Beth Israel Lahey Health
Lahey Hospital & Medical Center

2025 Community Health Needs Assessment

Acknowledgments

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

LHMC 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.

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

Lahey Hospital & Medical Center (LHMC) is a world-class, tertiary academic medical center providing comprehensive care to communities across northeastern Massachusetts and southern New Hampshire. LHMC has 333 licensed inpatient beds with more than 6,100 employees and over 1,200 clinicians on active medical staff. With close collaboration between specialties and satellites in multiple communities, LHMC offers distinctly integrated care and the most advanced services available north of Boston. LHMC is a teaching hospital and regional medical campus of University of Massachusetts' Chan School of Medicine. Lahey Medical Center, Peabody operates under the LHMC license and is a full-service, community-based hospital and medical center with 10 inpatient beds, an emergency department, as well as outpatient services, diagnostic imaging and an on-site bloodwork lab, pharmacy and more.

LHMC 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, LHMC 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. LHMC, 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 LHMC's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that LHMC 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 LHMC to engage the community and strengthen the community partnerships that are essential to LHMC's success now and in the future. The assessment engaged more than 1,500 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, government officials, and community residents.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of LHMC's mission. Finally, this report allows LHMC 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 LHMC's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that LHMC 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, LHMC completed its last assessment in the summer of 2022 and the report, along with the associated 2023-2025 IS, was approved by the LHMC Board of Trustees on September 12, 2022. The 2022 CHNA report was posted on LHMC'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 LHMC's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 8, 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 LHMC's CBSA.

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

Description of Community Benefits Service Area

LHMC's CBSA includes the nine municipalities of Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody in Middlesex and Essex Counties in the MetroWest and Northeast portions of 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 LHMC'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. LHMC 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. LHMC is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

LHMC'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, LHMC 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, LHMC is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

The LHMC CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns where LHMC operates licensed facilities. LHMC's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. While LHMC operates a licensed facility in Danvers, this service location is within Beverly and Addison Gilbert Hospital's (BH/AGH) CBSA. As a result, the community benefits activities for Danvers have been delegated to BH/AGH. This helps to ensure that activities are properly coordinated and address the identified needs.

Assessment Approach & Methods

Approach

It would be difficult to overstate LHMC's commitment to community engagement and a comprehensive, datadriven, collaborative, and transparent assessment and planning process. LHMC'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 experiencing homelessness, 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 LHMC and other BILH hospitals to conduct the CHNA. LHMC worked with JSI to ensure that the final LHMC 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 LHMC's assessment and planning activities. LHMC's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and 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 LHMC's staff in the CBAC promotes transparency and communication as well as ensuring 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 LHMC'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, LHMC collected a wide range of quantitative data to characterize the communities in the hospital's CBSA. LHMC 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 2025 LHMC 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, LHMC applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, LHMC 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, LHMC conducted 15 one-on-one and group 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 1,500 residents, and organized a community listening session. In total, the assessment process collected information from nearly 1,600 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

15 interviews
with community leaders

1,519 survey respondents

5 focus groups

- Individuals living in public housing
- Cambodian older adults
- Youth
- Survivors of domestic violence
- Individuals who are unstably housed or experiencing homelessness

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 LHMC. Community Benefits staff reviewed LHMC'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 is to identify available community resources in the CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

The LHMC 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 LHMC 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 LHMC's existing IS was augmented, revised, and tailored. When developing the IS, LHMC'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 LHMC'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 LHMC'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 LHMC's website, alongside the 2022 CHNA report and 2023-2025 IS, for easy viewing and download. As with all LHMC 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 LHMC'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 LHMC'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.

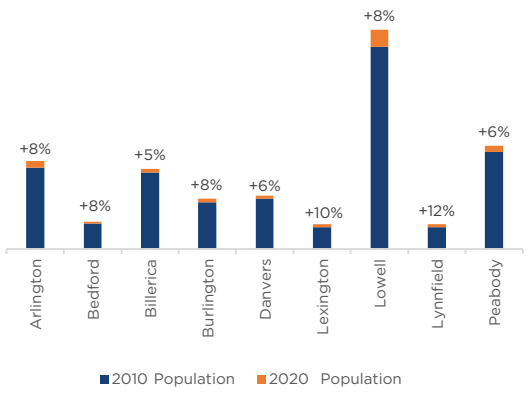
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the LHMC CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA are predominantly white and born in the United States, there are people of color, persons whose first language is not English, and foreign-born persons 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 LHMC's CBSA increased by 8%, from 348,158 to 374,763 people. Lynnfield saw the greatest percentage increase (12%) and Billerica saw the lowest (5%).

Population Changes by, Municipality, 2010 to 2020



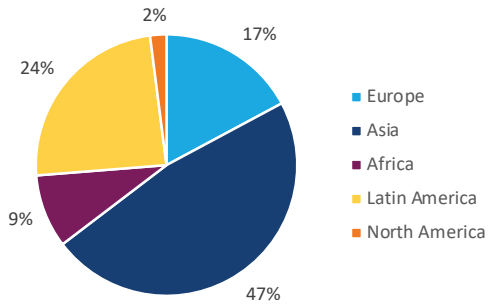
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

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]

22% of the LHMC 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]

28% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

37% 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]

18%

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/Wiliams, 2023

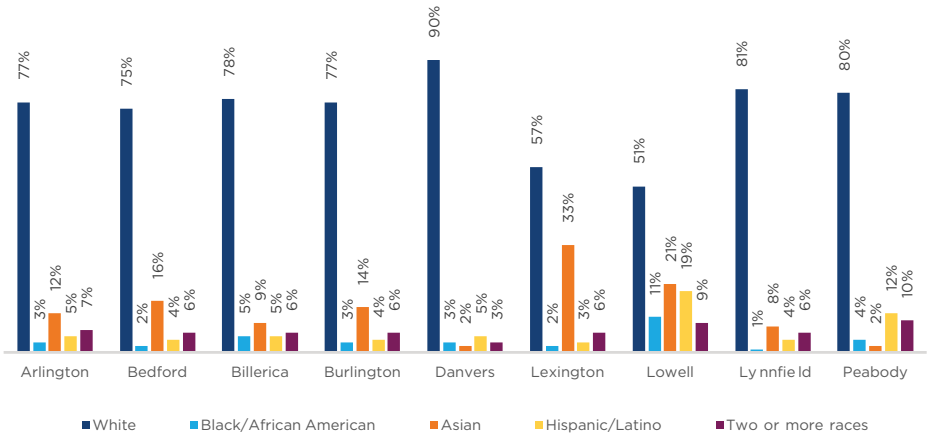
21% of LGBTQIA+ adults in Massachusetts are raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

LHMC's CBSA is diverse. Compared to the Commonwealth overall, the percentage of residents who identify as Black/African American is higher than the Commonwealth (7%) in Lowell (11%); the percentage who identify as Asian is higher than the Commonwealth (7%) in Arlington (12%), Bedford (16%), Billerica (9%), Burlington (14%), Lexington (33%), Lowell (21%), Lynnfield (8%); the percentage who identify as Hispanic/Latino is higher than the Commonwealth (13%) in Lowell (19%).

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]

31% of LHMC CBSA households included one or more people under 18 years of age.

33% of LHMC 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 LHMC'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 LHMC 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.

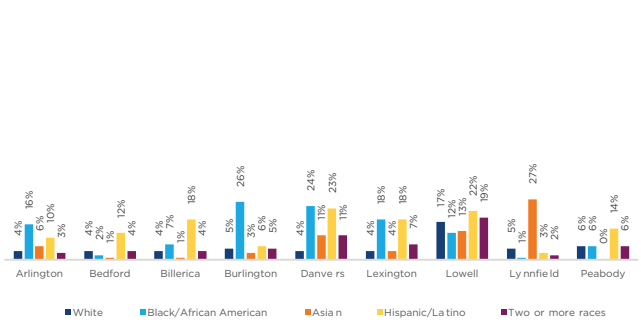
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care, particularly for those without personal vehicles or support networks.

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]

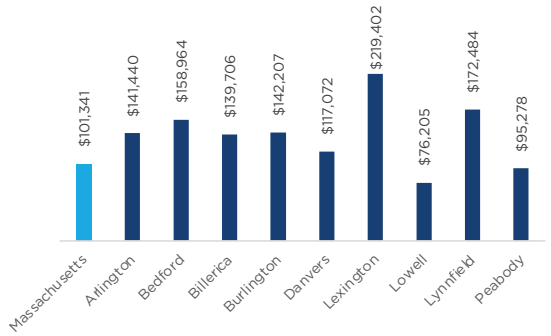
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains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

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



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

Median Household Income, 2019-2023

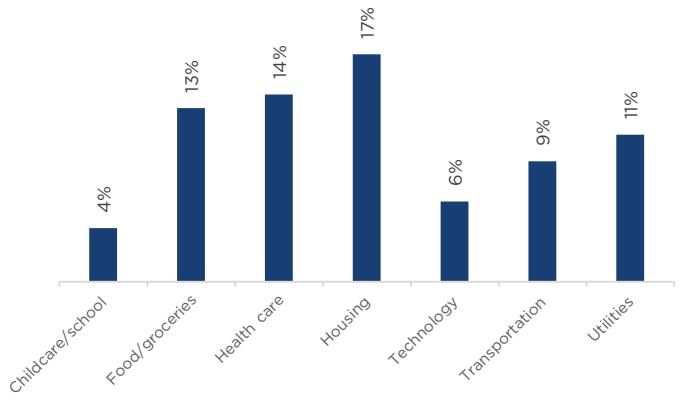


Source: US Census Bureau American Community Survey, 2019-2023

Across the LHMC CBSA, the percentage of individuals living below the poverty level tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of cumulative disadvantage over time.[12] Median household income is the total gross income before taxes, received within a one-year period by all members of a household. Median household income was higher than the Commonwealth in all CBSA communities with the exceptions of Lowell and Peabody.

In the 2025 LHMC Community Health Survey, survey respondents reported having trouble paying for 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



Source: 2025 LHMC Community Health Survey

Education

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

92% of CBSA residents 25 years of age and older have a high school degree or higher.

48% 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

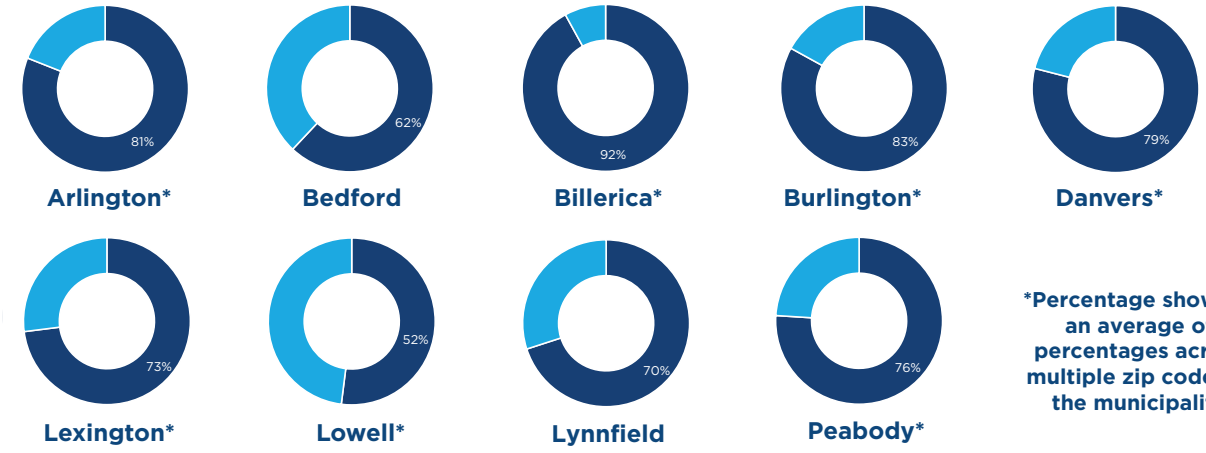
Food Insecurity and Nutrition

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.

12% of CBSA households received Supplemental Nutrition Assistance Program (SNAP) benefits within the past year. SNAP provides benefits to low-income families to help purchase healthy foods. The data below shows the percentage of residents who are eligible for SNAP benefits but not enrolled, highlighting a gap in food assistance access that may reflect barriers related to awareness, enrollment processes, or other inequities.

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



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

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

Neighborhood and Built Environment

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

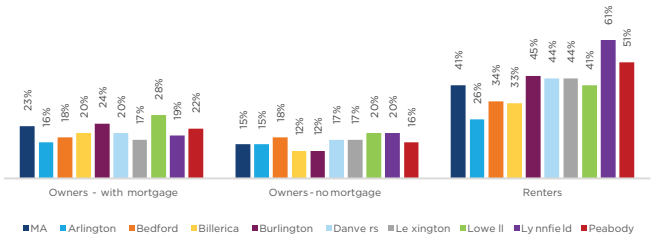
Housing

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

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

The percentage of owner-occupied housing units with housing costs in excess of 35% of household income was lower than the Commonwealth in most municipalities. Among renters, percentages were higher than the Commonwealth in Burlington, Danvers, Lexington, Lynnfield, and Peabody.

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,

48% of 2025 LHMC Community Health Survey respondents said "more affordable housing."

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

Source: 2025 LHMC 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 also 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:

40% of 2025 LHMC Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 LHMC Community Health Survey

9% of housing units in the LHMC 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 and bike lanes 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 LHMC Community Health Survey prioritized these improvements to the built environment.

35% of 2025 LHMC Community Health Survey respondents identified a need for better roads.

41% of 2025 LHMC Community Health Survey respondents identified a need for better sidewalks and trails.

Source: 2025 LHMC Community Health Survey

Systemic Factors

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

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of color, persons whose first language is not English, foreign-born individuals, individuals living with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment reinforced the challenges that residents throughout the LHMC CBSA face 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 full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

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

> "I haven't had a PCP in over 10 years. It is very difficult to find a good one who accepts my insurance and is taking new patients."
>
> - Survey respondent

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 the LHMC 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 are doing great work, but depending on how long they've been around, they don't necessarily have the historical perspectives on how best to come together. A lot of work is individualized - organizations doing things on their own instead of partnering up. It would be incredible for organizations to collaborate more within towns and with other communities."

-Interviewee

Behavioral Factors

The nation, including the residents of Massachusetts and LHMC'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 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 LHMC'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 LHMC Community Health Survey respondents said they would like their community to have better access to healthy food.

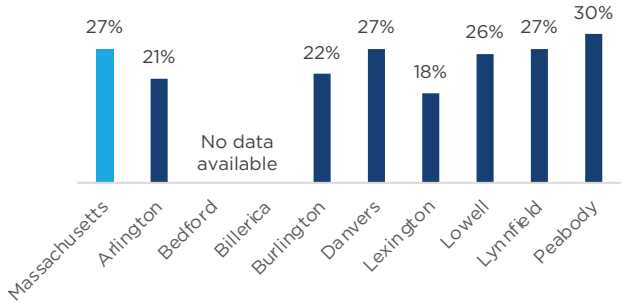
Source: 2025 LHMC Community Health Survey

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the LHMC 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 the same or higher than the Commonwealth in Danvers, Lynnfield, and Peabody.

Percentage of Adults Who are Obese, 2022



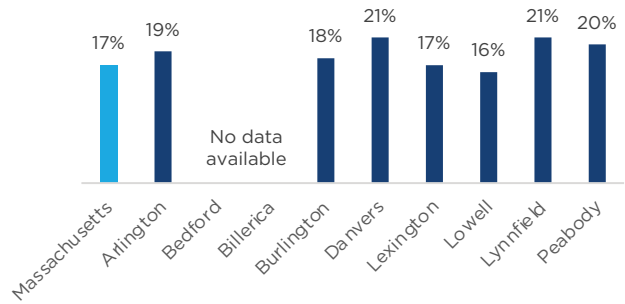
Source: CDC PLACES, 2022

Alcohol, Marijuana, and Tobacco Use

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

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

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC PLACES, 2022

Health Conditions

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

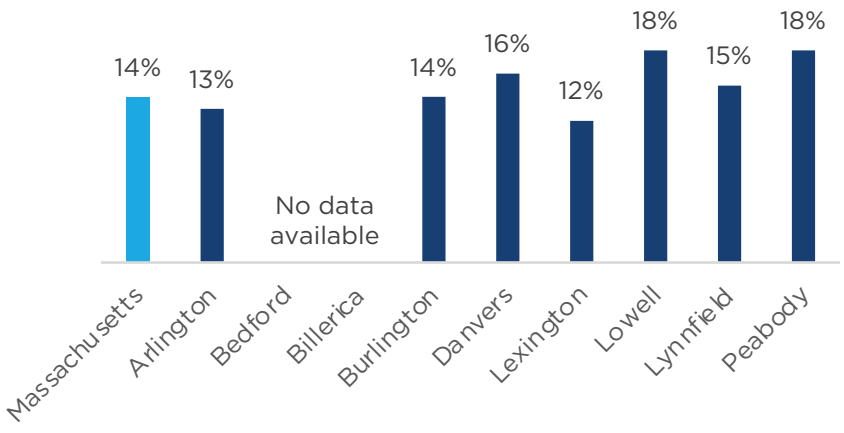
26% of 2025 LHMC Community Health Survey respondents said that health care in their community does not meet people's mental health needs.

Source: 2025 LHMC Community Health Survey

51%

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

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



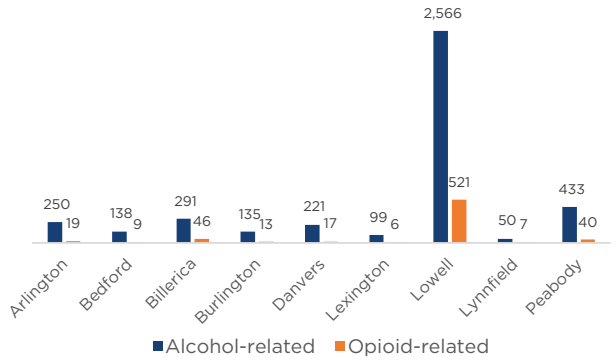
Source: CDC PLACES, 2022

Health Conditions

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

Looking across LHMC's CBSA, there were more alcohol-related emergency visits than there were opioid-related visits. The highest number of visits for both substances were in Lowell.

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



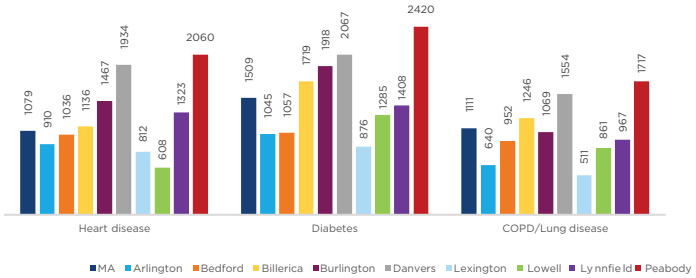
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

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 three 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 Billerica, Burlington, Danvers, and Peabody.

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



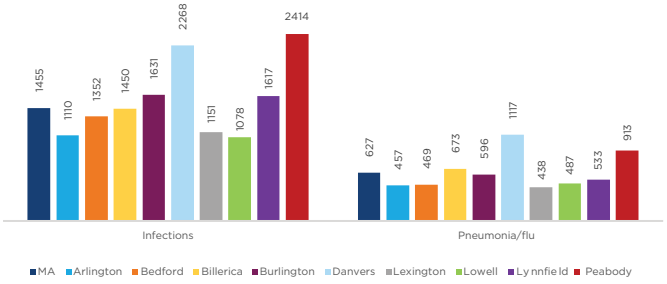
Source: Center for Health Information and Analysis, 2024

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 Danvers and Peabody had higher inpatient discharge rates for pneumonia/flu compared to the Commonwealth. Burlington, Danvers, and Peabody had higher discharge rates for infections.

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 Implementation Strategy (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, LHMC'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 LHMC's IS. This prioritization process helps to ensure that LHMC 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)*

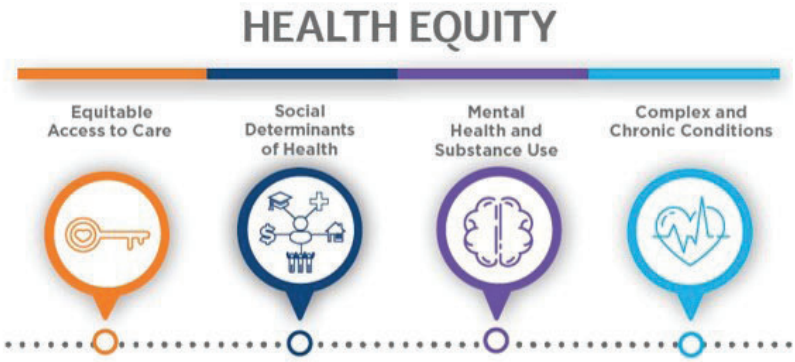
Community Health Priorities and Priority Cohorts

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

LHMC Community Health Needs Assessment: Priority Cohorts

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

LHMC Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by LHMC

It is important to note that there are community health needs that were identified by LHMC's assessment that were not prioritized for investment or included in LHMC's IS. Specifically, issues related to the built environment (i.e., improving roads/sidewalks and access to physical activity) were identified as community needs but were not included in LHMC's IS. While these issues are important, LHMC'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, LHMC recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. LHMC 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 LHMC's IS

The issues that were identified in the LHMC CHNA and are addressed in some way in the hospital's IS are housing issues, transportation barriers, language and cultural barriers to services, food insecurity, economic insecurity, long wait times for care, health insurance and cost barriers, emergency preparedness, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive/navigation services for individuals with substance use disorder, community-based behavioral health education and prevention programs, trauma, conditions associated with aging, healthy eating/active living, community-based chronic disease education and prevention, maternal health equity, and caregiver support.

Implementation Strategy

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

Included below, organized by priority area, are the core elements of LHMC'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 LHMC 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

LHMC 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 LHMC and/or its partners to improve the health of those living in its CBSA. LHMC 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, LHMC 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, LHMC'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. LHMC 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 LHMC 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.

- Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.
- Support community/regional programs and partnerships to enhance access to affordable and safe transportation.
- Advocate for and support policies and systems that address social determinants of health.

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

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

Evaluation of Impact of 2023-2025 Implementation Strategy

As part of the assessment, LHMC evaluated its current IS. This process allowed LHMC 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, LHMC and all BILH hospitals will review community benefits programs through an objective, consistent process.

For the 2023-2025 IS process, LHMC 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. LHMC 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	LHMC addressed social determinants through investments in transportation, housing, workforce, food access, and multi-sector partnerships. The hospital funded nine community grants, supported 33,000 rides for older adults, and increased partnerships to address the needs of newly-arrived families into the region. Workforce efforts included internships, employment workshops, job training, and supplier diversity contracts totaling $70 million. LHMC also invested in housing stabilization, helping families to avoid homelessness and access social services. Food access was expanded through community gardens, cooking classes, and produce distribution programs that served thousands of individuals, including 100 families through Citizens Inn and 175 older adults through farmers markets.
Equitable Access to Care	LHMC advanced equitable access through language services, patient navigation, financial counseling, and workforce development. Interpreter encounters increased dramatically across LHMC and its community health center partners, reaching over 225,000 in FY24. The hospital supported low-income and diverse patients through financial counseling, insurance enrollment, and school-based health services. Workforce equity initiatives included ESOL, career advising, internships, and job training for healthcare roles, wit h over 100 community members trained and 107 internships provided across BILH. LHMC also expanded career pipelines through partnerships with local schools and health centers.
Mental Health and Substance Use	LHMC strengthened mental health and substance use services through school partnerships, navigator programs, grantmaking, and outpatient care. It supported organizations like the Center for Hope and Healing and Place of Promise, provided funding for youth resilience efforts, and expanded mental health services in schools. Over 350 people participated in Mental Health First Aid trainings, and programs served culturally diverse communities, including older Cambodian adults and Portuguese- and Spanish-speaking residents. Through BILH Behavioral Health services, LHMC also expanded outpatient behavioral health care and recovery support, provided over 5,700 emergency psychological evaluations, and operated addiction services and trauma survivor groups to improve access and outcomes.
Complex and Chronic Conditions	To support individuals with chronic and complex conditions, LHMC provided cancer screening, chronic disease management, and wellness programming. The hospital conducted over 14,000 breast cancer risk assessments, with oncology nurse navigators supporting daily patient care. Chronic disease prevention programs included diabetes management, bone health classes, Tai Ji Quan, and fall prevention programs. LHMC also supported older adults through memory cafés, fitness classes, and Council on Aging programs, with participants reporting improved health, mobility, and reduced isolation. These services were tailored to meet the needs of older adults, low-income residents, and racially and ethnically diverse populations.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: 2026-2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

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

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

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

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

Are there any questions before we begin?

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

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

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

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

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

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

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

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

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

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

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

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

Lahey Hospital & Medical Center
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Peabody Municipal Leaders
- Burlington Municipal Leaders
- Billerica Municipal Leaders
- Bedford Municipal Leaders
- Lexington Municipal Leaders
- Lowell Municipal Leaders (in collaboration with Greater Lowell Health Alliance)
- Maggie Brennan, President and CEO, North Shore Community Health
- Coral Hope, Health Director, Town of Lynnfield
- Renata Ivnitskaya, Director of Residential Nursing, Northeast Arc
- Andy Sloane, Rainbow Coalition, Town of Arlington
- Agnes Misigah, Director of Housing, Policy, and Practice, Centerboard
- Griffin Jones (Commissioner) and Drake Pusey (Co-Chair), Arlington Human Rights Commission
- Birgitta Damon, CEO, LEO Inc.
- Senior Taskforce, Greater Lowell Health Alliance (in collaboration with Greater Lowell Health Alliance)
- Josh Eigen, Community Behavioral Health Center Director, Eliot Community Health Services

Community Health Priority Areas

Social Determinants of Health

- Community and Family Support
    - Parental stigma can prevent children, especially LGBTQIA+ youth, from accessing health, medical, housing and other resources
    - Lack of community spaces, especially for older adults
- Food Insecurity
    - SNAP and food banks provide important food access to communities in the region
    - Farming partnerships help expand access to produce which otherwise is too expensive
- Economic Insecurity
    - Need for additional education on financial literacy and long-term planning
    - Many students leaving school to work
    - Challenge of work authorization for individuals depending on immigration status
- Transportation
    - Difficult to travel without a car, especially if you do not live close to a main bus line
    - Lack of consistent transportation is a barrier for employment and healthcare access
    - Some organizations provide additional transportation vans for seniors, but the schedules are limited
- Housing
    - Price of housing has risen significantly; while some housing supports are available, they are typically short-term assistance
    - Quality and safety of housing for older adults living in place is a challenge

    - There is a limited amount of housing available, especially affordable housing units
    - Increase in temporary housing through shelters and hotels
- Community Safety
    - Gun violence, especially in schools, is a growing concern
        - Rise of programs like Stop the Bleed, CPR/first aid classes
    - Need for additional programming to address bullying, domestic violence and abuse

Access to Care

- Importance of having a trusted and non-judgmental relationships with healthcare providers
    - Some populations are fearful they will be punished for not having insurance or residency paperwork
    - Need for additional outreach and advocacy around school and provider safety
    - Addressing provider stigma; ensuring symptoms are treated and taken seriously rather than individuals being overlooked because of their condition or identify
- Concerns about ensuring access to sexual health, preventative health, and gender-affirming care
- Telehealth has helped ease the transportation barrier for many patients, but is not sufficient for all appointments
- Lack of primary care providers; many doctors are leaving the region
- Lack of free preventative care access in the community, especially for adults
- Need for expansion of access to home health care services and community care van models
- Need for culturally competent medical providers and translation services
- Program and Insurance Navigation
    - Need for additional social workers and support to assist in health system navigation and insurance registration, especially for MassHealth
    - Need for additional support in understanding healthcare billing, referrals, and telehealth
- Continuity of care is a challenge, especially for older patients and patients with memory needs
    - Increasing push to discharge patients quickly, making it harder to transition care or connect patients with resources

Mental Health and Substance Use

- Mental Health
    - LGBTQIA+ populations
    - Addressing stigma and fear in the community
    - Schools serve as first mental health resource for youth, but also sources of bullying and stress
        - Many services are only during the school year; gap in care during summers
    - Access to in-home services remains a challenge, even with expanded laws
    - Rise in loneliness, isolation, and hoarding challenges in older adults
    - Late diagnoses
- Substance Use
    - Opioid and alcohol misuse

Chronic and Complex Conditions

- Lyme Disease, cardiac disease, dementia, diabetes, hypertension, and chronic stress are common chronic conditions in the community
- More resources are needed on education for managing chronic conditions and healthy nutrition
- Need for additional resources for children/caretakers of elderly parents

- Falls are common driver of medical care for older populations in the community, but other conditions are identified during the appointment as well

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
    - LGBTQIA+

- Interviewees also identified concerns for individuals who are captured by the intersectionality of the priority populations (ex. An older adult who is LGBTQIA+ and a person of color), individuals living with disabilities, individuals with limited digital literacy or access to technology, individuals that are homeless/unstably housed, and caregivers

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout Lahey Hospital's region such as: LGBTQ Aging Project, Human Rights Commission, Disability Commission, Rainbow Commission, Council on Aging, Arlington Youth Counseling, Parents and Friends of Lesbians and Gays (PFLaG), Gleaner's Club, Gaining Grounds, Bedford At-Risk Group, Hoarding Task Force, Stroke Foundation, Northeast Independent Living, Lynn Community Health Center, Minuteman, Burlington Youth and Family Services, Lion's Club, Healthy Lynnfield, Homelessness Task Force, Haven from Hunger, Healthy Collaborative, NASCAP, Elliot Behavioral Health Services, Peabody Housing Authority, Haverhill Collaborative

- Municipal leadership, emergency services, religious organizations, schools, health departments, libraries, food/community pantries, and affinity groups are common organizations for collaboration
- Many programs were lost during COVID; organizations now need to re-establish funding sources and partnerships
- Desire across interviewees for increased communication and collaboration with Lahey Hospital

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

LHMC
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Eliot Day Center
Location: Eliot Day Center
Date, time: 9/5/2024
Facilitator: Greater Lowell Health Alliance
Approximate number of participants: 8

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Working out every day and going to the gym
    ii. Walking
    iii. I don't have a car so I have to walk. I got to get from point a to point b somehow.
    iv. Trying to eat the right food
    v. Getting the proper rest – that's where it all starts
    vi. Drinking enough water and staying hydrated
b. **What stops you from being as physically healthy as you'd like to be?**
    i. I take so much medication that it's hard to remember to take it and it's a lot of work.
    ii. Not having a solid foundation or structure. Living day to day and not knowing what tomorrow will bring, especially when you're not housed. Being in an unstructured environment and always wondering what your next move is.
    iii. Rent is so expensive around here.
    iv. Nothing stops me from being physically healthy except economic limitations. You're free to walk and go to the park when you want. There's no realistic reason not to feel physically healthy, except laziness.

