 2,176

1. Select a language.

Value	Percent	Responses
Take the survey in English	93.2%	1,993
شارك في الاستطلاع باللغة العربية	0.1%	3
参加简体中文调查	1.1%	24
參加繁體中文調查	0.0%	1
Reponn sondaj la nan lang kreyòl ayisyen	0.0%	1
हिंदी में सर्वेक्षण में भाग लें	0.5%	10
ធ្វើការស្ទង់មតិជាភាសាខ្មែរ	0.0%	1
Participe da pesquisa em português	0.9%	20
Пройдите анкету на русском языке	0.1%	3
Responda la encuesta en español	3.9%	83

Totals: 2,139

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	93.8%	2,025
I work in this community	30.0%	648
Other, please specify:	2.5%	55

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 %	859 40.0%	1,059 49.3%	117 5.4%	39 1.8%	73 3.4%	2,147
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 %	691 32.3%	1,119 52.3%	206 9.6%	71 3.3%	51 2.4%	2,138
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 %	740 34.6%	996 46.6%	190 8.9%	52 2.4%	160 7.5%	2,138
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 %	527 24.5%	1,034 48.1%	361 16.8%	85 4.0%	143 6.7%	2,150
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	623 29.1%	1,173 54.8%	214 10.0%	45 2.1%	86 4.0%	2,141
My community feels safe. Count Row %	876 40.7%	1,027 47.7%	148 6.9%	61 2.8%	39 1.8%	2,151

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	563 26.4%	1,118 52.3%	248 11.6%	79 3.7%	128 6.0%	2,136
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	246 11.5%	886 41.3%	374 17.5%	81 3.8%	556 25.9%	2,143
My community offers people options for staying cool during extreme heat. Count Row %	390 18.3%	987 46.2%	219 10.3%	57 2.7%	483 22.6%	2,136
My community has services that support people during times of stress and need. Count Row %	335 15.7%	1,024 48.0%	248 11.6%	63 3.0%	463 21.7%	2,133
I believe that all residents, including myself, can make the community a better place to live. Count Row %	989 46.2%	1,043 48.8%	45 2.1%	20 0.9%	42 2.0%	2,139
Totals Total Responses						2151

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	19.4%	412
Better access to health care	23.4%	497
Better access to healthy food	16.8%	357
Better access to internet	10.8%	229
Better access to public transportation	26.3%	558
Better parks and recreation	15.1%	321
Better roads	34.1%	725
Better schools	26.0%	552
Better sidewalks and trails	39.3%	836
Cleaner environment	13.8%	293
Lower crime and violence	12.8%	272
More affordable childcare	29.8%	633
More affordable housing	57.1%	1,214
More arts and cultural events	12.7%	270
More effective city services (like water, trash, fire department, and police)	12.0%	256
More inclusion for diverse members of the community	22.8%	484

Value	Percent	Responses
Stronger community leadership	11.0%	234
Stronger sense of community	10.6%	226
Other, please specify:	6.8%	145

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 %	185 9.0%	289 14.0%	1,119 54.2%	360 17.5%	110 5.3%	2,063
Health care in my community meets the mental health needs of people like me. Count Row %	193 9.5%	447 21.9%	765 37.5%	203 10.0%	430 21.1%	2,038
Totals Total Responses						2063

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

Value	Percent	Responses
A doctor's or nurse's office	84.9%	1,755
A public health clinic or community health center	7.0%	145
Urgent care provider	3.2%	66
A hospital emergency room	0.7%	15
No usual place	2.5%	52
Other, please specify:	1.6%	34

Totals: 2,067

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	10.7%	217
Not enough time	15.5%	315
Insurance problems	17.2%	350
No providers or staff speak my language	2.5%	50
Can’t get an appointment	30.6%	623
Cost	25.5%	518
Concern about COVID or other disease exposure	3.8%	78
Transportation	7.2%	146
Other, please specify:	8.1%	165
No barriers	36.9%	751

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)	41.6%	824
Alcohol or drug misuse	31.5%	625
Asthma	3.8%	75
Cancer	19.4%	384
Child abuse/neglect	6.1%	120
Diabetes	9.9%	197
Domestic violence	8.8%	175
Environment (like air quality, traffic, noise)	18.3%	363
Heart disease and stroke	12.8%	253
Hunger/malnutrition	9.7%	193
Homelessness	20.2%	401
Housing	38.9%	771
Mental health (anxiety, depression, etc.)	54.7%	1,083
Obesity	13.6%	270
Poor diet/inactivity	11.8%	234
Poverty	10.1%	200

Value	Percent	Responses
Smoking	7.2%	143
Suicide	7.0%	139
Trauma	8.3%	164
Underage drinking	8.1%	160
Vaping/E-cigarettes	16.1%	318
Violence	6.7%	133
Youth use of social media	32.1%	636
Infant death	0.8%	15
Rape/sexual assault	2.7%	54
Sexually transmitted infections (STIs)	2.2%	43
Teenage pregnancy	2.6%	52

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

Value	Percent	Responses
12th grade or lower (no diploma)	3.2%	65
High school (including GED, vocational high school)	6.6%	134
Started college but not finished	8.7%	176
Vocational, trade, or technical program after high school	2.9%	58
Associate degree (for example, AA, AS)	8.6%	173
Bachelor's degree (for example, BA, BS, AB)	30.7%	621
Graduate degree (for example, master's, professional, doctorate)	36.4%	737
Other, please specify:	1.0%	21
Prefer not to answer	1.8%	37

Totals: 2,022

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

Value	Percent	Responses
American Indian or Alaska Native	0.7%	15
Asian	6.2%	124
Black or African American	2.2%	45
Hispanic or Latine/a/o	8.7%	175
Middle Eastern or North African	0.4%	9
Native Hawaiian or Pacific Islander	0.1%	2
White	78.6%	1,584
Other, please specify:	1.1%	22
Not sure	0.4%	9
Prefer not to answer	3.9%	78

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.3%	26
Bisexual and/or Pansexual	3.6%	72
Gay or Lesbian	2.5%	49
Straight (Heterosexual)	82.2%	1,637
Queer	0.8%	16
Questioning/I am not sure of my sexuality	0.3%	6
I use a different term, please specify:	0.5%	10
I do not understand what this question is asking	1.1%	21
I prefer not to answer	7.8%	155

Totals: 1,992

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	79.7%	1,598
Male, Man	16.4%	328
Nonbinary, Genderqueer, not exclusively male or female	0.7%	14
I use a different term, please specify:	0.2%	4
I do not understand what this question is asking	0.1%	2
I prefer not to answer	3.0%	60

Totals: 2,006

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	6.1%	121
Food or groceries	18.2%	361
Formula or baby food	1.2%	23
Health care (appointments, medicine, insurance)	16.4%	324
Housing (rent, mortgage, taxes, insurance)	21.4%	424
Technology (computer, phone, internet)	7.5%	148
Transportation (car payment, gas, public transit)	11.4%	226
Utilities (electricity, water, gas)	17.8%	353
Other, please specify:	2.4%	47
None of the above	59.9%	1,186

14. What is your age?

Value	Percent	Responses
Under 18	0.6%	13
18-24	1.2%	25
25-44	35.1%	706
45-64	34.2%	687
65-74	17.3%	347
75-84	9.2%	185
85 and over	1.4%	29
Prefer not to answer	0.9%	18

Totals: 2,010

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

Value	Percent	Responses
Armenian	3.0%	60
Chinese (including Mandarin and Cantonese)	1.4%	29
English	88.4%	1,777
Haitian Creole	0.2%	4
Hindi	1.0%	20
Khmer	0.2%	5
Portuguese	1.5%	31
Russian	0.1%	3
Spanish	5.9%	118
Vietnamese	0.0%	1
Other, please specify:	3.1%	63
Prefer not to answer	1.1%	23

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	45.4%	913
Employed part-time (Less than 40 hours per week)	15.7%	316
Self-employed (Full- or part-time)	5.2%	105
A stay-at-home parent	4.8%	97
A student (Full- or part-time)	0.8%	16
Unemployed	2.3%	47
Unable to work for health reasons	1.8%	37
Retired	20.7%	416
Other, please specify:	1.7%	34
Prefer not to answer	1.6%	32

Totals: 2,013

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

Value	Percent	Responses
Yes	12.2%	243
No	84.7%	1,691
Prefer not to answer	3.2%	63

Totals: 1,997

18. I currently:

Value	Percent	Responses
Rent my home	18.6%	371
Own my home (with or without a mortgage)	69.5%	1,390
Live with parent or other caretakers who pay for my housing	3.5%	70
Live with family or roommates and share costs	3.9%	77
Live in a shelter, halfway house, or other temporary housing	0.7%	14
Live in senior housing or assisted living	1.6%	32
I do not currently have permanent housing	0.7%	14
Other	1.6%	32

Totals: 2,000

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

Value	Percent	Responses
I have always lived in the United States	80.9%	1,632
Less than one year	1.3%	26
1 to 3 years	2.5%	50
4 to 6 years	1.4%	28
More than 6 years, but not my whole life	13.0%	263
Prefer not to answer	0.9%	19

Totals: 2,018

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	57.0%	1,108
Faith community (such as a church, mosque, temple, or faith-based organization)	22.1%	429
School community (such as a college or education program that you attend or a school that your child attends)	21.7%	422
Work community (such as your place of employment or a professional association)	41.4%	805
A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)	10.4%	202
A shared interest group (such as a club, sports team, political group, or advocacy group)	33.3%	648
Another city or town where I do not live	14.0%	272
Other, please feel free to share:	6.4%	125

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	28.0%	372
No	72.0%	957

Totals: 1,329

Appendix C:
Resource Inventory

Northeast Hospital Corporation Community Resource List

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

Health Issue	Organization	Brief Description	Address	Phone	Website
	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
	Executive Office of 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
	Mass 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Behavioral Health Help Line	Available 24 hours a day, 7 days a week, connects individuals and families to the full range of treatment services for mental health and substance use.		833.773.2445	www.masshelpline.com
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 10th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-aging-independence
	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/helplines/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps?
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		988	www.veteranscrisisline.net
Domestic Violence	Healing Abuse Working for Change	Provides support in Survivor Services, including advocacy, counseling, legal assistance, support groups and 24/7 Confidential Hotline.	27 Congress St Ste 204 Salem	978.744.8552 24/7 Hotline 800-547-1649	hawcdv.org
	Jeanne Geiger Crisis Center	Provides support in Survivor Services, including advocacy, counseling, legal assistance, support groups and 24/7 Confidential Hotline.	2 Harris St Newburyport	978.465.0999 24/7 Confidential Hotline is available at 978.388.1888	www.jeannegeigercrisiscenter.org