Question 2

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?**
    a. Therapy, medication, and maintenance programs
    b. Making sure you have the right dose of medication. I had to change multiple times.

c. Things weren't working for me when I wasn't taking my medications. I didn't have a psychologist and thought I was doing well on my own. Then I realized how serious mental health is. I don't want to play with it anymore. I'm on 30 pills but it helps me get through the day.
d. We all know each other here. You can see the difference when people are taking their medications and not taking them. Someone needs to address it, but it's the manner that you address it in. When you address your situation, everything is good. Life still goes on.
e. Speak up for yourself and let people know how medication makes you feel. You need to know what works best for you. A lot of people don't know how to speak up for themselves.
f. I didn't even know what PTSD was. I came from a country with a traumatic civil war. I was held as a prisoner of war. I was having dreams, sweating, and starting drinking to drown out those things. It led to alcoholism. I had to go to rehab and those medications had their own side effects. I would be sick to my stomach. It worked a bit, but made me feel sicker so I stopped taking them. What else is there to take? What else do we need to do so we don't need to think of the demons? I made an effort to go to rehab. It started working and I feel better.
g. Find someone to talk to that you feel comfortable with.
h. Start journaling.

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

a. Many people think that being hospitalized is a bad thing.
b. A staff member said that they have had people stop taking their medication because they don't want to take it anymore.
c. Some people take medication and it changed the way they were. They want to be one way, but the medication changes who they are.
d. Shame
e. Setbacks
f. Pride
g. Death

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. A lot of people don't know about the community resources and lack the knowledge about what's available. Some people expect that others will do the work for them. I used to work at Stepping Stone in New Bedford and the model was that they would do ten steps before I could help them with one. Put the effort into helping yourself and then people will want to help you.

b. Social problems are synonymous with the economic problems – not heaving enough and you need to rely on government subsidies to survive. The bureaucratic system of hurrying up and waiting. The red tape. A lot of people give up. The take home pay is not enough to take home. We don't make enough to keep our heads above water. It's enough to keep the masses satisfied. You can't say too much, because who is going to hear you. The system keeps going on. The economic problems lead to the downfall of a lot of people. The government needs to put more funds just to do a little bit more. We have no choice and nowhere else to get it. When you're backed into the wall, the problems start.
c. We're comfortably numb. It's a vicious cycle.
d. I relapsed and am no better than anyone else. I hang out here every day. I don't forget where I came from. There's not enough help for any of us.
e. Everyone has a struggle, like mental health or alcoholism. People become the product of their environment and become complacent. You gravitate to where and who you know.
f. The housing problem right now. There's only so much I can do when I'm being told we need a case manager for the housing project. Hurry up and wait. I've gotten paperwork from everyone but my hands are tied.
g. Substance Use
    i. I've been clean for 36 years.
    ii. Some people have the mental strength to quit. It takes a lot of mental willpower and strength to say enough is enough.
    iii. I struggle everyday but don't use substances. You have to remind yourself.
    iv. I had almost 3 years and then I relapsed.
    v. Addiction is a powerful disease.
    vi. It took me all these years to realize how serious addiction and mental health is. It takes way more than just saying no.
    vii. You come back to the same people and get triggered to do the same things – triggers are all around.
h. Being sick and tired of being sick and tired.
i. You need the right support and community behind you.
j. Recidivism is what it is because they give you the tools and then expect you to be okay. If their mind isn't on it, then that's what it is.
k. The bridge to connect people from jails or drug centers to responsible stable situations so they can go back to the same situation as before.
l. We want to feel numb because we've been numb for so long and that's all we know.

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. We all struggle the same with alcohol and drugs. If you're homeless, you're homeless. If you're an addict, you're an addict. We all bleed the same color.
b. People think they're better than others, but they could be where we are in a matter of seconds. People forget where they come from.

c. When I first started working here, they would ask me what I know about it. I've been celebrating being sober for 9 years. I almost lost a house because my drug dealer had my rent. It doesn't matter what walk you walk. You can have a mansion, but the struggle is real and addiction doesn't discriminate – it's a mind-altering disease. I'm not here to judge people because I was you. I chose to get it together.

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. Veterans affairs
b. Recovery café – you need to be clean for 24 hours so many people can't utilize it.
    i. I used it and they knew I was using
c. Bridge club
d. The Justice Center
e. IOPs – you have to be referred and have clean time.
f. Eliot center – come where you are. Most of us don't judge.
    i. [Staff member X] has known me since I was in diapers. You can't come here for meals.
    ii. I kept hearing about [staff member X] – she can help you get set up – now I've met her and understand. She goes above and beyond and goes the extra mile for us. I see them blending in with people at the park.
    iii. When people walk the same life as you, they see people from their own eyes.
    iv. This is the safest place I could be. Not a single person on this street would ever do anything to me because there are 100 other people here who would protect me.
    v. It's laid back here. You can be yourself. You're treated as someone.
g. I go to rehab places but don't feel like I'm home. I don't blend in. Other places are so structured.

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

a. We need more places for homeless people to go. The college is taking over. Put more money into this. We might be able to eat more and get more good staff so this place doesn't close.
b. The shelter in Middletown doesn't do anything. They don't allow people who stay there to eat. They don't give them anything.
    i. They do harm reduction. Harm reduction is a big part of our community.

ii. I don't understand it.
iii. They're trying to make sure that people have their own supplies because of things that happen. They need people to clean up and educate themselves. Kids are back in school – this is their park too.

c. People are so high they don't even think. I see syringes and supplies everywhere. I've seen people smoking crack in front of cops. It's an epidemic. Everywhere you go, there's crack. The social effects of a system that doesn't care.
d. I used to live on Massachusetts Avenue. I was always running out the door administering Narcan. I used to find tons of needles.
e. I have Narcan on me at all times.
f. The influx of new people in the city, especially if they're coming from other cities. They think they have it easy. I've been in the city for 30 years. They come in with an attitude. Everyone gravitates towards Massachusetts Avenue and Melnea Cass Boulevard and it is so congested. They kicked them out but they still gravitated back.
g. The federal government makes money out of it. It's all money and politics.
h. We have enough abandoned buildings and empty courtrooms. Don't make them into luxury apartments. They're not filling the luxury apartments. We need another big shelter.

LHMC
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Cambodian Adults
Location: Cambodian Mutual Assistance Association
Date, time: 9/27/2024
Facilitator: Greater Lowell Health Alliance
Approximate number of participants: 10

Question 1

What do you like about your community?

1. Diversity (+2)
    a. We see many cultures and we adapt to it and try to help those in need
    b. Diversity is important. Acceptance of each other's culture is also important.
    c. Different points of views are valued and accepted
2. Self-Identity (+2)
    a. Last year I lived in New Hampshire and no one knew who I was or where I am from. I felt like a foreigner, but I feel like here I have identity
    b. I am comfortable with my identity here
3. Immigrants (+3)
    a. We can reach the community as a whole and bring different values and cultures into Lowell
    b. The Lowell community is evolving, but regardless it is an immigrant city (not only Asian but Africans, etc.)
4. Culture
    a. I hear people speak in Khmer and Cambodian; this feels like my homeland
    b. I learn more about the immigrant elderly people and I love seeing them come here to get services
5. Workplace Community (+5)
    a. I can do everything and anything in this place
    b. When you work with an organization and the staff don't feel like they belong, then the workplace is not relaxed which creates higher stress. The job may be high stress here, but since we work with people who are comfortable with each other the stress becomes low
    c. The calm workplace
    d. Even though I can't communicate in Khmer, as a group I feel like we get along very well, we feel that we are in a community that has so many cultures together. We get to enjoy so many different cultures together. We acknowledge that we wish we had more components of culture
    e. Even people that do not belong to the Cambodian community feel accepted and included here.

f. When I came here and began transitioning into a new culture with struggles and success, what I see is that they have made it work in the new culture.
g. We work in a place that brings a different meaning to the work we do in our community
h. It's never about the paycheck, it's about passion

Question 2

What health issues in your community do you think are the most important?

a. Diabetes (+1)
    a. My mother is prediabetic and the doctor told her to not eat chips, but she does not eat that because of our culture. One size does not fit all.
b. Mental Health (+7)
    a. The immigrants here are not just Asian, no one will exclude their mental health needs if we have equality in mental health care
    b. Mental health is not something standard in this culture and they refuse that they have trauma and PTSD from genocide. This gets pushed onto their future generations which turns into generational mental health issues and generational trauma.
        i. Mental health it is not something standard that is discussed in our community (there is a lot of generational trauma from the genocide of 1965).
    c. The younger generation is more open, the older generation needs more persuading in terms of what you're doing is not healthy
    d. Research shows that 60% [of the community] have PTSD and 50% have depression. There is denial and a lack of understanding of what mental health is and the implications/impact of mental health
    e. Trauma-informed care is also a part of the problem, it is not fully addressed by mainstream providers
    f. Mental health is a taboo in most cultures
    g. There is a mental health provider shortage. If you could convince everyone to seek help, it is not available
        i. When it comes to children there is not anyone period
        ii. Provider shortage with cultural expertise is a problem in health.
    h. Genocide is the biggest driving effect on mental health; when you can't speak the language you are by yourself and lonely. The older generation can't communicate with their grandkids, sometimes they stay at home alone by themselves
    i. People have depression but they don't realize that what they have is depression
    j. People get so depressed
c. Substance Use (+4)
    a. Substance use is seen as a taboo issue
    b. For someone to write in they need to acknowledge it first
    c. I told my friend she is an alcoholic and she denies it, she drinks a bottle of wine every day
    d. When someone gets in the habit of things, they don't see it as something wrong
    e. We feel lonely, we only want to have friends and family and to be accepted

f. Drinking alcohol is a routine
g. When do you notice that you have a problem?
h. Alcohol and tobacco is always involved in men, if you don't do that you are not a man
i. It is a social norm in the culture
j. When people are depressed or traumatized, alcohol helps to forget and masks the feelings so they don't have to address it
k. It is socially accepted
l. It is a form of self medicating and it numbs your pain
m. Human nature is to protect yourself. People might not want to self report
n. Some populations think that herbal alcohol helps with disease and access to western medicine is limited

d. Women's Health (+7)
    a. With postpartum depression, our partners don't help us
    b. Our partners don't support us
    c. Issues with women impact mental health and physical health, she may be going through physical health issues, but she can not prioritize her physical health.

Question 3

What barriers do people in your community experience?

a. Understanding Our Culture (+ 4)
    a. All the things that are relevant to the american culture are not relevant to ours
        i. The doctors say don't eat chips or pasta, but we don't eat that so there must be another reason [for health issues]
b. Norms and Judgement (+4)
    a. Each culture has their own remedies; when people come in they expect us to know them
    b. The norms people bring in to CMAA
    c. Natural remedies usage is looked down upon by medical providers.
        i. If you leave here people are going to judge you for certain remedies or rituals
    d. Eventually we hope they can trust us, but certain things they do can be a potential health harm.
    e. People might look at me and think that they have a bunch of diseases when in reality I am healthy
c. Accessing Resources With a Language Barrier (+2)
    a. Lots of resources out there are not readily accessible to the population we serve with limited English
    b. Here, we are the connection between them and resources
d. Service Navigation (+4)
    a. There is a lack of staff to provide services to minorities
    b. I wish we could hire five more staff and have the funding, but we can't find the right person to match the role
        i. Not enough funding to hire the right individuals with the right cultural background.
    c. The front desk is like a triage in the hospital; they are the face of an organization

    d. We lack the capacity to serve as we should, which results in a lack of services that we should give to the community
    e. It is the trust. When you don't identify with your community, how do you go to someone you can't trust?
    f. Medical debt programs need more support
    g. People are going to go back to the services and people they trust
e. Civic Engagement
    a. I hear that people don't pay attention to voting; older people don't know where to go to vote
    b. I try to persuade people to change their mind to vote
    c. People are confused about the process of voting
f. Transportation (+3)
    a. Transportation infrastructure system
    b. People decline invitations because they are on the other side of the river and it is hard to cross the bridge with traffic
        i. The way the city is separated creates a division
        ii. There is a huge separation with the bridge and river which prevents people from getting services and connecting
        iii. People have said they wish they could send their kids to CMAA but they can't because of traffic and the bridge
g. Health Literacy and Technology (+5)
    a. Home online portals are hard for older people to work and they get frustrated from it
        i. My mother doesn't know what a home online portal is and I still must do it for her. My mother is a very capable woman and she gets frustrated when she doesn't know how to work it
    b. Most literacy campaigns are hard for non-English speakers
    c. Not everyone has an email, but in this world you must have email. They don't know how to use email.
    d. I always forget I have a voicemail
    e. You need to educate the whole older population, everyone needs to have some sort of navigation support and know how that works.
h. Translation Access (+6)
    a. Recently someone translated something into Vietnamese and someone who came from Vietnam who was paid to read through it had no idea what it meant
        i. I think that this is a real issue, sometimes we want to get things translated but organizations don't know how to do it the right way
        ii. What I do is have 2-3 people check the translations before we send it out
    b. Are we getting the translation that makes sense to the people that we are trying to read?
        i. There needs to be specific translation for different dialects.
    c. The biggest mistake is sending the translation copy to the printing company. Internally we have submitted papers to the printer that is approved by us, but once they print it we realize that is not what was sent
        i. The characters, font, and spacing can get distorted when it is sent to the printer.

Question 4

What populations do you think are important to focus on?

a. Immigrants (+4)
    a. After the genocide, we have a mix of cultures in Lowell. In 2002 they sent Cambodians back.
        i. In 2023 there was a law made about the amendments that let the Cambodians move back to the US
    b. There are mental health issues in the people that got sent back to their home and cannot come back to the US
        i. They feel lost
        ii. They feel like they don't belong here
    c. They don't have the same cultural hub. The only hub they have is in Worcester and the challenge with this hub is the distance and traveling.
    d. People from Lynn, Fitchburg, and Rhode Island come here for Khmer
    e. We have people that are willing to get services from us and that is why what we do is so important.
    f. We have English classes in the evenings which are very diverse.
b. Middle-Aged Adults (+3)
    a. This age group (Sandwich generation) is trying to help both parents and children.
        i. We are trapped between the kids and our parents
        ii. We are trapped in the sandwich.
        iii. A middle-aged person works full time and has to help people in two other age groups with different needs
    b. My mother speaks the language, but my kids don't and that falls onto me.
c. Youth/Teens (+3)
    a. They must learn life skills, jobs, and resumes
    b. A lot of youth don't speak their parents' native language because they refuse to lean out of embarrassment or because their parents lost it
d. Elders (+2)
    a. They need a comfortable space for them to communicate with each other
e. Women (+6)
    a. For women, they feel a lot of pressure to cook and serve men.
        i. Most men expect me to go home, cook, take care of the kids, even though I work
        ii. The culture and household influences the way men treat women
        iii. As a woman you could be working full time and still expected to do everything else like cook and help with the kids
    b. If I struggle mentally, who is going to back me up? If I struggle physically, who is going to back me up?
    c. My kids are the only people that take my anger towards them. When I feel frustrated it goes to them, it is hard to break that cycle.
    d. This is not just because of the Khmer culture, it is women in general.

i. Women as a gender. Men are seen as superior or stronger, but women are actually stronger.

e. We must do a lot of masking, women are really good at masking, because the one person I believe in [partner] thinks that I have not done enough.
f. When I got a divorce, I went to therapy and I made my daughter also go to therapy. I want my daughter to be able to talk to someone and openly communicate with someone
    i. Women and men have a hard time understanding when you need to tell someone what you're feeling
g. People don't know about mental health resources, instead of taking my frustration out on family or my partner, I can talk to someone. We don't deal with our frustration.

Question 5

What are the most important resources in your community?

a. CMAA (+9)
b. Meta Center (+2)
    i. One of the best
    ii. They overrun themselves, every time I drive my dad there I am overwhelmed, they have all of my records.
    iii. They have an overwhelming amount of patients coming through, but they have a lack of specializations and capacity.
c. Boba Shops (+1)
    i. Boba Shops are a fun place for the younger kids to hang out
d. Parks (+3)
    i. Clemente Park
e. Khmer Broadcast (+3)
    i. This is not a health-related broadcast; it is good to hear what is going on in politics

Question 6

What resources would you like to see, or which ones could be improved?

a. Women's Mental Health (+5)
    i. If I go to a man and I explain my mental health concerns, I am not going to be understood by him
        1. I need someone that looks like me for me to believe that I belong
        2. I don't have certain people that look like us, I had a female primary care provider and I was comfortable, now I have an Indian man and I am not as comfortable
        3. A man chooses a male primary care provider and a woman chooses a female primary care provider
    ii. There is a lack of understanding of what women's mental health support looks like
    iii. There is a section of the community who don't realize what therapy is and different types of mental health interventions.
    iv. The language that we use to talk about mental health.
        1. Language usage in therapy is hard

v. Be there to listen to us, and try to figure out if you can help us
vi. I wish we could have good old-fashioned social workers who can be available if someone comes in and says I need to talk to someone

b. Support Groups (+4)
    i. What is happy hour? The more you drink the happier you are. People get together to socialize, but if I start talking about my problems and no one wants to hear about my problems we are just going to ignore my problems.
    ii. I want a group where for ten minutes we can talk about what is going on, so you can walk away happy and have someone listen to your feelings.
        1. The temple plays a role in this
            a. Older folks may disagree that there are these types of resources at the temple.
    iii. Different hubs for different services in different areas
c. Language Support (+4)
    i. When you go to a counselor and the counselor does not speak your language or culture it is hard
    ii. I need this [language access] to gain trust in my provider
        1. Until I can tell my story to someone who can understand, then I will gain trust.
    iii. Language, culture, and trust are very important to me
d. Medical Services (+2)
    i. I need all medical services that have a shared culture and language including clinical and social work
    ii. Universities need to recruit students from communities to enhance more services directed towards these communities
e. Broadcast for Health (+1)
    i. Like the Khmer broadcast, but instead of politics it is for health
f. Low-Cost Activities (+3)
    i. If people can't afford it, they can't access it
    ii. We need vouchers and reduced fees for people who want to go to events.
    iii. Improve the quality of my life.

Question 7

What would you tell decision-makers is the most important thing they should do/change?

a. Staffing Medical Facilities (+3)
    i. There needs to be a systemic change for the way we staff medical facilities
    ii. We appreciate every component of CMAA, if we have issues with the cleaner it is going to fall on us
    iii. They need more staff and more people, more providers to help other providers
b. Cambodian Representation (+2)
    i. We need more Cambodian representation in all places
    ii. We need more Cambodian representation in other locations besides the ones we have now like Lowell and California
c. Elderly Care (+2)
    i. We need to get the elderly out of the house and give them more spaces to go
        1. Give elderly people places to socialize especially within the Cambodian population because they are isolated
    ii. More time for kids to visit their grandparents

d. Transportation (+3)
    i. I see many buses, but the buses are empty
    ii. If it is raining outside, where am I supposed to wait? There are no bus stops, or appropriate bus stops (covered)
    iii. They need to clear the sidewalks
e. Counselors (+1)
    i. We want a counselor or social worker here at CMAA
f. Park Lot (+1)
    i. We want a bigger parking lot at CMAA
g. State Level Attention (+7)
    i. We need to harass the state to get things done
    ii. The city relies on spaces like these, which mean the state also relies on us
    iii. The healthcare-for-all grant keeps getting extended because they realize it is cheaper for them to invest into CMAA
        1. They give us 30 cents for a 1-dollar service
        2. They put a burden on us
        3. When we start providing services, we provide a need in a population. If the funding ends we are going to have to provide that service with zero funding
            a. We are going to have to do a lot more than what you are funding us
    iv. The length to implement programs is long and hard for us
    v. There are a lot of services for Spanish, could they be better? Yes. If you compare these services to CMAA, Khmer people have less access. People need to stop preaching equal access if they don't mean equal access
h. Funding (+ 6)
    i. Where am I going to come up with the money to fund this program? It takes me $25,000 to do the $10,000 program.
    ii. I was on the phone with the funding agency and I told them that if you want to do this, I am not applying for it because we are getting $60,000 but must split that in half and only do half of what we want to do.
        1. If you are giving different organizations funding and you send the same [amount of] money to an organization that must translate, you are giving that organization half the funding as other organizations [because translation is expensive]
        2. You cannot give us the same amount of money when we are going to have to complete more work than what you expect us to do
    iii. You are telling someone to do a job, but do you know how much it takes to do this job?
    iv. They finally started administering overhead and fringe benefits.
    v. Imbalances and inequities place a burden on small agencies. We do more with less
    vi. The government provides funding for services that are needed via grants, but then they take the funding away. But there is more funding that is needed to cover essential services.
        1. There is a need for services that were provided during the pandemic but then they were taken away.

LHMC
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals living in affordable housing
Location: Housing Corporation of Arlington
Date, time: 11/6/2024
Facilitator: JSI
Approximate number of participants: 6

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. Go to the doctor (+2)
    ii. Go to doctor, get check ups, and keep up with health
    iii. Spend time with family and loved ones
        1. One person said she can talk to her daughter, because her daughter gives good advice.
    iv. Be active physically and walk outside (+3)
        1. Bike rides, bike lanes and paths help
    v. Keeping a schedule of everything she does. Trying to work on walking, reading, and running errands. When she sticks to something it's helpful.
    vi. One person is living with a family member with mental health issues so they don't want to add to his problems. They haven't had alcohol in 10 years, and they have better mental and physical health. They try to be there for their family members. They also mentioned therapy, AA, and SMART programs.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Physical limitations
        1. One person has an autoimmune disease which leads to a lack of energy. She cannot cook every day, because she doesn't have energy. It is hard to exercise due to lack of energy.
        2. One person mentioned their orthopedic problems prevent them from being as active as they'd like
    ii. Someone doesn't have a primary care physician anymore because the provider retired
    iii. Anxiety about health problems (+2)
    iv. Lack of motivation, being in a rut (+2)
        1. "Cycle of not exercising and not cooking healthy food…downwards spiral"

v. Vitamins deficiencies
vi. Eating healthy in this country is difficult, because healthy food is expensive.

Question 2

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

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

a. Therapy and psychiatrist appointments (+3_
b. Taking things one day at a time.
c. Taking care of their body.
d. Finding Community
    i. One person is in a research group which makes her feel like she can do something for people that have problems like her.
    ii. Maintaining social connections and relationships (+1)
    iii. Getting involved in volunteering to help out for advocacy etc. (+1)

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

a. Going to group therapy, it feels like their problems come onto her.
b. Anxiety, especially agoraphobia
c. Making new connections with new providers can be challenging due to high turnover (+3)
    i. It takes a long time to build up trust with a therapist and they leave after five months. "they're in and out" "this has been going on for years" because it is a teaching hospital.
    ii. You get a good provider and then they leave, then a new doctor comes in and tries to change things.
    iii. Not enough continuity of care is difficult.
d. Rude or incompetent doctors (+1)
    i. Doctors eating while on the phone.
    ii. "They don't give you a psychologist, sometimes they don't know how to deal with you, they don't give you advice and they want you to make a decision. It's tiring. They are not prepared enough to deal with people with anxiety and depression."
e. Challenges with healthcare system (+2)
    i. So much of the healthcare system is broken. It is hard to get downtown for care.
    ii. You get someone you may like and then insurance doesn't cover it or it's too expensive
    iii. Not enough mental health professionals in the field. Insurance is terrible.
    iv. "We need better professionals working in mental health field"

f. Isolation is hard when living alone.
g. One person shared that after she moved here, she stopped walking and eating healthier

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. Anxiety is through the roof because of the election. Fears of programs getting dismantled.
b. Price and availability of housing is a problem. (+2)
    i. 238 people applied for an apartment and only one got it.
c. Transportation is an issue.
    i. "We have transportation, but it's not perfect."
d. Quality and enjoyability of available housing (+1)
    i. "Pest control is another issue."
    ii. Poor air quality due to people who smoke in buildings.
    iii. Living in this area is hard because you have neighbors you don't like, people don't clean, and there's a car beeping all night.
e. Affluent towns outside of HCA, feel isolated from the larger community.

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. Senior housing and the Council on Aging.
b. Food pantry on broadway called Arlington eats.
    i. It is lacking in some ways. One woman said the selection is not great.
c. There are a few urgent cares
d. Housing Authority.

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

a. One woman said there is no health clinic in Arlington and no hospital emergency room. (+2)
    i. People need to go to Boston or Cambridge for a primary care provider. "You're leaving Arlington to get a PCP"
    ii. A hospital was available, but they turned it into condos.

b. Lots of self navigating needed to get resources
    i. “All of these services are available and there's a wide net of them, but you have to weave your own net”.
c. Terrible nursing home care (+2)
    i. “Nursing home care is horrendous.”
    ii. “Unless you got money, it’s like hell on earth. I cry when I leave. I hope I croak before I get there.”

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?

- Lack of easy access to mental health care (+2)
- We need a clinic in the area for primary care providers
- We need more social workers and case managers
    - “Things are out there, you just need more social workers to connect people to them. Case managers would be really great. If there aren't resources, they'll tell you to go to Boston or Cambridge. There is not much a social worker can do for you if they don't have something in your area.”

LHMC
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Spanish speaking domestic violence survivors
Location: Center for Hope and Healing
Date, time: 11/7/2024
Facilitator: JSI
Approximate number of participants: 9
Language: Spanish

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. See your primary care doctor to make sure everything is good inside and out
    ii. Daily exercise (+3)
    iii. Shower
    iv. Eating healthy
    v. Taking medicines that are prescribed to you (+2)
    vi. Chronic diseases make some things complicated like exercise, do low impact exercises like walking and stretching instead
    vii. Gardening and grow plants
    viii. Spending quality time with the people you love
    ix. Waking up early and going outside
    x. Walking in the park
    xi. Go to activities in the community
    xii. Dancing
    xiii. Watch youtube exercises
    xiv. Sleeping
    xv. Walking a lot at work
    xvi. Taking vitamins and supplements
    xvii. Taking breaks and watching TV with family

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Consistency of taking medicines
    ii. When working a lot it's hard to prioritize your health
    iii. When having small kids, it's hard to sleep
    iv. Stress
    v. Chronic disease and chronic pain
    vi. If I had more money, then I would have more access to resources

vii. I wish there were more resources, but there is discrimination. It is not welcoming environment
viii. More resources for women who just gave birth
    1. Physical therapy for women who just gave birth that insurance covers in Chelsea MGH
ix. Advocacy for women
x. Better insurance
xi. Depression, anxiety, PTSD; sometimes it's hard to even get out of bed and eat
xii. Lack of private insurance

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. Yoga
b. Reading
c. Talking to a therapist, counselor, friends, or family
d. Self-care (getting hair, nails done)
e. Playing and spending time with your kids
f. Exercising
g. Reading the Bible (faith)
h. Painting and drawing
i. Going to support groups
j. Gardening
k. Laughing, crying, and expressing emotions
l. Going to the beach
m. Learning to say no, setting limits/boundaries
n. Eating healthy

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

a. Resources
b. Insurance
c. Unemployment/rising cost of living
d. Isolation
e. Constant changes in doctors and medical care, especially constant change in therapist where you're reliving the trauma
f. External judgements and critics
g. Lack of self esteem and confidence that comes from previous trauma (lack of emotional support from the people you love)

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. The cost of living. Everything has increased in price, like the rent, groceries, car and house insurance
        - i. The minimum wage is low in comparison to the cost of living
    - b. Lack of housing
    - c. Lack of work authorizations
- **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
    - b. Single moms

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. This type of organization, Center for Hope and Healing - that provide activities and support for the community -
        - i. They provide education and empowerment to the community about how systems work and how people can seek support from the complicated systems that exist
    - b. Public spaces, like parks
    - c. Some hospitals and health centers, but insurance is becoming stringent in terms of what services are covered

- **b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    - a. There are no other groups like this one that provides services that address social factors such as cost of living and groceries
    - b. Health advocates within health centers; many people are not listened to
    - c. This organization advocates for equity and the removal of barriers, there are other organizations that provide services, but they have a lot of requirements that are barriers for people to actually receive their services
    - d. Lack of affordable and free legal services, especially for survivors of sexual abuse
        - i. Processes for sexual abuse victims are not clear from district attorneys offices

e. Especially for children, it is complicated, there is a lot of misinformation, and a lack of communication

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?