	Saheli	Offers non-judgmental culturally sensitive services for domestic and sexual violence survivors from South Asia and the Middle East.	PO Box 1345 Burlington	866.472.4354	www.saheliboston.org
Food Assistance	Acord Food Pantry	Provides food assistance to residents of Essex, Hamilton, Ipswich, Manchester, Topsfield and Wenham.	69 Willow St South Hamilton	978.468.7424	www.acordfoodpantry.org
	Action Inc.	Offers emergency SNAP assistance and help applying for food assistance benefits.	370 Main St Gloucester	978.282.1000	www.actioninc.org
	Beverly Bootstraps	Offer emergency and long-term assistance including: access to food, housing stability, adult and youth programs, education, counseling and advocacy.	35 Park St Beverly	978.927.1561	www.beverlybootstraps.org
	Community Action, Inc.	Provides food assistance to residents of Amesbury, Merrimac, Salisbury, Newburyport, Newbury and West Newbury.	44A Friend St Amesbury	978.388.2570	www.communityactioninc.org/cai-amesbury-center/
	Danvers People to People Food Pantry	Provides food assistance to residents of Danvers.	12 Sylvan St Danvers	978.739.4188	www.danverscommunitycouncil.com/danvers-people-to-people-food-pantry
	MA Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program?
	My Brother's Table	Provides food assistance to residents of Lynn.	98 Willow St Lynn	781.595.3224	www.mybrotherstable.org
	Open Door-Gloucester Food Pantry	Provides food assistance to residents of Gloucester, Rockport, Ipswich, Manchester, and Essex.	28 Emerson Ave Gloucester	978.283.6776	www.foodpantry.org
	Open Door-Ipswich Community Food Pantry	Provides food assistance to residents of Topsfield, Rowley, Ipswich, Boxford, Hamilton, and Wenham.	00 Southern Heights Ipswich	978.283.6776	www.foodpantry.org
	Our Neighbors' Table	Provides food assistance to residents of Amesbury, Boxford, Byfield, Georgetown, Groveland, Merrimac, Newbury, Newburyport, Rowley, Salisbury, and West Newbury.	P.O. Box 592 Amesbury	978.388.1907	www.ourneighborstable.org
	People Helping People Food Pantry	Provides food assistance to Burlington residents.	21-23 Murray Ave Burlington	781.270.6625	www.peoplehelpingpeopleinc.org
	Project Bread Foodsource Hotline	Provides information about resources in your community as well as assist with SNAP applications over the phone.		800.645.8333	www.projectbread.org/foodsource-hotline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps?
	St. Stephen's Food Pantry	Provides food assistance to residents of Lynn.	74 South Common St Lynn	781.599.4220	www.ststephenslynn.org/food-pantry
	Action Inc. – Emergency Homeless Shelter	Temporary shelter providing advocacy, emergency food and clothing for persons who are unhoused.	370 Main St Gloucester	978.282.1000	www.actioninc.org/client-housing-services/emergency-shelter
	Amesbury Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	180 Main St Amesbury	978.388.2022	www.amesburyha.com
	Beverly Housing Authority	Provides housing assistance programs to low-resource individuals and families.	137R Bridge St Beverly	978.922.3100	www.beverlyhousing.net
	Burlington Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	15 Birchcrest St Burlington	781.272.7786	www.burlington.org/572/burlington-housing-authority
	Community Action, Inc.	Provides social service programs and housing resource assistance.	3 Washington Square Haverhill	978.373.1971	www.communityactioninc.org
	Danvers Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	14 Stone St Danvers	978.777.0909	www.danvershousing.org
	Essex Housing Authority	Provides affordable, subsidized rental housing for low-resource older adults and persons with disabilities.	Chebacco Terrace Essex	978.768.6821	www.essexha.org
	Family Promise North Shore Boston	Provides shelter, meals, job support and case management for people without housing.	35 Conant St Beverly	978.922.0787	www.familypromisensb.org
	Gloucester Housing Authority	Provides affordable, subsidized rental housing for residents of Gloucester.	259 Washington St Gloucester	978.281.4770	www.ghama.com

Housing Support	The Grace Center	Offers a safe, free day resource center for individuals without housing, older adults, people with disabilities by connecting them to critical services, including transportation, health screenings, showers, food, and legal services.	264 Main St Gloucester	978.675.6240	www.lifebridgenorthshore.org/gracecenter
	Harborlight Community Partners	Provides information and resources for low and moderate resource families and individuals.	600 Cummings Center Ste 270X Beverly	978.922.1305	www.harborlightcp.org
	The Haven Project	Provides direct services to youth aged 17-24 without housing.	57 Munroe St Lynn	781.913.5738	www.havenproject.net
	Ipswich Housing Authority	Provides affordable, subsidized rental housing for low-resource older adults and persons with disabilities.	1 Agawam Village Ipswich	978.356.2860	www.ipswichhousingauthority.com
	Lynn Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	10 Church St Lynn	781.581.8600	www.lhand.org
	Lynn Shelter Association	Temporary shelter providing services for persons who are unhoused.	181 Union St LL102 Lynn	781.581.0739	www.lsahome.org
	Manchester Housing Authority	Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities.	7 Office The Plains Manchester	978.526.1850	www.manchestermaha.org
	Newburyport Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	25 Temple St Newburyport	978.465.7216	www.nhahousing.com
	River House, Inc.	Provides emergency-shelter services for individuals without housing in the greater Beverly and North Shore area.	56 River St Beverly	978.921.1304	www.lifebridgenorthshore.org/locations/river-house
	Rockport Housing Authority	Provides affordable, subsidized rental housing for low-resource families.	13 Millbrook Park Rockport	978.546.3181	www.rockportma.gov/519/Housing-Authority
	Wellspring House Inc.	Provides services and programs that assist with families and individuals, finances, education and job training.	302 Essex Ave Gloucester	978.281.3558	www.wellspringhouse.org
	YWCA of Newburyport	Provides safe, affordable and supportive child care and youth development, housing and wellness opportunities.	13 Market St Newburyport	978.465.9922	www.ywcanewburyport.org
Mental Health and Substance Use	Advocates-Outpatient Counseling Clinic	Provides evidence-based, best practice therapies for individuals and families.	200 Corporate Place Ste. 6A Peabody	978.927.9410	www.advocates.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
	Danvers Treatment Center	Offers medication-assisted treatment and counseling for adults with substance use disorders by offering 3 types of medication-assisted treatments.	111 Middleton Rd Danvers	978.777.2121	www.bilhbehavioral.org
	Eliot Community Behavioral Health Centers	Provides substance use and mental health treatment programs including urgent and emergency services, crisis stabilization, individual and family therapy services and care coordination for youth, families and adults.	75 Sylvan St Bldg C Danvers	888.769.5201	www.eliotchs.org/cbhc/
	Eliot Community Behavioral Health Centers	Provides substance use and mental health treatment programs including urgent and emergency services, crisis stabilization, individual and family therapy services and care coordination for youth, families and adults.	95 Pleasant St Lynn	800.988.1111	www.eliotchs.org/cbhc/
	Eliot Community Human Services	Provides services for people of all ages throughout Massachusetts through a continuum of services includes diagnostic evaluation, 24-hour emergency services, and crisis stabilization, outpatient and court-mandated substance-use prevention services; individual, group and family outpatient counseling, early intervention, specialized psychological testing; day, residential, social and vocational programs for individuals with developmental disabilities, outreach and support services for people experiencing homelessness.	125 Hartwell Ave Lexington	781.861.0890	www.eliotchs.org