- Respect women and have trauma-informed approaches across programs and services
- More affordable and free legal services, especially for survivors of sexual abuse
- Center for Hope and Healing in every city/town across Massachusetts
- The work is about connecting with people and we need more organizations that focus on the needs of people, not based on metrics or based on what grants are asking for
- The assessment begins with community and then building a program based on people's real needs

LHMC
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Adolescents in Peabody
Location: Peabody High School
Date, time: 11/18/2024
Facilitator: JSI
Approximate number of participants: 17

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. **What are things you do to stay physically healthy/well?**
    i. Being involved in different things; staying busy (any activities, not just sports/exercise)
    ii. Drinking lots of water
    iii. Getting enough sleep
    iv. Eating well. It's not easy to eat healthy because seeing advertisements for unhealthy food makes it hard. Social media can cause bad outlooks on eating well and poor ideas of different foods/diets that are actually unhealthy. Healthy food is also harder to gain access to than unhealthy food (more convenient is less healthy), unhealthy food is cheaper, there are frequently deals/sales for unhealthier foods, and high schoolers don't have time in their day to make healthy meals
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Food disorders make it hard to eat healthily sometimes
    ii. Disorders (ADHD, autism) make it hard to function, and some things they'd like to do aren't really acceptable by social standards/adults limit what kids are allowed to do by either saying they're too old for something or telling them to not do something
    iii. Beauty standards impact health, partially by making kids eat more/less
    iv. When we are busy, we focus more on things we need to do rather than health. We have too much to do at once, and we don't prioritize ourselves
    v. Not enough time in the day; when we are busy it can be hard to have time to eat/sleep enough
    vi. Extracurriculars/too much homework prevents us from getting enough sleep
    vii. Overall, lots of contradicting ideas from online/parents/other sources about how to stay physically healthy which confuses kids, and time management is difficult so we can't prioritize everything at once

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. What helps to stay mentally healthy/well?

a. Staying active; not doing anything puts you in your head too much which can lead to harmful thoughts
b. Listening to music with headphones can help prevent overthinking, but it is not always available though due to rules set by school/parents
c. Having a support system; therapist, other people, etc. It helps to have your thoughts heard and have someone to unload things on and can help find coping mechanisms and strategies to help you. It gives you validation
d. Setting time for yourself in the day, even when you're busy taking time to relax and do something you want to do
e. Expressing gratitude; making others feel better makes you feel better

b. What barriers are there and what do you do to stay on track?

a. Grownups/teachers/parents/other adults can make it hard because they either prevent us from doing things or give conflicting messages that confuse the kids
b. Having toxic people in your life/people that aren't supportive can harm your own health by them either gaslighting or other things
c. Being so busy that you don't have time for yourself can be harmful
d. Friends and relationships can be both good and bad for mental health because they can affect how you see yourself
e. Disorders like anxiety or depression make it harder to take of yourself

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?
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?

Did not get to this question

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 in your community and school.

a. What are the most important resources in getting the help/support you need?

a. Family, not necessarily adults or immediate family
b. Parents and friends
c. Friend groups and family, some families have situations like immigrants family members that may prevent them from being the best source for advice because their experience doesn't apply
d. If a family doesn't have adults to talk to who have helpful experience, teachers are a good resource
e. Most important is having a good support system at home, it's hard to be okay anywhere if you're not okay at home
f. Having a community in the school that you're part of (sports teams, performing arts, etc.)
g. Any people you can trust, having no people you trust is really hard to deal with

b. Outside of school, any resources/clubs/community centers?

a. Guys go to the gym a lot (the YMCA)
b. The library has lots of activities, but people don't know about them or that there are activities for older kids as well. It is not advertised well and it is seen as lame/negative/bad (it's uncommon so it's bad)

c. Any places/people in the community that you lean on?

a. Guidance counselors, adjustment counselors, etc. are good for help
b. There are some really good guidance counselors/teachers that are good to rely on, but there are also counselors/teachers/deans who don't take students seriously and won't really help the kids. They'll be dismissive and downplay the issue
c. The health center is a resource

d. What do you wish was available to you in your school/community?

a. No real community center, some sort of community center that has a variety of things to do where everyone can be around each other
b. More things for art/recreational arts center/learning annex
c. A place to go with a lot of things to do, we have no place to go and hang out, places like malls/restaurants aren't great, a place that's always open that's a drop-in where people can gather and just hang out
d. If there were more advertisements for available resources since there's a lot we aren't aware of
e. We wish more activities were more accommodating for illnesses/disorders such as diabetes, they were often treated as annoying so having leaders in activities be more trained/knowledgeable in providing accommodations is important. Those with disabilities are often made feel like an annoyance
f. In school, having more freedom, we never have time for using the library in school since it's not allowed which isn't helpful
g. Communication problems in schools; things like club fairs are never advertised, lots of kids miss activities because we don't know about them. Information about things is hard to find and so it's hard to find resources that are available to us

h. There are performances in Peabody but we never know about them/where they are and it would be nice to know what is going on around us
i. Poster advertisements around the school are completely ignored; they're never taken down so there are lots of posters for events that have already passed
j. Kids are embarrassed to go to certain events and they feel like they'll be judged, or the anxiety about starting something new and messing up makes starting new things feel scary

e. How do you get your health information?

a. Ask adults, they often have our health records, and if they don't know then we have to wait until the next doctor's appointment which is often once a year
b. A lot of people use online resources/google or do their own research and self-diagnose from Google
c. Social media
d. MyChart, from certain doctor's offices, allows kids to ask doctors a question and access health information, parents have restricted access to it, but not every place/everyone has access to something like that

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?

- More things like the focus group and hearing teenagers out since no one listens to us or cares what we have to say, it's very difficult for us to get our voices out and heard; kids speaking up can be considered back talk/attitude
- Awareness in general is important, such as knowing resources that exist or knowing who you can trust
- Lots of input from kids are collected in online surveys which yield incredibly inaccurate information since kids often lie or don't bother truly answering the questions, kids are scared to be honest even if they're supposedly anonymous because of fear of getting in trouble
- Wish that things other than sports were prioritized; you never hear about options other than sports and lots of kids don't want to do sports
- If they gave things like performing arts or other clubs half as much funding and resources as they do sports, it would be a lot better
- A good resource in school would be a private area in the school for students to pray
- More private areas in general if we need space to be alone and rest or focus
- Ideally, bathrooms would be open all the time, however so many people at our school abuse any resources we have
- Lots of issues are kind of ignored because they're super normalized such as drugs and such, it would be good if there were resources to get help with issues like drugs that wouldn't immediately result in consequences
    - The health center has confidential counseling for substance abuse
- The health center can be seen as either a place weird kids go or as the same as the nurse's office

Community Listening Sessions

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

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

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

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

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

Goals:

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

BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

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

Participants will be asked to:

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

ROLE OF COMMUNITY FACILITATOR

Establish ground rules

Initiate and guide discussion

Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

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

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

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

LET'S REVIEW.

REMEMBER: YOU HAVE SUPPORT.

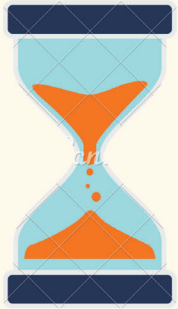
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial

Active listener

Authentic

Patient



Enthusiastic

INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish group agreements

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

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Consider accessibility

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

THANK YOU!

Feel free to send in any questions to Madison

madison_maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

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

Ground rules and introductions (5 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Area 2: Access to Care (12 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wrap up (1 minute)

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

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Lahey Hospital & Medical Center Community Listening Session

February 26, 2025 | 9:00-10:30am

Beth Israel Lahey Health

1

LHMC 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

LHMC Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Lahey Hospital & Medical Center

LHMC 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	Michelle Snyder, Community Benefits & Community Relations Manager, LHMC
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	Michelle Snyder

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Assessment Purpose and Process

Beth Israel Lahey Health

Assessment Purpose and Process

Purpose

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

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

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

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Lahey Hospital & Medical Center

Community Benefits Service Area

- H Lahey Hospital and Medical Center
- H Lahey Medical Center-Peabody
- 1 Lahey Hospital and Medical Center-Outpatient Rehabilitation Services at Danvers
- 2 Lahey Outpatient Center-Lexington MRI Suite
- 3 Lahey Health Outpatient Services
- 4 Lahey Neurology Outpatient Services
- 5 Lahey Hospital and Medical Center, Departments of Allergy and Immunology & Ophthalmology

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

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

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

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

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

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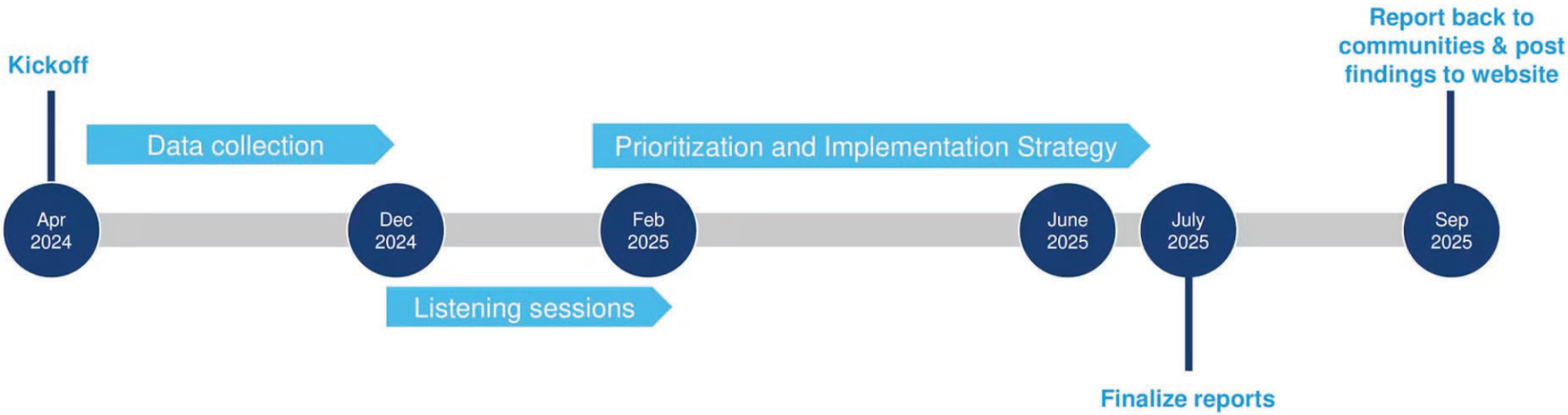
Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process

Meeting goals

Goals:

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

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Key Themes & Data Findings

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FY25 CHNA Progress

Activities to date

Collection of secondary data, e.g.:

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

15 Interviews

1,519 FY25 LHMC Community Health Survey Respondents

5 Focus Groups

- *Individuals in public housing (Housing Corporation of Arlington)*
- *Cambodian older adults (Cambodian Mutual Assistance Association, with Greater Lowell Health Alliance)*
- *Youth (North Shore Community Health/Peabody High School)*
- *Domestic violence survivors (Center for Hope and Healing)*
- *Homeless/unstably housed (Eliot Day Center, with Greater Lowell Health Alliance)*

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FY25 CHNA Progress

LHMC FY25 Community Health Survey Responses

1,519 responses

(Represents a 58% increase from 961 responses FY22)

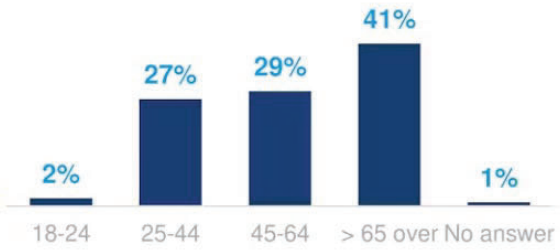
16% of respondents report a language other than English as the primary language spoken in their home **(up from 13% in FY22)**

77% of the respondents are women **(down from 80% in FY22)**

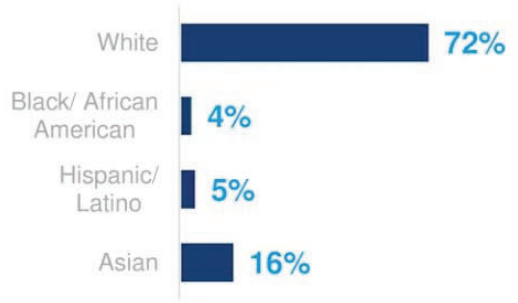
16% of the respondents identify as having a disability **(up from 10% in FY22)**

7% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(up from 4% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 183 in FY25 compared to 74 in FY22
- **Black/African American respondents:** 4% in FY25 compared to 2% in FY22
- **Hispanic respondents:** 5% in FY25 compared to 4% in FY22
- **Asian respondents:** 16% in FY25 compared to 11% in FY22

FY25 CHNA Progress

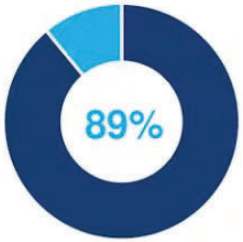
Community Benefits Service Area Strengths

FROM INTERVIEWS & FOCUS GROUPS:

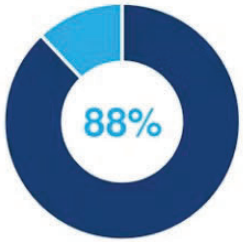
- Community organizations have come together to try and meet the needs of an increasingly diverse community
- Many local culture-based affinity groups
- Strong school systems that work well with other community organizations to meet the needs of youth and families

FROM FY25 LHMC COMMUNITY HEALTH SURVEY:

said they **feel like they belong** in their community
(same as FY22)



said they are **satisfied with quality of life in their community**
(same as FY22)



said the community **has good access to resources**
(compared to 89% in FY22)

FY25 CHNA Progress

Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

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

FY25 CHNA Progress
Social Determinants of Health

Primary concerns:

- Housing issues
- Transportation
- Language and cultural barriers to services
- Food insecurity
- Economic insecurity and high cost of living

Many migrant families in Massachusetts are staying in emergency assistance shelters

As of November 2024, there are:

- Over 200 families in Emergency Shelter in Peabody
- Between 1-50 families in Emergency Shelter in Burlington
- Between 1-50 families in Emergency Shelter in Lexington
- Between 51-200 families in Emergency Shelter in Danvers
- Over 200 families in Emergency Shelter in Lowell

When asked what they'd like to improve in their community, **48%** of FY25 LHMC Community Health Survey respondents reported **more affordable housing – the #1 response** (up from 40% in FY22)

When asked what they'd like to improve in their community, **40%** of FY25 LHMC Community Health Survey respondents reported **better access to public transportation** (up from 35% in FY22)

"For housing, both quantity and quality is an issue. It's difficult to find affordable apartments, but we also have housing that doesn't meet health and safety codes. People who are marginalized don't want to call an agency to improve their housing, because they fear they'll lose it. People are really living in difficult and poor conditions." ***- Interviewee***

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FY25 CHNA Progress

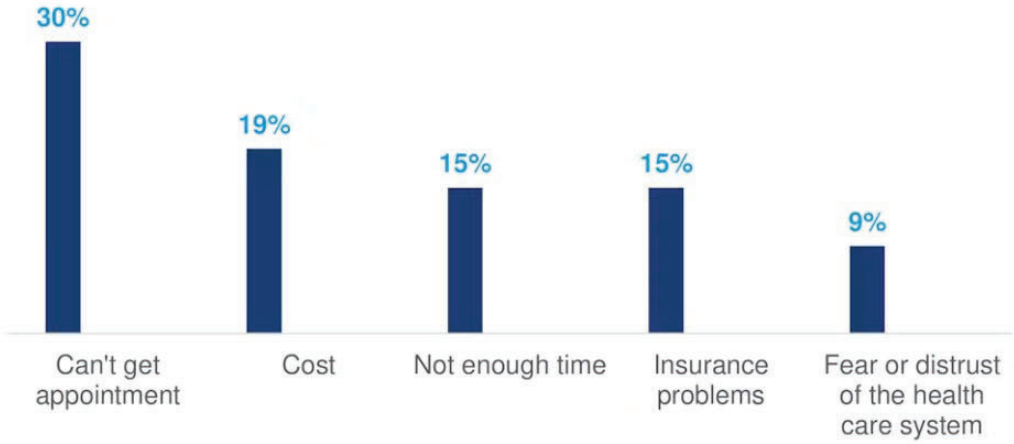
Preliminary Themes: Equitable Access to Care

Primary concerns:

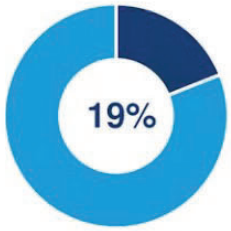
- Long wait times for care (all types – primary, behavioral, emergency, specialty)
- Language and cultural barriers to care
- Health insurance and cost barriers
- Navigating a complex health care system

What barriers keep you from getting needed health care?

(Top 5 responses from LHMC FY25 Hospital Community Health Survey)



*"I haven't had a PCP in over 10 years. It is very difficult to find a good one who accepts my insurance and is taking new patients."- **Survey respondent***



19% of FY25 LHMC Community Health Survey respondents reported that health care in their community does not meet people's physical health needs

FY25 CHNA Progress

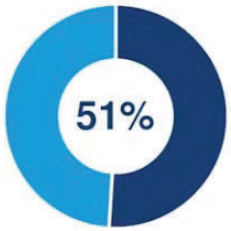
Preliminary Themes: Mental Health and Substance Use

Primary Concerns:

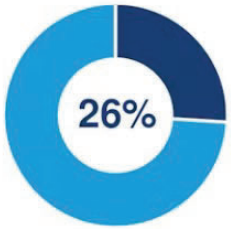
- Youth mental health
- Social isolation (especially for older adults)
- Lack of behavioral health providers (mental health and substance use)
- Lack of supportive and navigation services for individuals with SUD
- Need for community-based education and prevention programs
- Trauma experienced by migrants, new immigrants, and refugees

"Older adults are socially isolated and so lonely. There are folks in our community who feel disconnected, and need help and support." -Interviewee

AMONG LHMC FY25 COMMUNITY HEALTH SURVEY RESPONDENTS:



51% identified mental health as a heath issue that matters most in their community (#2 response)



26% reported that mental health care in the community does not meet people's needs

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Instructions

10

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Breakout Sessions

3

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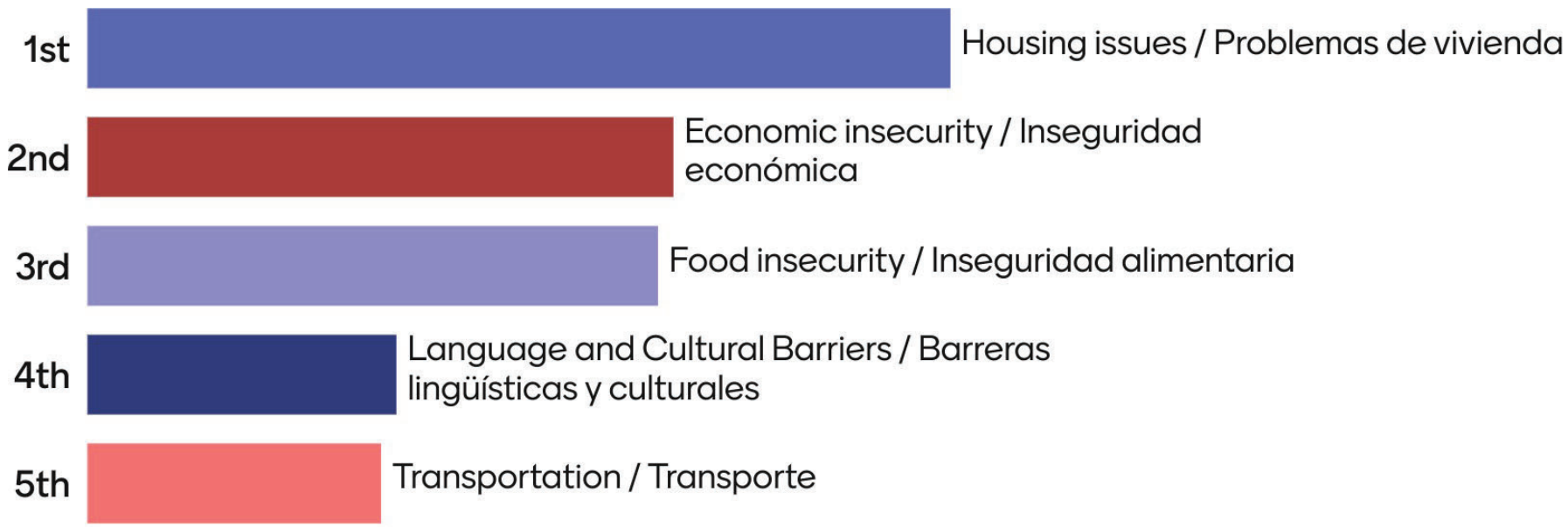
Mentimeter

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

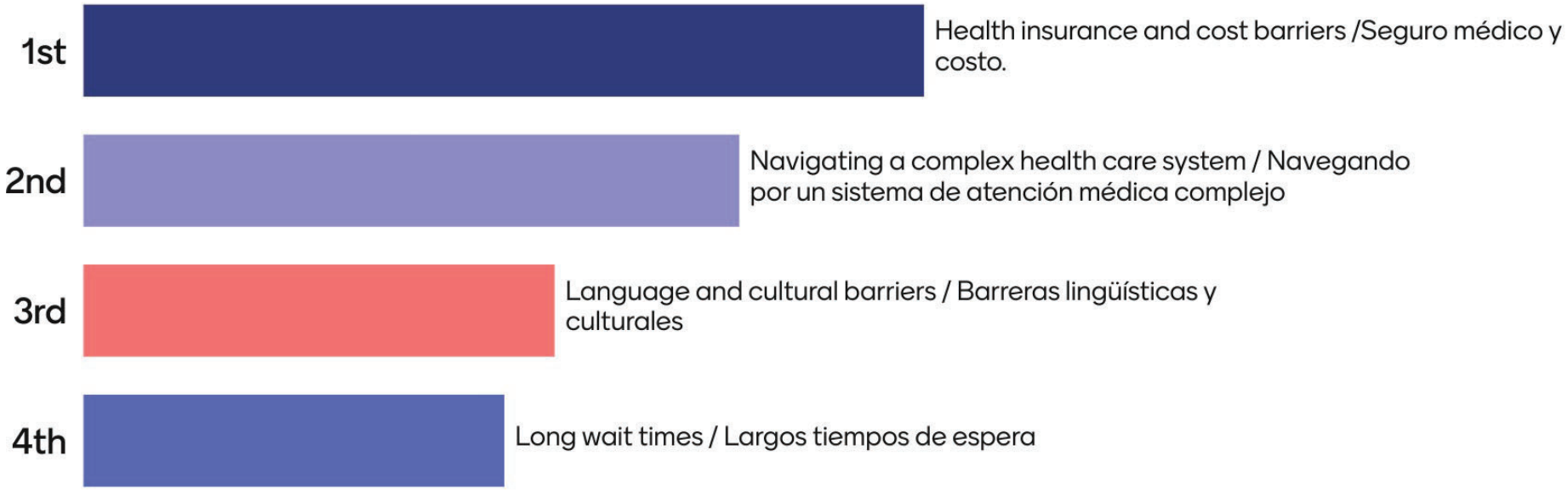


5

14 / 0

Mentimeter

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

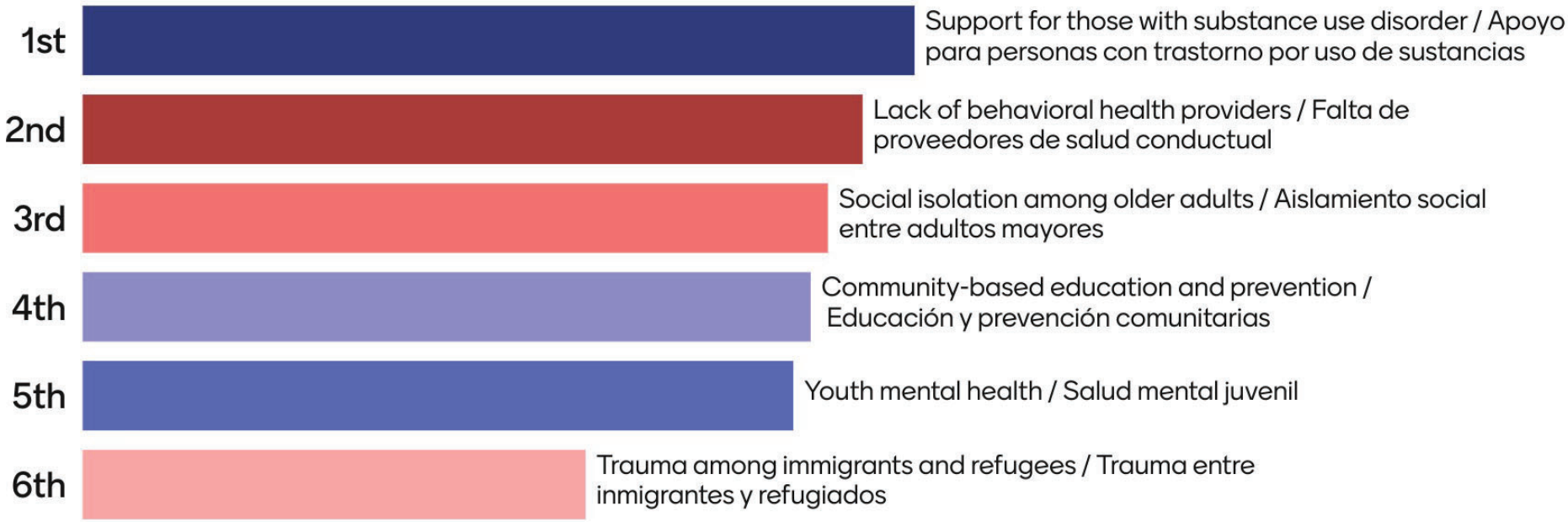


2

15 / 0

Mentimeter

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

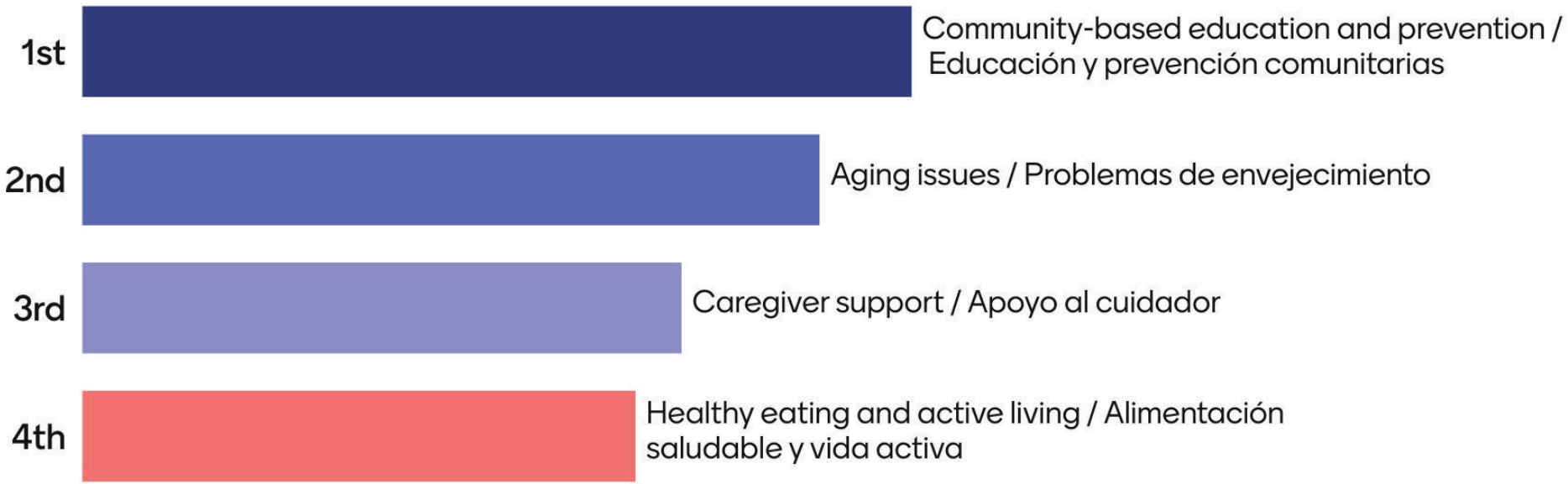


2

13 / 0

Mentimeter

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



3

13 / 0

Mentimeter

Reconvene

Beth Israel Lahey Health

Next Steps

Michelle Snyder

Manager, Community Benefits and Community Relations | Lahey Hospital & Medical Center

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Community Benefits Information on Website:

https://www.lahey.org/about/community-benefits-needs/program

Community Benefits Annual Meeting in September (Date TBA)

Appendix B:
Data Book

Secondary Data

Demographics

Demographics: Arlington – Danvers
Data Source: US Census Bureau, American Community Survey 2019 - 2023
Key
Significantly low compared to Massachusetts based on margin of error
Significantly high compared to Massachusetts overall based on margin of error

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
Population								
Total population	6992395	807258	1622896	46015	14343	41700	26223	27924
Male	48.9%	48.6%	49.4%	47.6%	47.8%	49.8%	48.2%	45.7%
Female	51.1%	51.4%	50.6%	52.4%	52.2%	50.2%	51.8%	54.3%
Age Distribution								
Under 5 years (%)	5.0%	5.4%	5.1%	4.8%	5.3%	3.9%	4.8%	4.4%
5 to 9 years	5.2%	5.6%	5.4%	5.1%	5.3%	4.7%	6.5%	4.1%
10 to 14 years	5.7%	6.2%	5.6%	6.7%	7.2%	5.0%	4.9%	4.4%
15 to 19 years	6.5%	6.4%	6.3%	5.0%	5.7%	5.8%	4.0%	6.3%
20 to 24 years	6.8%	6.2%	6.8%	3.7%	3.6%	5.5%	5.7%	5.9%
25 to 34 years	14.1%	12.5%	15.1%	15.5%	9.8%	14.8%	10.3%	11.6%
35 to 44 years	12.9%	12.6%	13.8%	14.3%	14.5%	13.0%	14.0%	13.0%
45 to 54 years	12.6%	12.8%	12.8%	15.6%	15.6%	12.9%	13.6%	12.0%
55 to 59 years	7.0%	7.3%	6.8%	6.2%	7.7%	8.7%	7.9%	8.6%
60 to 64 years	6.8%	7.0%	6.2%	6.1%	7.2%	7.7%	7.0%	7.5%
65 to 74 years	10.3%	10.7%	9.3%	9.8%	9.7%	11.2%	10.8%	11.5%
75 to 84 years	4.9%	5.0%	4.6%	5.0%	4.9%	4.9%	6.8%	7.3%
85 years and over	2.2%	2.4%	2.1%	2.0%	3.5%	1.9%	4.0%	3.4%
Under 18 years of age	19.6%	21.0%	19.6%	20.5%	22.6%	18.1%	17.9%	16.9%
Over 65 years of age	17.5%	18.0%	16.0%	16.9%	18.1%	17.9%	21.5%	22.2%

Demographics: Arlington – Danvers

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
Race/Ethnicity								
White alone (%)	70.70%	70.3%	69.0%	76.5%	74.5%	78.1%	76.5%	90.2%
Black or African American alone (%)	7.0%	4.1%	5.0%	2.5%	2.1%	4.7%	2.5%	2.7%
American Indian and Alaska Native (%) alone	0.2%	0.3%	0.2%	0.1%	0.0%	0.0%	0.0%	0.1%
Asian alone (%)	7.1%	3.5%	13.2%	12.1%	16.4%	8.5%	13.5%	1.9%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Some Other Race alone (%)	5.4%	12.1%	4.2%	1.7%	1.2%	3.1%	1.5%	1.8%
Two or More Races (%)	9.5%	9.7%	8.4%	7.1%	5.7%	5.6%	5.9%	3.2%
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	5.0%	4.1%	5.3%	4.3%	5.1%
Foreign-born								
Foreign-born population	1,236,518	151,560	366,954	8,134	3,348	6,223	4,790	2,489
Naturalized U.S. citizen	54.5%	56.4%	51.0%	54.3%	67.4%	55.3%	59.8%	65.5%
Not a U.S. citizen	45.5%	43.6%	49.0%	45.7%	32.6%	44.7%	40.2%	34.5%
Region of birth: Europe	18.1%	13.4%	16.9%	28.7%	23.2%	19.2%	18.8%	21.1%
Region of birth: Asia	30.5%	14.5%	42.9%	51.9%	59.7%	50.3%	61.5%	23.9%
Region of birth: Africa	9.5%	5.5%	7.6%	4.2%	4.0%	5.3%	6.2%	5.8%
Region of birth: Oceania	0.3%	0.2%	0.5%	0.4%	0.0%	0.1%	2.2%	0.0%
Region of birth: Latin America	39.4%	64.4%	29.7%	10.9%	6.3%	23.2%	8.4%	44.3%
Region of birth: Northern America	2.2%	2.0%	2.4%	3.9%	6.7%	1.9%	3.0%	4.9%
Language								
English only	75.2%	71.6%	71.7%	79.6%	77.1%	80.6%	80.5%	88.6%
Language other than English	24.8%	28.4%	28.3%	20.4%	22.9%	19.4%	19.5%	11.4%
Speak English less than "very well"	9.7%	12.2%	9.9%	5.2%	6.0%	6.1%	4.7%	3.8%

Demographics: Arlington – Danvers

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
Spanish	9.6%	18.8%	6.4%	2.2%	1.3%	4.0%	2.3%	3.7%
Speak English less than "very well"	4.1%	8.8%	2.4%	0.3%	0.4%	1.1%	0.8%	1.2%
Other Indo-European languages	9.2%	6.4%	12.2%	9.9%	8.3%	10.2%	9.5%	5.5%
Speak English less than "very well"	3.2%	2.2%	4.1%	2.6%	1.0%	3.4%	1.9%	1.8%
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	7.2%	9.0%	3.7%	6.0%	1.2%
Speak English less than "very well"	1.9%	0.9%	2.9%	2.0%	2.0%	1.2%	1.8%	0.4%
Other languages	1.6%	1.2%	2.0%	1.1%	4.3%	1.5%	1.8%	1.0%
Speak English less than "very well"	0.4%	0.4%	0.5%	0.2%	2.6%	0.3%	0.2%	0.4%
Employment								
Unemployment rate	5.1%	5.1%	4.2%	3.2%	5.5%	3.5%	3.6%	5.7%
Unemployment rate by race/ethnicity								
White alone	4.5%	4.3%	4.0%	3.4%	5.6%	3.4%	3.5%	5.5%
Black or African American alone	7.9%	4.6%	6.4%	0.0%	12.2%	2.6%	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%	2.8%	4.8%	0.5%	3.3%	4.1%
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	10.9%	-	-	-	0.0%	0.0%
Some other race alone	8.0%	7.9%	6.4%	0.0%	23.2%	19.3%	0.0%	9.7%
Two or more races	7.9%	8.6%	5.4%	2.9%	0.0%	4.7%	7.5%	1.0%
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	2.7%	7.2%	11.1%	7.3%	19.9%
Unemployment rate by educational attainment								
Less than high school graduate	9.1%	10.0%	8.1%	0.0%	0.0%	1.2%	0.0%	26.1%
High school graduate (includes equivalency)	6.4%	5.3%	5.9%	7.5%	21.0%	2.8%	6.5%	6.1%
Some college or associate's degree	5.2%	4.8%	4.9%	2.5%	12.4%	6.3%	5.6%	7.4%
Bachelor's degree or higher	2.7%	3.1%	2.7%	2.4%	2.8%	1.9%	1.2%	3.9%

Demographics: Arlington – Danvers

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
Income and Poverty								
Median household income (dollars)	101,341	99,431	126,779	141,440	158,964	139,706	142,207	117,072
Population living below the federal poverty line in the last 12 months								
Individuals	10.0%	9.4%	7.5%	5.4%	4.1%	4.5%	5.6%	5.2%
Families	6.6%	4.4%	6.7%	3.0%	3.3%	2.3%	2.0%	6.8%
Individuals under 18 years of age	11.8%	12.1%	7.4%	2.7%	3.0%	3.0%	4.9%	6.9%
Individuals over 65 years of age	10.2%	10.8%	8.6%	10.3%	3.1%	7.3%	9.2%	6.8%
Female head of household, no spouse	19.1%	18.2%	15.4%	8.6%	10.6%	8.0%	9.2%	9.1%
White alone	7.6%	7.2%	6.0%	4.4%	4.1%	4.4%	5.4%	4.1%
Black or African American alone	17.1%	14.1%	15.4%	15.8%	1.5%	6.9%	25.9%	23.6%
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	0.0%	100.0%	-	0.0%	0.0%
Asian alone	11.0%	9.3%	8.6%	5.8%	0.6%	0.7%	2.9%	10.5%
Native Hawaiian and Other Pacific Islander alone	21.7%	0.0%	4.7%	100.0%	-	0.0%	0.0%	0.0%
Some other race alone	20.1%	19.0%	14.2%	43.0%	50.9%	13.2%	9.1%	21.9%
Two or more races	15.7%	11.1%	10.5%	3.2%	3.5%	5.0%	4.8%	11.0%
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	10.2%	11.5%	17.6%	6.2%	22.8%
Less than high school graduate	24.4%	22.8%	20.4%	17.4%	11.1%	15.6%	12.8%	20.6%
High school graduate (includes equivalency)	12.7%	11.8%	12.1%	14.6%	11.1%	6.5%	10.5%	6.4%
Some college, associate's degree	9.2%	8.6%	8.2%	11.8%	9.2%	5.9%	3.6%	4.3%
Bachelor's degree or higher	4.0%	3.5%	3.4%	3.0%	2.1%	2.3%	4.4%	2.8%
With Social Security	29.8%	31.4%	25.8%	24.3%	25.4%	28.7%	35.1%	35.1%
With retirement income	22.9%	22.5%	20.9%	20.5%	23.0%	26.5%	27.4%	29.5%
With Supplemental Security Income	5.6%	5.8%	3.9%	2.3%	3.0%	2.8%	2.7%	2.1%
With cash public assistance income	3.5%	4.6%	2.8%	2.7%	1.4%	4.7%	1.3%	2.2%
With Food Stamp/SNAP benefits in the past 12 months	13.8%	16.0%	8.6%	5.6%	4.7%	7.1%	4.5%	6.7%

Demographics: Arlington – Danvers

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
Housing								
Occupied housing units	91.6%	94.9%	95.5%	96.4%	98.2%	98.9%	95.5%	96.8%
Owner-occupied	62.6%	64.0%	61.6%	60.6%	71.6%	78.1%	74.6%	68.9%
Renter-occupied	37.4%	36.0%	38.4%	39.4%	28.4%	21.9%	25.4%	31.1%
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.0%	0.0%	0.4%	0.0%	0.2%
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	0.3%	0.3%	1.5%	1.3%	2.1%
No telephone service available	0.8%	0.8%	0.6%	0.4%	0.0%	0.3%	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%	15.8%	18.4%	20.3%	23.8%	19.8%
Among owner-occupied units without a mortgage	15.4%	16.6%	15.2%	14.5%	17.7%	11.6%	11.6%	16.7%
Among occupied units paying rent	41.3%	46.3%	37.4%	25.8%	33.5%	32.7%	44.5%	44.2%
Access to Technology								
Among households								
Has smartphone	89.2%	88.7%	91.5%	89.6%	92.9%	91.5%	90.3%	86.4%
Has desktop or laptop	83.2%	81.0%	88.4%	90.9%	89.0%	88.4%	92.4%	84.9%
With a computer	95.1%	94.8%	96.5%	96.4%	96.9%	96.3%	96.2%	94.0%
With a broadband Internet subscription	91.8%	91.4%	94.2%	94.9%	96.6%	95.0%	95.7%	93.3%
Transportation								
Car, truck, or van -- drove alone	62.7%	69.3%	56.0%	45.8%	54.6%	69.9%	68.7%	73.4%
Car, truck, or van -- carpooled	6.9%	7.0%	6.4%	3.4%	6.9%	7.2%	7.0%	4.2%
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	12.5%	0.9%	1.7%	3.0%	2.6%
Walked	4.2%	2.8%	4.2%	2.0%	1.4%	1.4%	0.5%	2.0%
Other means	2.5%	2.6%	3.2%	5.8%	4.1%	1.3%	0.6%	0.3%
Worked from home	16.7%	14.6%	22.2%	30.5%	32.2%	18.6%	20.2%	17.5%
Mean travel time to work (minutes)	29.3	28.9	30.0	32.2	23.4	27.0	28.0	28.0

Demographics: Arlington – Danvers

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
Vehicles available among occupied housing units								
No vehicles available	11.8%	9.6%	10.4%	9.7%	6.5%	5.1%	3.1%	6.0%
1 vehicle available	35.8%	34.6%	36.5%	47.8%	31.7%	25.5%	30.0%	32.6%
2 vehicles available	35.8%	37.4%	37.8%	33.5%	47.0%	44.3%	45.3%	36.4%
3 or more vehicles available	16.6%	18.4%	15.3%	8.9%	14.8%	25.1%	21.6%	25.0%
Education								
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	5.2%	3.3%	1.0%	2.5%	2.5%	1.6%	1.9%
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	1.4%	1.4%	3.7%	1.9%	3.5%
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	10.8%	12.2%	25.8%	19.0%	22.5%
Some college, no degree	14.4%	15.2%	11.2%	7.9%	9.5%	17.1%	12.8%	16.3%
Associate's degree	7.5%	8.2%	5.7%	4.5%	5.0%	9.9%	6.5%	9.0%
Bachelor's degree	25.3%	24.9%	28.8%	30.6%	32.0%	26.0%	32.5%	29.5%
Graduate or professional degree	21.4%	17.5%	30.2%	43.8%	37.4%	15.0%	25.7%	17.3%
High school graduate or higher	91.4%	90.1%	93.4%	97.6%	96.1%	93.9%	96.5%	94.5%
Bachelor's degree or higher	46.6%	42.3%	59.0%	74.4%	69.4%	41.0%	58.2%	46.8%
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%	97.7%	96.8%	95.6%	97.3%	95.0%
Bachelor's degree or higher	49.4%	47.7%	60.9%	74.4%	66.2%	38.3%	54.6%	46.9%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	85.3%	89.6%	99.0%	80.1%	93.9%	93.9%	92.1%
Bachelor's degree or higher	30.7%	31.0%	40.0%	50.4%	21.6%	37.1%	60.3%	50.0%
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%	0.0%	-	100.0%	100.0%
Bachelor's degree or higher	24.4%	19.7%	31.3%	15.5%	0.0%	-	100.0%	0.0%
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	83.9%	90.3%	97.1%	97.8%	88.2%	94.2%	76.1%
Bachelor's degree or higher	64.0%	55.0%	71.3%	85.0%	88.4%	75.0%	83.4%	57.1%

Demographics: Arlington – Danvers

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers
Demographics								
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%	-	100.0%	100.0%	-
Bachelor's degree or higher	40.0%	95.2%	20.9%	0.0%	-	0.0%	0.0%	-
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	67.5%	73.6%	85.0%	83.0%	82.6%	75.4%	97.6%
Bachelor's degree or higher	20.0%	12.9%	27.1%	38.0%	71.6%	25.7%	46.3%	55.1%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	81.1%	85.6%	100.0%	92.4%	81.1%	95.2%	88.9%
Bachelor's degree or higher	33.6%	29.6%	46.1%	75.4%	79.9%	39.6%	47.4%	32.7%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	71.1%	77.6%	95.5%	93.6%	83.4%	79.5%	84.8%
Bachelor's degree or higher	23.3%	16.9%	34.9%	59.1%	79.6%	20.7%	49.3%	57.4%
Health insurance coverage among civilian noninstitutionalized population (%)								
With health insurance coverage	97.4%	97.2%	97.6%	98.9%	98.9%	98.7%	97.1%	98.6%
With private health insurance	73.8%	71.0%	80.0%	87.1%	82.8%	85.4%	82.5%	83.7%
With public coverage	37.1%	39.9%	29.9%	23.1%	27.5%	30.9%	27.9%	33.8%
No health insurance coverage	2.6%	2.8%	2.4%	1.1%	1.1%	1.3%	2.9%	1.4%
Disability								
Percent of population with a disability	12.1%	12.1%	9.8%	8.5%	9.6%	10.8%	9.3%	12.6%
Under 18 with a disability	4.9%	5.0%	4.1%	2.2%	3.9%	3.6%	4.9%	5.5%
18-64	9.4%	9.1%	7.1%	6.3%	7.7%	7.9%	5.9%	8.3%
65+	30.2%	31.0%	27.9%	24.6%	23.5%	28.4%	22.6%	30.8%

Demographics: Lexington – Peabody
Data Source: US Census Bureau, American Community Survey 2019 - 2023
Key
Significantly low compared to Massachusetts based on margin of error
Significantly high compared to Massachusetts overall based on margin of error

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Population							
Total population	6992395	807258	1622896	34085	114799	12964	54180
Male	48.9%	48.6%	49.4%	47.6%	49.5%	50.4%	47.6%
Female	51.1%	51.4%	50.6%	52.4%	50.5%	49.6%	52.4%
Age Distribution							
Under 5 years (%)	5.0%	5.4%	5.1%	3.7%	5.7%	6.8%	5.7%
5 to 9 years	5.2%	5.6%	5.4%	6.6%	5.7%	10.4%	4.8%
10 to 14 years	5.7%	6.2%	5.6%	9.8%	6.9%	6.2%	4.2%
15 to 19 years	6.5%	6.4%	6.3%	8.1%	6.7%	5.5%	5.0%
20 to 24 years	6.8%	6.2%	6.8%	2.7%	8.5%	3.4%	5.3%
25 to 34 years	14.1%	12.5%	15.1%	4.2%	15.8%	9.4%	12.6%
35 to 44 years	12.9%	12.6%	13.8%	11.6%	14.6%	14.6%	11.4%
45 to 54 years	12.6%	12.8%	12.8%	19.2%	11.1%	12.9%	12.1%
55 to 59 years	7.0%	7.3%	6.8%	7.4%	6.3%	6.8%	7.9%
60 to 64 years	6.8%	7.0%	6.2%	5.8%	6.4%	5.5%	6.8%
65 to 74 years	10.3%	10.7%	9.3%	11.5%	7.6%	10.3%	12.0%
75 to 84 years	4.9%	5.0%	4.6%	6.3%	3.6%	5.9%	6.8%
85 years and over	2.2%	2.4%	2.1%	3.2%	1.1%	2.3%	5.5%
Under 18 years of age	19.6%	21.0%	19.6%	26.4%	21.2%	27.4%	17.5%
Over 65 years of age	17.5%	18.0%	16.0%	21.0%	12.4%	18.5%	24.3%

Demographics: Lexington – Peabody

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Race/Ethnicity							
White alone (%)	70.70%	70.3%	69.0%	56.8%	50.9%	81.3%	79.9%
Black or African American alone (%)	7.0%	4.1%	5.0%	2.1%	10.8%	1.4%	3.6%
American Indian and Alaska Native (%) alone	0.2%	0.3%	0.2%	0.0%	0.1%	0.0%	0.5%
Asian alone (%)	7.1%	3.5%	13.2%	32.9%	21.1%	8.2%	2.0%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
Some Other Race alone (%)	5.4%	12.1%	4.2%	1.9%	7.7%	3.5%	4.3%
Two or More Races (%)	9.5%	9.7%	8.4%	6.2%	9.3%	5.6%	9.7%
Hispanic or Latino of Any Race (%)	12.9%	23.2%	9.0%	3.3%	19.3%	4.2%	12.4%
Foreign-born							
Foreign-born population	1,236,518	151,560	366,954	11,496	33,865	1,534	9,306
Naturalized U.S. citizen	54.5%	56.4%	51.0%	60.3%	53.4%	72.0%	63.8%
Not a U.S. citizen	45.5%	43.6%	49.0%	39.7%	46.6%	28.0%	36.2%
Region of birth: Europe	18.1%	13.4%	16.9%	16.3%	7.4%	15.6%	33.3%
Region of birth: Asia	30.5%	14.5%	42.9%	71.4%	46.2%	46.6%	9.7%
Region of birth: Africa	9.5%	5.5%	7.6%	3.0%	16.5%	0.0%	2.5%
Region of birth: Oceania	0.3%	0.2%	0.5%	0.8%	0.2%	0.0%	0.0%
Region of birth: Latin America	39.4%	64.4%	29.7%	5.7%	28.4%	26.8%	52.8%
Region of birth: Northern America	2.2%	2.0%	2.4%	2.8%	1.3%	11.0%	1.7%
Language							
English only	75.2%	71.6%	71.7%	60.0%	57.9%	83.8%	76.2%
Language other than English	24.8%	28.4%	28.3%	40.0%	42.1%	16.2%	23.8%
Speak English less than "very well"	9.7%	12.2%	9.9%	8.6%	19.5%	3.3%	10.0%

Demographics: Lexington – Peabody

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Spanish	9.6%	18.8%	6.4%	2.2%	13.1%	3.3%	8.1%
Speak English less than "very well"	4.1%	8.8%	2.4%	0.5%	5.9%	0.6%	4.1%
Other Indo-European languages	9.2%	6.4%	12.2%	14.1%	10.4%	7.7%	13.5%
Speak English less than "very well"	3.2%	2.2%	4.1%	1.7%	4.7%	0.7%	5.1%
Asian and Pacific Islander languages	4.4%	2.0%	7.8%	21.2%	15.1%	5.2%	1.5%
Speak English less than "very well"	1.9%	0.9%	2.9%	6.3%	8.1%	2.0%	0.6%
Other languages	1.6%	1.2%	2.0%	2.6%	3.5%	0.0%	0.7%
Speak English less than "very well"	0.4%	0.4%	0.5%	0.1%	0.9%	0.0%	0.2%
Employment							
Unemployment rate	5.1%	5.1%	4.2%	3.0%	5.4%	3.5%	4.8%
Unemployment rate by race/ethnicity							
White alone	4.5%	4.3%	4.0%	2.8%	4.9%	3.3%	5.3%
Black or African American alone	7.9%	4.6%	6.4%	0.0%	6.1%	0.0%	3.1%
American Indian and Alaska Native alone	6.9%	1.8%	5.5%	-	0.0%	-	0.0%
Asian alone	4.0%	3.3%	3.5%	3.7%	6.0%	0.0%	1.4%
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	10.9%	-	54.4%	-	-
Some other race alone	8.0%	7.9%	6.4%	4.2%	7.9%	18.6%	1.4%
Two or more races	7.9%	8.6%	5.4%	1.1%	2.9%	0.0%	4.8%
Hispanic or Latino origin (of any race)	8.1%	8.0%	6.2%	1.9%	5.3%	16.5%	4.6%
Unemployment rate by educational attainment							
Less than high school graduate	9.1%	10.0%	8.1%	11.5%	11.5%	0.0%	5.0%
High school graduate (includes equivalency)	6.4%	5.3%	5.9%	5.4%	5.8%	4.8%	3.6%
Some college or associate's degree	5.2%	4.8%	4.9%	9.7%	5.7%	2.7%	4.2%
Bachelor's degree or higher	2.7%	3.1%	2.7%	2.2%	3.0%	1.6%	2.7%

Demographics: Lexington – Peabody

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Income and Poverty							
Median household income (dollars)	101,341	99,431	126,779	219,402	76,205	172,484	95,278
Population living below the federal poverty line in the last 12 months							
Individuals	10.0%	9.4%	7.5%	4.3%	16.0%	6.1%	6.5%
Families	6.6%	4.4%	6.7%	7.2%	3.1%	10.7%	4.0%
Individuals under 18 years of age	11.8%	12.1%	7.4%	3.9%	19.2%	6.3%	3.9%
Individuals over 65 years of age	10.2%	10.8%	8.6%	7.7%	15.5%	4.7%	8.0%
Female head of household, no spouse	19.1%	18.2%	15.4%	29.9%	21.4%	0.0%	14.6%
White alone	7.6%	7.2%	6.0%	3.5%	17.2%	4.6%	6.0%
Black or African American alone	17.1%	14.1%	15.4%	17.6%	12.4%	1.1%	5.6%
American Indian and Alaska Native alone	19.1%	19.0%	12.7%	-	39.6%	-	40.8%
Asian alone	11.0%	9.3%	8.6%	3.8%	13.2%	27.2%	0.3%
Native Hawaiian and Other Pacific Islander alone	21.7%	0.0%	4.7%	-	2.4%	-	-
Some other race alone	20.1%	19.0%	14.2%	12.2%	16.9%	0.0%	17.2%
Two or more races	15.7%	11.1%	10.5%	7.2%	19.1%	1.9%	5.9%
Hispanic or Latino origin (of any race)	20.6%	17.1%	15.1%	18.0%	22.3%	2.6%	13.7%
Less than high school graduate	24.4%	22.8%	20.4%	26.5%	25.3%	26.7%	13.0%
High school graduate (includes equivalency)	12.7%	11.8%	12.1%	18.7%	16.8%	16.6%	10.8%
Some college, associate's degree	9.2%	8.6%	8.2%	9.7%	13.6%	3.0%	6.4%
Bachelor's degree or higher	4.0%	3.5%	3.4%	2.6%	6.3%	3.3%	2.6%
With Social Security	29.8%	31.4%	25.8%	29.9%	25.3%	29.6%	40.0%
With retirement income	22.9%	22.5%	20.9%	22.3%	16.6%	24.1%	29.7%
With Supplemental Security Income	5.6%	5.8%	3.9%	1.8%	10.1%	1.7%	5.5%
With cash public assistance income	3.5%	4.6%	2.8%	2.8%	6.4%	0.8%	3.3%
With Food Stamp/SNAP benefits in the past 12 months	13.8%	16.0%	8.6%	3.1%	25.3%	2.9%	10.4%

Demographics: Lexington – Peabody

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Housing							
Occupied housing units	91.6%	94.9%	95.5%	97.4%	96.1%	96.5%	96.6%
Owner-occupied	62.6%	64.0%	61.6%	81.0%	44.0%	86.5%	65.6%
Renter-occupied	37.4%	36.0%	38.4%	19.0%	56.0%	13.5%	34.4%
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.6%	0.6%	0.4%	0.3%
Lacking complete kitchen facilities	0.8%	0.9%	0.9%	1.5%	1.7%	1.9%	1.7%
No telephone service available	0.8%	0.8%	0.6%	0.4%	1.0%	1.6%	1.1%
Monthly housing costs <35% of total household income							
Among owner-occupied units with a mortgage	22.7%	24.6%	20.7%	16.9%	28.0%	18.6%	22.3%
Among owner-occupied units without a mortgage	15.4%	16.6%	15.2%	16.9%	20.4%	20.0%	16.2%
Among occupied units paying rent	41.3%	46.3%	37.4%	43.7%	41.4%	60.8%	51.3%
Access to Technology							
Among households							
Has smartphone	89.2%	88.7%	91.5%	93.6%	86.9%	90.7%	85.5%
Has desktop or laptop	83.2%	81.0%	88.4%	96.0%	77.1%	90.0%	79.3%
With a computer	95.1%	94.8%	96.5%	97.8%	92.4%	96.9%	93.1%
With a broadband Internet subscription	91.8%	91.4%	94.2%	97.3%	87.8%	95.8%	91.0%
Transportation							
Car, truck, or van -- drove alone	62.7%	69.3%	56.0%	54.1%	73.0%	68.4%	79.6%
Car, truck, or van -- carpooled	6.9%	7.0%	6.4%	4.7%	8.6%	4.7%	6.6%
Public transportation (excluding taxicab)	7.0%	3.7%	8.0%	5.7%	2.0%	1.5%	2.5%
Walked	4.2%	2.8%	4.2%	2.2%	3.9%	0.2%	0.9%
Other means	2.5%	2.6%	3.2%	1.7%	2.6%	0.4%	1.5%
Worked from home	16.7%	14.6%	22.2%	31.6%	10.0%	24.9%	8.8%
Mean travel time to work (minutes)	29.3	28.9	30.0	30.5	27.5	32.6	27.2