	Link House, Inc.	Provides residential programs in Salisbury, Newburyport, and Amesbury for men and women who struggle with substance use disorders.	110 Haverhill Rd Amesbury	978.462.0787	www.linkhouseinc.org
	North Shore Counseling Center (NSCC)	Provides evidence-based, best practice therapies for individuals, couples, and families.	100 Cummings Center Ste 307E Beverly	978.922.2280	www.nscc-inc.com
	North Shore Veterans Counseling Services Inc.	Provides counseling services to Veterans.	45 Broadway St Beverly	978.921.4851	www.northshoreveterans.com
	Ryan House	Provides treatment focused halfway house for those seeking recovery from substance abuse disorders and co-occurring disorders for adult men and women.	110 Green St Lynn	781.593.9434	www.bilhbehavioral.org
	Triumph Center	Provides counseling, social skills groups, summer programming and psychological evaluation services for children, adolescents, young adults and families, as well as consultation and evaluations for schools and other institutions.	100 Cummings Center Ste 207L Beverly	781.942.9277	www.triumphcenter.net
Senior Services	AgeSpan	Provides programs and services which are available and accessible to meet the diverse needs and changing lifestyles of older adults.	300 Rosewood Dr Ste 200 Danvers	978.683.7747	www.agespan.org
	Amesbury Council on Aging	Provides services for older adults in Amesbury including fitness, education, social services, and recreation.	68 Elm St Amesbury	978.388.8138	www.amesburyma.gov/323/Council-on-Aging
	Beverly Council on Aging	Provides services for older adults in Beverly including fitness, education, social services, recreation, and transportation.	90 Colon St Beverly	978.921.6017	www.beverlyma.gov/172/Council-on-Aging
	Burlington Council on Aging	Provides services for older adults in Burlington including fitness, education, social services, recreation, and transportation.	61 Center St Burlington	781.270.1950	www.burlington.org/509/council-on-aging
	Danvers Council on Aging	Provides services for older adults in Danvers including fitness, education, social services, recreation, and transportation.	25 Stone St Danvers	978.762.0208	www.danversma.gov/434/Senior-Social-Services
	Essex Council on Aging	Provides services for older adults in Essex including fitness, education, social services, recreation, and transportation.	17 Pickering St Essex	978.768.7932	www.essexma.org/essex-senior-center-council-aging
	Gloucester Council on Aging	Provides services for older adults in Gloucester including fitness, education, social services, recreation, and transportation.	6 Manuel F. Lewis St Gloucester	978.325.5800	www.gloucester-ma.gov/291/Council-on-Aging
	Greater Lynn Senior Services	Provides a broad range of services, including: information and referral; home care services; nutrition programs; transportation assistance; housing supports; clinical and protective services; programs designed to promote consumer engagement and better health and well-being.	8 Silsbee St Lynn	781.599.0110	www.glss.net
	Ipswich Council on Aging	Provides services for older adults in Ipswich including fitness, education, social services, recreation, and transportation.	25 Green St Ipswich	978.356.6650	www.ipswichma.gov/335/Council-on-Aging
	Manchester-by-the-Sea Council on Aging	Provides services for older adults in Manchester including fitness, education, social services, recreation, and transportation.	10 Central St Manchester	978.526.7500	www.manchester.ma.us/371/Council-On-Aging
	Newburyport Council on Aging	Provides services for older adults in Newburyport including fitness, education, social services, and recreation.	331 High St Newburyport	978.462.0430	www.cityofnewburyport.com/council-on-aging
	Rockport Council on Aging	Provides services for older adults in Rockport including fitness, education, social services, recreation, and transportation.	58 Broadway Rockport	978.546.2573	www.rockportma.gov/459/Council-on-Aging
	SeniorCare	Provide supportive services for older adults.	49 Blackburn Center Gloucester	978.281.1750	www.seniorcareinc.org

Transportation	Cape Ann Transportation Authority (CATA)	Provides public transportation to the Cape Ann area, which includes Gloucester, Essex, Ipswich and Rockport.	3 Pond Rd Gloucester	978.283.1886	www.canntran.com
	MBTA Commuter Rail Service	Provides service to the Cape Ann region.			www.mbta.com
	The Ride (MBTA)	Provides a 365 days a year door-to door, shared-ride transportation to persons who are unable to use bus, subway or trolley transportation.		617.222.3200	www.mbta.com/accessibility/the-ride
	Boys & Girls Club of Lynn	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	25 North Common St Lynn	781.593.1772	www.bgcl.org
	Cape Ann YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	7 Gloucester Crossing Rd Gloucester	978.283.0470	www.northshoreymca.org
	Danvers Community YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	34 Pickering St Danvers	978.774.2055	www.danversymca.org
	Demakes Family YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	40 Neptune Blvd Lynn	781.842.8811	www.ymcametronorth.org/locations/lynn-ymca
Additional Resources	Girls Incorporated of Lynn	Provides programs and experiences that advocates on behalf of girls.	50 High St Lynn	781.592.9744	www.girlsinclynn.org
	Greater Beverly YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	254 Essex St Beverly	978.927.6855	www.northshoreymca.org
	Ipswich Family YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	110 County Rd Ipswich	978.356.9622	www.northshoreymca.org
	Pathways for Children-Beverly office	Provides programming for children from birth to 13; robust social support services for families throughout Essex County; and professional development initiatives designed to inspire the next generation of teachers and youth/family services workers.	292 Cabot St Beverly	978.236.4101	www.pw4c.org
	Pathways for Children-Gloucester office	Provides programming for children from birth to 13; robust social support services for families throughout Essex County; and professional development initiatives designed to inspire the next generation of teachers and youth/family services workers.	29 Emerson Ave Gloucester	978.281.2400	www.pw4c.org
	Pathways for Children-Salem office	Provides programming for children from birth to 13; robust social support services for families throughout Essex County; and professional development initiatives designed to inspire the next generation of teachers and youth/family services workers.	79 Willson St Salem	978.515.5400	www.pw4c.org

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

Beverly Hospital/ Addison Gilbert Hospital

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's Office.

Priority: Equitable Access to Care

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and speciality care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations ● Youth ● Older Adults	Promote access to health care, health insurance, patient financial counselors, needed medications and other essentials for patients who are uninsured or underinsured.	● Financial Counseling ● Serving the Health Insurance Needs of Everyone (SHINE) Program ● Primary Care Support ● School Based Health Center ● Provide community grants to address need	● 1,053 people referred for services ● **Financial Counselors** at Beverly and Addison Gilbert Hospital assisted patients with existing Medicaid, patients who presented as self - pay and completed an application with a Financial Navigator, and patients who qualified for upgraded MassHealth coverage. o Baseline (FY23)**:** Financial Counselors dedicated more than 13,000 hours assisting 7,934 residents with applications and enrollments for disability (2501), Medicaid (1352), MassHealth (1,612), and more. The residents served included those over the age of 65 (68%) and those under the age of 65 (32%). o Year 1 (FY24): staff assisted 1300 patients and enrolled 1053 patients into entitlement programs. Of these patients, 889 were enrolled in MassHealth and 24 uninsured patients utilized Health Safety Net.