Demographics: Lexington – Peabody

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Vehicles available among occupied housing units							
No vehicles available	11.8%	9.6%	10.4%	4.8%	13.8%	5.6%	9.5%
1 vehicle available	35.8%	34.6%	36.5%	27.1%	39.5%	19.9%	34.7%
2 vehicles available	35.8%	37.4%	37.8%	52.6%	31.9%	48.3%	36.9%
3 or more vehicles available	16.6%	18.4%	15.3%	15.5%	14.8%	26.2%	18.8%
Education							
Educational attainment of adults 25 years and older							
Less than 9th grade	4.2%	5.2%	3.3%	1.0%	9.3%	0.9%	5.8%
9th to 12th grade, no diploma	4.4%	4.7%	3.2%	1.5%	7.4%	1.2%	3.6%
High school graduate (includes equivalency)	22.8%	24.4%	17.5%	4.5%	30.8%	17.2%	29.6%
Some college, no degree	14.4%	15.2%	11.2%	5.0%	15.0%	13.9%	16.1%
Associate's degree	7.5%	8.2%	5.7%	3.0%	7.6%	5.6%	11.0%
Bachelor's degree	25.3%	24.9%	28.8%	26.2%	18.0%	30.8%	22.3%
Graduate or professional degree	21.4%	17.5%	30.2%	58.8%	11.9%	30.3%	11.5%
High school graduate or higher	91.4%	90.1%	93.4%	97.5%	83.3%	97.8%	90.6%
Bachelor's degree or higher	46.6%	42.3%	59.0%	85.0%	29.9%	61.1%	33.9%
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%	98.3%	89.7%	97.7%	93.1%
Bachelor's degree or higher	49.4%	47.7%	60.9%	84.6%	34.8%	62.0%	35.4%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	85.3%	89.6%	89.2%	94.3%	100.0%	92.2%
Bachelor's degree or higher	30.7%	31.0%	40.0%	51.5%	30.2%	69.1%	28.5%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	85.2%	69.1%	-	76.4%	-	78.6%
Bachelor's degree or higher	24.4%	19.7%	31.3%	-	27.8%	-	0.0%

Demographics: Lexington – Peabody

				Areas of Interest			
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody
Demographics							
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	83.9%	90.3%	97.0%	67.8%	97.9%	73.8%
Bachelor's degree or higher	64.0%	55.0%	71.3%	89.1%	25.5%	62.2%	43.6%
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%	-	-
Bachelor's degree or higher	40.0%	95.2%	20.9%	-	16.9%	-	-
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	67.5%	73.6%	85.6%	71.3%	100.0%	72.5%
Bachelor's degree or higher	20.0%	12.9%	27.1%	54.6%	12.2%	61.9%	15.9%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	81.1%	85.6%	96.2%	79.5%	98.0%	78.4%
Bachelor's degree or higher	33.6%	29.6%	46.1%	80.1%	24.7%	42.8%	29.1%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	71.1%	77.6%	91.5%	74.4%	96.9%	70.3%
Bachelor's degree or higher	23.3%	16.9%	34.9%	63.7%	15.9%	63.5%	18.1%
Health insurance coverage among civilian noninstitutionalized population (%)							
With health insurance coverage	97.4%	97.2%	97.6%	99.2%	96.0%	98.6%	97.1%
With private health insurance	73.8%	71.0%	80.0%	90.0%	59.4%	88.7%	74.7%
With public coverage	37.1%	39.9%	29.9%	23.2%	46.1%	24.0%	40.7%
No health insurance coverage	2.6%	2.8%	2.4%	0.8%	4.0%	1.4%	2.9%
Disability							
Percent of population with a disability	12.1%	12.1%	9.8%	7.2%	14.8%	7.2%	16.5%
Under 18 with a disability	4.9%	5.0%	4.1%	2.3%	6.1%	5.3%	4.7%
18-64	9.4%	9.1%	7.1%	3.9%	13.1%	3.5%	11.3%
65+	30.2%	31.0%	27.9%	22.2%	40.0%	20.7%	38.2%

Health Status

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
Access to Care									
Ratio of population to primary care physicians	103.5	73.3	128.3	128.3	128.3	128.3	128.3	73.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	151.7	145.3	145.2	145.4	145.4	145.2	152.1	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	26.9	18.0	4.3	7.0	2.4	11.4	135.3	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	8.8	no data	no data	10.9	10.8	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	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.6	7.6	3.5	7.4	4.3	15.7	11.5	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	30.1	24.6	1.9	51.6	51.0	19.9	28.7	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	Data unavailable	21	no data	no data	21.5	27.3	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	Data unavailable	22.2	no data	no data	23.4	25.4	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	Data unavailable	29.2	no data	no data	29.8	30.3	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	Data unavailable	12.9	no data	no data	15.9	15.2	BRFSS, 2022

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
Chronic Conditions									
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	10.5	no data	no data	10.6	11.2	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	Data unavailable	6.3	no data	no data	7.1	6.8	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	3.6	no data	no data	4.3	4.5	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	Data unavailable	4.3	no data	no data	4.8	5.1	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	2	no data	no data	2.3	2.2	BRFSS, 2022
Cancer									
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	85.2	no data	no data	83.7	84.8	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	69.2	no data	no data	66.9	66.8	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)									
All sites	449.4	453.1	426.6	426.9	428.4	426.7	428.1	452.0	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	58.9	52.1	52.8	52.8	52.1	51.1	59.7	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	109.8	108.6	108.6	106.9	109.0	106.6	110.5	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	76.9	no data	no data	76.2	79.5	Behavioral Risk Factor Surveillance System, 2022
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	89.3	no data	no data	88	88.6	Behavioral Risk Factor Surveillance System, 2021
Adults age 18+ with poor or fair general health (crude %)	12.9	13.6	10.6	8.8	9.1	11.1	10.0	11.4	Behavioral Risk Factor Surveillance System, 2021

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
Communicable and Infectious Disease									
STI infection cases (per 100,000)									
Chlamydia	385.8	293.2	264.0	293.2	293.2	293.2	293.2	424.5	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	6.7	9.8	9.9	9.9	9.9	9.9	6.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	90.7	84.2	84.2	84.2	84.2	84.2	90.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	289.6	288.2	288.2	288.2	288.2	288.2	289.6	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.9	2.7	2.7	2.7	2.7	2.7	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	87.0	87.0	87.0	87.0	82.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.5	4.0	4.0	4.0	4.0	4.0	4.5	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
Substance Use									
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	Data unavailable	6.9	no data	no data	8.9	9.2	BRFSS, 2021
Binge drinking % (adults), age-adjusted	17.2	Data unavailable	Data unavailable	19.4	no data	no data	18.4	21.2	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	39.3	22.2	22.2	22.2	22.2	22.2	39.3	CDC- National Vital Statistics System, 2016-2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	59.8	32.6						
Female Drug Overdose Mortality Rate (per 100,000)	17.6	20.1	12.0						
Substance-related deaths (Age-adjusted rate per 100k)									
Any substance	61.9	59.8	41.1	27.4	*	54.4	41.0	56.2	
Opioid-related deaths	33.7	32.4	20.1	*	*	25.1	*	30.5	
Alcohol-related deaths	29.1	26.7	20.4	17.0	*	22.5	29.9	1.2	
Stimulant-related deaths	23.0	22.4	13.6	10.6	*	18.4	*	19.2	
Substance-related ER visits (age-adjusted rate per 100K)									
Any substance-related ER visits	1605.7	1421.3	1246.4	724.1	1311.5	852.3	597.7	1120.1	
Opioid-related ER visits	169.3	144.9	102.9	47.3	76.7	120.8	29.5	96.7	
Opioid-related EMS Incidents	248.8	244.2	176.3	56.1	125.1	95.0	87.2	288.4	
Alcohol-related ER visits	1235.6	1059.7	962.1	536.5	1065.8	586.2	433.5	826.4	
Stimulant-related ER visits	15.7	13.8	13.6	*	*	*	*	0.0	
Substance Addiction Services									
Individuals admitted to BSAS services (crude rate per 100k)	588.4	608.6	340.3	151.2	215.5	429.7	193.4	530.5	
Number of BSAS providers		140.0	201.0	1.0	0.0	2.0	1.0	13.0	
Number of clients of BSAS services (residents)		3092.0	3702.0	46.0	17.0	127.0	31.0	79.0	
Avg. distance to BSAS provider (miles)	17.0	18.0	17.0	19.0	28.0	18.0	20.0	16.0	

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
Buprenorphine RX's filled	9982.0	8521.4	6002.1	4301.6	3997.8	9461.3	5774.0	9481.3	
Individuals who received buprenorphine RX's		756.5	508.3	380.1	465.8	774.0	466.3	1538.1	
Naloxone kits received		23764.0	35323.0	648.0	397.0	248.0	140.0	1935.0	
Naloxone kids: Opioid deaths Ratio		73.0	78.0	*	*	15.0	*	143.0	
Fentanyl test strips received		42200.0	50130.0	1000.0	700.0	900.0	600.0	3000.0	
Environmental Health									
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	71.8	72.4	73.3	100.0	57.4	56.5	100.0	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			66.0	50.0	76.0	70.0	80.0	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			6.2	1.9	4.3	5.4	7.5	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			87.0	55.0	61.0	58.0	68.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6			9.0	30.6	18.6	8.7	10.18.3	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9			6.6	9.6	9.9	10.1	8.4	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	NS	0.0	NS	Center for Health Information and Analysis, 2020

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
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	36.9	36.9	36.9	36.9	57.4	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	23.3	no data	no data	22.9	23.9	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	32.3	no data	no data	33.2	33.4	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	Data unavailable	20.5	no data	no data	23	20.5	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	13.4	no data	no data	14.3	15.5	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	0.4	0.0	0.1	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	3.0	3.0	3.0	3.0	4.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	7.1	7.1	7.1	7.1	7.4	County Health Rankings, 2016-2022

Health Status: Arlington – Danvers

				Areas of Interest					
	Massachusetts	Essex County	Middlesex County	Arlington	Bedford	Billerica	Burlington	Danvers	Source
Safety/Crime									
Property Crimes Offenses (#)									Massachusetts Crime Statistics, 2023
Burglary	10028.0			45.0	10.0	26.0	19.0	20.0	
Larceny-theft	60647.0			197.0	60.0	148.0	401.0	291.0	
Motor vehicle theft	7224.0			19.0	2.0	18.0	27.0	26.0	
Arson	377.0			1.0	0.0	2.0	3.0	0.0	
Crimes Against Persons Offenses (#)									
Murder/non-negligent manslaughter	162.0			0.0	0.0	0.0		0.0	
Sex offenses	4365.0			6.0	1.0	14.0	11.0	21.0	
Assaults	72086.0			169.0	15.0	167.0	118.0	192.0	
Human trafficking	0.0			0.0	0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)									
Race/Ethnicity/Ancestry Bias	222.0			1.0	0.0			0.0	
Religious Bias	88.0			2.0	1.0			0.0	
Sexual Orientation Bias	80.0			2.0	0.0			0.0	
Gender Identity Bias	22.0			0.0	0.0			1.0	
Gender Bias	2.0			0.0	0.0			0.0	
Disability Bias	0.0			0.0	0.0			0.0	

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Access to Care								
Ratio of population to primary care physicians	103.5	73.3	128.3	128.3	128.3	73.3	73.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	151.7	145.3	145.2	145.3	152.4	151.7	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	26.9	18.0	0.0	80.5	7.7	22.0	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	7.8	18.5	10.4	13.9	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	53.3	2.8	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.6	7.6	3.3	10.7	2.4	10.7	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	30.1	24.6	28.3	8.9	69.6	31.6	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	Data unavailable	17.6	26.2	26.6	29.9	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	Data unavailable	20.9	28.3	24	26.6	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	Data unavailable	29.6	31.4	30.1	30.6	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	Data unavailable	12.5	24.7	15.2	19	BRFSS, 2022

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Chronic Conditions								
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	9.3	11.7	10.9	11.8	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	Data unavailable	6.5	10.4	6.9	7.9	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	2.9	6.2	4.4	5.6	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	Data unavailable	4	6.1	5.2	5.7	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	1.8	3.2	2.2	2.6	BRFSS, 2022
Cancer								
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	85.1	80.1	86	83.2	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	68.2	59.6	68.3	64.6	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)								
All sites	449.4	453.1	426.6	427.2	426.6	454.6	452.9	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	58.9	52.1	51.4	51.8	58.6	58.7	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	109.8	108.6	108.0	108.4	110.0	111.2	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	77.4	75.9	79.8	78.9	Behavioral Risk Factor Surveillance System, 2022
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	90.1	84.2	88.6	87.8	Behavioral Risk Factor Surveillance System, 2021
Adults age 18+ with poor or fair general health (crude %)	12.9	13.6	10.6	8.1	17.1	9.9	13.5	Behavioral Risk Factor Surveillance System, 2021

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Communicable and Infectious Disease								
STI infection cases (per 100,000)								
Chlamydia	385.8	293.2	264.0	293.2	293.2	424.5	424.5	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	6.7	9.8	9.9	9.9	6.7	6.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	90.7	84.2	84.2	84.2	90.7	90.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	289.6	288.2	288.2	288.2	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	2.7	2.7	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	87.0	87.0	82.0	82.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.5	4.0	4.0	4.0	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	5.5	13.9	8.6	12.1	BRFSS, 2021
Binge drinking % (adults), age-adjusted	17.2	Data unavailable	Data unavailable	17.4	15.8	20.8	20.1	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	39.3	22.2	22.2	22.2	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					
Female Drug Overdose Mortality Rate (per 100,000)	17.6	20.1	12.0					

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Substance-related deaths (Age-adjusted rate per 100k)								CDC- National Vital Statistics System, 2016-2020
Any substance	61.9	59.8	41.1	*	77.7	*	65.3	
Opioid-related deaths	33.7	32.4	20.1	*	44.4	*	30.0	
Alcohol-related deaths	29.1	26.7	20.4	0.0	37.7	0.0	30.6	
Stimulant-related deaths	23.0	22.4	13.6	*	29.9	*	15.7	
Substance-related ER visits (age-adjusted rate per 100K)								
Any substance-related ER visits	1605.7	1421.3	1246.4	482.2	3058.2	643.4	1151.6	
Opioid-related ER visits	169.3	144.9	102.9	*	468.6	73.5	107.5	
Opioid-related EMS Incidents	248.8	244.2	176.3	29.0	643.0	*	200.1	
Alcohol-related ER visits	1235.6	1059.7	962.1	307.9	2291.6	456.9	864.5	
Stimulant-related ER visits	15.7	13.8	13.6	0.0	27.2	0.0	*	
Substance Addiction Services								
Individuals admitted to BSAS services (crude rate per 100k)	588.4	608.6	340.3	84.2	1155.3	215.4	596.5	
Number of BSAS providers		140.0	201.0	1.0	29.0	4.0	6.0	
Number of clients of BSAS services (residents)		3092.0	3702.0	21.0	939.0	19.0	196.0	
Avg. distance to BSAS provider (miles)	17.0	18.0	17.0	24.0	15.0	18.0	17.0	
Buprenorphine RX's filled	9982.0	8521.4	6002.1	1558.6	11013.9	4276.9	11136.0	
Individuals who received buprenorphine RX's		756.5	508.3	148.0	928.6	407.7	985.7	
Naloxone kits received		23764.0	35323.0	307.0	1833.0	157.0	1230.0	
Naloxone kids: Opioid deaths Ratio		73.0	78.0	*	78.0	*	62.0	
Fentanyl test strips received		42200.0	50130.0	3200.0	7400.0	800.0	1400.0	

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Environmental Health								
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	71.8	72.4	66.8	100.0	55.2	77.4	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			50.0	63.0	90.0	81.0	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			5.0	24.1	0.5	6.4	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			67.0	77.0	70.0	64.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6			9.0	39.2	NS	23.1	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9			-	11.3	10.0	5.1	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	8.1	5.5	NS	19.5	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

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Mental Health								
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	57.4	36.9	36.9	36.9	57.4	57.4	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	20	23.8	23.1	22.3	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	31.9	36.5	33.4	31.2	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	Data unavailable	22.1	29.3	21.2	21.7	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	11.6	17.7	15	15.7	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	0.3	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	3.0	3.0	4.0	4.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	7.1	7.1	7.4	7.4	County Health Rankings, 2016-2022

Health Status: Lexington – Peabody

				Areas of Interest				
	Massachusetts	Essex County	Middlesex County	Lexington	Lowell	Lynnfield	Peabody	Source
Safety/Crime								
Property Crimes Offenses (#)								Massachusetts Crime Statistics, 2023
Burglary	10028.0			20.0	252.0	17.0	49.0	
Larceny-theft	60647.0			81.0	1628.0	81.0	385.0	
Motor vehicle theft	7224.0			8.0	202.0	3.0	22.0	
Arson	377.0			0.0	8.0	0.0	2.0	
Crimes Against Persons Offenses (#)								
Murder/non-negligent manslaughter	162.0			0.0	6.0	0.0	0.0	
Sex offenses	4365.0			6.0	51.0	1.0	23.0	
Assaults	72086.0			67.0	1804.0	31.0	363.0	
Human trafficking	0.0			0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)								
Race/Ethnicity/Ancestry Bias	222.0				1.0			
Religious Bias	88.0				0.0			
Sexual Orientation Bias	80.0				0.0			
Gender Identity Bias	22.0				0.0			
Gender Bias	2.0				0.0			
Disability Bias	0.0				0.0			

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

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

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
		No steady place	1908	1.30%	528	1.10%
		Worried about losing	1908	2.60%	528	2.70%
Housing	Current living situation	Steady place	1908	95.10%	528	95.80%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	510	22.00%
		Never	1963	87.80%	546	90.80%
		Sometimes	1963	9.90%	546	7.00%
Basic Needs	Food insecurity, past month	A lot	1963	2.30%	546	2.20%
		No internet	1938	1.30%	538	0.90%
		Does not work well	1938	6.60%	538	5.20%
Basic Needs	Current internet access	Works well	1938	92.20%	538	93.90%
		Somewhat or strongly disagree	1864	2.50%	516	1.60%
		Somewhat agree	1864	14.60%	516	10.30%
Neighborhood	Able to get where you need to go	Strongly agree	1864	82.80%	516	88.20%
		Never	1833	65.00%	504	73.80%
		Rarely	1833	22.80%	504	19.20%
	Experienced neighborhood violence,	Somewhat often	1833	8.50%	504	4.60%
Neighborhood	lifetime	Very often	1833	3.70%	504	2.40%

CHES – Youth

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
		No	1739	3.90%	469	3.20%
		Yes, adult in home	1739	80.50%	469	83.80%
		Yes, adult outside home	1739	37.30%	469	36.20%
Safety & Support	Have someone to talk to if needed help	Yes, friend or non-adult family	1739	43.00%	469	44.80%
		Not at all	1768	1.00%	473	1.70%
		Somewhat	1768	7.70%	473	6.80%
Safety & Support	Feel safe with my family/caregivers	Very much	1768	91.30%	473	91.50%
		Not at all	1760	5.90%	472	5.50%
		Somewhat	1760	29.10%	472	28.60%
Safety & Support	Feel I belong at school	Very much	1760	65.00%	472	65.90%
		Not at all	1745	2.40%	467	3.20%
		Somewhat	1745	17.10%	467	15.40%
Safety & Support	Feel my family/caregivers support my interests	Very much	1745	80.50%	467	81.40%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	471	66.50%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	471	5.30%
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	471	18.30%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	471	13.40%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	471	6.40%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	471	13.00%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	471	72.20%

CHES – Youth

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Safety & Support	Experienced intimate partner violence (a)	Ever	1589	13.10%	442	8.60%
		In past year	1567	7.80%	440	5.20%
Safety & Support	Experienced household violence (b)	Ever	1536	14.20%	420	11.00%
		In past year	1519	5.50%	417	5.30%
Safety & Support	Experienced sexual violence (c)	Ever	1558	9.20%	430	7.70%
		In past year	1551	3.10%	428	2.10%
Safety & Support	Experienced discrimination	Ever	1674	45.20%	446	44.80%
		In past year	1674	19.60%	446	19.50%
Employment	Worked for pay, past year	No	1652	51.50%	433	56.10%
		Yes, <10 hours per week	1652	18.10%	433	21.70%
		Yes, 11-19 hours per week	1652	13.30%	433	12.20%
		Yes, 20-34 hours per week	1652	10.30%	433	6.50%
		Yes, >35 hours per week	1652	6.80%	433	3.50%
Education	Educational challenges, past year	None of these	1484	66.80%	386	67.60%
		Frequent absences	1484	7.60%	386	8.30%
		Needed more support in school	1484	7.00%	386	6.50%
		Needed more support outside school	1484	6.30%	386	8.00%
		Safety concerns	1484	5.10%	386	5.20%
		Temperature in classroom	1484	18.50%	386	16.60%
Education	Hurt or harrassed by school staff, past year	Never	1503	87.70%	391	90.50%
		Once or twice	1503	9.10%	391	6.90%
		Monthly	1503	1.60%	391	1.30%
		Daily	1503	1.60%	391	1.30%

Data Notes:

a. 6.1% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
b. 9.1% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
c. 8.2% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES – Youth

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
		College-preparation	1459	57.90%	382	61.30%
		Extracurricular activities	1459	74.40%	382	82.20%
		Guidance counselor	1459	58.80%	382	59.40%
Education	Helpful school resources provided	Programs to reduce bullying, violence, etc.	1459	19.10%	382	24.30%
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	139	5.00%
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	106	5.70%
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%	72	20.80%
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%	234	10.70%
		Low	1376	22.10%	362	22.10%
		Medium	1376	33.00%	362	34.00%
		High	1376	18.40%	362	20.20%
Mental Health	Psychological distress, past month	Very high	1376	26.60%	362	23.80%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	394	14.70%
Mental Health	Suicide ideation, past year (d)	Yes	1338	14.60%	352	12.80%

Data Notes: d. 12.0% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES – Youth

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
Substance Use	Tobacco use, past month	Yes	1499	8.00%	390	6.70%
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	382	8.40%
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%	382	7.30%
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	383	9.40%
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%	*	*

CHES – Youth

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
		Yes	1445	7.30%	376	8.00%
Emerging Issues	Someone close died from COVID-19	Not sure	1445	5.70%	376	6.40%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (1)	Yes	767	25.40%	190	22.10%
Emerging Issues	Flooding in home or on street, past 5 years (1)	Yes	767	5.50%	190	7.40%
Emerging Issues	More ticks or mosquitoes, past 5 years (1)	Yes	767	20.20%	190	20.50%
Emerging Issues	Power outages, past 5 years (1)	Yes	767	25.40%	190	26.80%
Emerging Issues	School cancellation due to weather, past 5 years (1)	Yes	767	39.40%	190	38.90%
Emerging Issues	Unable to work due to weather, past 5 years (1)	Yes	767	7.60%	190	6.80%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (1)	Yes	767	33.30%	190	28.90%
Emerging Issues	Other climate impact, past 5 years (1)	Yes	767	0.90%	*	*
Emerging Issues	ANY climate impact, past 5 years (1)	Yes	767	59.70%	190	56.30%

Data Notes: 1. Asked on 2 splits (~50% of respondents)

Community Health Equity Survey (CHES) – Adult

CHES Adult: Arlington – Danvers

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		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	773	1.90%	3353	1.70%	*	*	111	7.20%	*	*	*	*
		Worried about losing	14888	8.00%	773	10.20%	3353	6.50%	154	9.70%	*	*	*	*	*	*
Housing	Current living situation	Steady place	14888	89.30%	773	87.50%	3353	91.60%	154	90.30%	111	90.10%	90	92.20%	33	87.90%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	571	37.30%	2437	39.10%	109	44.00%	73	17.80%	68	41.20%	*	*
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	374	5.90%	1689	4.70%	*	*	*	*	*	*	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	374	20.10%	1689	12.20%	77	7.80%	59	8.50%	*	*	*	*
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	374	17.40%	1689	13.30%	77	18.20%	59	8.50%	*	*	*	*
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	374	22.70%	1689	15.60%	77	24.70%	*	*	42	11.90%	*	*
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	374	8.00%	1689	6.00%	77	7.80%	*	*	*	*	*	*
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	374	14.20%	1689	9.40%	77	11.70%	*	*	*	*	*	*
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	374	19.80%	1689	11.90%	77	11.70%	59	8.50%	42	11.90%	*	*
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	374	43.60%	1689	27.10%	77	28.60%	59	16.90%	42	21.40%	*	*
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	768	18.00%	3366	12.40%	152	7.20%	111	11.70%	*	*	*	*

CHES Adult: Arlington – Danvers

			Massachusetts		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Not enough money	13814	16.50%	703	18.90%	3141	11.00%	147	8.80%	105	13.30%	80	7.50%	*	*
		Just enough money	13814	31.10%	703	32.70%	3141	24.90%	147	21.80%	105	12.40%	80	28.80%	30	50.00%
Basic Needs	End of month finances	Money left over	13814	52.40%	703	48.40%	3141	64.10%	147	69.40%	105	74.30%	80	63.80%	30	36.70%
		No internet	11425	3.00%	588	1.70%	2514	1.60%	*	*	*	*	*	*	*	*
		Does not work well	11425	9.30%	588	9.00%	2514	7.00%	*	*	*	*	*	*	*	*
Basic Needs	Current internet access (2)	Works well	11425	87.70%	588	89.30%	2514	91.50%	113	95.60%	75	94.70%	69	97.10%	*	*
		Somewhat or strongly disagree	11064	7.00%	572	5.90%	2521	5.50%	115	4.30%	85	5.90%	*	*	*	*
		Somewhat agree	11064	22.00%	572	22.40%	2521	21.70%	115	22.60%	85	15.30%	73	28.80%	*	*
Neighborhood	Able to get where you need to go (2)	Strongly agree	11064	71.00%	572	71.70%	2521	72.80%	115	73.00%	85	78.80%	73	65.80%	*	*
		Never	11008	58.60%	566	55.80%	2509	63.50%	115	62.60%	84	82.10%	73	67.10%	*	*
		Rarely	11008	28.90%	566	29.20%	2509	28.60%	115	31.30%	84	10.70%	73	28.80%	*	*
		Somewhat often	11008	9.10%	566	11.50%	2509	5.80%	115	5.20%	*	*	*	*	*	*
Neighborhood	Experienced neighborhood violence, lifetime (2)	Very often	11008	3.40%	566	3.50%	2509	2.10%	*	*	*	*	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	734	78.10%	3236	83.50%	147	85.00%	104	77.90%	90	84.40%	31	83.90%
		Not sure	14393	6.50%	734	7.90%	3236	6.60%	147	6.80%	104	6.70%	90	6.70%	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	736	71.30%	3233	75.50%	147	74.10%	104	75.00%	90	68.90%	31	64.50%
		Not sure	14366	10.20%	736	10.90%	3233	10.80%	147	15.00%	104	8.70%	90	15.60%	31	22.60%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	735	60.50%	3226	72.50%	146	69.20%	103	68.90%	89	68.50%	31	67.70%
		Not sure	14325	12.90%	735	13.60%	3226	11.60%	146	15.80%	103	10.70%	89	14.60%	31	16.10%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	730	78.60%	3222	82.70%	147	83.00%	103	77.70%	89	77.50%	31	87.10%
		Not sure	14336	7.00%	730	6.40%	3222	6.80%	147	10.90%	103	5.80%	89	10.10%	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	731	57.70%	3212	66.10%	147	63.90%	105	61.00%	89	57.30%	31	54.80%
		Not sure	14247	16.30%	731	17.60%	3212	17.40%	147	19.00%	105	19.00%	89	19.10%	31	25.80%

CHES Adult: Arlington – Danvers

			Massachusetts		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Experienced intimate partner violence (a)	Ever	13621	29.70%	693	34.20%	3068	26.50%	141	31.90%	102	22.50%	84	27.40%	*	*
		In past year	13359	4.50%	677	5.00%	3029	3.20%	*	*	102	4.90%	*	*	*	*
Safety & Support	Experienced sexual violence (b)	Ever	13628	21.00%	697	23.70%	3073	22.60%	140	28.60%	103	13.60%	86	22.10%	30	20.00%
		In past year	13593	1.40%	695	1.20%	3070	1.20%	*	*	*	*	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	725	56.30%	3160	59.10%	142	64.80%	105	49.50%	86	58.10%	30	40.00%
		In past year	14130	18.00%	725	18.90%	3160	17.20%	142	19.70%	105	13.30%	86	18.60%	*	*
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	388	21.60%	1542	19.30%	74	12.20%	37	13.50%	37	16.20%	*	*
Employment	Location of work (among all workers)	At home only	9173	7.50%	527	5.30%	2091	10.40%	95	12.60%	47	14.90%	52	13.50%	*	*
		Outside home only	9173	54.60%	527	56.50%	2091	42.40%	95	33.70%	47	29.80%	52	51.90%	*	*
		Both at home/outside home	9173	37.40%	527	38.00%	2091	46.60%	95	52.60%	47	55.30%	52	34.60%	*	*
Employment	Paid sick leave at work (among all workers) (2)	Yes	6903	75.30%	394	78.20%	1543	76.80%	73	82.20%	36	72.20%	37	78.40%	*	*
		Not sure	6903	4.20%	394	4.10%	1543	3.60%	*	*	*	*	*	*	*	*

Data Notes:

a. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
b. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Arlington – Danvers

			Massachusetts		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	365	60.50%	1509	63.00%	71	64.80%	44	65.90%	43	60.50%	*	*
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	171	9.90%	849	5.90%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	88	10.20%	443	7.70%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	154	9.10%	713	6.60%	37	13.50%	*	*	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care) (2)	Yes	334	25.40%	*	*	69	34.80%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care) (2)	Yes	2441	21.10%	129	20.90%	596	17.40%	30	20.00%	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care) (2)	Yes	998	7.00%	*	*	243	6.60%	*	*	*	*	*	*	*	*
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%	174	11.50%	*	*	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	360	15.80%	1655	12.60%	88	19.30%	43	11.60%	41	22.00%	*	*

CHES Adult: Arlington – Danvers

			Massachusetts		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		One or more visit	6747	51.20%	364	51.10%	1504	58.80%	70	60.00%	43	53.50%	42	57.10%	*	*
		Offered, didn't have	6747	7.00%	364	5.20%	1504	7.60%	70	12.90%	*	*	*	*	*	*
		Not offered	6747	22.10%	364	21.40%	1504	19.00%	70	17.10%	43	25.60%	42	26.20%	*	*
Healthcare Access	Telehealth visit, past year (1)	No healthcare visits	6747	20.30%	364	23.10%	1504	14.80%	70	10.00%	43	11.60%	42	14.30%	*	*
	Child had unmet	Yes	4184	20.20%	237	19.80%	1016	19.20%	44	15.90%	*	*	*	*	*	*
Healthcare Access	mental health care need (among parents)	Not sure	4184	3.80%	237	5.10%	1016	3.60%	*	*	*	*	*	*	*	*
		Low	13267	36.80%	689	33.50%	3024	38.70%	137	37.20%	101	51.50%	82	42.70%	*	*
		Medium	13267	32.00%	689	32.50%	3024	34.30%	137	29.20%	101	29.70%	82	37.80%	*	*
Mental Health	Psychological distress, past month	High	13267	13.90%	689	14.70%	3024	13.70%	137	18.20%	101	8.90%	82	8.50%	*	*
		Very high	13267	17.30%	689	19.30%	3024	13.40%	137	15.30%	101	9.90%	82	11.00%	*	*
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	524	13.70%	2311	10.90%	102	17.60%	77	7.80%	68	7.40%	*	*
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	674	6.20%	2981	7.00%	132	12.10%	*	*	80	8.80%	*	*

Data Notes: c. 4.7% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Arlington – Danvers

			Massachusetts		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	520	10.80%	2294	8.40%	*	*	*	*	*	*	*	*
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	701	49.90%	3027	56.30%	135	58.50%	99	59.60%	81	58.00%	*	*
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	707	6.40%	3057	4.40%	135	6.70%	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	707	7.10%	3061	5.40%	135	7.40%	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	707	9.90%	3058	11.20%	135	9.60%	101	7.90%	84	6.00%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	707	14.30%	3061	16.60%	135	18.50%	101	12.90%	85	12.90%	*	*
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	3061	0.40%	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	707	0.80%	3061	0.70%	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	*	*	3061	0.80%	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	*	*	3061	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	*	*	3061	0.30%	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	13626	0.60%	*	*	3061	0.50%	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	707	1.30%	3061	1.20%	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	707	1.60%	3061	0.60%	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	707	2.30%	3061	1.80%	135	3.70%	*	*	*	*	*	*

CHES Adult: Arlington – Danvers

			Massachusetts		Essex County		Middlesex County		Arlington		Bedford		Burlington		Danvers	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	COVID-19 vaccination, past year (1)	Yes	6729	67.80%	360	61.10%	1506	76.40%	68	82.40%	45	86.70%	44	68.20%	*	*
		Not sure	6729	3.60%	360	5.00%	1506	3.30%	*	*	*	*	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	335	30.10%	1445	17.90%	50	18.00%	*	*	42	11.90%	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	523	39.00%	2312	40.00%	99	52.50%	75	24.00%	58	34.50%	*	*
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	523	9.40%	2312	11.90%	99	12.10%	75	10.70%	58	10.30%	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	523	24.10%	2312	35.20%	99	43.40%	75	45.30%	58	34.50%	*	*
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	523	19.70%	2312	25.60%	99	19.20%	75	40.00%	58	25.90%	*	*
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	523	14.70%	2312	19.20%	99	28.30%	75	22.70%	58	17.20%	*	*
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	523	13.40%	2312	14.60%	99	12.10%	75	14.70%	58	15.50%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	523	24.50%	2312	32.40%	99	37.40%	75	26.70%	58	25.90%	*	*
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	523	1.90%	2312	1.70%	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	523	65.60%	2312	72.30%	99	81.80%	75	77.30%	58	70.70%	*	*

CHES Adult: Lexington – Peabody

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		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	773	1.90%	3353	1.70%	*	*	*	*	*	*
		Worried about losing	14888	8.00%	773	10.20%	3353	6.50%	*	*	83	13.30%	*	*
Housing	Current living situation	Steady place	14888	89.30%	773	87.50%	3353	91.60%	60	95.00%	83	86.70%	37	89.20%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	571	37.30%	2437	39.10%	46	23.90%	68	54.40%	*	*
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	374	5.90%	1689	4.70%	*	*	38	13.20%	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	374	20.10%	1689	12.20%	*	*	38	26.30%	*	*
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	374	17.40%	1689	13.30%	*	*	38	23.70%	*	*
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	374	22.70%	1689	15.60%	*	*	38	39.50%	*	*
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	374	8.00%	1689	6.00%	*	*	*	*	*	*
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	374	14.20%	1689	9.40%	*	*	38	23.70%	*	*
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	374	19.80%	1689	11.90%	*	*	38	34.20%	*	*
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	374	43.60%	1689	27.10%	*	*	38	60.50%	*	*
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	768	18.00%	3366	12.40%	60	10.00%	83	27.70%	*	*
		Not enough money	13814	16.50%	703	18.90%	3141	11.00%	*	*	75	21.30%	*	*
		Just enough money	13814	31.10%	703	32.70%	3141	24.90%	51	21.60%	75	41.30%	36	27.80%
Basic Needs	End of month finances	Money left over	13814	52.40%	703	48.40%	3141	64.10%	51	74.50%	75	37.30%	36	61.10%

CHES Adult: Lexington – Peabody

			Massachusetts		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Basic Needs	Current internet access (2)	No internet	11425	3.00%	588	1.70%	2514	1.60%	*	*	*	*	*	*
		Does not work well	11425	9.30%	588	9.00%	2514	7.00%	*	*	68	20.60%	*	*
		Works well	11425	87.70%	588	89.30%	2514	91.50%	47	93.60%	68	76.50%	*	*
Neighborhood	Able to get where you need to go (2)	Somewhat or strongly disagree	11064	7.00%	572	5.90%	2521	5.50%	*	*	*	*	*	*
		Somewhat agree	11064	22.00%	572	22.40%	2521	21.70%	39	28.20%	61	37.70%	*	*
		Strongly agree	11064	71.00%	572	71.70%	2521	72.80%	39	66.70%	61	60.70%	*	*
Neighborhood	Experienced neighborhood violence, lifetime (2)	Never	11008	58.60%	566	55.80%	2509	63.50%	38	81.60%	60	35.00%	*	*
		Rarely	11008	28.90%	566	29.20%	2509	28.60%	38	15.80%	60	40.00%	*	*
		Somewhat often	11008	9.10%	566	11.50%	2509	5.80%	*	*	60	18.30%	*	*
		Very often	11008	3.40%	566	3.50%	2509	2.10%	*	*	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	734	78.10%	3236	83.50%	56	91.10%	81	74.10%	37	81.10%
		Not sure	14393	6.50%	734	7.90%	3236	6.60%	*	*	81	11.10%	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	736	71.30%	3233	75.50%	56	76.80%	81	66.70%	37	70.30%
		Not sure	14366	10.20%	736	10.90%	3233	10.80%	56	8.90%	81	18.50%	37	13.50%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	735	60.50%	3226	72.50%	56	76.80%	80	61.30%	36	72.20%
		Not sure	14325	12.90%	735	13.60%	3226	11.60%	56	8.90%	80	18.80%	*	*
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	730	78.60%	3222	82.70%	55	87.30%	81	75.30%	37	83.80%
		Not sure	14336	7.00%	730	6.40%	3222	6.80%	*	*	81	7.40%	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	731	57.70%	3212	66.10%	54	74.10%	81	54.30%	36	55.60%
		Not sure	14247	16.30%	731	17.60%	3212	17.40%	54	14.80%	81	21.00%	*	*

CHES Adult: Lexington – Peabody

			Massachusetts		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Experienced intimate partner violence (a)	Ever	13621	29.70%	693	34.20%	3068	26.50%	54	18.50%	74	33.80%	36	19.40%
		In past year	13359	4.50%	677	5.00%	3029	3.20%	*	*	72	8.30%	*	*
Safety & Support	Experienced sexual violence (b)	Ever	13628	21.00%	697	23.70%	3073	22.60%	54	14.80%	76	18.40%	36	13.90%
		In past year	13593	1.40%	695	1.20%	3070	1.20%	*	*	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	725	56.30%	3160	59.10%	55	70.90%	77	68.80%	37	64.90%
		In past year	14130	18.00%	725	18.90%	3160	17.20%	55	30.90%	77	32.50%	37	24.30%
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	388	21.60%	1542	19.30%	32	18.80%	44	31.80%	*	*
Employment	Location of work (among all workers)	At home only	9173	7.50%	527	5.30%	2091	10.40%	38	13.20%	*	*	*	*
		Outside home only	9173	54.60%	527	56.50%	2091	42.40%	38	31.60%	59	61.00%	*	*
		Both at home/outside home	9173	37.40%	527	38.00%	2091	46.60%	38	55.30%	59	35.60%	*	*
Employment	Paid sick leave at work (among all workers) (2)	Yes	6903	75.30%	394	78.20%	1543	76.80%	32	71.90%	44	79.50%	*	*
		Not sure	6903	4.20%	394	4.10%	1543	3.60%	*	*	*	*	*	*

Data Notes:

a. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.
b. 3.9% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Lexington – Peabody

			Massachusetts		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	365	60.50%	1509	63.00%	*	*	41	75.60%	*	*
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	171	9.90%	849	5.90%	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	88	10.20%	443	7.70%	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	154	9.10%	713	6.60%	*	*	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care) (2)	Yes	334	25.40%	*	*	69	34.80%	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care) (2)	Yes	2441	21.10%	129	20.90%	596	17.40%	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care) (2)	Yes	998	7.00%	*	*	243	6.60%	*	*	*	*	*	*
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%	174	11.50%	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	360	15.80%	1655	12.60%	*	*	34	23.50%	*	*
Healthcare Access	Telehealth visit, past year (1)	One or more visit	6747	51.20%	364	51.10%	1504	58.80%	*	*	40	40.00%	*	*
		Offered, didn't have	6747	7.00%	364	5.20%	1504	7.60%	*	*	*	*	*	*
		Not offered	6747	22.10%	364	21.40%	1504	19.00%	*	*	40	17.50%	*	*
		No healthcare visits	6747	20.30%	364	23.10%	1504	14.80%	*	*	40	32.50%	*	*

CHES Adult: Lexington – Peabody

			Massachusetts		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	237	19.80%	1016	19.20%	*	*	*	*	*	*
		Not sure	4184	3.80%	237	5.10%	1016	3.60%	*	*	*	*	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	689	33.50%	3024	38.70%	53	41.50%	70	27.10%	36	36.10%
		Medium	13267	32.00%	689	32.50%	3024	34.30%	53	41.50%	70	31.40%	36	47.20%
		High	13267	13.90%	689	14.70%	3024	13.70%	53	15.10%	70	15.70%	*	*
		Very high	13267	17.30%	689	19.30%	3024	13.40%	*	*	70	25.70%	*	*
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	524	13.70%	2311	10.90%	*	*	54	13.00%	*	*
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	674	6.20%	2981	7.00%	*	*	70	8.60%	*	*
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	520	10.80%	2294	8.40%	*	*	55	14.50%	*	*
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	701	49.90%	3027	56.30%	55	49.10%	72	36.10%	37	45.90%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	707	6.40%	3057	4.40%	*	*	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	707	7.10%	3061	5.40%	*	*	72	6.90%	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	707	9.90%	3058	11.20%	*	*	72	11.10%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	707	14.30%	3061	16.60%	*	*	72	15.30%	*	*

Data Notes: c. 4.7% of respondents reported that they preferred not to answer this question. These responses were not included in calculating the above percentages.

CHES Adult: Lexington – Peabody

			Massachusetts		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	3061	0.40%	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	707	0.80%	3061	0.70%	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	*	*	3061	0.80%	*	*	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	*	*	3061	0.30%	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	*	*	3061	0.30%	*	*	*	*	*	*
Substance Use	Opioid use, not used as prescribed, past year	Yes	13626	0.60%	*	*	3061	0.50%	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	707	1.30%	3061	1.20%	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	707	1.60%	3061	0.60%	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	707	2.30%	3061	1.80%	*	*	*	*	*	*

CHES Adult: Lexington – Peabody

			Massachusetts		Essex County		Middlesex County		Lexington		Lowell		Peabody	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	COVID-19 vaccination, past year (1)	Yes	6729	67.80%	360	61.10%	1506	76.40%	*	*	40	62.50%	*	*
		Not sure	6729	3.60%	360	5.00%	1506	3.30%	*	*	40	12.50%	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	335	30.10%	1445	17.90%	*	*	34	26.50%	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	523	39.00%	2312	40.00%	44	38.60%	57	43.90%	*	*
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	523	9.40%	2312	11.90%	*	*	*	*	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	523	24.10%	2312	35.20%	44	50.00%	57	15.80%	*	*
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	523	19.70%	2312	25.60%	44	40.90%	57	33.30%	*	*
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	523	14.70%	2312	19.20%	44	18.20%	57	26.30%	*	*
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	523	13.40%	2312	14.60%	44	11.40%	57	24.60%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	523	24.50%	2312	32.40%	44	20.50%	57	40.40%	*	*
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	523	1.90%	2312	1.70%	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	523	65.60%	2312	72.30%	44	75.00%	57	66.70%	*	*

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

CHIA – Ages 0-17

					Lahey Hospital & Medical Center Community Benefits Service Area					
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
All Causes										
FY24 ED Volume (all cause) rate per 100,000	4923	2661	2620	3018	3148	3647	2127	6996	3388	5529
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1296	889	1412	1417	1343	745	1682	1261	1357
Allergy										
FY24 ED Volume rate per 100,000	293	263	350	302	416	465	280	199	541	745
FY24 Inpatient Discharges rate per 100,000	29	17	14	14	30	21	23	35	30	46
Asthma										
FY24 ED Volume rate per 100,000	347	172	140	160	187	272	134	457	177	350
FY24 Inpatient Discharges rate per 100,000	67	34	28	69	106	121	43	87	23	90
Attention Deficit Hyperactivity Disorder										
FY24 ED Volume rate per 100,000	77	65	98	76	49	111	70	130	85	55
FY24 Inpatient Discharges rate per 100,000	27	41	7	19	30	68	35	30	15	49
Complication of Medical Care										
FY24 ED Volume rate per 100,000	33	2	21	21	45	32	29	40	15	36
FY24 Inpatient Discharges rate per 100,000	49	30		74	22	35	32	49		33
Diabetes										
FY24 ED Volume rate per 100,000	21	13	14	11	7	32	8	58	30	14
FY24 Inpatient Discharges rate per 100,000	8	4	7	2	7	7	20	14		3
HIV/AIDS										
FY24 ED Volume rate per 100,000	0							0		
FY24 Inpatient Discharges rate per 100,000	0									

CHIA – Ages 0-17

					Lahey Hospital & Medical Center Community Benefits Service Area					
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Infection										
FY24 ED Volume rate per 100,000	1314	544	462	692	748	1164	365	2020	874	2057
FY24 Inpatient Discharges rate per 100,000	131	84	63	134	95	100	46	149	61	125
Injuries										
FY24 ED Volume rate per 100,000	922	799	791	714	756	874	794	1068	866	964
FY24 Inpatient Discharges rate per 100,000	49	32	7	26	19	46	35	54	30	27
Learning Disorders										
FY24 ED Volume rate per 100,000	22	4	49	23	19	14	20	19	15	16
FY24 Inpatient Discharges rate per 100,000	24	19	7	50	22	60	17	25	23	29
Mental Health										
FY24 ED Volume rate per 100,000	292	237	329	244	213	283	189	500	177	241
FY24 Inpatient Discharges rate per 100,000	75	98	98	55	64	125	96	67	61	95
Obesity										
FY24 ED Volume rate per 100,000	7					7		19		1
FY24 Inpatient Discharges rate per 100,000	12	4			7	17	8	10		16
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	150	32	35	95	103	164	55	365	139	284
FY24 Inpatient Discharges rate per 100,000	32	19		55	26	75	26	39	30	53
Poisonings										
FY24 ED Volume rate per 100,000	59	30	42	40	38	85	43	73	38	182
FY24 Inpatient Discharges rate per 100,000	6	4		9	3	7	5	11		1
STIs										
FY24 ED Volume rate per 100,000	4	2				3	2	1		
FY24 Inpatient Discharges rate per 100,000	1	2						2		5
Substance Use										
FY24 ED Volume rate per 100,000	48	32	63	59	11	53	26	114	38	23
FY24 Inpatient Discharges rate per 100,000	11	13	14	11		17	2	10	15	5
Age 0-17 Total	4923	2661	2620	3018	3148	3647	2127	6996	3388	5529

CHIA – Ages 18-44

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
All Causes										
FY24 ED Volume (all cause) rate per 100,000	11106	4415	4441	7224	6939	7441	2916	16149	4843	10215
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	1572	1219	2193	2059	1888	788	2700	1825	2097
Allergy										
FY24 ED Volume rate per 100,000	952	620	931	1268	1532	2178	625	527	1284	2985
FY24 Inpatient Discharges rate per 100,000	206	93	77	158	126	182	61	137	201	191
Asthma										
FY24 ED Volume rate per 100,000	552	115	126	239	152	437	67	748	139	306
FY24 Inpatient Discharges rate per 100,000	266	167	84	210	175	250	64	225	131	295
Breast Cancer										
FY24 ED Volume rate per 100,000	7		7	4		7	2	11		1
FY24 Inpatient Discharges rate per 100,000	9	2		7	3	35	8	6		3
CHF										
FY24 ED Volume rate per 100,000	14	4		2			2	13	7	5
FY24 Inpatient Discharges rate per 100,000	50	23	7	55	15	32	17	87	61	38
Complication of Medical Care										
FY24 ED Volume rate per 100,000	120	41	77	71	84	60	26	163	69	101
FY24 Inpatient Discharges rate per 100,000	645	557	364	704	691	498	268	683	595	568
COPD and Lung Disease										
FY24 ED Volume rate per 100,000	30	2		9	11	10	14	91		14
FY24 Inpatient Discharges rate per 100,000	40	2	7	55	11	25	11	52	23	36

CHIA – Ages 18-44

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Diabetes										
FY24 ED Volume rate per 100,000	309	67	77	177	171	247	40	596	85	339
FY24 Inpatient Discharges rate per 100,000	173	89	112	136	141	154	26	230	77	166
GYN Cancer										
FY24 ED Volume rate per 100,000	2	2						0		5
FY24 Inpatient Discharges rate per 100,000	4	4				7	2	7		
Heart Disease										
FY24 ED Volume rate per 100,000	12		7	4		10		15		9
FY24 Inpatient Discharges rate per 100,000	56	21	28	57	61	28	26	80	30	57
Hepatitis										
FY24 ED Volume rate per 100,000	26	21		21	7	21	2	46		9
FY24 Inpatient Discharges rate per 100,000	70	28	28	86	26	46	14	94	123	46
HIV/AIDS										
FY24 ED Volume rate per 100,000	24	4		7	7	3	5	99		
FY24 Inpatient Discharges rate per 100,000	14	4			7			20		1
Hypertension										
FY24 ED Volume rate per 100,000	447	95	77	182	103	358	58	867	85	352
FY24 Inpatient Discharges rate per 100,000	210	106	42	151	129	143	37	265	123	219

CHIA – Ages 18-44

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Hypertension										
FY24 ED Volume rate per 100,000	447	95	77	182	103	358	58	867	85	352
FY24 Inpatient Discharges rate per 100,000	210	106	42	151	129	143	37	265	123	219
Infection										
FY24 ED Volume rate per 100,000	1595	618	574	877	886	981	412	2317	789	1523
FY24 Inpatient Discharges rate per 100,000	338	180	112	359	248	240	87	434	232	315
Injuries										
FY24 ED Volume rate per 100,000	1775	762	574	1146	1058	1135	435	2616	704	1654
FY24 Inpatient Discharges rate per 100,000	237	100	161	196	198	218	52	271	154	217
Liver Disease										
FY24 ED Volume rate per 100,000	99	28	28	81	22	157	17	138	23	127
FY24 Inpatient Discharges rate per 100,000	191	84	49	201	145	164	61	275	131	158
Mental Health										
FY24 ED Volume rate per 100,000	1310	871	490	848	638	1049	359	2235	487	994
FY24 Inpatient Discharges rate per 100,000	834	548	448	764	527	773	271	737	642	809
Obesity										
FY24 ED Volume rate per 100,000	135	15	21	55	11	128	2	259	23	108
FY24 Inpatient Discharges rate per 100,000	324	106	84	237	198	297	37	384	92	372

CHIA – Ages 18-44

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Other Cancer										
FY24 ED Volume rate per 100,000	12		14		3	10	2	8		9
FY24 Inpatient Discharges rate per 100,000	23	13	49	26	15	28	17	25	23	23
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	122	32	49	79	68	75	17	251	100	164
FY24 Inpatient Discharges rate per 100,000	85	23	14	146	84	60	23	118	23	59
Poisonings										
FY24 ED Volume rate per 100,000	182	71	77	151	95	96	49	269	139	214
FY24 Inpatient Discharges rate per 100,000	33	8	7	26	30	32	8	43	23	36
Prostate Cancer										
FY24 ED Volume rate per 100,000	0		7							
FY24 Inpatient Discharges rate per 100,000	0								7	
STIs										
FY24 ED Volume rate per 100,000	77	17		16	38	21		90		31
FY24 Inpatient Discharges rate per 100,000	37	30	14	11	11	14	8	29	38	23
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	8	2	14		3	7		10	7	1
FY24 Inpatient Discharges rate per 100,000	19	10	14	11	22	10	2	27		31
Substance Use										
FY24 ED Volume rate per 100,000	2079	670	546	1414	1001	1300	306	3854	673	2110
FY24 Inpatient Discharges rate per 100,000	588	206	175	481	347	462	90	743	379	547
Tuberculosis										
FY24 ED Volume rate per 100,000	2			2	3			4		3
FY24 Inpatient Discharges rate per 100,000	8	10	7	11	3	3		11	7	5
Age 18-44 Total	11106	4415	4441	7224	6939	7441	2916	16149	4843	10215

CHIA – Ages 45-64

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
All Causes										
FY24 ED Volume (all cause) rate per 100,000	6844	3241	4420	5063	4868	5385	2773	8842	4286	6730
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	1311	1583	2081	1830	2450	929	2550	1276	2263
Allergy										
FY24 ED Volume rate per 100,000	797	675	1436	1428	1769	2067	838	312	1361	2809
FY24 Inpatient Discharges rate per 100,000	330	163	252	266	233	315	105	150	232	302
Asthma										
FY24 ED Volume rate per 100,000	299	76	98	103	106	193	23	353	23	125
FY24 Inpatient Discharges rate per 100,000	254	174	147	251	252	297	93	199	123	260
Breast Cancer										
FY24 ED Volume rate per 100,000	40	15	28	23	22	39	20	24	7	46
FY24 Inpatient Discharges rate per 100,000	57	28	21	55	49	32	70	29	54	94
CHF										
FY24 ED Volume rate per 100,000	78	17	7	4	15	46	8	108		51
FY24 Inpatient Discharges rate per 100,000	344	156	224	297	256	444	113	418	69	363
Complication of Medical Care										
FY24 ED Volume rate per 100,000	100	89	154	93	145	150	11	111	69	114
FY24 Inpatient Discharges rate per 100,000	428	254	308	438	416	505	216	418	355	488
COPD and Lung Disease										
FY24 ED Volume rate per 100,000	239	41	98	95	15	164	11	564	15	129
FY24 Inpatient Discharges rate per 100,000	415	191	161	297	187	480	81	623	108	400
Diabetes										
FY24 ED Volume rate per 100,000	759	176	301	469	481	616	128	1441	309	765
FY24 Inpatient Discharges rate per 100,000	688	307	399	671	504	777	172	904	208	671

CHIA – Ages 45-64

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
GYN Cancer										
FY24 ED Volume rate per 100,000	4	4					2	8		5
FY24 Inpatient Discharges rate per 100,000	16	26	7	21	45	28	8	14	54	9
Heart Disease										
FY24 ED Volume rate per 100,000	37	13		9	19	42	11	51	30	25
FY24 Inpatient Discharges rate per 100,000	280	148	217	206	286	336	160	263	116	273
Hepatitis										
FY24 ED Volume rate per 100,000	23			4	3	3		64	7	9
FY24 Inpatient Discharges rate per 100,000	83	58	21	43	26	32	5	123	15	66
HIV/AIDS										
FY24 ED Volume rate per 100,000	34		14	4	3	17	2	88		3
FY24 Inpatient Discharges rate per 100,000	34	28	7	7	11	25	2	65		14
Hypertension										
FY24 ED Volume rate per 100,000	1377	285	532	601	393	974	195	2308	502	948
FY24 Inpatient Discharges rate per 100,000	918	468	553	760	737	981	300	995	479	940
Infection										
FY24 ED Volume rate per 100,000	813	368	378	479	473	630	321	1056	495	773
FY24 Inpatient Discharges rate per 100,000	627	302	378	537	485	673	195	795	433	594

CHIA – Ages 45-64

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Injuries										
FY24 ED Volume rate per 100,000	1351	810	784	951	985	1232	639	1629	835	1402
FY24 Inpatient Discharges rate per 100,000	534	335	364	443	462	713	195	510	255	566
Liver Disease										
FY24 ED Volume rate per 100,000	113	19	28	74	53	204	40	150	69	116
FY24 Inpatient Discharges rate per 100,000	383	241	294	333	317	376	119	447	116	385
Mental Health										
FY24 ED Volume rate per 100,000	703	217	567	330	301	680	178	1297	224	560
FY24 Inpatient Discharges rate per 100,000	1042	646	665	822	699	1200	350	1054	502	1138
Obesity										
FY24 ED Volume rate per 100,000	138	41	49	83	22	146	17	203	54	121
FY24 Inpatient Discharges rate per 100,000	619	285	413	561	420	727	140	561	239	684
Other Cancer										
FY24 ED Volume rate per 100,000	30	10	7	14	11	21	5	20	7	11
FY24 Inpatient Discharges rate per 100,000	100	102	28	93	126	42	40	93	139	97
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	73	17	21	64	49	35	29	122	46	83
FY24 Inpatient Discharges rate per 100,000	228	82	147	170	164	272	61	337	116	269

CHIA – Ages 45-64

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Poisonings										
FY24 ED Volume rate per 100,000	82	58	21	55	38	68	32	129	69	86
FY24 Inpatient Discharges rate per 100,000	36	23	7	28	30	57	11	38	15	35
Prostate Cancer										
FY24 ED Volume rate per 100,000	12	2		2	3	10	8	10	23	1
FY24 Inpatient Discharges rate per 100,000	28	30	28	19	11	35	37	27	30	27
STIs										
FY24 ED Volume rate per 100,000	10	6				3	23	9	7	11
FY24 Inpatient Discharges rate per 100,000	6	4	7	4		7		1	23	12
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	24	2	14	21	30	39	14	24		22
FY24 Inpatient Discharges rate per 100,000	92	28	56	124	68	46	26	106	23	95
Substance Use										
FY24 ED Volume rate per 100,000	1492	272	882	1016	657	985	219	2863	495	1485
FY24 Inpatient Discharges rate per 100,000	858	376	532	700	512	809	181	1116	185	815
Tuberculosis										
FY24 ED Volume rate per 100,000	1							3		
FY24 Inpatient Discharges rate per 100,000	11	4	7	16	7	3	8	17	7	7
Age 45-64 Total	6844	3241	4420	5063	4868	5385	2773	8842	4286	6730