			● **SHINE Program -** The Serving the Health Information Needs of Everyone (SHINE) program helps Medicare beneficiaries and their caregivers navigate their health insurance options. The counselors are also available to review current coverage, compare costs and benefits of available options, and assist those with limited resources in enrolling in helpful programs o Baseline (FY23): SHINE counselors conducted 3,921 consultations for residents of the North Shore and Cape Ann. o Year #1 (FY24): SHINE counselors conducted 1,929 consultations for residents of the North Shore and Cape Ann. Total hours assisting: 1,187 ● **Gloucester School Based Health Center** - NHC, with support from funding received by the Department of Public Health, facilitated a School Based Health Center at The Gloucester High School. The program includes nurse practitioner and social worker visits along with various educational outreach activities such as social skills work groups and reproductive health classes. In addition, the center reduced barriers to food access (exasperated by Covid) by creating a Food Locker for students in need. o Baseline (FY23): Achieved more than 3,300 student encounters through individual visits with the nurse practitioner or social worker and/or outreach activities. In addition, provided 625 food orders serving 67 students, and made 117 free food deliveries to students and their families. o Year #1 (FY24): Achieved more than 3,500 student encounters through individual visits

			with the nurse practitioner or social worker and/or outreach activities. In addition, provided 957 food orders serving 110 students, and made 33 free food deliveries to students and their families. ● **Pharmacy Assistance Program –** NHC utilizes BILH mail-order and specialty pharmacies to offer a Patient Assistance Program for patients with family income at or below 300% of the federal poverty level. The pharmacies are registered as a Health Safety Net (HSN) pharmacies and provides courtesy fills for low-income NHC patients to ensure those without insurance leave with their medication. o Baseline (FY23): NHC provided $74,500 in financial assistance to low income and/or uninsured patients. o Year #1 (FY24): NHC provided $283,357 in financial assistance to low income and/or uninsured patients.
● Racially, ethnically and linguistically diverse adults	Support and/or provide initiatives that provide job readiness and career development opportunities to obtain employment or employment with higher wages.	● Accelerating Access to Higher Education ● Career and academic advising ● Hospital-sponsored community college courses ● Hospital-sponsored English Speakers of Other Languages (ESOL) classes ● Career Pipeline Programs ● Provide community grants to address need	● **Wellspring House Accelerating Access to Jobs Program** – NHC awarded $20,500 to Wellspring House to provide intensive education, job training and career counseling to adults in the North Shore region to help them obtain employment or transition to employment with higher wages. o Baseline (FY23): 346 people completed the job training program and transitioned to higher paying jobs. o Year #1 (FY24): 346 350 adult students participated in Wellspring's education, job training and career advising programs

			● Number of employees enrolled in hospital-sponsored college courses (Baseline(FY23): 4; Year 1(FY24): 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes).
● Racially, ethnically, and linguistically diverse populations	Promote equitable care, health equity and health literacy for patients, especially those who face cultural and linguistic barriers.	● Interpreter Services	● **Interpreter Services -** NHC offers an extensive interpreter services program that provides interpretation (translation) and assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The interpreter services program also routinely facilitates access to care, helps patients understand their course of treatment, and helps patients adhere to discharge instructions and other medical regimens o Baseline (FY23): NHC interpreters reported 11,480 encounters. The top three languages were: Spanish – 1747, Portuguese – 721, Albanian – 172. o Year #1 (FY24): NHC interpreters reported 354,591 encounters. The top three languages were Spanish, Portuguese, and
● Older Adults ● People with disabilities	Increase access to health services and screenings for homebound individuals by reducing barriers to care	● Home Blood Draw ● Transportation Support ● Provide community grants to address need	● **Home Blood Draw Program:** Mobile Phlebotomy Team from the NHC Laboratory performed free homebound lab visits to patients who were homebound due to illness or transportation issues. Patients served reported

	such as transportation, illness, etc.		increased access as well as reduced feelings of isolation as the visit provided them with a social opportunity. o Baseline (FY23): 5,129 home blood draws performed. o Year #1 (FY24): The program was discontinued in FY24.

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.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Low-resourced populations	Organize/support impactful programs that stabilize or increase access to safe, affordable housing.	• Welcome Home Program • Provide community grants to address need	• **Action Inc. Welcome Home Program** - NHC awarded a $75,000 three year grant ($25,000 per year) to continue support for the Welcome Home Program to help chronically homeless people secure and/or maintain permanent housing and connect them with medical services to improve their overall health. o Baseline (FY23): 11 chronically homeless individuals secured and maintained permanent supportive housing, and 95% received care from a primary care physician. o Year #1 (FY24): 12 chronically homeless individuals secured and maintained permanent supportive housing, and 76% received care from a primary care physician. • **Massachusetts Coalition for the Homeless "CASA" Program –** NHC awarded a $45,000 three-year grant ($15,000 per year) to MCH to support the CASA Project, an upstream homelessness prevention model

			which embeds highly trained advocates inside community health centers and public schools to assist those facing a financial crisis to obtain or retain housing. o Baseline (FY23): 999 households received assistance with applying for affordable and/or elder/disabled housing, and 350 (34%) seeking assistance secured new/permanent housing. o Year #1 (FY24): 1,736 households received assistance with applying for affordable and/or elder/disabled housing.
● Youth ● Older Adults ● Low-resourced individuals ● Racially, ethnically, and linguistically diverse adults	Alleviate food insecurity and promote active living by advocating for system changes, increasing opportunities for physical activity, and providing healthy, low-cost food resources to communities.	● Senior Mobile Markets ● Medically Tailored Groceries Program ● Council on Aging Exercise Classes ● Provide community grants to address need	● **The Open Door Medically Tailored Groceries (MTG) Program** – NHC awarded a $75,000 three year grant ($25,000 per year) for continuation of the MTG program for food insecure, low-resourced individuals and families living in Gloucester and surrounding cities/towns. The program is managed by a Registered Dietitian who provides nutrition counseling and education sessions for those who have, or who are at risk for developing chronic illness. o Baseline (FY23): Provided the MTG program for 29 people, screened and connected 500