CHIA – Ages 65+

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
All Causes										
FY24 ED Volume (all cause) rate per 100,000	5485	3319	4722	4296	5785	6836	3804	4160	5214	7003
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	3668	4294	4509	5510	6839	3655	3205	5191	7348
Allergy										
FY24 ED Volume rate per 100,000	798	747	1975	1587	2663	2826	1423	132	2344	3590
FY24 Inpatient Discharges rate per 100,000	671	379	609	585	691	702	450	121	1005	1027
Asthma										
FY24 ED Volume rate per 100,000	155	32	77	47	26	154	49	103	46	125
FY24 Inpatient Discharges rate per 100,000	314	252	294	352	389	483	271	153	386	664
Breast Cancer										
FY24 ED Volume rate per 100,000	69	19	28	16	11	75	43	42	7	51
FY24 Inpatient Discharges rate per 100,000	216	228	231	225	343	333	268	115	301	488
CHF										
FY24 ED Volume rate per 100,000	270	69	126	117	114	483	55	197	185	324
FY24 Inpatient Discharges rate per 100,000	1445	1106	1338	1580	1750	2346	935	1110	1779	2608
Complication of Medical Care										
FY24 ED Volume rate per 100,000	158	100	147	124	183	257	128	106	208	206
FY24 Inpatient Discharges rate per 100,000	809	616	833	841	1230	1189	707	536	1052	1391
COPD and Lung Disease										
FY24 ED Volume rate per 100,000	350	50	77	177	80	444	46	430	69	202
FY24 Inpatient Discharges rate per 100,000	1111	640	952	1246	1069	1554	511	861	967	1717

CHIA – Ages 65+

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Diabetes										
FY24 ED Volume rate per 100,000	860	200	413	537	733	1071	189	944	742	1082
FY24 Inpatient Discharges rate per 100,000	1509	1045	1057	1719	1918	2067	876	1285	1408	2420
GYN Cancer										
FY24 ED Volume rate per 100,000	7				3	10	5	2		5
FY24 Inpatient Discharges rate per 100,000	27	30	14	19	30	21	29	10	15	59
Heart Disease										
FY24 ED Volume rate per 100,000	90	26	84	26	45	154	17	46	30	84
FY24 Inpatient Discharges rate per 100,000	1079	910	1036	1136	1467	1934	812	608	1323	2060
Hepatitis										
FY24 ED Volume rate per 100,000	7	2			3			13		
FY24 Inpatient Discharges rate per 100,000	51	21	35	21	30	46	11	52		60
HIV/AIDS										
FY24 ED Volume rate per 100,000	7				3		2	20		
FY24 Inpatient Discharges rate per 100,000	14	23	7	2			14	15		12
Hypertension										
FY24 ED Volume rate per 100,000	1774	518	812	611	512	2006	409	1647	967	1379
FY24 Inpatient Discharges rate per 100,000	1758	1442	1695	1745	2166	2439	1461	1230	2050	2597

CHIA – Ages 65+

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Infection										
FY24 ED Volume rate per 100,000	718	396	490	469	726	834	371	513	564	811
FY24 Inpatient Discharges rate per 100,000	1455	1110	1352	1450	1631	2268	1151	1078	1617	2414
Injuries										
FY24 ED Volume rate per 100,000	1257	836	1099	971	1253	2121	1040	852	1005	1791
FY24 Inpatient Discharges rate per 100,000	1365	1178	1471	1383	1734	2543	1326	724	1864	2783
Liver Disease										
FY24 ED Volume rate per 100,000	65	15	14	26	42	161	32	41	23	95
FY24 Inpatient Discharges rate per 100,000	421	283	364	369	401	505	210	328	425	693
Mental Health										
FY24 ED Volume rate per 100,000	347	169	168	194	129	659	134	338	193	321
FY24 Inpatient Discharges rate per 100,000	1456	1202	1429	1376	1658	2508	1122	982	1663	2918
Obesity										
FY24 ED Volume rate per 100,000	72	17	21	19	22	111	2	53	15	71
FY24 Inpatient Discharges rate per 100,000	764	400	455	637	565	1028	274	509	711	1374
Other Cancer										
FY24 ED Volume rate per 100,000	58	28	35	16	19	71	26	22	38	33
FY24 Inpatient Discharges rate per 100,000	285	237	245	316	405	390	295	143	425	507

CHIA – Ages 65+

				Lahey Hospital & Medical Center Community Benefits Service Area						
	Massachusetts	Arlington	Bedford	Billerica	Burlington	Danvers	Lexington	Lowell	Lynnfield	Peabody
Pneumonia/Influenza										
FY24 ED Volume rate per 100,000	79	34	42	57	99	118	49	73	54	71
FY24 Inpatient Discharges rate per 100,000	627	457	469	673	596	1117	438	487	533	913
Poisonings										
FY24 ED Volume rate per 100,000	30	19	35	19	53	60	37	34	23	57
FY24 Inpatient Discharges rate per 100,000	44	26	35	62	68	57	32	28	30	66
Prostate Cancer										
FY24 ED Volume rate per 100,000	62	32	35	7	26	78	14	20	54	44
FY24 Inpatient Discharges rate per 100,000	221	198	273	213	278	397	265	110	270	387
STIs										
FY24 ED Volume rate per 100,000	1	2		2	3	3				
FY24 Inpatient Discharges rate per 100,000	7			2	7	3	8	2		7
Stroke and Other Neurovascular Diseases										
FY24 ED Volume rate per 100,000	63	43	84	43	68	372	23	37	46	202
FY24 Inpatient Discharges rate per 100,000	290	226	196	266	408	419	271	208	317	418
Substance Use										
FY24 ED Volume rate per 100,000	391	152	308	347	221	451	96	554	185	428
FY24 Inpatient Discharges rate per 100,000	552	413	427	620	439	720	195	526	417	756
Tuberculosis										
FY24 ED Volume rate per 100,000	1							1	7	
FY24 Inpatient Discharges rate per 100,000	15	19	21	23	38	10	14	27		23
Age 65+ Total	5485	3668	4722	4509	5785	6839	3804	4160	5214	7348

Community Health Survey

- FY25 LHMC 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)	☐	☐	☐	☐	☐

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.

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

   First Name: _____

   Email: _____

   Daytime Phone #: _____

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

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

FY25 BILH CHNA Survey - Lahey Hospital and Medical Center

Response Counts

Completion Rate:	**90.5%**		
	Complete		1,374
	Partial		145

Totals: 1,519

1. Select a language.

Value	Percent	Responses
Take the survey in English	87.7%	1,310
شارك في الاستطلاع باللغة العربية	0.1%	2
参加简体中文调查	7.5%	112
參加繁體中文調查	0.1%	1
Reponn sondaj la nan lang kreyòl ayisyen	0.7%	11
हिंदी में सर्वेक्षण में भाग लें	0.7%	10
Participe da pesquisa em português	1.8%	27
Пройдите анкету на русском языке	0.1%	1
Responda la encuesta en español	1.3%	19

Totals: 1,493

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	94.4%	1,421
I work in this community	22.4%	337
Other, please specify:	1.9%	28

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 %	517 34.7%	819 55.0%	82 5.5%	17 1.1%	54 3.6%	1,489
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 %	494 33.5%	819 55.5%	104 7.1%	25 1.7%	33 2.2%	1,475
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 %	558 38.1%	676 46.1%	87 5.9%	28 1.9%	117 8.0%	1,466
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 %	401 26.9%	755 50.6%	197 13.2%	50 3.4%	88 5.9%	1,491
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	459 31.5%	818 56.1%	103 7.1%	19 1.3%	59 4.0%	1,458
My community feels safe. Count Row %	572 38.8%	799 54.1%	70 4.7%	14 0.9%	21 1.4%	1,476

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	454 31.4%	768 53.1%	95 6.6%	30 2.1%	100 6.9%	1,447
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	247 17.1%	605 42.0%	142 9.9%	44 3.1%	403 28.0%	1,441
My community offers people options for staying cool during extreme heat. Count Row %	336 23.2%	644 44.5%	142 9.8%	41 2.8%	284 19.6%	1,447
My community has services that support people during times of stress and need. Count Row %	271 18.8%	666 46.2%	161 11.2%	44 3.1%	300 20.8%	1,442
I believe that all residents, including myself, can make the community a better place to live. Count Row %	613 42.5%	745 51.6%	33 2.3%	16 1.1%	37 2.6%	1,444
Totals Total Responses						1491

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	13.0%	188
Better access to health care	20.9%	301
Better access to healthy food	17.3%	249
Better access to internet	8.6%	124
Better access to public transportation	39.8%	574
Better parks and recreation	19.3%	278
Better roads	35.1%	507
Better schools	19.1%	275
Better sidewalks and trails	41.4%	597
Cleaner environment	14.4%	208
Lower crime and violence	9.4%	135
More affordable childcare	22.6%	326
More affordable housing	47.9%	691
More arts and cultural events	18.7%	270
More effective city services (like water, trash, fire department, and police)	12.7%	183
More inclusion for diverse members of the community	20.0%	289

Value	Percent	Responses
Stronger community leadership	11.9%	171
Stronger sense of community	11.8%	170
Other, please specify:	6.0%	86

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 %	119 8.5%	142 10.1%	784 55.9%	285 20.3%	73 5.2%	1,403
Health care in my community meets the mental health needs of people like me. Count Row %	104 7.6%	255 18.6%	577 42.1%	146 10.7%	288 21.0%	1,370
Totals Total Responses						1403

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

Value	Percent	Responses
A doctor's or nurse's office	84.0%	1,185
A public health clinic or community health center	7.2%	102
Urgent care provider	2.7%	38
A hospital emergency room	2.1%	29
No usual place	1.9%	27
Other, please specify:	2.1%	30

Totals: 1,411

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	9.3%	129
Not enough time	15.2%	211
Insurance problems	14.6%	203
No providers or staff speak my language	4.4%	61
Can’t get an appointment	29.6%	412
Cost	19.1%	265
Concern about COVID or other disease exposure	3.8%	53
Transportation	9.1%	126
Other, please specify:	6.7%	93
No barriers	37.6%	523

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)	51.5%	695
Alcohol or drug misuse	23.1%	311
Asthma	4.8%	65
Cancer	19.7%	266
Child abuse/neglect	5.0%	68
Diabetes	15.1%	204
Domestic violence	7.6%	103
Environment (like air quality, traffic, noise)	24.2%	327
Heart disease and stroke	18.3%	247
Hunger/malnutrition	6.8%	92
Homelessness	13.9%	187
Housing	29.8%	402
Mental health (anxiety, depression, etc.)	50.6%	683
Obesity	17.5%	236
Poor diet/inactivity	12.2%	165
Poverty	6.7%	91

Value	Percent	Responses
Smoking	6.4%	86
Suicide	6.1%	82
Trauma	6.2%	83
Underage drinking	6.9%	93
Vaping/E-cigarettes	12.2%	164
Violence	4.5%	61
Youth use of social media	28.4%	383
Infant death	1.1%	15
Rape/sexual assault	1.5%	20
Sexually transmitted infections (STIs)	1.5%	20
Teenage pregnancy	1.9%	26

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

Value	Percent	Responses
12th grade or lower (no diploma)	3.2%	44
High school (including GED, vocational high school)	8.3%	115
Started college but not finished	9.1%	126
Vocational, trade, or technical program after high school	3.4%	47
Associate degree (for example, AA, AS)	7.6%	105
Bachelor's degree (for example, BA, BS, AB)	30.2%	419
Graduate degree (for example, master's, professional, doctorate)	35.1%	487
Other, please specify:	1.2%	17
Prefer not to answer	1.9%	27

Totals: 1,387

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

Value	Percent	Responses
American Indian or Alaska Native	0.8%	12
Asian	16.1%	228
Black or African American	3.5%	49
Hispanic or Latine/a/o	4.8%	68
Middle Eastern or North African	0.6%	8
Native Hawaiian or Pacific Islander	0.3%	4
White	71.7%	1,014
Other, please specify:	1.0%	14
Not sure	0.3%	4
Prefer not to answer	3.5%	49

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.3%	18
Bisexual and/or Pansexual	3.1%	42
Gay or Lesbian	1.4%	19
Straight (Heterosexual)	82.9%	1,113
Queer	0.3%	4
Questioning/I am not sure of my sexuality	0.5%	7
I use a different term, please specify:	0.8%	11
I do not understand what this question is asking	2.1%	28
I prefer not to answer	7.5%	100

Totals: 1,342

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	77.3%	1,060
Male, Man	19.0%	261
Nonbinary, Genderqueer, not exclusively male or female	0.4%	5
Questioning/I am not sure of my gender identity	0.1%	2
I use a different term, please specify:	0.2%	3
I do not understand what this question is asking	0.8%	11
I prefer not to answer	2.2%	30

Totals: 1,372

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

Value	Percent	Responses
Childcare or school	4.2%	55
Food or groceries	13.2%	173
Formula or baby food	0.3%	4
Health care (appointments, medicine, insurance)	13.7%	179
Housing (rent, mortgage, taxes, insurance)	16.7%	219
Technology (computer, phone, internet)	6.1%	80
Transportation (car payment, gas, public transit)	8.9%	117
Utilities (electricity, water, gas)	11.1%	146
Other, please specify:	2.3%	30
None of the above	65.6%	859

14. What is your age?

Value	Percent	Responses
Under 18	0.1%	2
18-24	1.9%	26
25-44	27.4%	380
45-64	28.5%	395
65-74	18.5%	256
75-84	17.8%	247
85 and over	4.5%	63
Prefer not to answer	1.2%	17

Totals: 1,386

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

Value	Percent	Responses
Armenian	2.0%	27
Cape Verdean Creole	0.1%	2
Chinese (including Mandarin and Cantonese)	7.2%	99
English	82.3%	1,133
Haitian Creole	1.1%	15
Hindi	1.7%	24
Khmer	0.4%	5
Portuguese	1.8%	25
Russian	0.2%	3
Spanish	2.8%	39
Vietnamese	0.1%	1
Other, please specify:	5.2%	71
Prefer not to answer	1.5%	20

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	34.6%	481
Employed part-time (Less than 40 hours per week)	13.4%	186
Self-employed (Full- or part-time)	3.6%	50
A stay-at-home parent	4.3%	60
A student (Full- or part-time)	1.0%	14
Unemployed	3.2%	45
Unable to work for health reasons	2.3%	32
Retired	33.0%	459
Other, please specify:	2.3%	32
Prefer not to answer	2.2%	30

Totals: 1,389

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

Value	Percent	Responses
Yes	16.1%	220
No	80.4%	1,100
Prefer not to answer	3.6%	49

Totals: 1,369

18. I currently:

Value	Percent	Responses
Rent my home	17.2%	240
Own my home (with or without a mortgage)	65.7%	917
Live with parent or other caretakers who pay for my housing	3.5%	49
Live with family or roommates and share costs	3.9%	55
Live in a shelter, halfway house, or other temporary housing	1.0%	14
Live in senior housing or assisted living	5.4%	76
I do not currently have permanent housing	1.3%	18
Other	1.9%	26

Totals: 1,395

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

Value	Percent	Responses
I have always lived in the United States	74.3%	1,038
Less than one year	0.9%	13
1 to 3 years	3.1%	44
4 to 6 years	2.5%	35
More than 6 years, but not my whole life	18.5%	259
Prefer not to answer	0.6%	8

Totals: 1,397

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	57.3%	740
Faith community (such as a church, mosque, temple, or faith-based organization)	27.2%	352
School community (such as a college or education program that you attend or a school that your child attends)	18.1%	234
Work community (such as your place of employment or a professional association)	34.9%	451
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)	11.1%	144
A shared interest group (such as a club, sports team, political group, or advocacy group)	28.5%	368
Another city or town where I do not live	13.3%	172
Other, please feel free to share:	6.4%	83

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	31.7%	258
No	68.3%	555

Totals: 813

Appendix C:
Resource Inventory

Lahey Hospital and Medical Center Community Resource List

Community Benefits Service Area includes: Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody

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
Statewide Resources	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
	Massachusetts Behavioral Health Help Line (BHHL)	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 Services Network Inc.	Provides support, advocacy and resources to victims.	PO Box 536 Concord	888.399.6111	www.dvsn.org
	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	www.hawcdv.org
Domestic Violence	REACH Beyond Domestic Violence	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 540024 Waltham	781.891.0724 Hotline: 800.899.4000	www.reachma.org
	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
	Arlington EATS Market	Provides food assistance to residents of Arlington.	117 Broadway Arlington	339.707.6757	www.arlingtoneats.org
	Bedford Food Pantry	Provides food assistance to residents of Bedford.	12 Mudge Way Bedford	781.275.7727	www.bedfordfoodpantry.org

Food Assistance	Billerica Food Pantry	Provides food assistance to residents of Billerica.	11 Concord Rd Billerica	978.357.7560	www.billericacommunitypantry.com
	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
	Haven from Hunger	Provides food assistance to residents of Peabody and Lynnfield.	71 Wallis St Peabody	978.531.1530	www.citizensinn.org/haven-from-hunger
	Lexington Interfaith Food Pantry	Provides food assistance to residents of Lexington.	6 Meriam St Lexington	781.861.5060	www.lexingtonfoodpantry.org
	MA Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families in Massachusetts.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program?
	Merrimack Valley Food Pantry	Provides food assistance and personal care items to residents of the Merrimack Valley.	1703 Middlesex St Lowell	978.454.7272	www.mvfb.org
	The Open Pantry of Greater Lowell	Provides food assistance to residents of Greater Lowell.	13 Hurd St Lowell	978.453.6693	www.theopenpantry.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 referrals to food assistance programs in Massachusetts.		800.645.8333	www.projectbread.org/foodsource-hotline
	Supplemental Nutritional Assistance Program (SNAP)	Provides food assistance to individuals and families in Massachusetts.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps?
	Arlington Housing Authority	Provides housing assistance programs to low-resource individuals and families.	4 Winslow St # 1 Arlington	781.646.3400	www.arlingtonhousing.org
	Bedford Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	1 Ashby Place Bedford	781.275.2428	www.bedfordma.gov/480/Bedford-Housing-Authority
	Billerica Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	16 River St Billerica	978.667.2175	www.billericahousing.org
	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
	Citizens Inn, Inc.	Provides social service programs and housing resource assistance.	81 Main St Peabody	978.531.9775	www.citizensinn.org

Housing Support	Community Teamwork Inc.	Provides services and programs that assist with family and children, finances, education and job training, food and nutrition, and housing and utilities.	155 Merrimack St Lowell	978.459.0551	www.commteam.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
	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
	Heading Home	Provides emergency shelter, transitional, and permanent housing for extremely low-resource families and individuals.	186 Massachusetts Ave Boston	617.864.8140	www.headinghomeinc.org
	House of Hope	Temporary shelter providing advocacy, emergency food and clothing for persons who are unhoused.	812 Merrimack St Lowell	978.458.2870	www.houseofhopelowell.org
	Housing Corporation of Arlington	Provides information and resources for low and moderate resource families and individuals in Arlington.	252 Massachusetts Ave Arlington	781.859.5294	www.housingcorparlington.org
	Lexington Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	1 Countryside Village Lexington	781.861.0900	www.lexingtonhousing.org
	Lowell Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	350 Moody St Lowell	978.364.5311	www.lhma.org
	Lowell Transitional Living Center	Provides assistance to individuals without housing for shelter, showers, laundry, and food.	205-209 Middlesex St Lowell	978.458.9888	www.ltlc.org
	Lynnfield Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	600 Ross Dr Lynnfield	781.581.5783	www.lynnfieldma.gov/184/Lynnfield-Housing-Authority
	Metro Housing Boston	Provides information and resources for low and moderate resource families and individuals.	1411 Tremont St Boston	617.859.0400	www.MetroHousingBoston.org
	Mission of Deeds	Provides basic home essentials to those in need of assistance.	6 Chapin Ave Reading	781.944.9797	www.missionofdeeds.org
	North Shore Community Action Programs	Provides a wide range of social services for individuals and families in need of assistance.	119 Rear Foster St Peabody	978.531.0767	www.nscap.org
	Peabody Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	75 Central St Peabody	978.531.1938	www.peabodyhousing.org

	Advocates Community Behavioral Health Centers	Provides routine appointments, same-day access for urgent issues, and 24/7 crisis intervention for people of all ages.	675 Main St Waltham	781.893.5110	www.advocates.org/services/cbhc
	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
	Arbour Counseling Services	Provides therapy and individual treatment plans for individual, couple, family, and group counseling starting at age 5 as well as psychiatric services.	21 George St Lowell	978.453.5736	www.arbourhealth.com
	Arlington Youth Counseling Center	Provides a variety of high quality, innovative, and therapeutic outpatient and school-based mental health services including individual, group, and family counseling, psychiatric evaluation and medication management.	670R Mass Ave Arlington	781.316.3255	www.arlingtonma.gov/departments/health-human-services/arlington-youth-counseling-center-aycc/services
	Bedford Youth and Family Services	Offers counseling for children, adolescents, adults, and families, adult and youth information and referral, community education, substance use education, screening and diversion.	12 Mudge Way Bedford	781.275.7727	www.bedfordma.gov/299/Youth-Family-Services
	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/

Mental Health and Substance Use	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
	North Shore Veterans Counseling Services Inc.	Provides counseling services to Veterans.	45 Broadway St Beverly	978.921.4851	www.northshoreveterans.com
	Riverside Outpatient Center	Offers comprehensive mental health services for children and families.	6 Kimball Ln Ste 310 Lynnfield	781.246.2010	www.riversidecc.org/child-family-services/mental-health-substance-use-youth/outpatient-counseling-medication-youth/
	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.	36 Woburn St Reading	781.942.9277	www.triumphcenter.net
	Vinfen Community Behavioral Health Center	Provides urgent and routine outpatient services; crisis intervention services to support individuals and families.	391 Varnum Ave Lowell	978.674.6744	www.vinfen.org/services/cbhc/
	Youth Counseling Connection	Provides walk-in, accessible crisis counseling services for Lexington teens who are experiencing suicidal thoughts. They are a resource for Lexington teens who are struggling, feeling stressed, anxious, depressed or just need a place to talk and get support.	7 Harrington Rd Lexington	781.862.0330	www.youthcounselingconnection.org

	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
Senior Services	Arlington Council on Aging	Provides services for older adults in Arlington including fitness, education, social services, recreation, and transportation.	27 Maple St Arlington	781.316.3400	www.arlingtonma.gov/departments/health-human-services/council-on-aging
	Bedford Council on Aging	Provides services for older adults in Bedford including fitness, education, social services, recreation, and transportation.	12 Mudge Way Bedford	781.275.6825	www.bedfordma.gov/council-on-aging
	Billerica Council on Aging	Provides services for older adults in Billerica including fitness, education, social services, recreation, and transportation.	25 Concord Rd Billerica	978.671.0916	www.billericacoa.org
	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
	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
	Lexington Senior Center	Provides services for older adults in Lexington including fitness, education, social services, recreation, and transportation.	39 Marrett Rd Lexington	781.698.4840	www.lexingtonma.gov/354/Senior-Services
	Lowell Senior Center	Provides services for older adults in Lowell including fitness, education, social services, recreation, and transportation.	276 Broadway St Lowell	978.674.4131	www.lowellma.gov/373/senior-center
	Lynnfield Council On Aging	Provides services for older adults in Lynnfield including fitness, education, social services,	525 Salem St Lynnfield	781.598.1078	www.lynnfieldma.gov/235/Council-On-Aging
	Minuteman Senior Services	Provide supportive services for older adults and persons with disabilities.	1 Burlington Woods Dr Ste 101 Burlington	888.222.6171	www.minutemansenior.org

	Peabody Council on Aging	Provides services for older adults in Peabody including fitness, education, social services, recreation, and transportation.	79 Central St Peabody	978.531.2254	www.peabodycoa.org
	Bedford Local Transit	Offers scheduled fixed runs to shopping malls and other stops in Bedford, Billerica, and Burlington, and also on-demand door-to-door service within Bedford.	12 Mudge Way Bedford	781.275.2255	www.bedfordma.gov/521/Bedford-Local-Transit-BLT
	Lexpress	Provide local bus service to Lexington residents.	39 Marrett Rd Lexington	781.861.1210	www.lexingtonma.gov/lexpress
Transportation	Lowell Regional Transit Authority (LRTA)	Provides public transportation to the Greater Lowell area.	115 Thorndike St Lowell	978.459.0164	www.lrta.com
	MBTA Bus	Provide local bus service to Boston.			www.mbta.com
	MBTA Commuter Rail Service	Lowell Line stops in Lowell, North Billerica, Wilmington, Woburn, Winchester, and Medford.			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
Additional Resources	Arlington Boys & Girls Club	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	60 Pond Ln Arlington	781.648.1617	www.abgclub.org
	Billerica Boys & Girls Club	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	19 Campbell Rd Billerica	978.667.2193	www.billericabgc.com
	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
	YMCA of Greater Lowell	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	35 YMCA Dr Lowell	978.454.7825	www.greaterlowellymca.org

	YMCA of Metro North / Torigian Family YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	259 Lynnfield St Peabody	978.977.9622	www.ymcametronorth.org
	North Suburban YMCA / YMCA of Greater Boston	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	137 Lexington St Woburn	781.935.3270	www.ymcaboston.org/northsuburban

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

Lahey Hospital & Medical Center

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 specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations ● Racially, ethnically, linguistically diverse populations	Provide and promote career support services and career mobility programs to hospital employees and encourage locally-focused recruitment and retention.	● Career and academic advising ● Hospital-sponsored community college courses ● Hospital-sponsored English Speakers of Other Language (ESOL) classes	● # of BILH employees attending/receiving BILH-sponsored classes/workshops or services ○ Citizenship classes (Baseline(FY23): 20; Year 1(FY24): 14) ○ Career development workshops (Baseline(FY23): 135; Year 1(FY24): 15) ○ Financial literacy classes (Baseline(FY23): 189: Year 1(FY24): 207) ○ Career development services (Baseline(FY23): data not available ○ Year 1(FY24): 1044) ● # of BILH-sponsored courses sponsored (Year 1(FY24): 9 college-level courses and 2 pre-college courses)

			○ # of LHMC employees enrolled (Year 1(FY24): 39) ● # of BILH employees participating in hospital-sponsored ESOL classes (Baseline(FY23): 45; Year 1(FY24): 82) ● # of community referrals and hires (Baseline(FY23): 225 and 70 hired; Year 1(FY24): 412 and 111 hired) ● # of presentations at community events about employment opportunities (Baseline(FY23): 67; Year 1(FY24): 33) ● # of community members participating in paid training or Associate Nursing Residency program ○ Baseline(FY23): 89, including Patient Care Technician or Nursing Assistant – 30, Pharmacy Tech - 16; Perioperative LPN – 3, Medical Assistant – 21, Behavioral Health role – 4, Associate Degree Nursing Residency program – 15; Year 1(FY24): 99, including Patient Care Technician or Nursing Assistant – 41, Pharmacy Tech – 22, Medical Assistant – 29, Behavioral health role – 3, Associate Degree Nursing Residency program – 4 o Year 1(FY24): BILH trained total of 99 community members to Patient Care Technician or Nursing Assistant (41), Pharmacy Tech (22), Medical Assistant (29), Behavioral Health roles (3) or into the Associate Degree Nursing Residency program (4).

			LHMC participated in offering these trainings ● # of internships and # of permanent hires (Baseline(FY23): data not available; Year 1(FY24): 107 across BILH with 37 hired permanently) ● # of clinical affiliation agreements with vocational technical high schools and # of paid and unpaid clinical placements (Baseline(FY23): data not available; Year 1(FY24): 10 clinical affiliation agreements, 47 high school students in paid cooperative education placements and 11 into unpaid clinical placements)
● Racially, ethnically, linguistically diverse populations ● LGTBQIA+	Promote equitable care, health equity and health literacy for patients, especially those who face cultural and linguistic barriers.	● Interpreter Services ● Lowell Community Health Center Keys to Health Equity Project: Language Supports	● # of Lahey Clinic Hospital Interpreter Services encounters (Baseline(FY23): 101,449; top 3 languages Spanish, Portuguese-Brazilian; Chinese-Mandarin; Year 1(FY24): 225,176; top 3 languages Spanish, Portuguese-Brazilian; Chinese-Mandarin) ● # of Lowell Community Health Center Interpreter Services encounters: (Baseline(FY23): 176,347 sessions of interpretation (in-house interpreters= 71,779; external languages line=104,568) with 17,000 patients served; Year 1(FY24): 206,099 sessions of interpretation (in-house interpreters = 84,728 in 12 different languages; external language line 121,371 with over 20,000 patients served; top languages Spanish, Portuguese, Khmer, Haitian-Creole and Pashto)

● Youth/adolescents ● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations	Promote access to health care, health insurance and patient financial counselors for patients and community members who are uninsured or underinsured.	● Patient Financial Counseling ● Serving the Health Insurance Needs of Everyone (SHINE) Program ● Primary Care Support ● Peabody High School Student-Based Health Center ● Provide community grants to support needs ● Explore ways to enhance care navigation within the community	● # of patients screened for insurance eligibility (Baseline(FY23): 17,871; Year 1(FY24): 7,051) ○ # approved for entitlement programs (Baseline(FY23): 2,103; Year 1(FY24): 794) ○ # patients served with Health Safety Net (Baseline(FY23): 2,749; Year 1(FY24): 3,514) ● # of Primary Care practices providing community-based care (Baseline(FY23): 6; Year 1(FY24): 6) ● # of students provided services through the Peabody Veterans Memorial High School Student-based Health Center (Baseline(FY23): 377; Year 1(FY24): 360) ● # of medical visits to Peabody Veteran's Memorial High School Student-based Health Center (Baseline(FY23): Medical: 748, Onsite: 747, Telehealth: 1 and Behavioral health: 1286; Year 1 (FY24): Medical: 853 and Behavioral health: 711) ○ # of students in the suspension diversion program (Baseline(FY23): 21; Year 1(FY24): 44) ○ % of students who have MassHealth or who are uninsured/underinsured: (Baseline(FY23): 68%; Year 1(FY24): 71%) ○ # of school clearance and immunization visits (Baseline(FY23): data not available; Year 1(FY24): 63 ages 4-14)

			● 1 community-based navigation program funded through community grants ○ 220 people served ○ # of community-based navigation programs funded through community grants (Baseline(FY23): 1; Year 1(FY24): 1) o # of individuals served by Community Health Worker (Baseline(FY23): 338; Year 1(FY24): 220) o # of individuals who secured housing through Community Health Worker (Baseline(FY23: data not available; Year 1(FY24): 23)

Priority: Social Determinants of Health

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Youth/adolescents • Older adults • Low-resourced populations • Racially, ethnically, linguistically diverse populations • LGTBQIA+	Provide advocacy or grant funding to support programs, policies, and initiatives that work to improve the health of the community.	• Peabody Council on Aging Transportation Support • Provide grants to support emerging community needs	• 9 grants to community organizations • 3 grants providing support to community housing efforts • 33,346 rides of which 6,791 required the use of a wheelchair lift
• Youth/adolescents • Older adults • Low-resourced populations • Racially, ethnically, linguistically diverse populations • LGTBQIA+	Advocate for and support policies and systems that improve the health of the communities.	• Support relevant policies when proposed	• # of bills supporting equitable healthcare access advocated through state hospital association or community coalitions: Baseline (FY23): data not available; Year 1(FY24): 23
• Youth/adolescents • Older adults • Low-resourced populations • Racially, ethnically, linguistically diverse populations	Collaborate with local community partners to support programs that strengthen the local workforce and address underemployment.	• Radiology Internship Program	• # of internships provided for students in Lahey Clinic Hospital Radiology Department ○ Baseline(FY23): 2 internships for students in Diagnostic Ultrasound, and 2 internships for students in Vascular Ultrasound; Lahey Clinic Hospital Nuclear Medicine provided 3, 3-month internships for Regis College Nuclear Medicine students.

			One student completed 2 internships and the second student completed 1 internship. Lahey Clinic Hospital Diagnostic Radiology had 5 graduating second years. Lahey Clinic Hospital Diagnostic Radiology had 6 first years from Jan. 2023 to May 2023, from May 2023 to August 2023, 8 First Years, and from Sept. 2023 to Dec. 2023, 7 second years and 6 first years ○ Year 1(FY24): Lahey Clinic Hospital provided 1 internship for students in Diagnostic Ultrasound. Lahey Clinic Hospital Nuclear Medicine provided 2, 3-month internships for Regis College Nuclear Medicine students. Lahey Clinic Hospital Diagnostic Radiology had 8 graduating second years. Lahey Clinic Hospital Diagnostic Radiology had 6 first years) o # of students hired for employment (Baseline(FY23): 5; Year 1(FY24): 4) ● Community Teamwork Secure Jobs Program:

			○ # participants who establish and maintain savings accounts (Year 1(FY24): Goal) ○ # participants who maintain a budget for at least 3 months (Year 1(FY24): Goal) ○ # of Secure Jobs graduates who obtain safe and affordable housing that they are able to maintain with their income (Year 1(FY24): Goal) ○ Secure Jobs graduates obtain sustainable employment in the first year (Year 1(FY24): Goal) ○ Secure Jobs graduates maintain employment for 90 days (Year 1(FY24): Goal) ○ Secure Jobs graduates increase their income in the first year of employment (Year 1(FY24): Goal) ○ # of participants who increase their employability through job readiness as demonstrated by the reduction or elimination of barriers, acquisition of soft and hard job skills, and/or training (Year 1(FY24): Goal)

● Youth/adolescents ● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations ● LGTBQIA+	Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners.	● Domestic Violence Initiative ● Provide grant funding to support community collaboration	o # Domestic Violence Initiative Meetings: (Year 1(FY24): Program staff left) o # of partnerships developed to support community collaboration with the Lowell Community Roundtable to address resources and support for newly arrived families (Baseline(FY23): 1) o # of meetings attended (Baseline(FY23): 8) o # of organizations provided with financial support to increase community-based collaboration through regional coalitions (Baseline(FY23): 1; Year 1(FY24): 1) o # of events hosted by Middlesex 3 Coalition (Baseline(FY23): data not yet available; Year 1(FY24): 19) o # of attendees at events (Baseline(FY23): data not yet available; Year 1(FY24): 1,328) o # of new partnerships developed (Baseline(FY23): data not yet available: Year 1(FY24): 35) o # of sectors represented in Middlesex 3 Coalition (Baseline(FY23): 5; Year 1(FY24): 5) o # of community trainings to increase the capacity of the external organizations (Baseline(FY23): 4; Year 1(FY24): 2)

			o # of participants (Year 1(FY24): 30 organizations and grantees) o % of respondents who were satisfied or very satisfied with the workshops (Year 1(FY24): 100%) o % of survey respondents who stated that the workshops were directly relevant to their role at their organization (Year 1(FY24): 90%)
● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations	Support programs that stabilize and promote access to affordable housing.	● Burlington Affordable Housing Coordinator ● Provide grant funding to support community housing supports	● # of encounters for the Burlington Affordable Housing Coordinator (Baseline(FY23): 28; Year 1(FY24): 33) o # of referrals to housing services to families to stabilize housing (Baseline(FY23): 10; Year 1(FY24): 16) ● # of grants provided to organizations working to stabilize housing (Baseline(FY23): 1; Year 1(FY24): 3) o # of families served by the Housing Corporation of Arlington to provide an integrated set of social service programs that provide affordable housing, prevent homelessness, connect families to vital resources, and help low-income people develop as

			leaders so that they may advocate for themselves and their community (Baseline(FY23): 119; Year 1(FY24): 78) ● # of families who were provided funding to prevent homelessness and create more stable tenancies (Baseline(FY23): 56; Year 1(FY24): 42) ● # of households provided referrals to social services (Baseline(FY23): 119; Year 1(FY24): 78) o # of families living in shelters who were provided stabilized housing through Citizens Inn (Baseline(FY23): data not available; Year 1(FY24): 13 families)
● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations	Support education, systems, programs, and environmental changes to increase knowledge and access to affordable, healthy foods.	● Merrimack Valley Food Bank Community Market Program ● Mill City Grows Community Gardens Program ● Cooking Up Good Health	● # of Individuals provided food and their demographics o Mill City Grows: ▪ FY24: 8,525 individuals served

		● Council on Aging Farmers Market Program	● Decreased social isolation ○ Mill City Grows Community Gardens Program ▪ Year 1: 20% increase in social connections formed via the garden (95% in 2023 vs. 74% in 2022) ○ Farmers Market Program ▪ Baseline: 83% of survey respondents say that socialization is an important component of the program; Year 1: data not collected ● # of families provided with resources to increase food security through Citizens Inn (Year 1(FY24): 100 families) ● # of active gardeners in the Mill City Grows Community Gardens Program (Baseline(FY23): data not available; Year 1(FY24): 591) ○ # of community gardens (Baseline(FY23): 21; Year 1(FY24): 21) ○ % of garden beds enrolled (Baseline(FY23): data not yet available; Year 1(FY24): 90%) ○ # of individuals enrolled in school-based cooking classes (Baseline(FY23): data not yet available; Year 1(FY24): 25)

			● # of Merrimack Valley Food Bank community market sites (Baseline(FY23): 4; Year 1(FY24): 5) ○ # of individuals served (Baseline(FY23): 553; Year 1(FY24): 635) ● # of Cooking Up Good Health sessions (Baseline(FY23): 12; Year 1(FY24): 12) ○ # attendees (Baseline(FY23): 71; Year 1(FY24): 120 participants) ● # of individuals provided free, fresh produce through the New Entry Sustainable Farming Project Council on Aging Farmers Market program (Baseline(FY23): 50-80 seniors per week at the Arlington, Burlington and Billerica Councils on Aging; Year 1(FY24): 175 unduplicated individuals) ○ Pounds of produce distributed (Baseline(FY23): 17,500; Year 1(FY24): 17,500) ○ # of shares (Baseline(FY23): 3,500; Year 1(FY24): 3,500) ○ % of individuals who reported increasing their daily intake of fruits and vegetables (Baseline(FY23): 69%; Year 1(FY24): 82%) ○ % individuals reported ate a greater variety of fruits and/or vegetables (Baseline(FY23): 72%; Year 1(FY24): 85%)

			○ % of individuals who reported eating higher quality produce (Baseline(FY23): 8%; Year 1(FY24): 86%)

Priority: Mental Health and Substance Use

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Youth ● Low-resourced Populations ● Racially, ethnically, linguistically diverse populations ● LGTBQIA+	Enhance relationships and partnerships with schools, youth-serving organizations, and other community partners to build capacity and increase resiliency, coping, and prevention skills.	● Provide community grants or education to address need	● # of grants provided to organizations to address issues related to mental health and substance use (Baseline(FY23): 6; Year 1(FY24): 7) ○ # of individuals served by the Center for Hope and Healing programs for survivors of domestic violence (Baseline(FY23): 98; Year 1(FY24): 78) ▪ # of support groups held (Baseline(FY23): 48; Year 1(FY24): 50) ○ # of individuals served by the Place of Promise long-term residential addiction recovery program (Baseline(FY23): 28; Year 1(FY24): 46) ▪ # of individuals who obtained medical insurance (Baseline(FY23): 32; Year 1(FY24): 40) ▪ # of individuals who obtained necessary paperwork for employment (Baseline(FY23): 32; Year 1(FY24): 43) ○ # of students who attend Burlington High School "Wellness Days" (Baseline(FY23): 870; Year 1(FY24): 850) ▪ # of vendors who participated (Baseline(FY23): 45; Year 1(FY24): 156) ○ # of individuals served by the Burlington High School adjustment counselor to provide preventative and supportive services for students identified to be at high-risk for mental health disorder (Baseline(FY23): 81; Year 1(FY24): 80) ▪ Demographics of individuals served (Baseline(FY23): 22 African American, 10

			Asian, 1 Asian/Caucasian, 36 Caucasian; Year 1(FY24): 27 African American, 9 Asian, 1 Asian/Caucasian, 32 Caucasian) ○ Torigian YMCA's Youth Mental Health Support and Substance Use Prevention Program ▪ Provide financial assistance to ensure the 40% of families served can access Y programs and services, including the proposed mental health supports (Year 1(FY24): Goal) ▪ Hire a Behavioral Analyst to provide mental and behavioral health support and referrals to the over 1,000 youth across the Torigian Family YMCA childcare programs (Year 1(FY24): Goal) ▪ # YMCA staff trained in Youth Mental Health First Aid so that they are able to identify, understand, and respond to signs of mental health and substance use challenges among children and adolescents ages 12-18 (Year 1(FY24): Goal) ○ Khmer Older Adult Action Group (KOAAG) through the Greater Lowell Health Alliance, which engages older Cambodian adults as paid community ambassadors to identify community needs and implement interventions ▪ # members who attend at least 1 monthly meeting (Year 1(FY24): Goal) ▪ # of community events, trainings, or educational sessions, or produce and distribute at least 3 Khmer-language resources (flier, brochure, video, etc.) for the elder Cambodian community that

			address mental health and/or the factors that drive mental health needs in the Cambodian community ▪ # of older adult Asian participants in the 2025 Community Health Needs Assessment who report an increase in reporting that there are opportunities for them to engage in their community and make their voices heard (Q. 26, 2022 Baseline(FY23): 38.5%), that their overall mental health is better than the year before (Q.27, 2022 Baseline(FY23): 26.6%), and a decrease in the percent of participants reporting not being able to afford mental health care (Q.35,2022 Baseline(FY23): 6.4%);Year 1: Goal) ○ # of school districts who participate in the shared Youth Risk Behavior Survey (Baseline(FY23): 9; Year 1(FY24): data not yet available) ○ Peabody Division of Social Services Community-based Navigator program to increase access to mental health and substance use support services in the Spanish and Brazilian-Portuguese speaking communities ▪ # and demographics of individuals utilizing behavioral health navigation services (Year 1(FY24): Goal) ▪ # of individuals screened and referred to services (Year 1(FY24): Goal) ▪ Successful access and utilization of the recommended resources by navigation participants (Year 1(FY24): Goal)

			▪ Increased knowledge about the resources available to participants through educational activities (Year 1(FY24): Goal) ▪ Number of community partners engaged through the grant period (Year 1(FY24): Goal) ● # of Mental Health First Aid educational sessions provided to the community (Baseline(FY23): Program began in Year 1; Year 1(FY24): 21) ○ # of individuals trained (Baseline: Program began in Year 1; Year 1(FY24): 350)
● Youth ● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations ● LGTBQIA+	Provide access to high-quality and culturally and linguistically appropriate mental health and/or substance use services through screening, monitoring, counseling, navigation, and treatment services.	● BIILH Collaborative Care Model ● Outpatient Behavioral Health Programs ● Hospital-Based Addiction Support ● Trauma Survivors Support Group	● # of individuals served through the Collaborative Care Model to increase access to behavioral healthcare (Baseline(FY23): 6 practices in the Lahey Clinic Hospital service area served 3179 individuals; Year 1(FY24): 7 practices in the Lahey Clinic Hospital service area served 2708 individuals) ● # of initial and follow-up psychological evaluations were conducted by the Emergency Services team (Baseline(FY23): data not available; Year 1(FY24): 5,704) ● # of individuals provided with mental health recovery beds at HART House (Baseline(FY23): data not available; Year 1(FY24): 78 women and 141 children) ○ # of bed days for individuals at HART House (Baseline(FY23): data not available; Year 1(FY24): 4,905) ● # of telepsychiatry services provided through BILH Behavioral Services within the Lahey Clinic Hospital community benefits service area to enhance outpatient behavioral healthcare (Baseline(FY23): 95; Year 1(FY24):data not yet available) ● # of screenings for hospital-based addiction services through the Emergency Department (Baseline(FY23): 140

			at Lahey Peabody; Year 1(FY24): 171 at Lahey Peabody and 40 at Lahey Burlington) ● # of sessions of the Trauma Support Group (Baseline(FY23): 11; Year 1(FY24): 11) ○ # of participants (Baseline(FY23): 31; Year 1(FY24): 20) ○ # of informational packets sent monthly to survivors of trauma (Baseline(FY23): 20; Year 1(FY24): 25)
● Youth ● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations ● LGTBQIA+	Improve systems for management and control of substance use disorder through education, reducing access to substances, and multidisciplinary efforts.	● LHMC Medication Disposal Program ● Burlington Police Department Substance Use Coordinator ● Burlington Council on Aging Outreach Workers ● Burlington Youth and Family Services	● Pounds of medications disposed of through the hospital-based medication disposal boxes (Baseline(FY23): data not available; Year 1(FY24): 850) ● # of encounters through the Burlington Council on Aging's social worker outreach program (Baseline(FY23): 3,283; Year 1(FY24): 4,116) ○ # of referrals provided (Baseline(FY23): 614; Year 1(FY24): 679) ● # of individuals served by the Burlington Police Department substance use coordinator (Baseline(FY23): 81; Year 1(FY24): 77) ○ # of individuals who accepted recovery services (Baseline(FY23): 28; Year 1(FY24): 33) ○ # of referrals made by the community (Baseline(FY23): data not available: Year 1(FY24): 58, with 19 walk-ins) ● # of individuals served by Burlington Youth & Family Services (Baseline(FY23): 4,286; Year 1(FY24): 4,146)

			○ # of referrals made to other organizations (Baseline(FY23): 285; Year 1(FY24): 270) ○ # of trainings (Baseline(FY23): 6; Year 1(FY24): 4 ○ # of support groups and individuals served by support groups (Baseline(FY23): 10 groups and 81 attended; Year 1(FY24): 10 groups, and 103 attended)
● Youth ● Older adults ● Low-resourced populations ● Racially, ethnically, linguistically diverse populations	Participate in multi-sector community coalitions to convene collaborators to identify and advocate for policy, systems, and environmental changes to increase resiliency, reduce substance use, and prevent opioid overdoses and deaths.	● A Healthy Lynnfield ● Middlesex District Attorney (DA) Opioid Task Force ● Local substance use prevention coalitions	● # of sponsorships for A Healthy Lynnfield (Baseline(FY23): 1; Year 1(FY24): 1) ● # of substance use coalition meetings attended (Baseline(FY23): 4; Year 1(FY24): 4) ● # of new partnerships developed (Baseline(FY23): 2 grantees: Year 1(FY24): 2 grantees)

Priority: Complex and Chronic Conditions

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Older Adults ● Low Resource Individuals ● Racially, Ethnically, Linguistically Diverse	Address barriers to timely cancer screening and follow-up cancer care through navigation	● Cancer Programs: Screening and Prevention ● Oncology Nurse Navigator and Supportive Services for Cancer Patients	● # of people served and their demographics ○ Breast Cancer Risk Assessment FY24 respondents: ▪ Age 20-39: 3% ▪ Age 40-49: 20% ▪ Age 50-59: 23% ▪ Age 60-69: 28% ▪ Age 70-79: 20% ▪ Age 80-99: 5% ● # of breast cancer risk assessments conducted (Baseline(FY23): 21,029; Year 1(FY24): 14,684) ○ # unique individuals screened (Baseline(FY23): 20,553; Year 1(FY24): 14,436) ○ % of patients screened who were identified as having a high-risk mutation (Baseline(FY23): 27%; Year 1(FY24): 29%) ○ % of patients screened who were identified as having a high lifetime risk of breast cancer (Baseline(FY23): 13%; Year 1(FY24): 13%) ● # of patients served by nurse oncology-navigators (Baseline(FY23): 10-15 patients per day; Year 1(FY24): 10-15 patients per day)

● Older 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	● Burlington Diabetes Care Program ● Bone Health Program ● Tai Ji Quan: Moving for Better Balance ● A Matter of Balance ● Memory Café Program ● Enhance Fitness Program ● Provide support for community-based exercise classes	● # of individuals served by the Burlington Diabetes Care Program (Baseline(FY23): 32; Year 1(FY24): 33) ○ % reduction in A1C (Baseline(FY23): 42%; Year 1(FY24): 50%) ○ % maintained a healthy A1C of 6.5 or below (Baseline(FY23): 38%; Year 1(FY24): 34%) ● # of Bone Health and Osteoporosis Program classes held (Baseline(FY23): 6; Year 1(FY24): 6) ○ # of participants (Baseline(FY23): 40; Year 1(FY24): 35) ● # of free sessions of Tai Ji Quan: Moving for Better Balance sessions for the community (Baseline(FY23): 48 classes; Year 1(FY24): 48 classes) ○ # of individuals served (Baseline(FY23): 17 participants started the program in October 2022; 16 completed the program (attended at least 75% of the sessions); Year 1(FY24): 9 participants started the program in October 2023; 8 completed the program (attended at least 75% of the sessions) and 1 did not complete the program; ages ranged from 67 to 81 years of age: 7 females and 2 males) ● # of sessions of A Matter of Balance provided (Baseline(FY23): 2; Year 1(FY24): 3) ○ % of survey respondents who report a decreased risk of falls

			(Baseline(FY23): data not available; Year 1(FY24): 100%) ● # of individuals served by the Burlington Council on Aging Memory Café (Baseline(FY23): 60; Year 1(FY24): 60) ● # of Enhance Fitness Programs supported (Baseline(FY23): 2, Year 1(FY24): 2) ○ # of individuals served (Baseline(FY23): 92 individuals across both sites and graduated 100% of participants at the Greater Boston YMCA site; Year 1(FY24): 41 individuals across both sites and at least 75% of individuals at both sites demonstrated improved fitness assessments) ○ % of participants reporting increased strength and mobility (Baseline(FY23): data not available; Year 1(FY24): 85%) ● # of individuals served by the Burlington Council on Aging exercise classes (Baseline(FY23): 359; Year 1(FY24): 327)

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Lahey Hospital & Medical Center

FY26-FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Lahey Hospital & Medical Center (LHMC) is a world-class, tertiary academic medical center providing comprehensive care to communities across northeastern Massachusetts and southern New Hampshire. LHMC has 333 licensed inpatient beds with more than 6,100 employees and over 1,200 clinicians on active medical staff. With close collaboration between specialties and satellites in multiple communities, LHMC offers distinctly integrated care and the most advanced services available north of Boston. LHMC is a teaching hospital and regional medical campus of University of Massachusetts' Chan School of Medicine. Lahey Medical Center, Peabody operates under the LHMC license and is a full-service, community-based hospital and medical center with 10 inpatient beds, an emergency department, as well as outpatient services, diagnostic imaging and an on-site bloodwork lab, pharmacy and more.

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 LHMC's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. LHMC'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 LHMC's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those with limited resources, individuals who speak a language other than English, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

LHMC collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). LHMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk and crafting a collaborative, evidence-informed Implementation Strategy (IS.). Between September 2024 and February 2025, LHMC conducted 15 one-on-one and group 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 1,500 residents, and organized a community listening session. In total, the assessment process collected information from more than 1,600 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its Implementatio n Strategy (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, LHMC'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 LHMC's IS. This prioritization process helps to ensure that LHMC maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

LHMC'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, LHMC'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. LHMC is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

LHMC's CBSA includes the nine municipalities of Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody in Middlesex and Essex Counties in the MetroWest and Northeast portions of 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 LHMC'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. LHMC 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. LHMC is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

LHMC's CHNA focused on identifying the leading community health needs and priority populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who are marginalized due to their race, ethnicity, immigration status, disability status, or other personal characteristics. By prioritizing these cohorts, LHMC is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

Beth Israel Lahey Health
Lahey Hospital & Medical Center

Community Benefits Service Area

- H Lahey Hospital and Medical Center
- H Lahey Medical Center-Peabody
- 1 Lahey Hospital and Medical Center-Outpatient Rehabilitation Services at Danvers
- 2 Lahey Outpatient Center-Lexington MRI Suite
- 3 Lahey Health Outpatient Services
- 4 Lahey Neurology Outpatient Services
- 5 Lahey Hospital and Medical Center, Departments of Allergy and Immunology & Ophthalmology

Prioritized Community Health Needs and Cohorts

LHMC 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.

LHMC Priority Cohorts

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

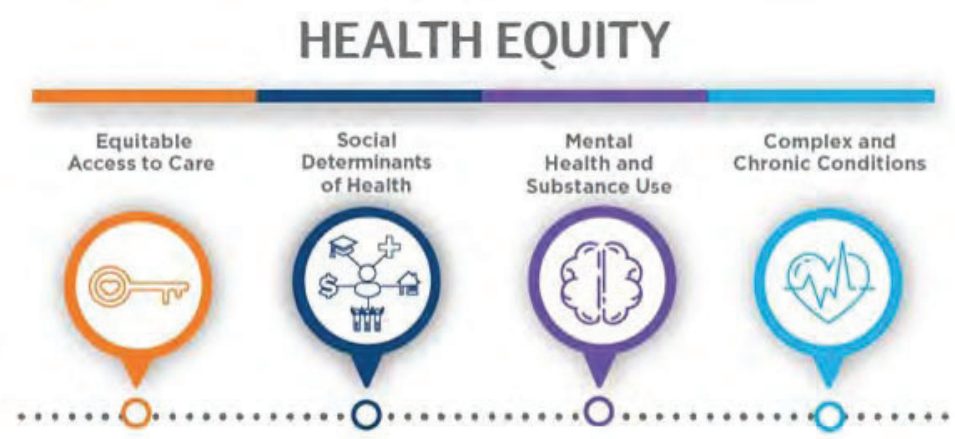
Community Health Needs Not Prioritized by LHMC

It is important to note that there are community health needs that were identified by LHMC's assessment that were not prioritized for investment or included in LHMC's IS. Specifically, issues related to the built environment (i.e., improving roads/sidewalks and access to physical activity) were identified as community needs but were not included in LHMC's IS. While these issues are important, LHMC'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, LHMC recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. LHMC 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 LHMC's IS

The issues that were identified in the LHMC CHNA and are addressed in some way in the hospital's IS are housing issues, transportation barriers, language and cultural barriers to services, food insecurity, economic insecurity, long wait times for care, health insurance and cost barriers, emergency preparedness, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive/navigation services for individuals with substance use disorder, community-based behavioral health education and prevention programs, trauma, conditions associated with aging, healthy eating/active living, community-based chronic disease education and prevention, and caregiver support.

LHMC 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: LHMC 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 LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC 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, LHMC 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.	• All priority populations	• Health insurance eligiblility and enrollment assistance programs • Expanded primary care and medical specialty care services for Medicaid covered, uninsured, and underinsured populations • Programs and activities to support culturally/ linguistically competent care and interpreter services • Programs and activities with community health workers and peer support workers • Emergency medical services, training, leadership, and community preparedness activities	• # of individuals served/enrolled • # of clinical practices supported	• Community health centers • Private, non-profit, health-related agencies • Hospital-based activities • Older adult services agencies • Local primary and secondary schools
Advocate for and support policies and systems that improve access to care.	• All priority populations	• Advocacy activities	• # of policies supported	• To be determined

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 LHMC Community Health Survey reinforced that these issues have considerable impacts on health status and access to care in the region, especially issues related to housing, food insecurity, nutrition, transportation, and economic instability.

Resources/Financial Investment: LHMC 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 LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC 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, LHMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• All priority populations	• Community-based food access, nutrition support, and education programs	• # of people served • # of organizations/ housing sites served • % of people reporting increased consumption of healthy food	• Non-profit, community-based agencies • Elder services agencies
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations	• Homelessness prevention and housing stability programs • Housing assistance, navigation, and resident support activities	• # of people served • # of people who secured safe 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
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 • Youth employment and internship programs	• # of people served • # of people hired • # of interns engaged • # of programs or classes organized	• Local primary and secondary schools • Vocational/ technical schools • Hospital-based activities
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation.	• Older adults • Individuals living with disabilities	• Subsidized transportation and rideshare assistance programs	• # of people served	• Older adult services 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 remained a major issue in the CBSA, with ongoing concern about opioids and alcohol. It was also recognized as closely connected to other community health challenges like mental health and economic insecurity.

Resources/Financial Investment: LHMC 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 LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC 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, LHMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• All priority populations	• Behavioral health support groups • Medication disposal programs	• # of people served • # of classes/ groups organized • Pounds of medication disposed	• Non-profit community-based activities • 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	• Health education, awareness, and wellness activities for all age groups • Substance use and mental health screening, monitoring, counseling, and referral programs • Crisis intervention and early response programs and activities • Outreach, support, and navigation programs and activities • Substance use and mental health screening, monitoring, counseling, and referral programs • Primary care and behavioral health integration and collaborative care programs	• # of people served • # of referrals made • # of support groups/trainings conducted • # of clinical practices supported	• Private, non-profit, health related agencies • Children and family services agencies • Schools • Elder services agencies • Hospital-based activities • Law enforcement • Health departments
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activity

Priority: Chronic and Complex Conditions

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

Resources/Financial Investment: LHMC expends substantial resources to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC 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, LHMC 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	• Fitness, nutrition, and healthy living programs and activities • Chronic disease management, treatment, and self-care support programs • Cancer education, wellness, navigation, and survivorship support programs	• # of people served • # of classes organized	• Elder services agencies • Local health departments • Hospital-based activities
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activity

General Regulatory Information

Contact Person:	Michelle Snyder, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was adopted by authorized governing body:	September 8, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 8, 2025
Date written plan was required to be adopted	February 15, 2026
Authorized governing body that adopted the written plan:	Lahey Hospital & Medical Center Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 12, 2022
Name and EIN of hospital organization operating hospital facility:	Lahey Hospital & Medical Center: 04-2704686
Address of hospital organization:	41 Burlington Mall Rd. Boston, MA 01805

Beth Israel Lahey Health
Lahey Hospital & Medical Center

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