			clients to TOD Smart Choice meal plans, provided free nutrition counseling for 251 people, and 12 nutrition workshops for more than 120 participants. o Year #1 (FY24) Provided the MTG program for 20 people, screened and connected 800 clients to TOD Smart Choice meal plans, provided free nutrition counseling for 251 people, and 14 nutrition workshops for more than 120 participants. ● **Beverly Bootstraps Mobile Markets -** NHC awarded $15,000 to Beverly Bootstraps to deliver free fresh produce and nutrition information to older adults living in housing sites throughout Beverly. o Baseline (FY23): Provided weekly mobile markets to 12 housing sites in Beverly, achieving 5,000 resident encounters. More than 65% of the participants reported eating more fresh fruits and vegetables as a result of the markets. o Year #1 (FY24): Provided weekly mobile markets to 12 housing sites in Beverly, achieving more than 5,000

			resident encounters. Of those participants, 93% reported eating more fresh fruits and vegetables as a result of the markets.
● All	Advocate for policy, systems, programs, and environmental changes that address the Social Determinants of Health.	● Support relevant policies when proposed	● Number of bills NHC advocated for to address SDoH and access to care. (Baseline: data not available; Year 1: BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for 9 bills that supported access to services to address the root causes of poor health outcomes for all Massachusetts residents).

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**
● Older Adults ● Low-resourced populations ● Youth ● Racially, Ethnically, & Linguistically Diverse Populations	Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	● BILH Collaborative Care Model ● Centralized Bed Mgmt. ● Community Clinics/Counseling	● Addiction Consults o Baseline: 220 o Year 1: 160 ● Outpatient Mental Health Counseling o Baseline: 3,656 o Year 1: 1,408 ● **Collaborative Care Model**- NHC implemented the Collaborative Care Model, integrating Behavior Health clinicians into more than ten primary care sites in the CBSA. Clinicians provided convenient access to mental health services. o Baseline (FY23): 1.288 patients reached; Year 1 o Year #1 (FY24): The program was implemented in 11 sites reaching 1,430 patients
● Adults ● Youth ● Same cohorts as above for all strategies	Build the capacity of community members to understand the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.	● Mental Health First Aid ● Provide community grants to address need	● Number of community members trained in Mental Health First Aid (Baseline(FY23): 49; Year 1(FY24): 380) ● **Rendever Virtual Reality Program –** NHC awarded a $10,000 grant to SeniorCare to provide the Rendever Virtual Program to help older adults reduce feelings of anxiety, chronic stress, depression, and social isolation through the use of virtual reality (VR).

			○ Baseline (FY23): The Technology Navigator trained 6 staff members to facilitate the program for 63 older adults. ○ Year #1 (FY24): The Technology Navigator trained 3 additional staff members to facilitate the program, reaching a total of 90 older adults.
● Adults ● Youth	Implement/support evidence-based programs that promote healthy development, support children and families, and increase their resilience.	● Nurturing Parents Program ● Moms do Care Program ● Connecting Young Moms ● Provide community grants to address need	● **Compass Moms Do Care Program** - provided support for pregnant and parenting women with a history of substance use. In FY20 the COVID - 19 pandemic led to suspension of in - person groups and in - person behavioral health services. As a result, the program supported women through "porch visits," grocery runs, formula, and diaper assistance, and ongoing individual work. ○ Baseline (FY23): Provided support for 89 women, 77 of whom were new enrollees ○ Year #1 FY24): Provided support for 91 women, 80 of whom were new enrollees ● **Nurturing Parents Program** - NHC provided $20,000 to Pathways for Children in FY23 for continuation of the Nurturing Parents Program, a program designed to improve parenting skills and prevent child abuse and neglect. ○ Baseline (FY23): 11 fathers participated in the Nurturing Fathers program at the Middleton pre-release facility and 10 parents

			and 8 children participated in Nurturing Families in Beverly. All attendees demonstrated an increase in overall averages for all parenting skills, with final scores all falling in the high average category. o Year #1 (FY24): Eleven fathers enrolled in the January 2024 Nurturing Fathers Program held at the Essex County Correctional Center in Middleton, with 5 completing the program. In addition, 7 parents and 10 children participated in a Spanish speaking Nurturing Program in Beverly.
● Youth ● Adults	Improve systems for management and control of substance use disorder through education, reducing access to substances, and multidisciplinary efforts.	● Teach to Reach Recovery Coaches ● Ryan Recovery House ● BILH Behavioral Services (BILHBS) ● Detox/Opiate Treatment Services ● Medication Boxes ● NeedyMeds Program	● **Gloucester Police Department "Teach to Reach" Program** – NHC awarded $15,000 to the Gloucester Police Department for continuation of the "Teach to Reach" program designed to increase peer to peer recovery coach services and job training and workforce development opportunities in the community. o Baseline (FY23): 20 participants graduated from the "Teach to Reach" program and 17 of the graduates earned Recovery Coach Certification. o Year #1 (FY24): 25 participants graduated from the "Teach to Reach" program and have been recovery coaches and/or have gained employment in addiction recovery services.

			● **BILH Behavioral Services -** provided individual and group mental health counseling services in the community for children and adults with mental health issues. o Baseline (FY23): Counseling sessions held in Beverly, Gloucester, and Danvers reached 3,656 people, and intensive care coordination and family support and training was provided to more than 300 youth meeting serious emotional disturbance criteria. o Year #1 (FY24:) More than 40,000 counseling sessions were held in Beverly, Gloucester, and Danvers reaching 1,408 people. ● **Medication Disposal Box** - NHC invested in a medication disposal box located in the Emergency Department at Beverly Hospital. The box helps community members safely dispose of unwanted or expired medications to remove potentially dangerous medications from the community and reduce the risk of unintentional use. Medications can be dropped off 24 hours a day/7 day a week and are safely disposed of in accordance with Drug Enforcement Agency regulations. o Baseline (FY23): 1,500 pounds of unwanted medications were collected and disposed of

			○ Year #1 (FY24): collected and disposed of 435 pounds of unwanted medications ● **The High Risk Intervention Team (HRIT)** - a multidisciplinary team with pharmacists, social workers, RNs, community health workers, and recovery coaches that provides services to high risk clients to support their complex needs, including but not limited to medication education and pill box setup, home visits, accompaniment to PCP appointments, rounds in Skilled Nursing Facilities (SNFs) to coordinate discharge care, assistance with obtaining insurance, assistance getting needed community and mental health services, assistance with recovery services for substance use disorders, assistance with housing needs, assistance obtaining food sources, and any and all interventions designed to assist patients to be cared for in their homes or a community setting. ○ Baseline (FY23): 5,520 patients were served. Of all the patients served, 80% had a public payor (Medicare or Medicaid) and 40% had a mental health diagnosis or substance use disorder. ○ Year #1 (FY24): Program discontinued ● NHC provides financial support for the NeedyMeds Program. (Baseline(FY23): NHC provided $1,000 to support the

			NeedyMeds Program, Year 1(FY24): data not available)
● Youth	Participate in multi-sector community coalitions to convene collaborators to identify and advocate for policy, systems, and environmental changes to increase resiliency, promote mental health, reduce substance use, and prevent opioid overdoses and deaths.	● DanversCares ● Be Healthy Beverly ● Ipswich Aware	● Number of mental health/substance use focused coalitions NHC participates in and/or supports (Baseline(FY23): NHC staff were actively engaged with 3 community coalitions focused on mental health/substance use; DanversCares, Ipswich Aware and Be Healthy Beverly, Year 1(FY24: NHC staff were actively engaged with 3 community coalitions focused on mental health/substance use; DanversCares, Ipswich Aware and Be Healthy Beverly).

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**
● Youth ● Adults	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.	● Enhance fitness ● Breast Cancer Risk & Assessment ● Health Screenings ● High Risk Intervention Team (HRIT) ● Oncology Nurse Navigator ● Provide community grants to address need	● **BCRA** - Recognizing the risk for breast cancer is not the same for all women, NHC provided free risk assessment at Beverly and Addison Gilbert Hospitals using a tablet screening tool to help women evaluate their lifetime risk for breast cancer. Results from the assessment are shared with the person's physician, are reviewed in a follow up consultation to determine if they might benefit from a higher level of screening beyond regular checkups and mammograms. o Baseline (FY23): Conducted 3,962 free screenings, identifying 1,222 women with a high lifetime risk of developing breast cancer. o Year #1 (FY24): Conducted 7,552 free screenings, identifying 2,358 women at high risk and 1,340 with a high lifetime risk of developing breast cancer ● **Oncology Nurse Navigators** – Oncology nurse navigators at Northeast Hospital Corporation support patients by connecting them with community resources, including health care and support services and assisting them in the transition from active treatment to survivorship. o Baseline (FY23): The Oncology Nurse Navigators at NHC dedicated 7,931 hours to assist more than 900 patients and their families or caregivers.

			○ Year # 1 (FY24): The Oncology Nurse Navigators at NHC served 1,633 patients and their families. ● **Enhance Fitness** – NHC awarded $38,500 to the North Shore YMCA annually to provide free Enhance Fitness classes to help participants improve overall health and increase their physical ability and activity level. ○ Baseline (FY23): 100 community members participated in the program at three locations in the community. As per a participant survey, 76% of the participants reported that they maintained or increased their feeling of general overall health after participating in the program and 84.5% of the participants reported their physical abilities improved after participating in the program. ○ Year #1 (FY24): 80 community members participated in the program at three locations in the community as of September 30, 2024. Of the participants more than 20% were economically disadvantaged.

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

FY26-FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Northeast Hospital Corporation (NHC) consists of multiple entities organized to serve the needs of those in its communities (referred to throughout this report as BH/AGH). With a consistently recognized reputation for high-quality care and safety, Beverly Hospital is home to centers of excellence in maternal-newborn health, cardiovascular services, orthopedics and general surgical services. There are 373 licensed inpatient beds across three campuses, with more than 2,500 employees and over 1,000 clinicians on active medical staff. Addison Gilbert Hospital is an acute care facility in Gloucester with specialties in emergency medicine, adult inpatient care, oncology services and ambulatory services. BayRidge Hospital is an inpatient psychiatric care facility in Lynn that offers high-quality mental health care, as well as substance use disorder treatment and partial-hospitalization and outpatient services.

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 BH/AGH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BH/AGH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage BH/AGH's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

BH/AGH collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). BH/AGH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for 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, BH/AGH conducted 18 one-on-one interviews with key collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 2,100 residents, and organized a community listening session. In total, the assessment process collected information from more than 2,200 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

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

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

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

The following goals and strategies are developed so that they:

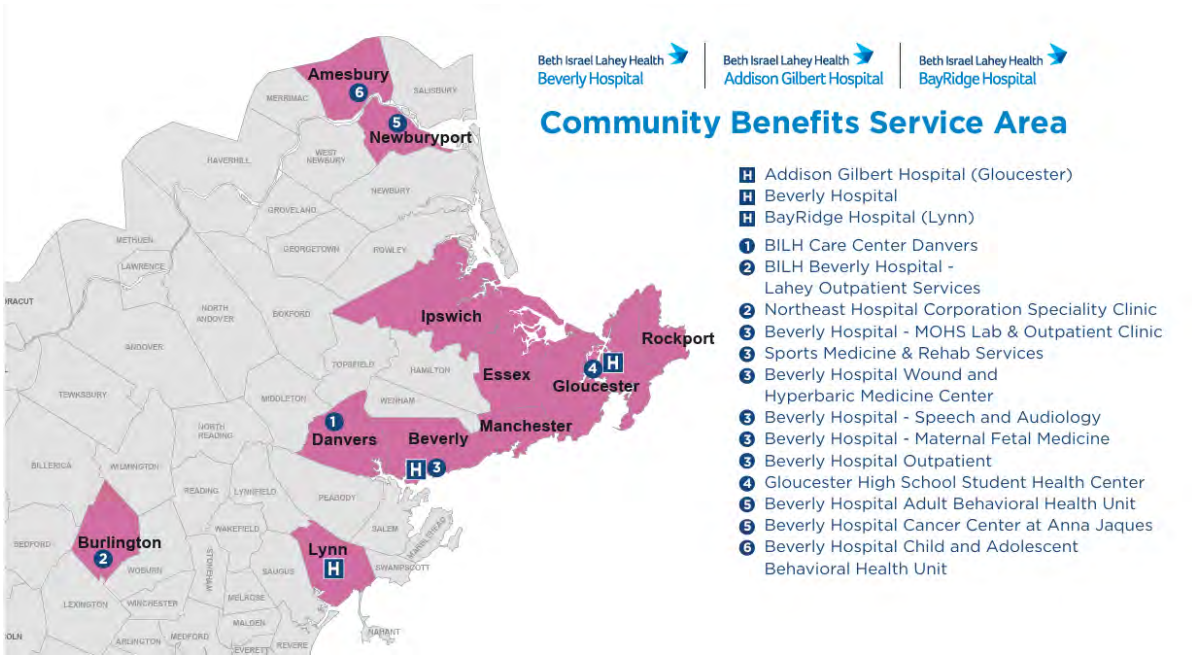
- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the systemic, fair, and just treatment of all people
- Could be scaled to other BILH hospitals
- Are flexible to respond to emerging community needs

Recognizing that community benefits planning is ongoing and will change with continued community input, BH/AGH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. BH/AGH is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

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

BH/AGH's CHNA focused on identifying the leading community health needs and priority populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities. By prioritizing these cohorts, BH/AGH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.



Prioritized Community Health Needs and Cohorts

BH/AGH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the 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.

BH/AGH Priority Cohorts

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

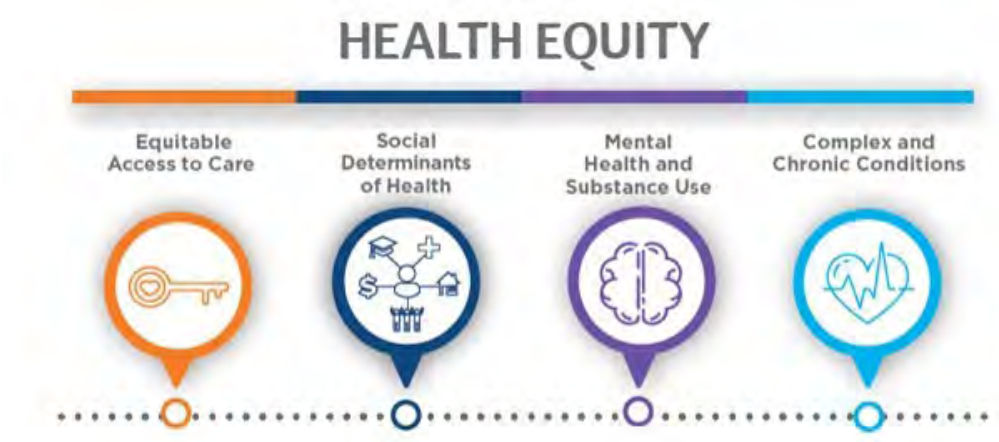
Community Health Needs Not Prioritized by BH/AGH

It is important to note that there are community health needs that were identified by BH/AGH's assessment that were not prioritized for investment or included in BH/AGH's IS. Specifically, improving the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in BH/AGH's IS. While these issues are important, BH/AGH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, BH/AGH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. BH/AGH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in BH/AGH's IS

The issues that were identified in the BH/AGH CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, transportation, economic insecurity, access to affordable childcare, language and cultural barriers to services, long wait times, navigating the health care system, health insurance and cost barriers, youth mental health, depression/anxiety/stress, substance use, lack of behavioral health providers, social isolation among older adults, youth substance use, behavioral health education and prevention, community-based chronic disease education and screenings, conditions associated with aging, maternal health, and chronic disease (e.g., cardiovascular disease, diabetes, cancer).

BH/AGH 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: BH/AGH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BH/AGH and/or its partners to improve the health of those living in its CBSA. Additionally, BH/AGH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BH/AGH supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BH/AGH will continue to commit resources through the same array of direct, in-kind, 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	• Health insurance eligibility and enrollment assistance services • 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 people served/enrolled • # of referrals made • # of sessions conducted	• Local primary and secondary schools • Hospital-based activities
Advocate for and support policies and systems that improve access to care.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital -based activities

Priority: Social Determinants of Health

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• Low-resourced populations • Older adults	• Food access, nutrition support, and education programs and activities • Fitness and education programs and activities	• # of people served • # of pantries/ farmers markets • # of classes organized	• 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	• Housing assistance, navigation, and resident support activities • Housing stability and homelessness prevention programs and activities	• # of people/ families served • # of people who secured housing	• 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
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation.	• Low-resourced populations • Older adults	• Transportation and rideshare assistance programs	• # of people served • # of rides provided	• Local/regional public transportation agencies • Hospital-based activities
Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.	• All priority populations	• Career advancement and mobility programs	• # of employees served • # of people hired • # of classes organized	• Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• All priority populations	• Medication/needle disposal programs	• Pounds of medication disposed of • # of needles disposed of	• Hospital-based activities
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Primary care and behavioral health integration and collaborative care programs • Expand access to services for individuals and families • Health education, awareness, and wellness activities for all age groups • Crisis intervention and early response programs and activities • Participation in community coalitions	• # of people served • # of referrals made • # of clinical practices supported • # of classes organized • # of community meetings attended	• 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: BH/AGH expends substantial resources to achieve the goals and objectives in its IS. These resources are expended, according to its current

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	• All priority populations	• Medically prescribed meals to support chronic disease management • Chronic disease management, treatment, and self-care programs • Cancer education, wellness, navigation, and survivorship support programs • Fitness, nutrition, and healthy living programs and activities • Support groups (peer and professional-led)	• # of people served/screened • # of classes organized • # of counseling sessions held • Amount of materials distributed	• Private, non-profit, and health-related agencies • Hospital-based activities
Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.	• Low-resourced populations	• Culturally responsive prenatal/postnatal case management and care coordination programs • Prenatal/postnatal peer support groups	• # of people served • # of people referred	• Hospital-based activities
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

General Regulatory Information

Contact Person:	Marylou Hardy, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 11, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 11, 2025
Date written plan was required to be adopted	February 15, 2026
Authorized governing body that adopted the written plan:	Northeast Hospital Corporation Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 8, 2022
Name and EIN of hospital organization operating hospital facility:	Northeast Hospital Corporation 04-2121317
Address of hospital organization:	85 Herrick Street Beverly, MA 01915

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital