Beth Israel Lahey Health
Mount Auburn Hospital

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for Mount Auburn Hospital (MAH) 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 collaborators from throughout MAH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

MAH 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.

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

Mount Auburn Hospital is a Harvard Medical School-affiliated teaching hospital located in Cambridge, Massachusetts. Mount Auburn has 217 licensed inpatient beds with more than 2,100 employees and over 650 clinicians on active medical staff. With comprehensive services and expertise in obstetrics and gynecology and cardiovascular and digestive care, Mount Auburn provides advanced care in a community setting.

MAH 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, MAH 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. MAH, 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 MAH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that MAH 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 MAH to engage the community and strengthen the community partnerships that are essential to MAH's success now and in the future. The assessment engaged more than 1,400 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, 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 MAH's mission. Finally, this report allows MAH 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 MAH's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the current and historical injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that MAH 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, MAH completed its last assessment in the summer of 2022 and the report, along with the associated 2023-2025 IS, was approved by the MAH Board of Trustees on September 13, 2022. The 2022 CHNA report was posted on MAH'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 MAH's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 9, 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 MAH's CBSA.

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

Description of Community Benefits Service Area

MAH's CBSA includes the six municipalities of Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown to the west of the City of Boston. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban).

There is also diversity with respect to community needs. There are segments of the MAH'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. MAH 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. MAH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

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

Assessment Approach & Methods

Approach

It would be difficult to overstate MAH's commitment to community engagement and a comprehensive, datadriven, collaborative, and transparent assessment and planning process. MAH'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, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

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 MAH and other BILH hospitals to conduct the CHNA. MAH worked with JSI to ensure that the final MAH 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 MAH's assessment and planning activities. MAH's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and members of the hospital's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Local public health departments/boards of health
- Additional municipal staff (such as human services, planning, etc.)
- Education
- Housing (such as community development corporations, local public housing authority, etc.)
- Social services
- Regional planning and transportation agencies
- Older adult service agencies
- 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 MAH's staff in the CBAC promotes transparency and communication as well as ensures that there is a direct link between the hospital and many of the community's leading health and community-based organizations. The CBAC meets quarterly to support MAH'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, MAH collected a wide range of quantitative data to characterize the communities in the hospital's CBSA. MAH 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 MAH 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, MAH applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, MAH 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, MAH conducted 15 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 700 residents, and organized a community listening session. In total, the assessment process collected information from 800 community residents, clinical and social service providers, and other key community partners. In the spirit of collaboration MAH community benefit staff worked with Cambridge Health Alliance, the City of Cambridge and the Town of Arlington as each entity was similarly conducting community health needs assessments at the same time. This collaboration included attending regularly scheduled meetings together to update eachother on our community engagement activities and to share quantitative and qualitative data with eachother.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

763 survey respondents

5 focus groups

- Youth
- LGBTQIA+ adults
- Community outreach workers
- Spanish-speaking adults
- English language learners

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across 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 MAH. Community Benefits staff reviewed MAH's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which includes a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify available community resources in the CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

The MAH 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 MAH 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 MAH's existing IS was augmented, revised, and tailored. When developing the IS, MAH'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 MAH'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 MAH'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 MAH's website, alongside the 2022 CHNA report and 2023-2025 IS, for easy viewing and download. As with all MAH 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, and community residents engaged in supporting the health and well-being of residents throughout MAH'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 MAH'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.

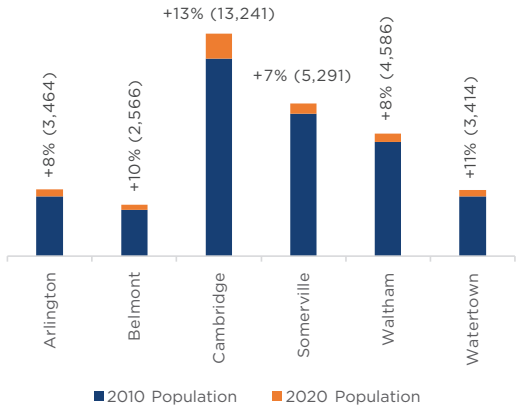
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the MAH CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were people of color, immigrants, non-English speakers, and foreign-born populations in all communities. Interviewees and focus group participants reported that these populations face 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, posed health literacy challenges, exacerbated isolation, and may have led 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 MAH's CBSA increased by 10%, from 341,036 to 373,598 people. Cambridge saw the greatest percentage increase (13%) and Somerville saw the lowest (7%).

Population Changes by Municipality, 2010 to 2020



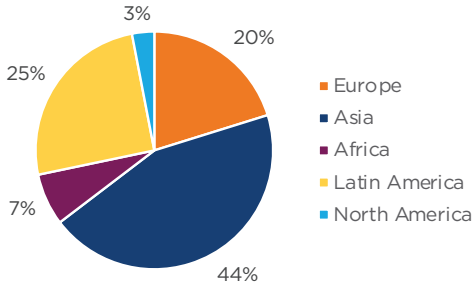
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

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]

26% of the MAH 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]

31% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

28% 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]

14%

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.

14%

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

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

Gender Identity and Sexual Orientation

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

7%

of adults in Massachusetts identify as LGBTQIA+.

Source: Gallup/Williams, 2023

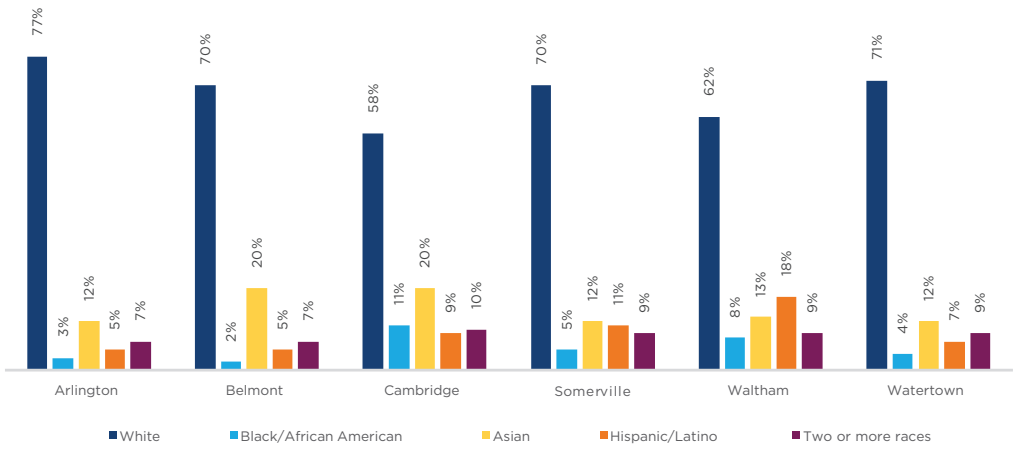
21% of LGBTQIA+ adults in Massachusetts are raising children

Source: Gallup/Williams, 2019

Race and Ethnicity

MAH's CBSA is diverse. Compared to the Commonwealth overall, the percentage of residents who identify as Black/African American is significantly high in Cambridge; the percentage who identify as Asian is significantly high in all communities; and the percentage who identify as Hispanic/Latino is significantly high in Waltham.

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]

21% of MAH CBSA households included one or more people under 18 years of age.

25% of MAH 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 MAH'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 MAH 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.

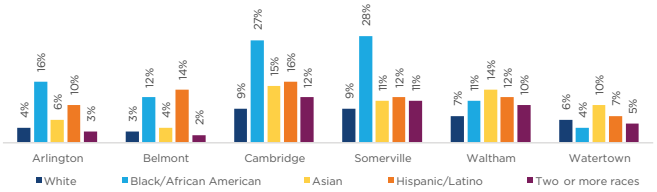
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

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]

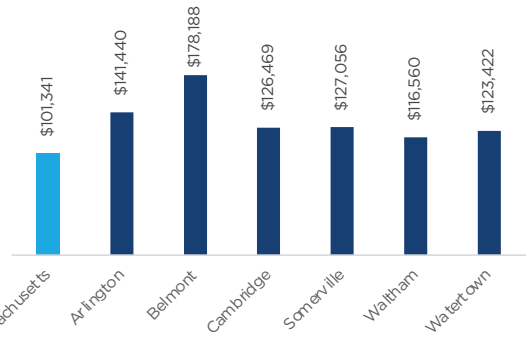
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains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

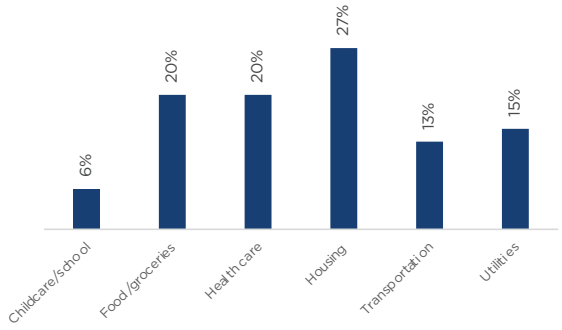


Source: US Census Bureau American Community Survey, 2019-2023

Across the MAH 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 municipalities.

In the 2025 MAH Community Health Survey, survey respondents reported 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 MAH Community Health Survey

"The reality is that wages are staying the same, while costs are going up. Economic, food, and housing insecurity are issues in our community. These are things I am really worried about. If we could get these baseline needs addressed, other things might become easier."

-Interviewee

Education

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

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

71% 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

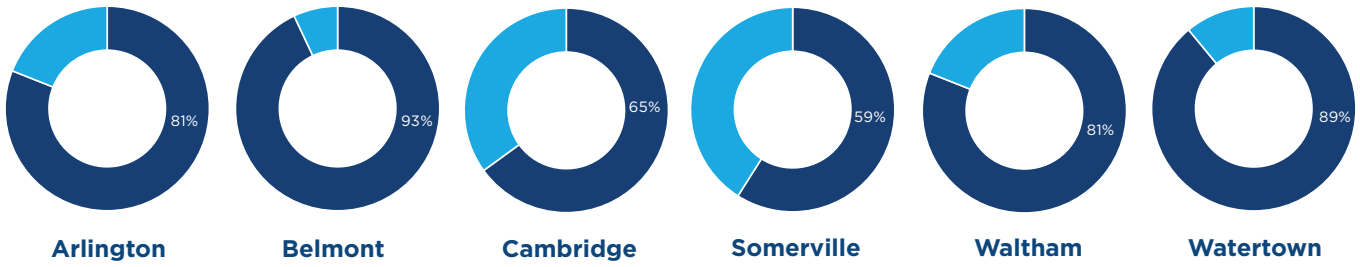
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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.

7%

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 Recieving Benefits, 2023



Source: The Food Bank of Western Massachusetts and the Massachusetts Law Reform Institute
Percentages shown are the average across zip codes in each community.

Neighborhood and Built Environment

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

Housing

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

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

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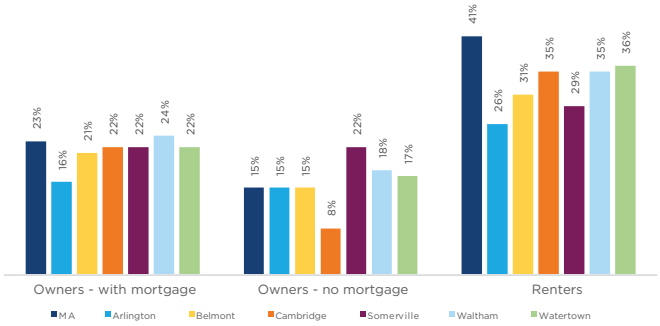
The percentage owner-occupied housing units (with and without a mortgage) with housing costs in excess of 35% of household income was higher than the Commonwealth in Waltham. Among renters, percentages were lower than the Commonwealth in all CBSA municipalities.

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,

58% of 2025 MAH Community Health Survey respondents said "more affordable housing."

27% of 2025 MAH Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 MAH Community Health Survey

Transportation

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

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

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

25% of 2025 MAH Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 MAH Community Health Survey

9% of housing units in the MAH CBSA did not have an available vehicle.

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

Roads/Sidewalks

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

27% of 2025 MAH Community Health Survey respondents identified a need for better roads.

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

Source: 2025 MAH 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 MAH CBSA faced with respect to long wait-times, provider/workforce shortages, and service gaps which impacted people's ability to access services in a timely manner. This was true with respect to primary care, behavioral health, 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 provider panels being full, resulting in providers not being able to accept 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]

> "There are no free clinics or health centers that are well known – you have places in Cambridge, but that's far. Getting appointments has been very difficult."
>
> -Interviewee

Populations facing barriers and disparities

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

Community Connections and Information Sharing

A great strength of the MAH CBSA were the strong community-based organizations and task forces that worked to meet the needs of CBSA residents. While many organizations in the region are working to address community needs, interviewees, focus group participants, and listening session attendees noted challenges related to coordination and communication. Participants described a fragmented system where organizations often operate independently, making it difficult to share information, align efforts, or effectively connect individuals to available resources. They emphasized the need for more consistent collaboration and shared tools across clinical and community-based organizations to improve access and streamline support.

> "There are a lot of non-profits and resources in our region, but the coordination of resources can be hard. Many organizations have screening tools for social needs, as do many clinical organizations. But not all clinical organizations want to partner with community organizations. It would be great if we could be using the same tools and listening to each other."
>
> -Interviewee

Behavioral Factors

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

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

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

24% of 2025 MAH Community Health Survey respondents said they would like their community to have better access to healthy food.

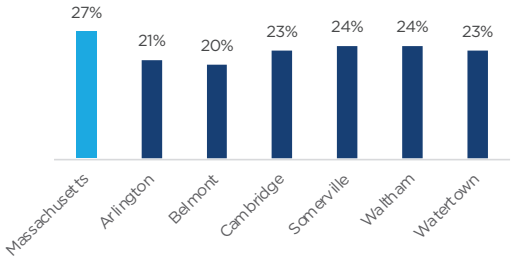
Source: 2025 MAH Community Health Survey

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the MAH 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) lower than the Commonwealth in all CBSA municipalities.

Percentage of Adults Who are Obese, 2022



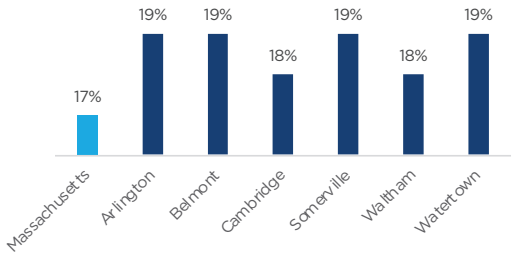
Source: CDC PLACES, 2022

Alcohol, Marijuana, and Tobacco Use

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

Clinical service providers reported linkages between substance use and mental health concerns, noting that individuals may use substances such as marijuana, alcohol, or vape tobacco as a way to cope with stress.

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 MAH'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 sessions, and the 2025 MAH 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.

63% of high school students in Cambridge Public Schools reported that their mental health was not good sometimes, most of the time, or always in the past 30 days.

Source: 2022 Cambridge Public Schools Teen Health Survey

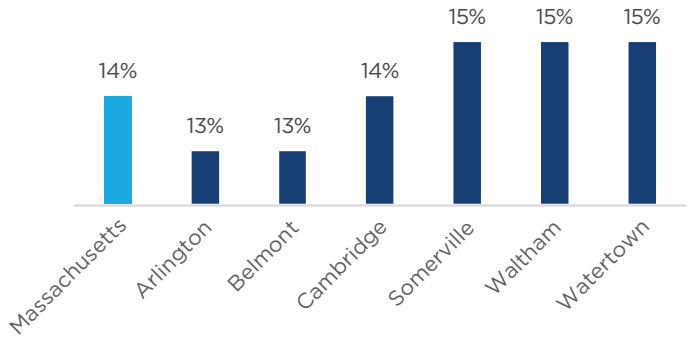
37% of 2025 MAH Community Health Survey respondents reported that mental health care in the community does not meet people's needs. fairly or very often.

Source: 2025 MAH Community Health Survey

50%

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

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



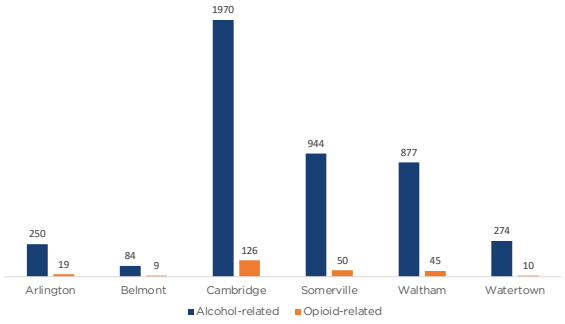
Source: CDC PLACES, 2022

Health Conditions

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

Interviewees, focus group and listening session participants reported that alcohol use was normalized, and use was prevalent among both adults and youth. Looking across the service area, there were more alcohol-related emergency visits than there were opioid-related visits. The highest number of visits for both substances were in Cambridge.

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



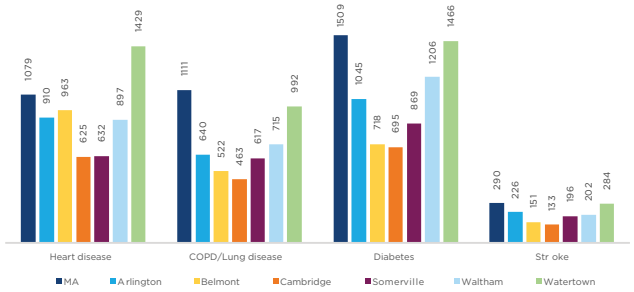
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

Chronic and Complex Conditions

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

Looking across four of the more common chronic/complex conditions, inpatient discharge rates among adults 65 years of age and older were consistently lower than the Commonwealth in all CBSA communities. Watertown had a higher inpatient rate for heart disease (1,429 per 100,000) compared to the Commonwealth overall (1,079 per 100,000).

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



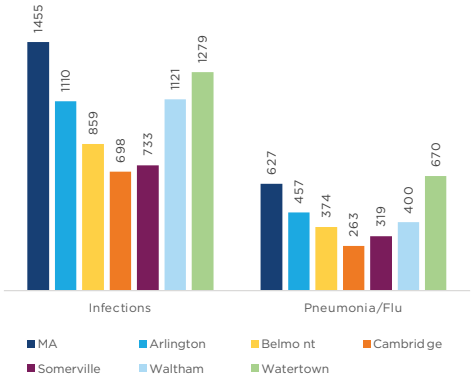
Source: Center for Health Information and Analysis, 2024

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 listening sessions 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 all CBSA municipalities, with the exception of Watertown, had lower inpatient discharge rates for infections and pneumonia/flu compared to the Commonwealth.

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



Source: Center for Health Information and Analysis, 2024

Priorities

Federal and Commonwealth Community Benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, MAH'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 MAH's IS. This prioritization process helps to ensure that MAH 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)*

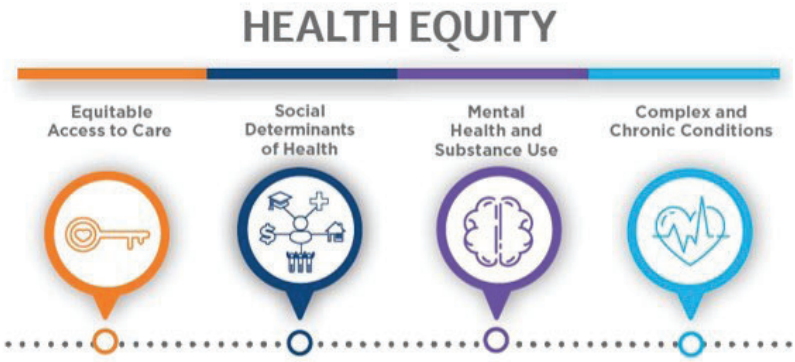
Community Health Priorities and Priority Cohorts

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

MAH Community Health Needs Assessment: Priority Cohorts

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

MAH Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by MAH

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

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

Implementation Strategy

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

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

MAH 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 MAH and/or its partners to improve the health of those living in its CBSA. MAH 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, MAH 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, MAH'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. MAH 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 MAH 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.
- Support cities/towns to promote resilience, emergency care and emergency preparedness.
- Advocate for and support policies and systems that improve access to care.

SOCIAL DETERMINANTS OF HEALTH

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

Strategies to address the priority:

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

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

- Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.
- Support programs and partnerships that advance maternal health equity by expanding access to culturally responsive care, addressing social determinants of health, and reducing disparities in maternal and infant outcomes.
- Advocate for and support policies and systems that address those with chronic and complex conditions.

Evaluation of Impact of 2023-2025 Implementation Strategy

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

For the 2023-2025 IS process, MAH 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. MAH 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	MAH addressed social determinants through community health grants, food access initiatives, housing partnerships, and systems-level collaboration. The hospital invested in food distribution programs, CSA shares, and SNAP Match at local farmers markets, with year-over-year increases in participation. Housing support was delivered through partnerships with Metro Housing Boston, Housing Corporation of Arlington, and the Somerville Homeless Coalition, supporting stable housing for dozens of individuals and families. MAH also funded coalitions, attended over 40 community meetings, and screened patients for social needs, helping connect them to services and promote long-term health and housing stability.
Equitable Access to Care	Mount Auburn Hospital expanded access to care through financial counseling, transportation support, interpreter services, and a wide range of workforce development initiatives. Financial counselors assisted over 4,000 individuals, and interpreter services grew to over 40,000 encounters. MAH offered bilingual outreach to new and expecting mothers and provided doula support and infant car seats to families in need. MAH provided over 1,700 rides for where transportation was a barrier to accessing medical care. The hospital also supported health literacy education programs reached over 170 participants. The hospital also supported career mobility through ESOL, advising, community college classes, internships, and job placement.
Mental Health and Substance Use	MAH strengthened behavioral health services through integrated care, culturally responsive counseling, education, and community partnerships. The Collaborative Care Model served nearly 1,400 patients across 12 sites, while social workers supported substance use navigation in the ED. Support groups for bereavement and new parents reached hundreds, with high participant satisfaction. Mental Health First Aid trainings were offered to over 350 people system-wide, and MAH awarded grant funding to De Novo Center for Healing and Justice to expand access to trauma-informed care, especially for underserved populations.
Complex and Chronic Conditions	MAH supported individuals with complex and chronic conditions through stroke education, cancer support, and older adult wellness initiatives. The stroke nurse navigator program reached hundreds of patients and families, distributing thousands of educational materials and delivering presentations that significantly increased knowledge of stroke risks and symptoms. Older adults participated in health education sessions on brain health, heart disease, fall prevention, and nutrition. MAH also hosted a Survivorship Day event, supported caregiver groups, and offered free breast cancer support sessions. Participants consistently reported improved knowledge, confidence, and ability to apply new skills to manage their health.

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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 with historically marginalized populations, 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?**

Mount Auburn Hospital (MAH)
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Lauren Shebairo, Associate Clinical Director, De Novo Center for Justice and Healing
- Suzanne Johanet, President, Belmont Food Collaborative
- Wesley Chin, Director, Belmont Health Department
- Hannah Daniel, Coordinated Entry Program Manager, Cambridge Multiservice Center
- Derrick Neal, Chief Public Health Officer, City of Cambridge
- Rachel Tanenhous, Executive Director, Commission for Persons with Disabilities, City of Cambridge
- Karin Carroll, Director of Health and Human Services, City of Somerville
- Griffin Jones and Drake Pusey, Co-Chairs of the Human Rights Commission, Town of Arlington
- Ashley Speliotis, Executive Director, Somerville Council on Aging
- Meaghan Ritcey, Public Health Nurse, City of Waltham
- BJ Osuagwu, Executive Director, Healthy Waltham
- Klavdia Brisson, Chief Clinical Officer, Charles River Community Health
- Lt. Dan Unsworth, Watertown Police Department and Chair, Watertown Cares
- Abby Myers, Director of Public Health, City of Watertown
- Renata Ivnitskaya, Director of Residential Nursing, Northeast Arc

Community Health Priority Areas

Social Determinants of Health

- Housing
    - Not enough affordable housing
    - Seeing larger homeless populations in many parts of the service area. While most go to Cambridge or Somerville for shelter overnight, there are people struggling in communities outside of the cities. There are very little resources for them in these communities.
    - Housing security is a base need that has ripple effects for other needs – if you don't have secure housing, it's difficult to focus on food and other needs.
    - Communities are seeing more and more development but not necessarily new buildings that are affordable for people in the community

- Economic insecurity
    - Wages not keeping up with inflation. "Nearly everyone is struggling with economic challenges."
- Transportation
    - In communities outside of Cambridge/Somerville, people have more limited access to public transportation. Bus routes have recently been reduced.
- Food
    - Many seniors struggle with food access

    - People accessing food services need to feel dignity and respect. Right now, people are waiting in parking lots to receive services

Access to Care

- Some people avoid seeking care – especially people of color and people with issues related to their immigration status. Healthcare settings can be intimidating for these populations
- Would like to see more clinicians that speak a language other than English – communities in the service area are extremely diverse and continue to diversify. There are some translation/interpretation resources but "it's not the same as speaking to someone directly."

Mental Health and Substance Use

- Overdose deaths have been declining
- There are many resources in the service area, but people may be unaware of what resources are available to them
    - It's often difficult for people with substance use disorder to navigate the services available to them. Need more support.
- Rates of alcoholism are high – this should be more of a focus.
- Affordability is a challenge – some behavioral health services are not covered by insurance, and people cannot afford out of pocket costs.
- Many individuals that the police encounter are struggling with dual issues of mental health and substance use
- Difficult to find longer-term care/supports for people with substance use disorder – "it's easier to make sure that people are safe in the moment, but it's a whole other issue to get themlong-term care and follow up."
    - There is a program in Waltham that integrates embeds two clinicians with Police Department. Several interviewees mentioned this program and would like to see similar programs. They ride in cruisers with officers and can help in diverting people from criminal charges or ending up the emergency room
- Would like to see more recovery coaches and peer-to-peer models.

Chronic and Complex Conditions

- Residents are concerned about heart disease, cancer, and diabetes
- Would like to see more preventative care in the community
- Individuals with chronic diseases spend a lot of time coordinating their care (between different doctors appointments, specialty care, medication management)
- Would like to see more programs that focus on healthy eating/active living. There are some current initiatives (e.g., Zumba in the park) that could be expanded. These types of activities get people into the community and moving

Priority Populations

- Agreement across interviewees that the following populations should continue to be the priority, as they face the most significant barriers to care and services:
    - Youth
    - Racially/ethnically/linguistically diverse
        - Linguistically diverse populations are unable to navigate systems easily

        - Immigrants need to understand the best 'starting place' to receive services. These are often with municipalities
    - Low-resourced/low-income populations
    - LGBTQIA+
    - Older adults
        - Some resources are only available digitally/remotely, which is difficult for some older adults.
- Several interviewees also suggested individuals living with disabilities as another priority population that faces significant barriers to care and community services

Community Resources, Partnership, and Collaboration

- There is sometimes a lack of communication between organizations. There are many organizations in the service area, but would like to see more collaboration in spreading awareness about community resources
- Municipalities/cities offer a variety of programs are generally good partners
- Specific organizations mentioned: Wayside, SomerViva, Somerville Cambridge Elder Services, Waltham Africano Center, Watertown Cares, Belmont/Watertown United Methods Church, Watertown Community Foundation, schools, police departments, Community Fridge (Watertown)

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*].

Mount Auburn Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: English language learners
Location: Zoom
Date, time: 10/17/2024
Facilitator: JSI
Approximate number of participants: 9
Languages: Haitian Creole and 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. Being physically active - things like walking, and going to the gym.
    ii. Being with family and friends
    iii. Eating healthy - participants try to eat vegetables and drink lots of water
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Time - not enough time to do all you want to do.
    ii. I like to sleep
    iii. Eating unhealthy also affects physical activity - eating too much sugar, or drinking too much alcohol
    iv. Other commitments and obligations (kids, work)

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. Blocking out bad thoughts - "I just stay on my phone and block out or not pay attention to what's happening around me."
    b. I cry when it's necessary
    c. Listening to music
b. **What stops you from being as mentally healthy as you'd like to be?**
    a. Having too much to do
    b. Not having enough money to pay bills and do everything you want to do
    c. Stress, anxiety
    d. Feeling depressed

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. To live comfortably, people need a well paying job and the ability to make money
    b. Education is important
    c. Community safety - "Sometimes I feel safe in my community and sometimes I don't"
    d. There is no easy access to transportation
    e. Need better access to healthy foods
    f. More places for people to sleep
    g. "They (people in the community) ask for help from different organizations for the things they need. If they get help, great, if they don't get help, they have to live with what they have."
- **b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?**
    a. People that are immigrants or who don't speak English

Question 4

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

- **a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    a. The hospital
    b. Unsure of other resources
- **b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. School - would like more educational opportunities
        i. Opportunities to learn English, that last longer than one or two days
        ii. Professional schooling for nursing, finance, etc.
    b. Employment - would like more opportunities
        i. "I'm not looking for a specific type of work. I am not documented, but [am looking for] a job that pays well."
        ii. Also assistance with searching for jobs
    c. Help with immigration paperwork

Mount Auburn Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: LGBTQIA+ Adults
Location: Zoom
Date, time: 10/17/2024
Facilitator: City of Cambridge staff; JSI
Approximate number of participants: 5

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Walking
    ii. Using community spaces
    iii. Class-pass/yoga, volleyball league, group fitness classes
    iv. Go on Walks or go to the gym when it's cold
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Mental health, they have difficulty getting to places because of their mental health and potential danger since they are trans
    ii. Money, they need financially accessible options
    iii. Weather
    iv. Time/scheduling
    v. "Life. Life can stop you"
    vi. "The exhaustion is real"

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. Community, getting engaged, volunteering
    b. Mental health disability vs everyday anxiety
    c. Need people to help and support you with disability
    d. Mindfulness, meditation
    e. Insurance makes therapy more accessible
    f. Music

g. Talking with/texting friends
h. Validation, validation, validation
i. Being in nature

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

a. Stigma
b. Vulnerability
c. Their mental health itself
d. Others not understanding
e. Providers need to be trained in unique issues
f. Vulnerability - "Is this person trained? How am I going to be treated?
g. Bureaucratic and social barriers to care
h. Stigmas and biases
i. Discrimination and policies around housing and HIV status
j. We are the ones that need to educate the providers
k. Even marketing is not welcoming or inclusive
l. Trust/fear
    i. How to find a trusted provider
m. Community health, patient-centered, not disease-centered and impersonal
n. Language use around being LGBTQ+ inclusive and disability inclusive

Question 3

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

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

a. Housing costs
    i. Living with 4 roommates so if one person gets sick, everyone gets sick
    ii. Housing is bad for mental health
    iii. May have to move in with their partner even if they are not ready (due to costs)
b. Job disparities, especially for non-binary people and the intersections with housing
c. Substance use
d. HIV
e. Intersecting public health issues, need to start with housing
    i. Affordable and accessible
    ii. One participant currently lives in a third floor walkup with mold
f. Lack of awareness of sexual health resources- what is safe? What should I be doing?
    i. Where to get free condoms etc
        1. Fenway, Planned Parenthood, school things (MIT, Tufts vending machine)
    ii. Sex becoming taboo again
    iii. DoxyPep
g. COVID vaccines

h. Misinformation
    i. "It's either misinformation or no information"
    ii. Can't even have these conversation
    iii. Misinformation about gender affirming care
i. Online dialogue

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

a. Older adults- isolation, lack gathering places and programs
b. Young people are fearing getting older
c. Low income people
d. Immigrants
e. People with disabilities
f. Neurodivergent people
g. "People who need it most have the worst access"
h. People of color had additional mistrust in medical institutions

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. Fenway (mixed opinions)
b. McLean (Belmont)
c. Social/informal- Meetup, FB Groups
d. Place looking inclusive but are not really in their experience
e. What's going on in the school?
    i. Public signs for events and resources; what insurances, what services- we want ads!
f. Small medical places are closing, so people get shifted into bigger hospitals/systems that don't care enough, don't have capacity, and don't have follow up
g. One participant's cat gets card from Chewy on its birthday, but their provider doesn't recognize them (the person)
h. Housing/people displaced/generational trauma

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?

- Food insecurity
- Lots of resources but still difficult to access
- Vet bills, costs
- Everything costs so much, no one gives you comfort
- No one is coming to you, you have to fight to get to them
- Put an ad on the T!
- “Peer respites”- spaces to heal together, not straight to hospital alone

Mount Auburn Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Waltham Verge Rx Program
Location: Waltham
Date, time: 10/22/2024
Facilitator: JSI
Language: English and Spanish
Approximate number of participants: 15

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Eating fruits and vegetables
    ii. Not eating excessively
        1. "It's good to know that everyone has a level. So we can eat well, but not excessively. So it's important to know your balance. It's good to have a schedule for when we eat and to eat a healthy quantity."
        2. "About a year ago, I had a surgery where they removed 80% of my stomach. But we shouldn't wait until we need that kind of surgery. Yes, the surgery has helped a lot; has helped my motivation. But let's not wait until things get that bad, we should grasp control of our lives beforehand."
    iii. Watching sugar intake - especially at breakfast.
    iv. Exercise and drinking water
        1. "In reality, nutrition has to be the same as good exercise. And drinking enough water. Not eating excessively, making a healthy breakfast. Lunch, eating a moderate amount and dinner, being cautious to not eat too much and walking after dinner. Again, drinking water to replace other types of drinks. I used to run a lot, but when I stopped, I noticed a big difference. Exercise is going to keep us healthy and keep our moods up."

b. **What stops you from being as physically healthy as you'd like to be?**
    i. "Here, a lot of us work and we don't eat breakfast and then our nutrition becomes disorganized. And gaining weight and losing our health not only when we eat too much, but also when our overall nutrition is disorganized."

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. Faith
    i. "Many people may go to church. It's not just physical, it's when we look at each in our eyes. We can see if someone is sad."
    ii. "Usually, when people are sad, they want to be alone., But that's when they need to be with others. When they're isolated, they can have thoughts that are not connected to their health. This is why community is important. Religious communities can feel like family. This is why we need community, so we can support each other."
b. Resources to help with mental health struggles
c. Family and friends
d. Said they did not tell their doctor when they were struggling, but they did admit it at a future appointment
e. Walking, exercise, being outside

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

a. Depression
    i. "Life can be unjust. Other times you want to connect with others but our circle is too small. But if you're new, you can feel like an outsider. When you're an outsider it can be lonely. If someone has depression, and you don't have friends and in my church, no one supports me or pushes me. It can be really hard, so you just stay alone. So then these thoughts of suicide come in, thoughts like: You should just end it. In my example, I've had hard weeks. First my dad and then my brother, who had depression and killed himself. Then my grandfather. You feel overwhelmed, who can take care of me, who is making sure I have eaten. It's really hard. You feel so alone."

Question 3

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

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

a. Transportation:

i. “It takes a lot when I have an appointment. Like if I have a referral, it takes a lot because I don’t drive and someone needs to come with me because of my ear problems.”

b. Cost and Insurance
    i. “I try to get medicine, but they say my health insurance doesn’t cover my medications. I know my blood sugar is high, but I can’t do anything about it. I don’t know why my insurance doesn't cover the machine to check my sugar.”
    ii. “In my case, my insurance doesn’t cover anything. I have a $80 copay, so it’s better not to go to your appointment. I was able to schedule a mammogram. Initially, I would have had to pay $800 and with the cost of living makes it so hard.”
    iii. “The last time I was here, I tried to be seen, but I was told that if I didn’t have money I couldn’t be seen. Were they going to kick me out? I can’t pay with just my social security.”
    iv. “It’s sad, because we work and we get insurance, but it’s expensive and doesn’t cover anything. How can we regulate this? How can we fix this? If we pay for insurance, how come an emergency isn’t covered. It doesn’t make any sense.”
    v. “The emergency room is never covered. They have to do something for sick people. They need to help us. I have been fighting for 1.5 years to get the machine to check my sugar.”
    vi. “I got sick recently and I needed to go to the emergency room. I got a bill. I don’t have insurance. It would be good to help us with that. I was only there for a little bit and I got a bill for $3,000.
    vii. “Many people who live here don’t have social security and cannot qualify for insurance, so how do people pay for care? Then, others have children, how can they pay for food and housing when we get paid so little?”

c. Accessible Housing
    i. “If I have an uncle who uses a wheelchair, are the buildings and the places we live accessible? Would I be able to move him easily? I believe no. It would be necessary to have accessible places, but like was stated earlier, the cost of living is so expensive and the cost of childcare is so expensive, like $35 a day.”

d. Employment
    i. “There should be a place, especially for latinos who do not have a work permit, where we can go when we’ve been mistreated by our employer. We get contracted and we work hours and then we don’t get paid. We get taken advantage of.”

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

Question 4

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

a. **Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    a. WATCH offers classes - GED and Computer classes
    b. Programs for older adults
    c. English classes
b. **What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. We had a problem in January and we went to the clinic and they never called back. They don't answer the phone either. We are forgotten.
    b. The city has a program to help with rental assistance, but they ask for so much paperwork and people don't have it and the paperwork is mostly in English. They asked for too much paperwork. They offer you resources but then you don't qualify, especially Latinos.
    c. The city should offer support programs for parents - "there are a lot of moms that recently arrived in this country and they need support from the school to help read their children's grades."
    d. "There are some programs for those who want their GED or to learn about computers. But for people who want to go to college, there are no resources for us. I would like to keep advancing, but my economic situation doesn't allow me to apply to college. College is too expensive here. I know a lot of people who would want to go to college, not just for themselves but to help others."
    e. Therapists and providers who speak Spanish
        i. Interpreters make people feel uncomfortable. There's no privacy. You don't know if the translator is actually saying what you're saying.

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?

- "Many of us are learners. We are missing a place where we can share our talents. But because many of us don't have our documents, we're scared to share. Where can we feel comfortable sharing our skills or start a business? We need a place where we can show others what we can do. I know a lot of you cook really well, it would be great for a place for you all to sell your cooking. For me, I like to play a clown, but there's no place for me to show my talent."
    - "Now that you've said you like to be a clown. And that makes me feel emotional. I've known you for 2 months and I know you have so much joy in your heart and it is so beautiful that you want to share that talent."

- My dream has always been to learn how to embroider. In Guatemala there are no opportunities. My mom said, if I want to do something with my life, the only thing I could do is study for teaching in my country. I decided to come to this country, I would love to accomplish my dream to learn how to embroider. It would be great for classes for me to learn."

Mount Auburn Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Cambridge Community Engagement Team
Location: Cambridge Learning Center
Date, time: 11/13/2024
Facilitator: JSI
Approximate number of participants: 10

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Exercise and eat well
    ii. Eat less fried food, more veggies/fruits
    iii. Eat healthy food
    iv. Get vaccines
        1. Good experiences both times
    v. One participant fasts
    vi. Need to be mentally healthy
    vii. Take the stairs
    viii. Yoga
    ix. Meditation
    x. Walking is big
    xi. Some participants stretch
    xii. Biking

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Cost of food
    ii. Time
    iii. Stress
    iv. Easier/cheaper to eat unhealthy
    v. Winter time affects activity
    vi. Kids order out more
    vii. Portion sizes at school are smaller and unhealthier

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
    b. Reading
    c. Spend time with friends and family
    d. Music and media takes your mind off of things
    e. Talking to friends on the phone
    f. Shopping
    g. Exercise
    h. Drawing and coloring
    i. Worship, prayer, and religious music
    j. Reconnect with friends
    k. Helping people
    l. Getting a massage

b. **What stops you from being as mentally healthy as you'd like to be?**
    a. Social isolation a challenge
    b. Social media
    c. Having a lot of responsibility, and not feeling like enough
    d. Work situations
    e. Other people's problems, taking them on
    f. Tired from lack of sleep
    g. Different culture between parents
    h. Financial stability
    i. Working too much, stress with work
    j. Not being able to take time off

Question 3

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

a. **What social factors are most problematic in your community?**
    a. Language
        i. Cambridge has decent language services
    b. Housing is number one
    c. Cost of food
    d. Cost of living
    e. Education

i. School aptitude
ii. Bullying in schools
iii. Teachers spread thin in school

f. Transportation an issue
g. Construction
h. Everyone's capacity is at capacity
i. Addiction
    i. Vaping among young people, even in middle school
    ii. Marijuana is big
j. Kids are suffering from low mental health, a lot of pressure
k. Social media and gaming effects on youth
l. Mental health is affected by all
m. It is very tough to get care as an immigrant
n. Some people are afraid to go get care because of costs
o. The system is so hard to navigate
p. Immigration status for jobs, healthcare, and housing
q. Power imbalance
r. Politics
s. Challenges accessing care, lack of primary care providers, referrals out of network

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. Community Economic Opportunity Cambridge (CEOC)
b. Multiservice Organization
c. Food pantries
d. Voucher programs
e. Salvation Army
f. Center for Families
g. Health Connector
h. Harvard/MIT are not really helping, some tutoring, but they used to be more involved
i. Senior Center
j. Community Engagement Team here at this building
k. Community Learning Center (CLC)
l. HSB
m. YMCA
n. Library

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

a. More housing
b. Immigration lawyers
c. More primary care providers
d. Better healthcare navigation
e. More diversity in the healthcare workforce
f. Can't just be a translator, you want someone to be part of the culture
g. Long step until referral
    i. Better referral process, allow nurse practitioners to do more
h. Too long of a wait for specialists
i. Better follow-up

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?

- Overall decent care, good follow-up with BILH
- It is easy to get lost in the system
- Need better healthcare literacy
- Mental health can't be solid until everything around people are okay, especially for youth
- Supports for parents
- If the doctor is late to my appointment, there should be repercussions to that

Mount Auburn Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Young adults
Location: Waltham Valor High School
Date, time: 12/5/2024
Facilitator: JSI
Approximate number of participants: 10
Language: Spanish and English

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 and other people your age. What kinds of things do people your age do to stay physically healthy?**
    i. Drink plenty of water, stay hydrated
    ii. Walking in the community for example
    iii. Mostly walk out of necessity (to go to work)
    iv. The new path they made from garden crest to market basket is a good place to go on walks
    v. Exercise and take care of your diet
    vi. Eat fruit, vegetables, proteins (that's eating healthy)
    vii. Sports
    viii. I play soccer and basketball
    ix. Play on the community fields

b. **Let's talk more about water and its importance - the habits of drinking water, how you look at this in your life.**
    i. When I drink a lot of soda or coffee I try to drink more water.
    ii. 8 glasses (of water)
    iii. In the summer I try to drink more water

c. **How about sleeping? How much do you sleep?**
    i. The normal thing is 8 hours but here that is not possible.
    ii. 5-6 hours

d. **What prevents people your age from being physically healthy?**
    i. Mental health
    ii. Work prevents you from getting enough sleep, for example.
    iii. Not having time to cook
    iv. It's easier to buy fast food
    v. The ease of food
        1. Easy options are junk foods
        2. Most of the time that keeps us from eating healthy

3. Instant soups are so much easier then cooking a meal after a long day

vi. Men who don't like to cook
vii. Learning (to cook) can be seen on TikTok or Youtube but the time is still a big impact
viii. Many are alone here and have to work long hours
ix. This takes away our time to exercise and eat healthy, there is no time for this.
x. Not knowing in the community where to buy healthy things or take advantage of different sports

Question 2

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

a. Think about yourself and others your age. What kinds of things do you and people you know do to stay mentally healthy? What things help keep you in good spirits

a. Supporting my family, knowing that I can send them money for what they need - back home things are more expensive. What I earn here is more than what they earn at home, being able to help them helps me to be well and feel well.
    i. For me to be able to support them
b. Being proud of where you are because mental health and life are not easy
c. Finding someone to talk to helps me when I am feeling sad or down
d. Exercises helps me feel better, but there is no time for that and I focus on work
e. Taking walks stepping away, finding a calm space
f. High school, we talk about our problems and people here listen and try to find resource for us
    i. My counselor and our wraparound partners
    ii. These people ask me how I'm feeling and if I need anything

b. What prevents you and others your age from having the mental health you would like to have?

a. It depends on the topic or situation, if I need to seek help or someone to talk to.

Question 3

a. When does one feel good?

a. Having a bike or walking, it impacts you. You arrive faster if you have transportation, you can exercise if you have to walk or use a bike.
b. Having transportation helps you get there faster and have more time
c. To be able to sleep more

b. Examples of Social Determinants of Health

a. Access to better jobs
    i. With better hours
    ii. Applying to jobs
    iii. Career support
    iv. Improve as a professional
    v. Trainings at work to support in advancing
b. I entered my current job as a dishwasher, a tough job. I applied myself and slowly was able to increase my position and have better conditions and I am learning to do more things
c. I had others who taught me and when I had free time I also pushed myself
d. Developing my English so I can have more options in jobs
e. More opportunities
    i. Having people give us more opportunities as well

Question 4

Community Resources I want to ask you about resources: the people and places in your community that help you stay physically and mentally healthy. This could include a wide range of places and people, such as parents, teachers, coaches, doctors' offices, etc.

a. What are the key places or people that help people your age stay healthy? What do they do to show they support you?
    a. Making food in group communities (church groups)
    b. Joining group chats - this helps make connections

b. Are there types of places or resources that you would like to be available to you, but they aren't?
    a. Having easier access to health care, but also being able to communicate
    b. Having access to learning about health and its impact and where it comes from
        i. Have access to learn about health
    c. Talks in the community
    d. They say everything is normal and they don't support us
    e. Access to instructions and translation services
    f. Access to understanding about health and when to go to visit the clinics
    g. Helping to access health records from the doctor

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?

- Appropriate translation
- More ease of appointments
- The conversations can be so long and it takes time so I prefer not to use the translation because of the time

Community Listening Sessions

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

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

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

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

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

Goals:

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

EVENT AGENDA

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

BREAKOUT DISCUSSION GROUPS

Around 50 minutes (JSI will keep time!)

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

Participants will be asked to:

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

ROLE OF COMMUNITY FACILITATOR

Establish ground rules

Initiate and guide discussion

Maintain open environment for sharing ideas

BREAKOUT DISCUSSION GUIDE

(EVERYTHING YOU NEED, IN ONE DOCUMENT)

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

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

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

LET'S REVIEW.

REMEMBER: YOU HAVE SUPPORT.

YOUR NEXT STEPS

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

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

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

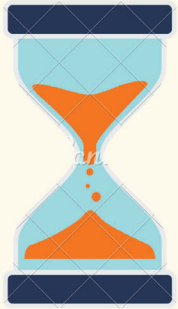
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial

Active listener

Authentic

Patient



Enthusiastic

INCLUSIVE FACILITATION

inclusive means including everyone

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

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

Dedicate time for personal reflection

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

Establish group agreements

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

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

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

Consider accessibility

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

THANK YOU!

Feel free to send in any questions to Madison

madison_maclean@jsi.com

BILH Community Listening Session 2025: Breakout Discussion Guide

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

Ground rules and introductions (5 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Area 2: Access to Care (12 minutes)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wrap up (1 minute)

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

Mentimeter

Mount Auburn Hospital Community Listening Session

February 27, 2025 | 3:00-4:30pm

Beth Israel Lahey Health

MAH Community Listening Session

Join a language channel / Antre nan yon chanèl lang

1. Find **Interpretation** or **Language** icon on your Zoom toolbar
   Jwenn entèpretasyon oswa icon lang sou paj Zoom ou a

2. Choose your preferred language
   Chwazi lang ou

3. Mute original audio to only hear the interpreted audio
   Mète odyo orijinal la pou sèlman tande entèpretasyon an

Mount Auburn Hospital Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Mount Auburn Hospital

Mount Auburn Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
3:00-3:05	Zoom orientation and Welcome	JSI
3:05-3:10	Overview of assessment purpose, process, and guiding principles	Mary DeCourcey, Community Benefits & Community Relations Manager, Mount Auburn Hospital
3:10-3:25	Presentation of preliminary themes and data findings	JSI
3:25-3:30	Transition to Breakout Groups	JSI
3:30-4:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
4:25-4:30	Wrap up and Next Steps	Mary DeCourcey

Assessment Purpose and Process

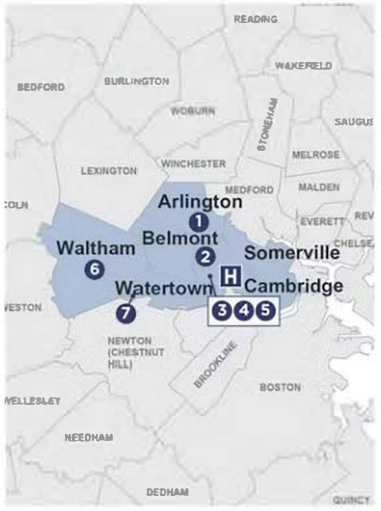
Assessment Purpose and Process

Purpose

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

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

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



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Mount Auburn Hospital

Community Benefits Service Area

- H Mount Auburn Hospital
- 1 Mount Auburn Hospital Radiology at Arlington
- 2 Mount Auburn Hospital MRI Center
- 3 Mount Auburn Hospital Rehabilitation Services; Outpatient Physical & Occupational Therapy
- 4 Mount Auburn Hospital Mobile PET Unit
- 5 Mount Auburn Hospital Employee Assistance Program, Occupational Health & Rehabilitation Services
- 6 Mount Auburn Hospital Imaging and Specimen Collection
- 7 Mount Auburn Hospital Radiology at Watertown

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

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

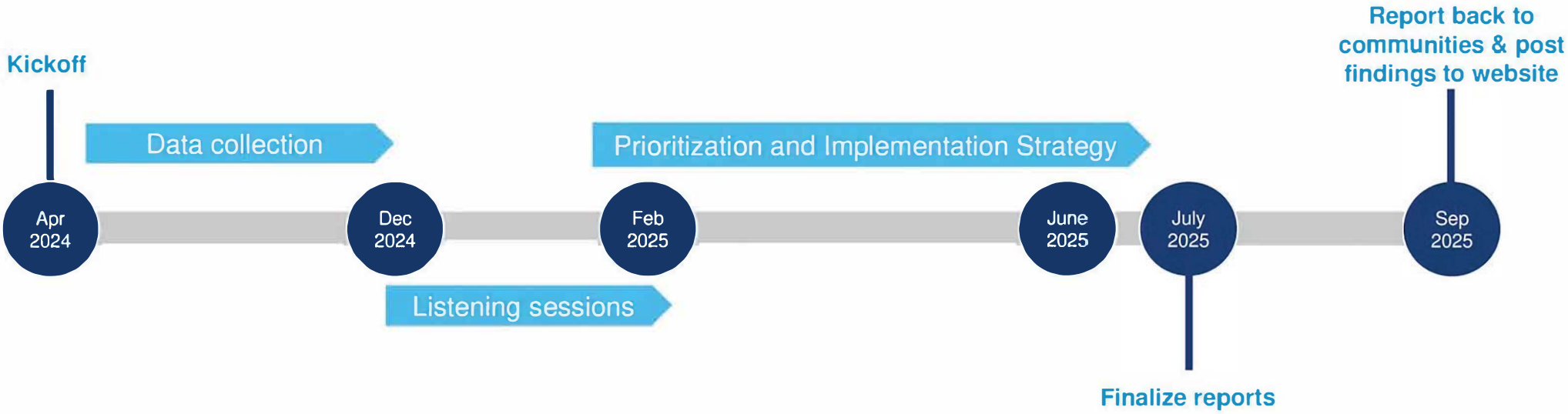
Community Engagement: Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

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

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

Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



Assessment Purpose and Process
Meeting goals

Goals:

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

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

Key Themes & Data Findings

FY25 CHNA Progress

Activities to date

Collection of secondary data, e.g.:

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

15 **Interviews**

763 **FY25 Mount Auburn Hospital Community Health Survey Respondents**

5 **Focus Groups**

- *Waltham Youth (Waltham Partnership for Youth)*
- *LGBTQIA+ Adults (Cambridge LGBTQ Commission)*
- *Cambridge Engagement Center (outreach workers)*
- *Adults in a diabetes support group (Waltham Fields Community Farm CSA Program)*
- *ESOL students and new immigrants (Lamplight Literacy)*

FY25 CHNA Progress

FY25 MAH Community Health Survey Responses

763 responses

(A 186% increase from 267 responses in FY22)

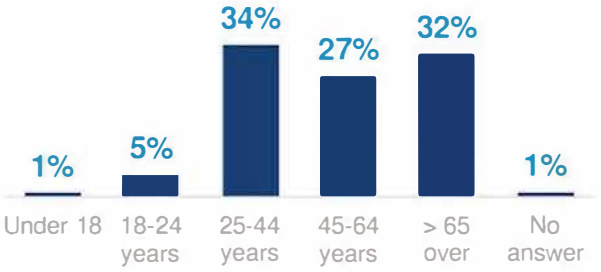
29% of respondents report a language other than English as the primary language spoken in their home **(up from 21% in FY22)**

76% of the respondents are women **(down from 78% in FY22)**

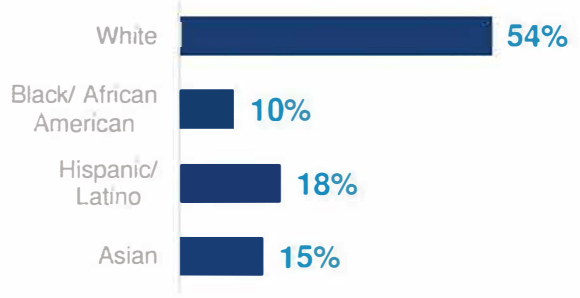
19% of the respondents identify as having a disability **(up from 14% in FY22)**

14% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(up from 11% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 139 in FY25 compared to 40 in FY22
- **Hispanic respondents:** 18% in FY25 compared to 11% in FY22
- **Asian respondents:** 15% in FY25 compared to 19% in FY22
- **Black/African American respondents:** 10% in FY25 compared to 4% in FY22

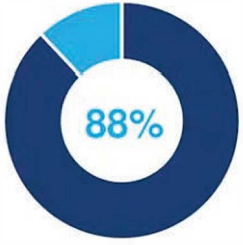
FY25 CHNA Progress

Community Benefits Service Area Strengths

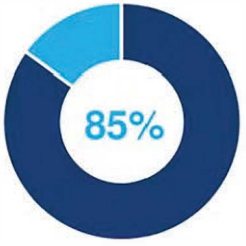
FROM INTERVIEWS & FOCUS GROUPS:

- Strong network of community organizations that are willing to work collaboratively and think outside the box to address community health issues
- New programs and partnerships have emerged to address racial equity, disconnect between law enforcement and individuals with SUD, and language/cultural barriers to care

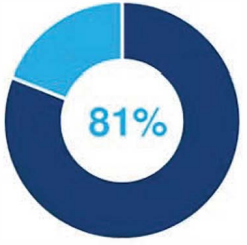
FROM FY25 MAH COMMUNITY HEALTH SURVEY:



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



said they are **satisfied with quality of life in their community**
(compared to 88% in 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 consistent between FY22 and FY25, with 4 categories emerging as the preliminary priority areas. Information from focus groups reinforced findings from interviews and survey results.

FY25 CHNA Progress
Social Determinants of Health

Primary concerns:

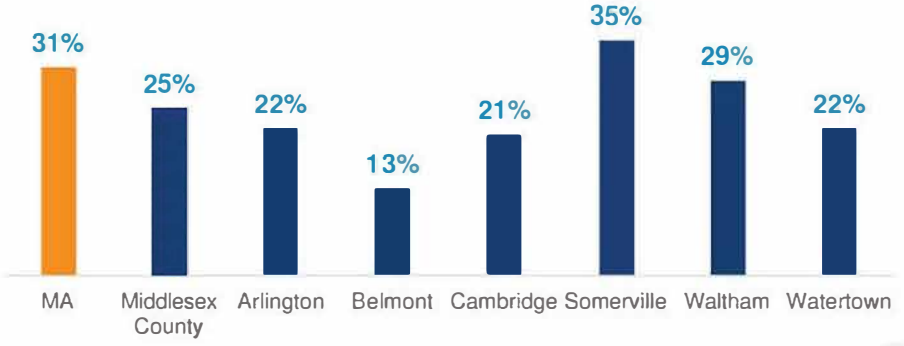
- Housing issues (affordability, displacement, homelessness)
- Economic insecurity and high cost of living
- Food insecurity
- Transportation

"Housing. It's a nightmare out there. A few years ago I was barely scraping by. Housing is really stressful for your mental health. This is an issue for people in Cambridge and Boston and everywhere – it's completely unaffordable for everyone."
– Focus group participant

When asked what they'd like to improve in their community, **58%** of FY25 MAH Community Health Survey respondents reported **more affordable housing** (#1 response)

20% of FY25 Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

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



Data Source: MDPH Community Health Equity Survey, 2023

FY25 CHNA Progress

Preliminary Themes: Equitable Access to Care

Primary concerns:

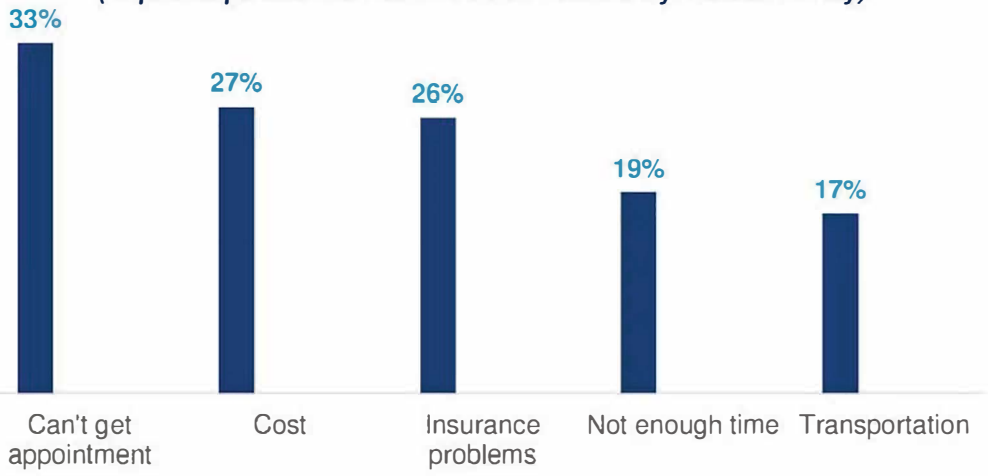
- Language and cultural barriers to care
- Long wait times for primary care and behavioral health care (acknowledging that workforce was identified as an issue among providers)
- Navigating a complex health care system
- Cost and insurance barriers

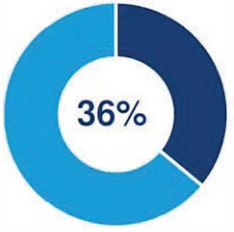
"There are no free clinics or health centers that are well known – you have places in Cambridge, but that's far. Getting appointments has been very difficult."

*- **Interviewee***

What barriers keep you from getting needed health care?

(Top 5 responses from FY25 MAH Community Health Survey)





36% of FY25 MAH 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
- Recovery supports for individuals with SUD
- Trauma experienced by migrants, immigrants, and refugees
- Behavioral health care navigation
- Social isolation and mental health issues among older adults
- Need for more behavioral health prevention and education
- Expanding programs that bridge behavioral health care and law enforcement

AMONG FY25 MAH COMMUNITY HEALTH SURVEY RESPONDENTS:

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

25% identified alcohol or drug misuse as a health issue that matters most in their community

37% reported that mental health care in the community does not meet people's needs

"Mental health and substance use treatment is hard to get. Even with a PCP and referrals, it's challenging to navigate. I was referred to a therapist but they didn't take my insurance. What do I do next? Online directories are not helpful, and there is a lack of easily accessible and relevant information."
- ***Interviewee***

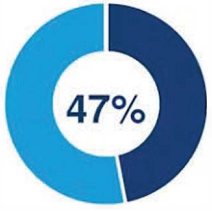
FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

Primary Concerns:

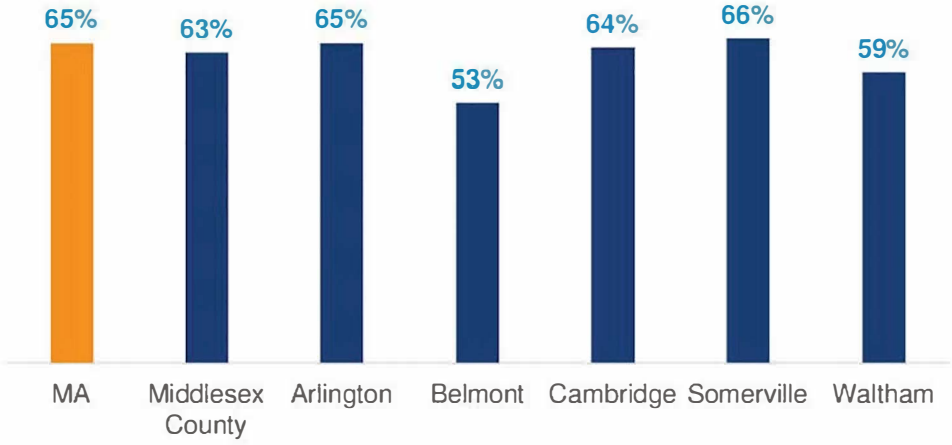
- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Healthy eating/active living
- Desire for more community-based education and screenings (e.g., at housing complexes, councils on aging, libraries, schools)

AMONG FY25 MAH COMMUNITY HEALTH SURVEY RESPONDENTS:



47% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community

Percent of Adults Reporting At Least 1 Chronic Condition (2023)

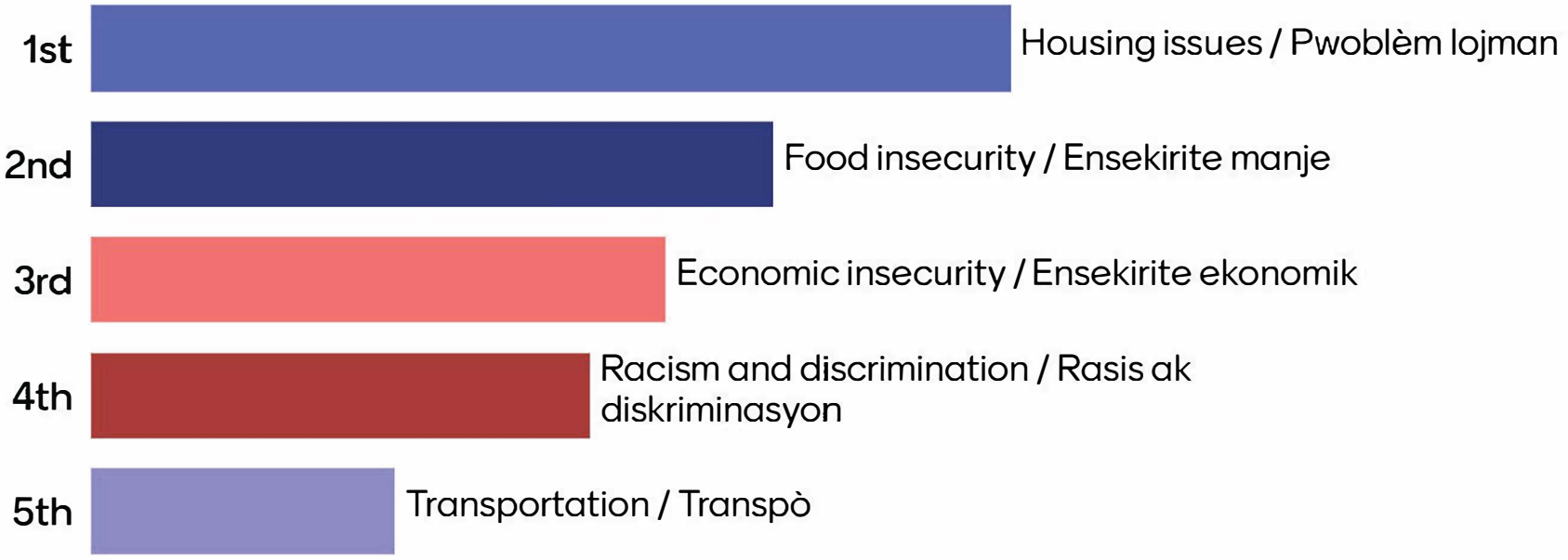


Data Source: MDPH Community Health Equity Survey, 2023

"It's really hard for people to focus on mental health when they have urgent medical needs. We need to recognize that these issues often happen in tandem."
-Interviewee

Instructions

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



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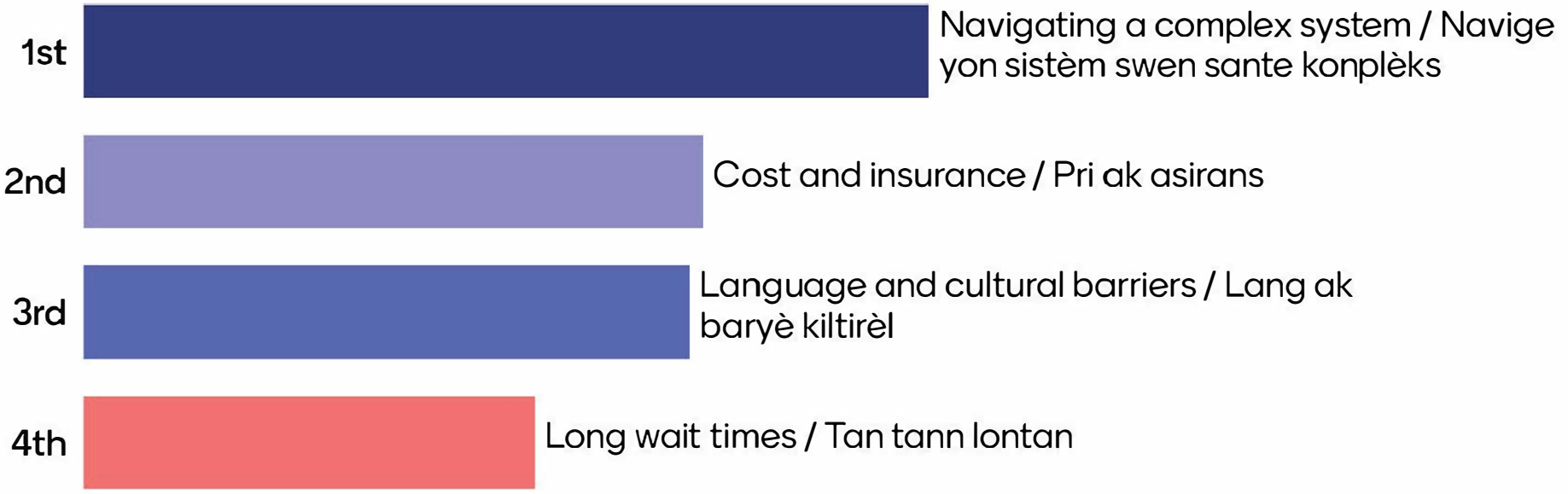
Equitable Access to Care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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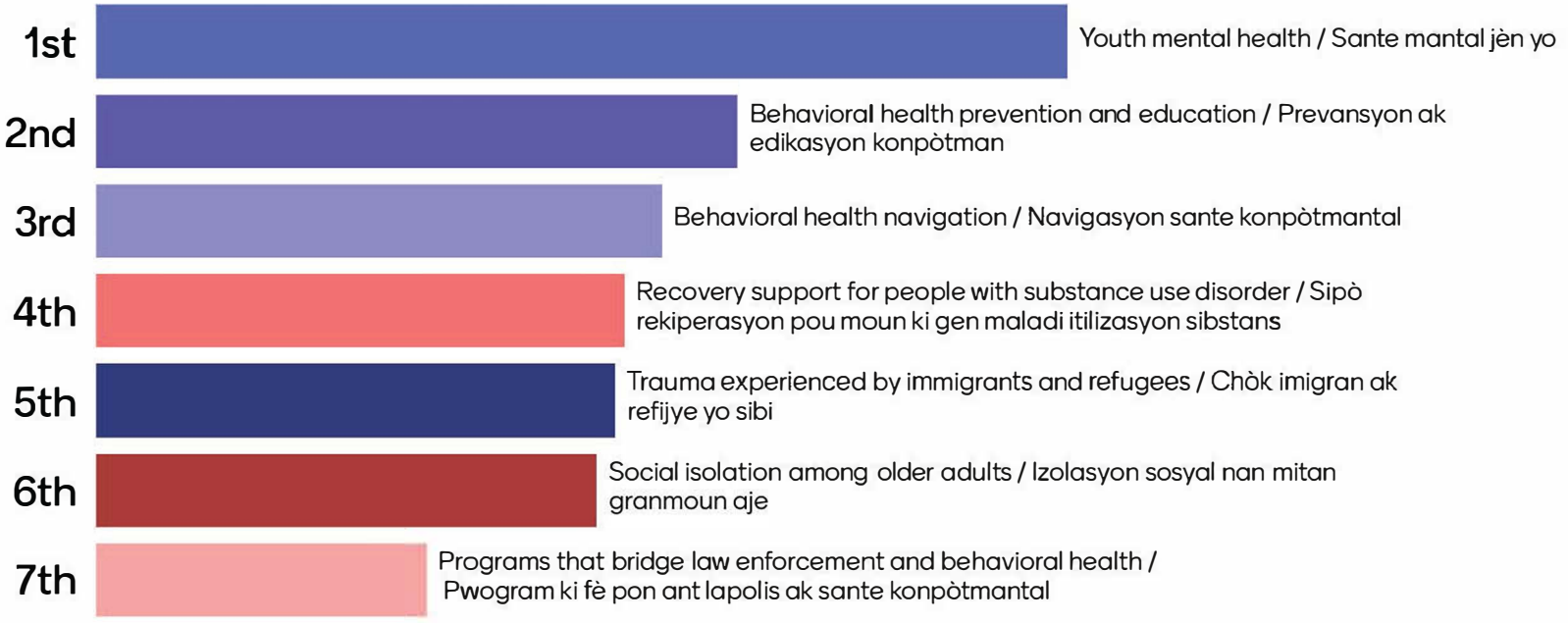
Mental Health and Substance Use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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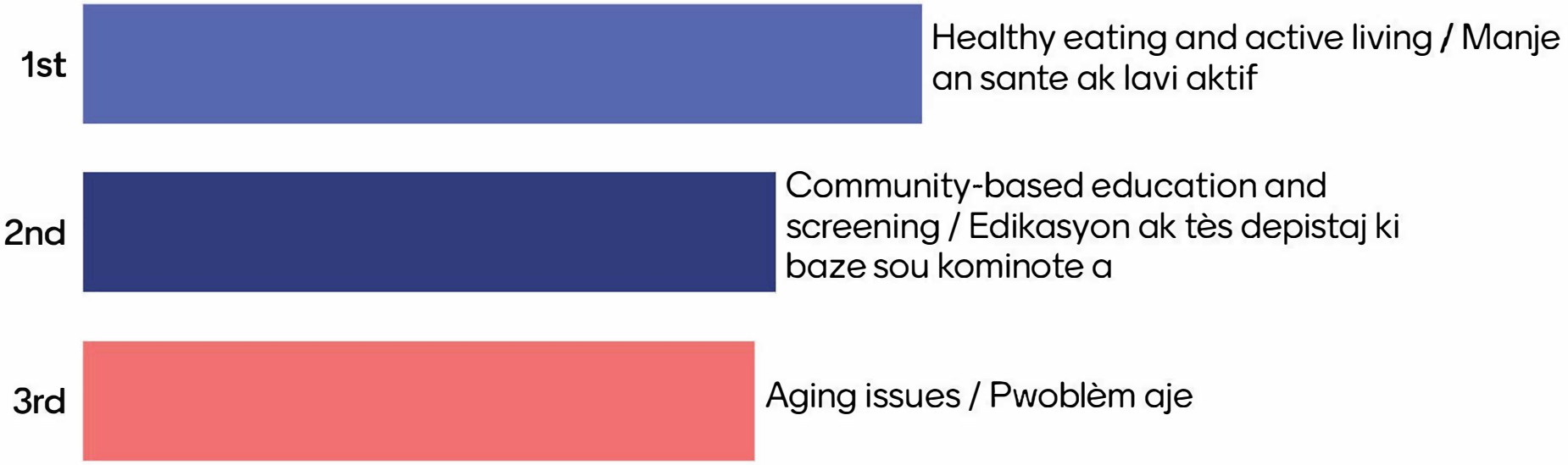
Chronic and Complex Conditions: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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Reconvene

Next Steps

Mary DeCourcey

Manager, Community Benefits & Community Relations | Mount Auburn Hospital

mdecourc@mah.org

Community Health & Community Benefits Information on Website:

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

Community Benefits Annual Meeting in September

Appendix B:
Data Book

Secondary Data

Demographics

Demographics: Arlington – Somerville

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	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Population						
Total population	6992395	1622896	46015	27009	117794	80549
Male	48.9%	49.4%	47.6%	47.7%	49.9%	49.2%
Female	51.1%	50.6%	52.4%	52.3%	50.1%	50.8%
Age Distribution						
Under 5 years (%)	5.0%	5.1%	4.8%	5.0%	4.0%	4.0%
5 to 9 years	5.2%	5.4%	5.1%	7.0%	3.4%	2.6%
10 to 14 years	5.7%	5.6%	6.7%	7.0%	2.9%	2.6%
15 to 19 years	6.5%	6.3%	5.0%	7.4%	7.5%	4.0%
20 to 24 years	6.8%	6.8%	3.7%	3.2%	14.8%	10.9%
25 to 34 years	14.1%	15.1%	15.5%	9.5%	26.9%	33.4%
35 to 44 years	12.9%	13.8%	14.3%	15.2%	12.9%	15.4%
45 to 54 years	12.6%	12.8%	15.6%	15.0%	7.9%	9.6%
55 to 59 years	7.0%	6.8%	6.2%	6.5%	3.7%	4.1%
60 to 64 years	6.8%	6.2%	6.1%	6.1%	3.8%	3.9%
65 to 74 years	10.3%	9.3%	9.8%	11.2%	7.5%	5.9%
75 to 84 years	4.9%	4.6%	5.0%	5.4%	3.4%	2.6%
85 years and over	2.2%	2.1%	2.0%	1.7%	1.3%	1.0%
Under 18 years of age	19.6%	19.6%	20.5%	24.4%	12.3%	10.4%
Over 65 years of age	17.5%	16.0%	16.9%	18.3%	12.2%	9.5%

Demographics: Arlington – Somerville

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Race/Ethnicity						
White alone (%)	70.7%	69.0%	76.5%	69.6%	57.5%	69.5%
Black or African American alone (%)	7.0%	5.0%	2.5%	1.7%	10.5%	4.6%
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.0%	0.1%	0.2%
Asian alone (%)	7.1%	13.2%	12.1%	20.4%	19.7%	11.7%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Some Other Race alone (%)	5.4%	4.2%	1.7%	1.7%	2.5%	4.6%
Two or More Races (%)	9.5%	8.4%	7.1%	6.6%	9.6%	9.3%
Hispanic or Latino of Any Race (%)	12.9%	9.0%	5.0%	4.7%	9.0%	11.4%
Foreign-born						
Foreign-born population	1,236,518	366,954	8,134	6,812	33,920	19,972
Naturalized U.S. citizen	54.5%	51.0%	54.3%	56.1%	40.4%	42.5%
Not a U.S. citizen	45.5%	49.0%	45.7%	43.9%	59.6%	57.5%
Region of birth: Europe	18.1%	16.9%	28.7%	23.8%	20.5%	21.4%
Region of birth: Asia	30.5%	42.9%	51.9%	60.5%	47.2%	30.9%
Region of birth: Africa	9.5%	7.6%	4.2%	2.7%	9.8%	4.6%
Region of birth: Oceania	0.3%	0.5%	0.4%	0.5%	1.2%	1.0%
Region of birth: Latin America	39.4%	29.7%	10.9%	9.7%	18.2%	37.3%
Region of birth: Northern America	2.2%	2.4%	3.9%	2.8%	3.2%	4.8%
Language						
English only	75.2%	71.7%	79.6%	69.5%	65.8%	71.2%
Language other than English	24.8%	28.3%	20.4%	30.5%	34.2%	28.8%
Speak English less than "very well"	9.7%	9.9%	5.2%	7.6%	7.9%	10.5%

Demographics: Arlington – Somerville

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Spanish	9.6%	6.4%	2.2%	3.7%	6.6%	8.9%
Speak English less than "very well"	4.1%	2.4%	0.3%	0.7%	1.4%	3.9%
Other Indo-European languages	9.2%	12.2%	9.9%	12.2%	12.0%	13.6%
Speak English less than "very well"	3.2%	4.1%	2.6%	2.0%	2.6%	4.9%
Asian and Pacific Islander languages	4.4%	7.8%	7.2%	13.2%	11.5%	4.9%
Speak English less than "very well"	1.9%	2.9%	2.0%	4.6%	2.5%	1.3%
Other languages	1.6%	2.0%	1.1%	1.4%	4.0%	1.5%
Speak English less than "very well"	0.4%	0.5%	0.2%	0.2%	1.4%	0.4%
Employment						
Unemployment rate	5.1%	4.2%	3.2%	4.5%	3.4%	2.9%
Unemployment rate by race/ethnicity						
White alone	4.5%	4.0%	3.4%	4.2%	3.0%	3.0%
Black or African American alone	7.9%	6.4%	0.0%	13.7%	6.2%	1.1%
American Indian and Alaska Native alone	6.9%	5.5%	0.0%	100.0%	23.5%	0.0%
Asian alone	4.0%	3.5%	2.8%	4.1%	2.9%	1.7%
Native Hawaiian and Other Pacific Islander alone	4.8%	10.9%	-	-	0.0%	0.0%
Some other race alone	8.0%	6.4%	0.0%	0.0%	3.9%	3.9%
Two or more races	7.9%	5.4%	2.9%	7.8%	4.4%	4.1%
Hispanic or Latino origin (of any race)	8.1%	6.2%	2.7%	5.9%	7.8%	4.4%
Unemployment rate by educational attainment						
Less than high school graduate	9.1%	8.1%	0.0%	0.0%	20.8%	5.0%
High school graduate (includes equivalency)	6.4%	5.9%	7.5%	0.2%	8.3%	4.9%
Some college or associate's degree	5.2%	4.9%	2.5%	5.1%	5.3%	3.5%
Bachelor's degree or higher	2.7%	2.7%	2.4%	3.7%	2.3%	1.9%

Demographics: Arlington – Somerville

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Income and Poverty						
Median household income (dollars)	101,341	126,779	141,440	178,188	126,469	127,056
Population living below the federal poverty line in the last 12 months						
Individuals	10.0%	7.5%	5.4%	3.5%	12.4%	10.1%
Families	6.6%	6.7%	3.0%	1.7%	2.7%	1.8%
Individuals under 18 years of age	11.8%	7.4%	2.7%	2.3%	14.2%	10.3%
Individuals over 65 years of age	10.2%	8.6%	10.3%	6.5%	10.2%	16.5%
Female head of household, no spouse	19.1%	15.4%	8.6%	10.6%	23.5%	25.3%
White alone	7.6%	6.0%	4.4%	2.9%	8.8%	8.9%
Black or African American alone	17.1%	15.4%	15.8%	12.1%	26.8%	27.5%
American Indian and Alaska Native alone	19.1%	12.7%	0.0%	0.0%	32.9%	6.0%
Asian alone	11.0%	8.6%	5.8%	3.5%	15.3%	11.3%
Native Hawaiian and Other Pacific Islander alone	21.7%	4.7%	100.0%	-	0.0%	0.0%
Some other race alone	20.1%	14.2%	43.0%	21.1%	19.1%	9.4%
Two or more races	15.7%	10.5%	3.2%	2.1%	11.6%	10.5%
Hispanic or Latino origin (of any race)	20.6%	15.1%	10.2%	14.0%	15.8%	12.0%
Less than high school graduate	24.4%	20.4%	17.4%	9.9%	27.7%	21.5%
High school graduate (includes equivalency)	12.7%	12.1%	14.6%	11.4%	24.3%	15.3%
Some college, associate's degree	9.2%	8.2%	11.8%	7.0%	17.9%	13.5%
Bachelor's degree or higher	4.0%	3.4%	3.0%	2.6%	6.6%	4.6%
With Social Security	29.8%	25.8%	24.3%	23.6%	18.1%	14.7%
With retirement income	22.9%	20.9%	20.5%	21.0%	14.6%	12.4%
With Supplemental Security Income	5.6%	3.9%	2.3%	2.5%	2.9%	2.9%
With cash public assistance income	3.5%	2.8%	2.7%	2.1%	2.8%	2.5%
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.6%	5.6%	4.2%	8.1%	8.5%

Demographics: Arlington – Somerville

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Housing						
Occupied housing units	91.6%	95.5%	96.4%	95.6%	90.8%	94.3%
Owner-occupied	62.6%	61.6%	60.6%	64.2%	33.7%	34.3%
Renter-occupied	37.4%	38.4%	39.4%	35.8%	66.3%	65.7%
Lacking complete plumbing facilities	0.3%	0.3%	0.0%	0.2%	0.5%	0.3%
Lacking complete kitchen facilities	0.8%	0.9%	0.3%	0.3%	1.0%	0.7%
No telephone service available	0.8%	0.6%	0.4%	1.2%	0.5%	0.5%
Monthly housing costs <35% of total household income						
Among owner-occupied units with a mortgage	22.7%	20.7%	15.8%	21.0%	22.4%	22.1%
Among owner-occupied units without a mortgage	15.4%	15.2%	14.5%	15.1%	8.3%	21.9%
Among occupied units paying rent	41.3%	37.4%	25.8%	30.9%	35.2%	28.8%
Access to Technology						
Among households						
Has smartphone	89.2%	91.5%	89.6%	91.6%	94.3%	93.8%
Has desktop or laptop	83.2%	88.4%	90.9%	93.4%	92.1%	89.3%
With a computer	95.1%	96.5%	96.4%	96.8%	97.9%	96.3%
With a broadband Internet subscription	91.8%	94.2%	94.9%	95.7%	94.0%	93.7%
Transportation						
Car, truck, or van -- drove alone	62.7%	56.0%	45.8%	48.9%	20.9%	30.7%
Car, truck, or van -- carpooled	6.9%	6.4%	3.4%	5.7%	3.1%	4.8%
Public transportation (excluding taxicab)	7.0%	8.0%	12.5%	11.1%	19.4%	19.6%
Walked	4.2%	4.2%	2.0%	2.0%	19.3%	8.4%
Other means	2.5%	3.2%	5.8%	3.9%	9.0%	7.6%
Worked from home	16.7%	22.2%	30.5%	28.4%	28.3%	29.0%
Mean travel time to work (minutes)	29.3	30.0	32.2	29.5	26.1	30.7

Demographics: Arlington – Somerville

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Vehicles available among occupied housing units						
No vehicles available	11.8%	10.4%	9.7%	7.1%	33.7%	21.8%
1 vehicle available	35.8%	36.5%	47.8%	37.4%	48.3%	49.2%
2 vehicles available	35.8%	37.8%	33.5%	45.6%	15.2%	23.3%
3 or more vehicles available	16.6%	15.3%	8.9%	9.9%	2.8%	5.6%
Education						
Educational attainment of adults 25 years and older						
Less than 9th grade	4.2%	3.3%	1.0%	1.4%	2.6%	4.1%
9th to 12th grade, no diploma	4.4%	3.2%	1.4%	1.0%	1.7%	2.9%
High school graduate (includes equivalency)	22.8%	17.5%	10.8%	7.8%	6.0%	13.3%
Some college, no degree	14.4%	11.2%	7.9%	5.5%	7.1%	8.2%
Associate's degree	7.5%	5.7%	4.5%	4.1%	2.4%	3.4%
Bachelor's degree	25.3%	28.8%	30.6%	28.3%	29.8%	34.6%
Graduate or professional degree	21.4%	30.2%	43.8%	51.9%	50.4%	33.4%
High school graduate or higher	91.4%	93.4%	97.6%	97.6%	95.7%	93.0%
Bachelor's degree or higher	46.6%	59.0%	74.4%	80.2%	80.2%	68.0%
Educational attainment by race/ethnicity						
White alone	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	96.0%	97.7%	97.9%	97.5%	95.6%
Bachelor's degree or higher	49.4%	60.9%	74.4%	80.3%	85.1%	72.7%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	89.6%	99.0%	100.0%	84.9%	92.5%
Bachelor's degree or higher	30.7%	40.0%	50.4%	56.1%	36.6%	45.6%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	69.1%	100.0%	100.0%	100.0%	53.7%
Bachelor's degree or higher	24.4%	31.3%	15.5%	100.0%	44.1%	5.5%

Demographics: Arlington – Somerville

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville
Demographics						
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	90.3%	97.1%	97.2%	97.1%	92.4%
Bachelor's degree or higher	64.0%	71.3%	85.0%	83.5%	92.1%	76.1%
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	98.5%	100.0%	-	100.0%	76.9%
Bachelor's degree or higher	40.0%	20.9%	0.0%	-	62.5%	0.0%
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	73.6%	85.0%	87.0%	89.1%	62.0%
Bachelor's degree or higher	20.0%	27.1%	38.0%	51.9%	55.2%	21.2%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	85.6%	100.0%	97.1%	92.3%	89.0%
Bachelor's degree or higher	33.6%	46.1%	75.4%	86.9%	71.7%	56.7%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	77.6%	95.5%	92.7%	85.6%	76.2%
Bachelor's degree or higher	23.3%	34.9%	59.1%	64.5%	60.7%	41.5%
Health insurance coverage among civilian noninstitutionalized population (%)						
With health insurance coverage	97.4%	97.6%	98.9%	98.2%	98.2%	97.9%
With private health insurance	73.8%	80.0%	87.1%	86.9%	85.8%	81.5%
With public coverage	37.1%	29.9%	23.1%	23.7%	21.4%	23.1%
No health insurance coverage	2.6%	2.4%	1.1%	1.8%	1.8%	2.1%
Disability						
Percent of population with a disability	12.1%	9.8%	8.5%	7.9%	7.4%	8.5%
Under 18 with a disability	4.9%	4.1%	2.2%	5.1%	2.8%	5.4%
18-64	9.4%	7.1%	6.3%	4.0%	5.7%	5.6%
65+	30.2%	27.9%	24.6%	24.2%	22.7%	36.6%

Demographics: Waltham – Watertown

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	Middlesex County	Waltham	Watertown
Demographics				
Population				
Total population	6992395	1622896	64723	35270
Male	48.9%	49.4%	49.3%	46.8%
Female	51.1%	50.6%	50.7%	53.2%
Age Distribution				
Under 5 years (%)	5.0%	5.1%	5.1%	5.4%
5 to 9 years	5.2%	5.4%	3.4%	3.6%
10 to 14 years	5.7%	5.6%	3.1%	3.5%
15 to 19 years	6.5%	6.3%	7.8%	4.0%
20 to 24 years	6.8%	6.8%	12.5%	4.2%
25 to 34 years	14.1%	15.1%	17.9%	21.5%
35 to 44 years	12.9%	13.8%	12.8%	16.0%
45 to 54 years	12.6%	12.8%	9.9%	10.8%
55 to 59 years	7.0%	6.8%	6.9%	6.5%
60 to 64 years	6.8%	6.2%	5.2%	6.6%
65 to 74 years	10.3%	9.3%	8.5%	10.6%
75 to 84 years	4.9%	4.6%	5.4%	5.4%
85 years and over	2.2%	2.1%	1.4%	1.9%
Under 18 years of age	19.6%	19.6%	13.4%	14.8%
Over 65 years of age	17.5%	16.0%	15.3%	17.9%

Demographics: Waltham – Watertown

			Areas of Interest	
	Massachusetts	Middlesex County	Waltham	Watertown
Demographics				
Race/Ethnicity				
White alone (%)	70.7%	69.0%	62.2%	71.1%
Black or African American alone (%)	7.0%	5.0%	7.5%	4.2%
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.9%	0.2%
Asian alone (%)	7.1%	13.2%	12.9%	11.9%
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.1%	0.0%
Some Other Race alone (%)	5.4%	4.2%	7.3%	3.7%
Two or More Races (%)	9.5%	8.4%	9.2%	9.0%
Hispanic or Latino of Any Race (%)	12.9%	9.0%	18.2%	6.5%
Foreign-born				
Foreign-born population	1,236,518	366,954	17,229	9,332
Naturalized U.S. citizen	54.5%	51.0%	45.4%	50.6%
Not a U.S. citizen	45.5%	49.0%	54.6%	49.4%
Region of birth: Europe	18.1%	16.9%	10.9%	20.4%
Region of birth: Asia	30.5%	42.9%	41.3%	44.1%
Region of birth: Africa	9.5%	7.6%	7.1%	10.2%
Region of birth: Oceania	0.3%	0.5%	0.0%	0.7%
Region of birth: Latin America	39.4%	29.7%	37.3%	22.4%
Region of birth: Northern America	2.2%	2.4%	3.4%	2.1%
Language				
English only	75.2%	71.7%	66.5%	68.8%
Language other than English	24.8%	28.3%	33.5%	31.2%
Speak English less than "very well"	9.7%	9.9%	10.1%	9.8%

Demographics: Waltham – Watertown

			Areas of Interest	
	Massachusetts	Middlesex County	Waltham	Watertown
Demographics				
Spanish	9.6%	6.4%	13.1%	4.9%
Speak English less than "very well"	4.1%	2.4%	4.6%	1.6%
Other Indo-European languages	9.2%	12.2%	11.4%	17.0%
Speak English less than "very well"	3.2%	4.1%	2.8%	5.3%
Asian and Pacific Islander languages	4.4%	7.8%	7.3%	6.0%
Speak English less than "very well"	1.9%	2.9%	2.3%	1.4%
Other languages	1.6%	2.0%	1.7%	3.3%
Speak English less than "very well"	0.4%	0.5%	0.4%	1.4%
Employment				
Unemployment rate	5.1%	4.2%	3.5%	5.5%
Unemployment rate by race/ethnicity				
White alone	4.5%	4.0%	3.1%	4.8%
Black or African American alone	7.9%	6.4%	7.0%	9.0%
American Indian and Alaska Native alone	6.9%	5.5%	18.4%	-
Asian alone	4.0%	3.5%	1.4%	4.3%
Native Hawaiian and Other Pacific Islander alone	4.8%	10.9%	0.0%	-
Some other race alone	8.0%	6.4%	6.4%	9.0%
Two or more races	7.9%	5.4%	4.4%	9.7%
Hispanic or Latino origin (of any race)	8.1%	6.2%	5.8%	10.6%
Unemployment rate by educational attainment				
Less than high school graduate	9.1%	8.1%	2.5%	19.1%
High school graduate (includes equivalency)	6.4%	5.9%	6.7%	12.9%
Some college or associate's degree	5.2%	4.9%	4.0%	2.9%
Bachelor's degree or higher	2.7%	2.7%	1.8%	3.6%

Demographics: Waltham – Watertown

			Areas of Interest	
	Massachusetts	Middlesex County	Waltham	Watertown
Demographics				
Income and Poverty				
Median household income (dollars)	101,341	126,779	116,560	123,422
Population living below the federal poverty line in the last 12 months				
Individuals	10.0%	7.5%	8.6%	6.1%
Families	6.6%	6.7%	3.3%	4.3%
Individuals under 18 years of age	11.8%	7.4%	9.1%	3.3%
Individuals over 65 years of age	10.2%	8.6%	9.6%	10.4%
Female head of household, no spouse	19.1%	15.4%	10.7%	4.3%
White alone	7.6%	6.0%	6.8%	5.5%
Black or African American alone	17.1%	15.4%	11.2%	3.7%
American Indian and Alaska Native alone	19.1%	12.7%	0.0%	0.0%
Asian alone	11.0%	8.6%	13.9%	10.4%
Native Hawaiian and Other Pacific Islander alone	21.7%	4.7%	0.0%	-
Some other race alone	20.1%	14.2%	12.0%	9.4%
Two or more races	15.7%	10.5%	9.9%	5.1%
Hispanic or Latino origin (of any race)	20.6%	15.1%	11.6%	7.4%
Less than high school graduate	24.4%	20.4%	20.5%	19.4%
High school graduate (includes equivalency)	12.7%	12.1%	11.6%	7.8%
Some college, associate's degree	9.2%	8.2%	7.2%	10.2%
Bachelor's degree or higher	4.0%	3.4%	3.7%	4.0%
With Social Security	29.8%	25.8%	24.9%	25.2%
With retirement income	22.9%	20.9%	19.4%	19.5%
With Supplemental Security Income	5.6%	3.9%	5.7%	1.8%
With cash public assistance income	3.5%	2.8%	1.8%	2.2%
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.6%	7.6%	5.4%

Demographics: Waltham – Watertown

			Areas of Interest	
	Massachusetts	Middlesex County	Waltham	Watertown
Demographics				
Housing				
Occupied housing units	91.6%	95.5%	95.6%	95.0%
Owner-occupied	62.6%	61.6%	48.8%	48.8%
Renter-occupied	37.4%	38.4%	51.2%	51.2%
Lacking complete plumbing facilities	0.3%	0.3%	0.1%	0.3%
Lacking complete kitchen facilities	0.8%	0.9%	1.0%	1.5%
No telephone service available	0.8%	0.6%	1.0%	0.5%
Monthly housing costs <35% of total household income				
Among owner-occupied units with a mortgage	22.7%	20.7%	23.6%	21.5%
Among owner-occupied units without a mortgage	15.4%	15.2%	18.1%	16.8%
Among occupied units paying rent	41.3%	37.4%	35.4%	35.5%
Access to Technology				
Among households				
Has smartphone	89.2%	91.5%	91.3%	91.8%
Has desktop or laptop	83.2%	88.4%	89.3%	88.9%
With a computer	95.1%	96.5%	96.4%	96.7%
With a broadband Internet subscription	91.8%	94.2%	93.9%	94.7%
Transportation				
Car, truck, or van -- drove alone	62.7%	56.0%	55.6%	49.2%
Car, truck, or van -- carpooled	6.9%	6.4%	10.2%	6.8%
Public transportation (excluding taxicab)	7.0%	8.0%	5.4%	8.2%
Walked	4.2%	4.2%	6.2%	5.0%
Other means	2.5%	3.2%	2.6%	4.1%
Worked from home	16.7%	22.2%	20.0%	26.6%
Mean travel time to work (minutes)	29.3	30.0	24.6	26.2

Demographics: Waltham – Watertown

			Areas of Interest	
	Massachusetts	Middlesex County	Waltham	Watertown
Demographics				
Vehicles available among occupied housing units				
No vehicles available	11.8%	10.4%	7.8%	10.5%
1 vehicle available	35.8%	36.5%	39.2%	47.3%
2 vehicles available	35.8%	37.8%	40.7%	34.9%
3 or more vehicles available	16.6%	15.3%	12.3%	7.4%
Education				
Educational attainment of adults 25 years and older				
Less than 9th grade	4.2%	3.3%	4.0%	3.6%
9th to 12th grade, no diploma	4.4%	3.2%	3.4%	1.1%
High school graduate (includes equivalency)	22.8%	17.5%	18.8%	13.8%
Some college, no degree	14.4%	11.2%	11.7%	9.0%
Associate's degree	7.5%	5.7%	5.7%	5.3%
Bachelor's degree	25.3%	28.8%	29.0%	31.8%
Graduate or professional degree	21.4%	30.2%	27.4%	35.5%
High school graduate or higher	91.4%	93.4%	92.6%	95.2%
Bachelor's degree or higher	46.6%	59.0%	56.4%	67.2%
Educational attainment by race/ethnicity				
White alone	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	96.0%	96.0%	96.2%
Bachelor's degree or higher	49.4%	60.9%	58.3%	67.5%
Black alone	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	89.6%	85.8%	96.4%
Bachelor's degree or higher	30.7%	40.0%	41.3%	69.7%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	69.1%	56.2%	-
Bachelor's degree or higher	24.4%	31.3%	16.2%	-

Demographics: Waltham – Watertown

			Areas of Interest	
	Massachusetts	Middlesex County	Waltham	Watertown
Demographics				
Asian alone	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	90.3%	96.2%	98.0%
Bachelor's degree or higher	64.0%	71.3%	79.8%	86.2%
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	98.5%	100.0%	-
Bachelor's degree or higher	40.0%	20.9%	0.0%	-
Some other race alone	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	73.6%	77.2%	65.0%
Bachelor's degree or higher	20.0%	27.1%	25.7%	38.0%
Two or more races	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	85.6%	80.1%	93.8%
Bachelor's degree or higher	33.6%	46.1%	47.0%	43.9%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	77.6%	74.3%	80.7%
Bachelor's degree or higher	23.3%	34.9%	31.8%	53.9%
Health insurance coverage among civilian noninstitutionalized population (%)				
With health insurance coverage	97.4%	97.6%	97.4%	98.9%
With private health insurance	73.8%	80.0%	79.5%	82.1%
With public coverage	37.1%	29.9%	30.5%	29.1%
No health insurance coverage	2.6%	2.4%	2.6%	1.1%
Disability				
Percent of population with a disability	12.1%	9.8%	10.4%	10.8%
Under 18 with a disability	4.9%	4.1%	2.7%	4.2%
18-64	9.4%	7.1%	8.1%	6.8%
65+	30.2%	27.9%	28.6%	31.3%

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

Health Status

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Source
Access to Care						
Ratio of population to primary care physicians	103.5	128.3	128.3	128.3	128.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.2	145.4	145.3	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	4.3	25.7	10.1	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	8.8	8.3	10.6	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9				CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0				Massachusetts Death Report, 2021
Risk Factors						
Farmers Markets Accepting SNAP, Rate per 100,00 low-income population	1.8	4.8	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	7.6	3.5	3.5	6.6	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	1.9	9.3	0.0	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	21	19.8	22.7	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	22.2	22.1	24.4	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	29.2	29.5	29.7	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	12.9	12.6	14.9	BRFSS, 2022

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Source
Chronic Conditions						
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	10.5	10.2	10.7	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	6.3	6.1	7.4	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	3.6	3.3	3.8	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	4.3	4.1	4.6	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	2	1.9	2.3	BRFSS, 2022
Cancer						
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	85.2	84.8	84.5	BRSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	69.2	69.6	67.5	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)						
All sites	449.4	426.6	426.9	426.3	426.4	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	52.8	52.5	52.0	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	108.6	111.2	108.5	State Cancer Profiles, 2016-2020
Prevention and Screening						
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	76.9	76.9	77.6	Behavioral Risk Factor Surveillance System, 2022
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	18.2	15.5	15.2	14.7	16.6	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	89.3	89.5	88.4	Behavioral Risk Factor Surveillance System, 2021

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Source
Communicable and Infectious Disease						
STI infection cases (per 100,000)						
Chlamydia	385.8	264.0	293.2	293.2	293.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	9.8	9.9	9.9	9.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	84.2	84.2	84.2	84.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	288.2	288.2	288.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	2.7	2.7	2.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19						
Percent of Adults Fully Vaccinated	78.1	87.7	87.0	87.0	87.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.0	4.0	4.0	4.0	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	
Substance Use						
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	6.9	6.5	7.6	BRFSS, 2021
Binge drinking % (adults), age-adjusted	17.2	Data unavailable	19.4	18.9	17.6	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	39.3				CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)	17.9	18.2				Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6				
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0				

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Source
Substance-related deaths (Age-adjusted rate per 100k)						MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance	61.9	41.1	27.4	*	58.2	
Opioid-related deaths	33.7	20.1	*	*	36.4	
Alcohol-related deaths	29.1	20.4	17.0	*	20.1	
Stimulant-related deaths	23.0	13.6	10.6	*	28.6	
Substance-related ER visits (age-adjusted rate per 100K)						MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	724.1	449.5	3049.3	
Opioid-related ER visits	169.3	102.9	47.3	30.4	142.7	
Opioid-related EMS Incidents	248.8	176.3	56.1	55.0	345.4	
Alcohol-related ER visits	1235.6	962.1	536.5	288.6	2644.8	
Stimulant-related ER visits	15.7	13.6	*	0.0	*	
Substance Addiction Services						MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	151.2	58.6	206.9	
Number of BSAS providers		201.0	1.0	3.0	18.0	
Number of clients of BSAS services (residents)		3702.0	46.0	*	167.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	19.0	15.0	14.0	
Buprenorphine RX's filled	9982.0	6002.1	4301.6	2868.7	3026.1	
Individuals who received buprenorphine RX's		508.3	380.1	300.4	290.5	
Naloxone kits received		35323.0	648.0	478.0	4433.0	
Naloxone kids: Opioid deaths Ratio		78.0	*	*	108.0	
Fentanyl test strips received		50130.0	1000.0	1700.0	5300.0	

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	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	72.4	73.3	100.0	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	56.0	67.0	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	6.2	8.5	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	88.0	70.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		9.0	5.9	14.6	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	4.6	5.9	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	5.5	NS	NS	0.0	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3				EPA - National Air Toxics Assessment, 2018

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	**Middlesex County**	**Arlington**	**Belmont**	**Cambridge**	**Source**
Mental Health						
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	36.9	36.9	36.9	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	23.3	22.3	22.4	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	32.3	31.8	32.7	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	20.5	20.4	22.1	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	13.4	12.9	13.9	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.0	0.1	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	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.1	7.1	7.1	County Health Rankings, 2016-2022

Health Status: Arlington – Cambridge

			Areas of Interest			
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Source
Safety/Crime						
Property Crimes Offenses (#)						Massachusetts Crime Statistics, 2023
Burglary	10028.0		45.0	46.0	283.0	
Larceny-theft	60647.0		197.0	131.0	2334.0	
Motor vehicle theft	7224.0		19.0	10.0	144.0	
Arson	377.0		1.0	1.0	14.0	
Crimes Against Persons Offenses (#)						
Murder/non-negligent manslaughter	162.0		0.0	0.0	0.0	
Sex offenses	4365.0		6.0	0.0	75.0	
Assaults	72086.0		169.0	64.0	1430.0	
Human trafficking	0.0		0.0	0.0	0.0	
Hate Crimes Offenses (#)						
Race/Ethnicity/Ancestry Bias	222.0		1.0	0.0	28.0	
Religious Bias	88.0		2.0	0.0	8.0	
Sexual Orientation Bias	80.0		2.0	0.0	4.0	
Gender Identity Bias	22.0		0.0	0.0	3.0	
Gender Bias	2.0		0.0	1.0	0.0	
Disability Bias	0.0		0.0	0.0	0.0	

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	Middlesex County	Somerville	Waltham	Watertown	Source
Access to Care						
Ratio of population to primary care physicians	103.5	128.3	128.3	128.3	128.3	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.4	145.5	145.2	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	30.9	10.7	11.3	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	11.9	12.4	10.5	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9				CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0				Massachusetts Death Report, 2021
Risk Factors						
Farmers Markets Accepting SNAP, Rate per 100,00 low-income population	1.8	4.8	34.5	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	7.6	14.8	8.0	12.0	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	0.0	14.8	0.0	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	23.6	24.1	22.5	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	24.7	24.9	23.1	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	29.9	30	29.4	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	16.1	17.2	15.1	BRFSS, 2022

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	Middlesex County	Somerville	Waltham	Watertown	Source
Chronic Conditions						
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	11.2	11.1	11	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	7.7	7.8	6.7	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	4.5	4.6	4.3	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	5	5	4.7	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	2.5	2.4	2.2	BRFSS, 2022
Cancer						
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	83.2	83.3	83	BRSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	66.5	66.5	67.5	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)						
All sites	449.4	426.6	426.6	426.4	426.3	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	52.0	51.7	52.5	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	109.2	108.0	106.6	State Cancer Profiles, 2016-2020
Prevention and Screening						
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	76.6	76.6	76.3	Behavioral Risk Factor Surveillance System, 2022
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	18.2	15.5	16.9	16.0	16.4	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	87.9	87.3	88.4	Behavioral Risk Factor Surveillance System, 2021

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	Middlesex County	Somerville	Waltham	Watertown	Source
Communicable and Infectious Disease						
STI infection cases (per 100,000)						
Chlamydia	385.8	264.0	293.2	293.2	293.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	9.8	9.9	9.9	9.9	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	84.2	84.2	84.2	84.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	288.2	288.2	288.2	288.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	2.7	2.7	2.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19						
Percent of Adults Fully Vaccinated	78.1	87.7	87.0	87.0	87.0	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.0	4.0	4.0	4.0	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	
Substance Use						
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	9.1	9.6	8.6	BRFSS, 2021
Binge drinking % (adults), age-adjusted	17.2	Data unavailable	18.8	18.2	19.4	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	39.3				CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-Adjusted)	17.9	18.2				Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6				
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0				

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	**Middlesex County**	**Somerville**	**Waltham**	**Watertown**	**Source**
Substance-related deaths (Age-adjusted rate per 100k)						MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance	61.9	41.1	67.1	64.5	32.8	
Opioid-related deaths	33.7	20.1	26.7	27.0	*	
Alcohol-related deaths	29.1	20.4	42.5	35.4	19.0	
Stimulant-related deaths	23.0	13.6	15.1	22.0	*	
Substance-related ER visits (age-adjusted rate per 100K)						MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	1737.0	1592.9	986.7	
Opioid-related ER visits	169.3	102.9	78.4	86.2	46.7	
Opioid-related EMS Incidents	248.8	176.3	202.4	141.1	96.2	
Alcohol-related ER visits	1235.6	962.1	1496.7	1303.7	807.7	
Stimulant-related ER visits	15.7	13.6	*	*	*	
Substance Addiction Services						MA Bureau of Substance Addiction Services (BSAS) Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	270.2	450.8	189.6	
Number of BSAS providers		201.0	15.0	17.0	6.0	
Number of clients of BSAS services (residents)		3702.0	133.0	229.0	24.0	
Avg. distance to BSAS provider (miles)	17.0	17.0	13.0	17.0	11.0	
Buprenorphine RX's filled	9982.0	6002.1	5527.8	4951.1	4441.1	
Individuals who received buprenorphine RX's		508.3	602.1	519.8	467.0	
Naloxone kits received		35323.0	2133.0	527.0	202.0	
Naloxone kids: Opioid deaths Ratio		78.0	78.0	23.0	*	
Fentanyl test strips received		50130.0	3500.0	800.0	200.0	

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	**Middlesex County**	**Somerville**	**Waltham**	**Watertown**	**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	72.4	74.6	52.4	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		74.0	62.0	72.0	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		12.2	11.7	8.4	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		82.0	70.0	79.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		21.3	17.9	7.9	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9		9.8	7.7	6.8	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	5.5	NS	NS	NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.3				EPA - National Air Toxics Assessment, 2018

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	**Middlesex County**	**Somerville**	**Waltham**	**Watertown**	**Source**
Mental Health						
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	36.9	36.9	36.9	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	24.1	23.6	24.2	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	33.6	34.2	33.2	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	22.5	24.1	21.5	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	15	15.2	14.7	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	0.2	U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health						
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.1	7.1	7.1	County Health Rankings, 2016-2022

Health Status: Somerville – Watertown

			Areas of Interest			
	Massachusetts	Middlesex County	Somerville	Waltham	Watertown	Source
Safety/Crime						
Property Crimes Offenses (#)						Massachusetts Crime Statistics, 2023
Burglary	10028.0		133.0	56.0	35.0	
Larceny-theft	60647.0		891.0	283.0	324.0	
Motor vehicle theft	7224.0		106.0	25.0	14.0	
Arson	377.0		1.0	3.0	1.0	
Crimes Against Persons Offenses (#)						
Murder/non-negligent manslaughter	162.0		1.0	0.0	0.0	
Sex offenses	4365.0		39.0	15.0	7.0	
Assaults	72086.0		438.0	323.0	182.0	
Human trafficking	0.0		0.0	0.0	0.0	
Hate Crimes Offenses (#)						
Race/Ethnicity/Ancestry Bias	222.0		5.0	1.0		
Religious Bias	88.0		1.0	1.0		
Sexual Orientation Bias	80.0		0.0	1.0		
Gender Identity Bias	22.0		1.0	0.0		
Gender Bias	2.0		0.0	0.0		
Disability Bias	0.0		0.0	0.0		

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

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

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

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**	**%**
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 harassed 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%
Education	Helpful school resources provided	College-preparation	1459	57.90%	382	61.30%
		Extracurricular activities	1459	74.40%	382	82.20%
		Guidance counselor	1459	58.80%	382	59.40%
		Programs to reduce bullying, violence, racism	1459	19.10%	382	24.30%

CHES – Youth

			Massachusetts		Middlesex County	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**
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, past month	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	Opioid 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 – Cambridge

Data Notes:

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.
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		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Housing	Current living situation	No steady place	14888	2.50%	3353	1.70%	*	*	*	*	348	4.60%
		Worried about losing	14888	8.00%	3353	6.50%	154	9.70%	*	*	348	9.20%
		Steady place	14888	89.30%	3353	91.60%	154	90.30%	60	93.30%	348	85.90%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	109	44.00%	43	32.60%	263	53.20%
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	*	*	*	*	176	3.40%
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	77	7.80%	*	*	176	11.90%
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	1689	13.30%	77	18.20%	30	16.70%	176	13.60%
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	77	24.70%	*	*	176	17.00%
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	77	7.80%	*	*	176	5.10%
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	77	11.70%	*	*	176	8.00%
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	77	11.70%	*	*	176	9.70%
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	1689	27.10%	77	28.60%	30	23.30%	176	27.30%

CHES Adult: Arlington – Cambridge

			Massachusetts		Middlesex County		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Basic Needs	End of month finances	Not enough money	13814	16.50%	3141	11.00%	147	8.80%	56	10.70%	336	11.90%
		Just enough money	13814	31.10%	3141	24.90%	147	21.80%	56	12.50%	336	20.80%
		Money left over	13814	52.40%	3141	64.10%	147	69.40%	56	76.80%	336	67.30%
Basic Needs	Current internet access (2)	No internet	11425	3.00%	2514	1.60%	*	*	*	*	270	3.30%
		Does not work well	11425	9.30%	2514	7.00%	*	*	*	*	270	8.10%
		Works well	11425	87.70%	2514	91.50%	113	95.60%	46	100.00%	270	88.50%
Neighborhood	Able to get where you need to go (2)	Somewhat or strongly disagree	11064	7.00%	2521	5.50%	115	4.30%	*	*	254	6.70%
		Somewhat agree	11064	22.00%	2521	21.70%	115	22.60%	41	12.20%	254	20.90%
		Strongly agree	11064	71.00%	2521	72.80%	115	73.00%	41	85.40%	254	72.40%
Neighborhood	Experienced neighborhood violence, lifetime (2)	Never	11008	58.60%	2509	63.50%	115	62.60%	41	70.70%	255	49.40%
		Rarely	11008	28.90%	2509	28.60%	115	31.30%	41	24.40%	255	37.30%
		Somewhat often	11008	9.10%	2509	5.80%	115	5.20%	*	*	255	9.00%
		Very often	11008	3.40%	2509	2.10%	*	*	*	*	255	4.30%

CHES Adult: Arlington – Cambridge

			Massachusetts		Middlesex County		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	3236	83.50%	147	85.00%	59	79.70%	343	79.30%
		Not sure	14393	6.50%	3236	6.60%	147	6.80%	59	8.50%	343	7.00%
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	3233	75.50%	147	74.10%	59	74.60%	343	68.20%
		Not sure	14366	10.20%	3233	10.80%	147	15.00%	59	10.20%	343	13.40%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	3226	72.50%	146	69.20%	59	78.00%	344	75.30%
		Not sure	14325	12.90%	3226	11.60%	146	15.80%	59	11.90%	344	11.00%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	3222	82.70%	147	83.00%	59	83.10%	341	80.40%
		Not sure	14336	7.00%	3222	6.80%	147	10.90%	*	*	341	4.70%
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	3212	66.10%	147	63.90%	58	63.80%	342	62.60%
		Not sure	14247	16.30%	3212	17.40%	147	19.00%	58	15.50%	342	19.30%
Safety & Support	Experienced intimate partner violence (a)	Ever	13621	29.70%	3068	26.50%	141	31.90%	54	18.50%	327	27.50%
		In past year	13359	4.50%	3029	3.20%	*	*	*	*	321	6.50%
Safety & Support	Experienced sexual violence (b)	Ever	13628	21.00%	3073	22.60%	140	28.60%	57	24.60%	322	26.40%
		In past year	13593	1.40%	3070	1.20%	*	*	*	*	322	3.70%
Safety & Support	Experienced discrimination	Ever	14130	55.20%	3160	59.10%	142	64.80%	59	59.30%	336	67.00%
		In past year	14130	18.00%	3160	17.20%	142	19.70%	59	15.30%	336	20.50%

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 – Cambridge

			Massachusetts		Middlesex County		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	74	12.20%	*	*	183	17.50%
Employment	Location of work (among all workers)	At home only	9173	7.50%	2091	10.40%	95	12.60%	37	18.90%	234	12.00%
		Outside home only	9173	54.60%	2091	42.40%	95	33.70%	37	29.70%	234	32.90%
		Both at home/outside home	9173	37.40%	2091	46.60%	95	52.60%	37	51.40%	234	55.10%
Employment	Paid sick leave at work (among all workers) (2)	Yes	6903	75.30%	1543	76.80%	73	82.20%	*	*	185	75.70%
		Not sure	6903	4.20%	1543	3.60%	*	*	*	*	185	5.90%
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	71	64.80%	30	53.30%	168	63.70%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	849	5.90%	*	*	*	*	108	4.60%
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	443	7.70%	*	*	*	*	53	11.30%
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	713	6.60%	37	13.50%	*	*	81	14.80%
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%	596	17.40%	30	20.00%	*	*	99	21.20%
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%	174	11.50%	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	1655	12.60%	88	19.30%	*	*	202	19.30%

CHES Adult: Arlington – Cambridge

			Massachusetts		Middlesex County		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Telehealth visit, past year (1)	One or more visit	6747	51.20%	1504	58.80%	70	60.00%	30	66.70%	167	59.30%
		Offered, didn't have	6747	7.00%	1504	7.60%	70	12.90%	*	*	167	11.40%
		Not offered	6747	22.10%	1504	19.00%	70	17.10%	*	*	167	16.80%
		No healthcare visits	6747	20.30%	1504	14.80%	70	10.00%	30	16.70%	167	12.60%
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	1016	19.20%	44	15.90%	*	*	103	24.30%
		Not sure	4184	3.80%	1016	3.60%	*	*	*	*	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	3024	38.70%	137	37.20%	56	53.60%	326	29.40%
		Medium	13267	32.00%	3024	34.30%	137	29.20%	56	25.00%	326	35.60%
		High	13267	13.90%	3024	13.70%	137	18.20%	56	8.90%	326	16.60%
		Very high	13267	17.30%	3024	13.40%	137	15.30%	56	12.50%	326	18.40%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	102	17.60%	*	*	239	18.40%
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	2981	7.00%	132	12.10%	*	*	322	14.30%

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: Arlington – Cambridge

			Massachusetts		Middlesex County		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	*	*	*	*	251	12.40%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	135	58.50%	57	59.60%	328	60.70%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	135	6.70%	*	*	331	4.80%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	135	7.40%	*	*	332	6.90%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	135	9.60%	*	*	331	14.50%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	135	18.50%	57	10.50%	332	22.90%
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%	3061	0.70%	*	*	*	*	332	1.80%
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	3061	0.80%	*	*	*	*	332	3.00%
Substance Use	Fentanyl use, past year	Yes	13626	0.60%	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	332	1.80%
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%	3061	1.20%	*	*	*	*	332	2.40%
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	*	*	*	*	332	1.80%
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	135	3.70%	*	*	332	6.00%

CHES Adult: Arlington – Cambridge

			Massachusetts		Middlesex County		Arlington		Belmont		Cambridge	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	COVID-19 vaccination, past year (1)	Yes	6729	67.80%	1506	76.40%	68	82.40%	30	80.00%	168	75.00%
		Not sure	6729	3.60%	1506	3.30%	*	*	*	*	168	3.00%
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	50	18.00%	*	*	156	23.70%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	99	52.50%	46	32.60%	256	46.90%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	99	12.10%	46	21.70%	256	14.10%
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	99	43.40%	46	26.10%	256	35.90%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	99	19.20%	*	*	256	17.20%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	99	28.30%	46	21.70%	256	16.00%
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	99	12.10%	46	17.40%	256	11.70%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	99	37.40%	46	28.30%	256	42.20%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	*	*	*	*	256	2.30%
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	99	81.80%	46	69.60%	256	77.00%

CHES Adult: Somerville

Data Notes:

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.
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		Somerville	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	3353	1.70%	191	2.60%
		Worried about losing	14888	8.00%	3353	6.50%	191	7.90%
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	191	88.50%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	139	54.70%
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	90	8.90%
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	90	16.70%
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	1689	13.30%	90	14.40%
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	90	22.20%
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	*	*
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	90	12.20%
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	90	16.70%
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	1689	27.10%	90	36.70%
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	3366	12.40%	186	23.10%
		Not enough money	13814	16.50%	3141	11.00%	182	9.90%
		Just enough money	13814	31.10%	3141	24.90%	182	34.60%
Basic Needs	End of month finances	Money left over	13814	52.40%	3141	64.10%	182	55.50%
		No internet	11425	3.00%	2514	1.60%	*	*
		Does not work well	11425	9.30%	2514	7.00%	143	7.70%
Basic Needs	Current internet access (2)	Works well	11425	87.70%	2514	91.50%	143	90.90%

CHES Adult: Somerville

			Massachusetts		Middlesex County		Somerville	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		Somewhat or strongly disagree	11064	7.00%	2521	5.50%	*	*
		Somewhat agree	11064	22.00%	2521	21.70%	132	22.70%
Neighborhood	Able to get where you need to go (2)	Strongly agree	11064	71.00%	2521	72.80%	132	75.00%
		Never	11008	58.60%	2509	63.50%	132	52.30%
		Rarely	11008	28.90%	2509	28.60%	132	33.30%
		Somewhat often	11008	9.10%	2509	5.80%	132	10.60%
Neighborhood	Experienced neighborhood violence, lifetime (2)	Very often	11008	3.40%	2509	2.10%	132	3.80%
		Yes	14393	80.60%	3236	83.50%	184	82.10%
Safety & Support	Can count on someone for favors	Not sure	14393	6.50%	3236	6.60%	184	8.70%
		Yes	14366	73.20%	3233	75.50%	183	76.50%
Safety & Support	Can count on someone to care for you if sick	Not sure	14366	10.20%	3233	10.80%	183	12.60%
		Yes	14325	64.60%	3226	72.50%	182	68.10%
Safety & Support	Can count on someone to lend money	Not sure	14325	12.90%	3226	11.60%	182	13.20%
	Can count on someone for support with family	Yes	14336	79.20%	3222	82.70%	184	87.50%
Safety & Support	trouble	Not sure	14336	7.00%	3222	6.80%	184	4.30%
		Yes	14247	62.30%	3212	66.10%	182	69.80%
Safety & Support	Can count on someone to help find housing	Not sure	14247	16.30%	3212	17.40%	182	18.10%
		Ever	13621	29.70%	3068	26.50%	171	24.00%
Safety & Support	Experienced intimate partner violence (a)	In past year	13359	4.50%	3029	3.20%	*	*
		Ever	13628	21.00%	3073	22.60%	171	28.70%
Safety & Support	Experienced sexual violence (b)	In past year	13593	1.40%	3070	1.20%	*	*
		Ever	14130	55.20%	3160	59.10%	180	68.90%
Safety & Support	Experienced discrimination	In past year	14130	18.00%	3160	17.20%	180	19.40%

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: Somerville

			Massachusetts		Middlesex County		Somerville	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	104	16.30%
Employment	Location of work (among all workers)	At home only	9173	7.50%	2091	10.40%	138	8.00%
		Outside home only	9173	54.60%	2091	42.40%	138	33.30%
		Both at home/outside home	9173	37.40%	2091	46.60%	138	58.70%
Employment	Paid sick leave at work (among all workers) (2)	Yes	6903	75.30%	1543	76.80%	106	73.60%
		Not sure	6903	4.20%	1543	3.60%	*	*
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	90	65.60%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	849	5.90%	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	443	7.70%	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	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%	596	17.40%	53	9.40%
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%	174	11.50%	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	1655	12.60%	97	10.30%

CHES Adult: Somerville

			Massachusetts		Middlesex County		Somerville	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Telehealth visit, past year (1)	One or more visit	6747	51.20%	1504	58.80%	88	69.30%
		Offered, didn't have	6747	7.00%	1504	7.60%	88	6.80%
		Not offered	6747	22.10%	1504	19.00%	88	13.60%
		No healthcare visits	6747	20.30%	1504	14.80%	88	11.40%
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	1016	19.20%	55	12.70%
		Not sure	4184	3.80%	1016	3.60%	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	3024	38.70%	175	30.90%
		Medium	13267	32.00%	3024	34.30%	175	36.60%
		High	13267	13.90%	3024	13.70%	175	19.40%
		Very high	13267	17.30%	3024	13.40%	175	13.10%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	126	8.70%
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	2981	7.00%	174	9.80%
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	137	6.60%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	176	51.10%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	176	4.00%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	176	6.30%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	176	14.80%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	176	24.40%
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%	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%	*	*

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: Somerville

			Massachusetts		Middlesex County		Somerville	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	176	2.80%
		Yes	6729	67.80%	1506	76.40%	89	80.90%
Emerging Issues	COVID-19 vaccination, past year (1)	Not sure	6729	3.60%	1506	3.30%	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	76	21.10%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	143	53.80%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	143	15.40%
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	143	29.40%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	143	21.00%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	143	18.20%
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	143	19.60%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	143	45.50%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	143	74.10%

CHES Adult: Waltham – Watertown

Data Notes:

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.
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		Waltham		Watertown	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	3353	1.70%	*	*	*	*
		Worried about losing	14888	8.00%	3353	6.50%	124	8.90%	*	*
Housing	Current living situation	Steady place	14888	89.30%	3353	91.60%	124	90.30%	54	94.40%
Housing	Issues in current housing (2)	Yes, at least one	11103	37.00%	2437	39.10%	92	52.20%	38	28.90%
Basic Needs	Trouble paying for childcare/school (1)	Yes	7486	4.60%	1689	4.70%	*	*	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food) (1)	Yes	7486	18.80%	1689	12.20%	65	16.90%	*	*
Basic Needs	Trouble paying for health care (1)	Yes	7486	15.00%	1689	13.30%	65	18.50%	*	*
Basic Needs	Trouble paying for housing (1)	Yes	7486	19.40%	1689	15.60%	65	24.60%	*	*
Basic Needs	Trouble paying for technology (1)	Yes	7486	8.40%	1689	6.00%	65	10.80%	*	*
Basic Needs	Trouble paying for transportation (1)	Yes	7486	12.60%	1689	9.40%	65	18.50%	*	*
Basic Needs	Trouble paying for utilities (1)	Yes	7486	17.20%	1689	11.90%	65	15.40%	*	*
Basic Needs	Trouble paying for ANY basic needs (1)	Yes	7486	35.20%	1689	27.10%	65	33.80%	*	*
Basic Needs	Applied for/received economic assistance	Yes	14928	20.30%	3366	12.40%	126	15.10%	54	9.30%
		Not enough money	13814	16.50%	3141	11.00%	122	14.80%	*	*
		Just enough money	13814	31.10%	3141	24.90%	122	28.70%	50	22.00%
Basic Needs	End of month finances	Money left over	13814	52.40%	3141	64.10%	122	56.60%	50	76.00%
		No internet	11425	3.00%	2514	1.60%	*	*	*	*
		Does not work well	11425	9.30%	2514	7.00%	95	11.60%	*	*
Basic Needs	Current internet access (2)	Works well	11425	87.70%	2514	91.50%	95	87.40%	39	100.00%

CHES Adult: Waltham – Watertown

			Massachusetts		Middlesex County		Waltham		Watertown	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Neighborhood	Able to get where you need to go (2)	Somewhat or strongly disagree	11064	7.00%	2521	5.50%	90	7.80%	*	*
		Somewhat agree	11064	22.00%	2521	21.70%	90	30.00%	40	25.00%
		Strongly agree	11064	71.00%	2521	72.80%	90	62.20%	40	72.50%
Neighborhood	Experienced neighborhood violence, lifetime (2)	Never	11008	58.60%	2509	63.50%	89	49.40%	40	67.50%
		Rarely	11008	28.90%	2509	28.60%	89	40.40%	40	32.50%
		Somewhat often	11008	9.10%	2509	5.80%	89	6.70%	*	*
		Very often	11008	3.40%	2509	2.10%	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	3236	83.50%	122	77.90%	52	88.50%
		Not sure	14393	6.50%	3236	6.60%	122	8.20%	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	3233	75.50%	120	70.80%	52	71.20%
		Not sure	14366	10.20%	3233	10.80%	120	10.00%	52	15.40%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	3226	72.50%	120	65.00%	52	75.00%
		Not sure	14325	12.90%	3226	11.60%	120	12.50%	52	15.40%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	3222	82.70%	120	77.50%	52	92.30%
		Not sure	14336	7.00%	3222	6.80%	120	7.50%	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	3212	66.10%	119	55.50%	52	80.80%
		Not sure	14247	16.30%	3212	17.40%	119	17.60%	52	11.50%
Safety & Support	Experienced intimate partner violence (a)	Ever	13621	29.70%	3068	26.50%	119	24.40%	49	22.40%
		In past year	13359	4.50%	3029	3.20%	*	*	*	*
Safety & Support	Experienced sexual violence (b)	Ever	13628	21.00%	3073	22.60%	119	27.70%	49	26.50%
		In past year	13593	1.40%	3070	1.20%	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	3160	59.10%	122	63.90%	51	68.60%
		In past year	14130	18.00%	3160	17.20%	122	20.50%	51	23.50%

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: Waltham – Watertown

			Massachusetts		Middlesex County		Waltham		Watertown	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Employment	Have multiple jobs (among all workers) (2)	Yes	6896	20.90%	1542	19.30%	66	16.70%	*	*
		At home only	9173	7.50%	2091	10.40%	85	9.40%	*	*
		Outside home only	9173	54.60%	2091	42.40%	85	29.40%	31	41.90%
Employment	Location of work (among all workers)	Both at home/outside home	9173	37.40%	2091	46.60%	85	60.00%	31	48.40%
		Yes	6903	75.30%	1543	76.80%	66	81.80%	*	*
Employment	Paid sick leave at work (among all workers) (2)	Not sure	6903	4.20%	1543	3.60%	*	*	*	*
Healthcare Access	Reported chronic condition (1)	Yes	6821	65.20%	1509	63.00%	56	58.90%	*	*
Healthcare Access	Unmet need for short-term illness care (among those who needed this care) (2)	Yes	3455	7.60%	849	5.90%	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care) (2)	Yes	1674	9.00%	443	7.70%	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care) (2)	Yes	3052	9.00%	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%	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%	174	11.50%	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care) (2)	Yes	6941	15.20%	1655	12.60%	64	23.40%	*	*

CHES Adult: Waltham – Watertown

			Massachusetts		Middlesex County		Waltham		Watertown	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Telehealth visit, past year (1)	One or more visit	6747	51.20%	1504	58.80%	57	61.40%	*	*
		Offered, didn't have	6747	7.00%	1504	7.60%	*	*	*	*
		Not offered	6747	22.10%	1504	19.00%	57	15.80%	*	*
		No healthcare visits	6747	20.30%	1504	14.80%	57	17.50%	*	*
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	1016	19.20%	*	*	*	*
		Not sure	4184	3.80%	1016	3.60%	*	*	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	3024	38.70%	116	27.60%	49	30.60%
		Medium	13267	32.00%	3024	34.30%	116	37.10%	49	38.80%
		High	13267	13.90%	3024	13.70%	116	14.70%	49	12.20%
		Very high	13267	17.30%	3024	13.40%	116	20.70%	49	18.40%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	82	15.90%	*	*
Mental Health	Suicide ideation, past year (c)	Yes	13036	7.40%	2981	7.00%	112	8.00%	48	12.50%
Substance Use	Tobacco use, past month (2)	Yes	10305	14.10%	2294	8.40%	98	7.10%	*	*
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	116	56.00%	50	60.00%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	119	6.70%	50	14.00%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	119	6.70%	50	16.00%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	119	9.20%	50	16.00%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	119	13.40%	50	24.00%
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%	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%	*	*	*	*

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: Waltham – Watertown

			Massachusetts		Middlesex County		Waltham		Watertown	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	*	*	*	*
		Yes	6729	67.80%	1506	76.40%	57	80.70%	*	*
Emerging Issues	COVID-19 vaccination, past year (1)	Not sure	6729	3.60%	1506	3.30%	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19) (2)	Yes	6196	22.00%	1445	17.90%	46	15.20%	*	*
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years (2)	Yes	10422	37.40%	2312	40.00%	98	53.10%	39	48.70%
Emerging Issues	Flooding in home or on street, past 5 years (2)	Yes	10422	11.00%	2312	11.90%	98	14.30%	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years (2)	Yes	10422	32.20%	2312	35.20%	98	21.40%	39	28.20%
Emerging Issues	Power outages, past 5 years (2)	Yes	10422	24.50%	2312	25.60%	98	33.70%	39	23.10%
Emerging Issues	School cancellation due to weather, past 5 years (2)	Yes	10422	17.60%	2312	19.20%	98	13.30%	*	*
Emerging Issues	Unable to work due to weather, past 5 years (2)	Yes	10422	14.80%	2312	14.60%	98	14.30%	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years (2)	Yes	10422	28.30%	2312	32.40%	98	41.80%	39	35.90%
Emerging Issues	Other climate impact, past 5 years (2)	Yes	10422	1.70%	2312	1.70%	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years (2)	Yes	10422	67.20%	2312	72.30%	98	78.60%	39	74.40%

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

CHIA - Ages 0 – 17

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Causes							
FY24 ED Volume (all cause) rate per 100,000	4923	2661	2878	2481	3175	3858	3268
FY24 Inpatient Discharges (all causes) rate per 100,000	1396	1296	1077	1066	1216	1389	1523
Allergy							
FY24 ED Volume rate per 100,000	293	263	196	168	188	307	233
FY24 Inpatient Discharges rate per 100,000	29	17	29	19	21	13	22
Asthma							
FY24 ED Volume rate per 100,000	347	172	148	143	188	307	198
FY24 Inpatient Discharges rate per 100,000	67	34	74	34	44	55	51
Attention Deficit Hyperactivity Disorder							
FY24 ED Volume rate per 100,000	77	65	77	20	38	41	36
FY24 Inpatient Discharges rate per 100,000	27	41	44	19	16	24	31
Complication of Medical Care							
FY24 ED Volume rate per 100,000	33	2	25	22	28	40	22
FY24 Inpatient Discharges rate per 100,000	49	30	33	18	42	44	39
Diabetes							
FY24 ED Volume rate per 100,000	21	13	22	4	6	21	8
FY24 Inpatient Discharges rate per 100,000	8	4	3	7	2	6	5
HIV/AIDS							
FY24 ED Volume rate per 100,000	0						
FY24 Inpatient Discharges rate per 100,000	0						
Infection							
FY24 ED Volume rate per 100,000	1314	544	544	629	928	1118	719
FY24 Inpatient Discharges rate per 100,000	131	84	96	65	90	105	122

CHIA - Ages 0 – 17

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Injuries							
FY24 ED Volume rate per 100,000	922	799	974	500	545	593	667
FY24 Inpatient Discharges rate per 100,000	49	32	37	22	24	35	56
Learning Disorders							
FY24 ED Volume rate per 100,000	22	4	14	18	28	23	34
FY24 Inpatient Discharges rate per 100,000	24	19	29	15	22	35	25
Mental Health							
FY24 ED Volume rate per 100,000	292	237	218	92	131	197	102
FY24 Inpatient Discharges rate per 100,000	75	98	107	60	75	67	48
Obesity							
FY24 ED Volume rate per 100,000	7		3			1	
FY24 Inpatient Discharges rate per 100,000	12	4	7	12	14	20	8
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	150	32	55	31	91	188	108
FY24 Inpatient Discharges rate per 100,000	32	19	22	13	31	27	28
Poisonings							
FY24 ED Volume rate per 100,000	59	30	22	21	31	21	31
FY24 Inpatient Discharges rate per 100,000	6	4	3	1	1	1	2
STIs							
FY24 ED Volume rate per 100,000	4	2		7	3	3	
FY24 Inpatient Discharges rate per 100,000	1	2					
Substance Use							
FY24 ED Volume rate per 100,000	48	32	7	17	34	26	17
FY24 Inpatient Discharges rate per 100,000	11	13	7	5	19	6	2
Age 0-17 Total	4923	2661	2878	2481	3175	3858	3268

CHIA - Ages 18 – 44

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Cause							
FY24 ED Volume (all cause) rate per 100,000	11106	4415	3674	8094	9017	8673	6875
FY24 Inpatient Discharges (all causes) rate per 100,000	2251	1572	1444	1586	1825	2078	2157
Allergy							
FY24 ED Volume rate per 100,000	952	620	429	685	727	931	733
FY24 Inpatient Discharges rate per 100,000	206	93	129	96	136	139	164
Asthma							
FY24 ED Volume rate per 100,000	552	115	103	143	188	618	358
FY24 Inpatient Discharges rate per 100,000	266	167	144	152	182	156	204
Breast Cancer							
FY24 ED Volume rate per 100,000	7			3	8	7	
FY24 Inpatient Discharges rate per 100,000	9	2	7	11	2	3	2
CHF							
FY24 ED Volume rate per 100,000	14	4		2	3	1	
FY24 Inpatient Discharges rate per 100,000	50	23	14	33	36	26	34
Complication of Medical Care							
FY24 ED Volume rate per 100,000	120	41	55	80	75	95	96
FY24 Inpatient Discharges rate per 100,000	645	557	466	512	559	669	699
COPD and Lung Disease							
FY24 ED Volume rate per 100,000	30	2	7	8	4	41	8
FY24 Inpatient Discharges rate per 100,000	40	2	7	24	13	24	22

CHIA - Ages 18 – 44

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Diabetes							
FY24 ED Volume rate per 100,000	309	67	29	61	67	262	196
FY24 Inpatient Discharges rate per 100,000	173	89	74	83	75	125	144
GYN Cancer							
FY24 ED Volume rate per 100,000	2	2		0	1		
FY24 Inpatient Discharges rate per 100,000	4	4	3	4	4		2
Heart Disease							
FY24 ED Volume rate per 100,000	12			3	4	7	2
FY24 Inpatient Discharges rate per 100,000	56	21	44	54	42	30	31
Hepatitis							
FY24 ED Volume rate per 100,000	26	21		9	4	13	5
FY24 Inpatient Discharges rate per 100,000	70	28	11	39	54	49	45
HIV/AIDS							
FY24 ED Volume rate per 100,000	24	4	3	16	11	58	5
FY24 Inpatient Discharges rate per 100,000	14	4	11	11	7	10	14
Hypertension							
FY24 ED Volume rate per 100,000	447	95	55	128	95	395	221
FY24 Inpatient Discharges rate per 100,000	210	106	59	98	167	169	125
Infection							
FY24 ED Volume rate per 100,000	1595	618	463	1180	1268	1248	926
FY24 Inpatient Discharges rate per 100,000	338	180	170	178	222	228	179

CHIA - Ages 18 – 44

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Injuries							
FY24 ED Volume rate per 100,000	1775	762	781	1392	1416	1344	1233
FY24 Inpatient Discharges rate per 100,000	237	100	129	141	136	196	142
Liver Disease							
FY24 ED Volume rate per 100,000	99	28	48	44	75	231	54
FY24 Inpatient Discharges rate per 100,000	191	84	114	89	131	211	110
Mental Health							
FY24 ED Volume rate per 100,000	1310	871	377	887	872	948	667
FY24 Inpatient Discharges rate per 100,000	834	548	540	591	814	774	761
Obesity							
FY24 ED Volume rate per 100,000	135	15	3	11	23	132	96
FY24 Inpatient Discharges rate per 100,000	324	106	111	121	186	213	224
Other Cancer							
FY24 ED Volume rate per 100,000	12		7	1	2	16	11
FY24 Inpatient Discharges rate per 100,000	23	13	25	15	12	23	28
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	122	32	37	73	68	126	73
FY24 Inpatient Discharges rate per 100,000	85	23	40	36	52	41	42

CHIA - Ages 18 – 44

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Poisonings							
FY24 ED Volume rate per 100,000	182	71	40	103	147	114	79
FY24 Inpatient Discharges rate per 100,000	33	8	11	13	19	23	22
Prostate Cancer							
FY24 ED Volume rate per 100,000	0						
FY24 Inpatient Discharges rate per 100,000	0						
STIs							
FY24 ED Volume rate per 100,000	77	17	11	57	53	40	28
FY24 Inpatient Discharges rate per 100,000	37	30	14	25	23	37	19
Stroke and Other Neurovascular Diseases							
FY24 ED Volume rate per 100,000	8	2	3	7	7	6	8
FY24 Inpatient Discharges rate per 100,000	19	10	7	14	14	16	31
Substance Use							
FY24 ED Volume rate per 100,000	2079	670	355	975	1046	1315	753
FY24 Inpatient Discharges rate per 100,000	588	206	222	286	390	407	375
Tuberculosis							
FY24 ED Volume rate per 100,000	2		3	0		1	
FY24 Inpatient Discharges rate per 100,000	8	10	3	11	3	4	5
Age 18-44 Total	11106	4415	3674	8094	9017	8673	6875

CHIA - Ages 45 – 64

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Causes							
FY24 ED Volume (all cause) rate per 100,000	6844	3241	2985	4186	3969	4645	4036
FY24 Inpatient Discharges (all causes) rate per 100,000	2291	1311	1151	1044	1117	1553	1475
Allergy							
FY24 ED Volume rate per 100,000	797	675	511	463	351	786	420
FY24 Inpatient Discharges rate per 100,000	330	163	129	105	120	224	133
Asthma							
FY24 ED Volume rate per 100,000	299	76	70	80	64	281	150
FY24 Inpatient Discharges rate per 100,000	254	174	140	122	110	224	162
Breast Cancer							
FY24 ED Volume rate per 100,000	40	15	11	8	8	37	19
FY24 Inpatient Discharges rate per 100,000	57	28	51	32	36	47	31
CHF							
FY24 ED Volume rate per 100,000	78	17	44	15	16	55	19
FY24 Inpatient Discharges rate per 100,000	344	156	155	145	142	203	201
Complication of Medical Care							
FY24 ED Volume rate per 100,000	100	89	29	70	65	49	59
FY24 Inpatient Discharges rate per 100,000	428	254	211	167	169	299	278
COPD and Lung Disease							
FY24 ED Volume rate per 100,000	239	41	25	55	57	134	45
FY24 Inpatient Discharges rate per 100,000	415	191	129	169	170	284	179

CHIA - Ages 45 – 64

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Diabetes							
FY24 ED Volume rate per 100,000	759	176	159	154	151	530	250
FY24 Inpatient Discharges rate per 100,000	688	307	255	281	299	491	378
GYN Cancer							
FY24 ED Volume rate per 100,000	4	4	3	2	1	1	
FY24 Inpatient Discharges rate per 100,000	16	26	14		3	16	
Heart Disease							
FY24 ED Volume rate per 100,000	37	13		5	17	23	8
FY24 Inpatient Discharges rate per 100,000	280	148	137	119	161	173	198
Hepatitis							
FY24 ED Volume rate per 100,000	23			7	3	3	
FY24 Inpatient Discharges rate per 100,000	83	58	11	77	37	52	42
HIV/AIDS							
FY24 ED Volume rate per 100,000	34			39	8	30	8
FY24 Inpatient Discharges rate per 100,000	34	28	14	33	4	4	45
Hypertension							
FY24 ED Volume rate per 100,000	1377	285	259	314	267	981	520
FY24 Inpatient Discharges rate per 100,000	918	468	403	361	374	633	551
Infection							
FY24 ED Volume rate per 100,000	813	368	318	561	566	488	542
FY24 Inpatient Discharges rate per 100,000	627	302	303	263	289	395	400
Injuries							
FY24 ED Volume rate per 100,000	1351	810	751	811	636	979	858
FY24 Inpatient Discharges rate per 100,000	534	335	296	267	231	361	309

CHIA - Ages 45 – 64

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Liver Disease							
FY24 ED Volume rate per 100,000	113	19	29	37	52	122	31
FY24 Inpatient Discharges rate per 100,000	383	241	207	174	195	301	227
Mental Health							
FY24 ED Volume rate per 100,000	703	217	303	384	433	497	332
FY24 Inpatient Discharges rate per 100,000	1042	646	559	540	569	800	653
Obesity							
FY24 ED Volume rate per 100,000	138	41	37	11	21	92	85
FY24 Inpatient Discharges rate per 100,000	619	285	277	173	249	375	389
Other Cancer							
FY24 ED Volume rate per 100,000	30	10	40	16	3	43	19
FY24 Inpatient Discharges rate per 100,000	100	102	74	33	55	69	54
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	73	17	25	33	32	52	56
FY24 Inpatient Discharges rate per 100,000	228	82	100	83	108	100	144

CHIA - Ages 45 – 64

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Poisonings							
FY24 ED Volume rate per 100,000	82	58	25	55	43	55	36
FY24 Inpatient Discharges rate per 100,000	36	23	14	16	18	26	22
Prostate Cancer							
FY24 ED Volume rate per 100,000	12	2		1	1	16	8
FY24 Inpatient Discharges rate per 100,000	28	30	11	16	13	30	19
STIs							
FY24 ED Volume rate per 100,000	10	6		7	4	7	5
FY24 Inpatient Discharges rate per 100,000	6	4	3	9	4	3	2
Stroke and Other Neurovascular Diseases							
FY24 ED Volume rate per 100,000	24	2	7	8	6	16	5
FY24 Inpatient Discharges rate per 100,000	92	28	18	35	33	43	39
Substance Use							
FY24 ED Volume rate per 100,000	1492	272	222	1005	647	922	383
FY24 Inpatient Discharges rate per 100,000	858	376	274	431	423	632	500
Tuberculosis							
FY24 ED Volume rate per 100,000	1			1	3		
FY24 Inpatient Discharges rate per 100,000	11	4	3	18	6	20	8
Age 45-64 Total	6844	3241	2985	4186	3969	4645	4036

CHIA - Ages 65+

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Causes							
FY24 ED Volume (all cause) rate per 100,000	5485	3319	2974	3139	2827	3439	3706
FY24 Inpatient Discharges (all causes) rate per 100,000	4476	3668	3196	2300	2333	3421	4533
Allergy							
FY24 ED Volume rate per 100,000	798	747	425	387	316	768	434
FY24 Inpatient Discharges rate per 100,000	671	379	274	222	295	465	414
Asthma							
FY24 ED Volume rate per 100,000	155	32	37	50	36	169	59
FY24 Inpatient Discharges rate per 100,000	314	252	244	205	172	346	292
Breast Cancer							
FY24 ED Volume rate per 100,000	69	19	14	7	8	106	56
FY24 Inpatient Discharges rate per 100,000	216	228	144	133	120	193	213
CHF							
FY24 ED Volume rate per 100,000	270	69	62	44	69	225	93
FY24 Inpatient Discharges rate per 100,000	1445	1106	892	690	852	1095	1623
Complication of Medical Care							
FY24 ED Volume rate per 100,000	158	100	100	107	99	83	113
FY24 Inpatient Discharges rate per 100,000	809	616	537	376	393	649	662
COPD and Lung Disease							
FY24 ED Volume rate per 100,000	350	50	40	50	74	259	167
FY24 Inpatient Discharges rate per 100,000	1111	640	522	463	617	715	992

CHIA - Ages 65+

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Diabetes							
FY24 ED Volume rate per 100,000	860	200	114	160	228	550	329
FY24 Inpatient Discharges rate per 100,000	1509	1045	718	695	869	1206	1466
GYN Cancer							
FY24 ED Volume rate per 100,000	7		3	4	1	13	
FY24 Inpatient Discharges rate per 100,000	27	30	51	27	2	18	14
Heart Disease							
FY24 ED Volume rate per 100,000	90	26	22	14	28	38	17
FY24 Inpatient Discharges rate per 100,000	1079	910	963	625	632	897	1429
Hepatitis							
FY24 ED Volume rate per 100,000	7	2		1		1	
FY24 Inpatient Discharges rate per 100,000	51	21	44	42	37	47	51
HIV/AIDS							
FY24 ED Volume rate per 100,000	7			10	2	4	
FY24 Inpatient Discharges rate per 100,000	14	23		11	21	1	5
Hypertension							
FY24 ED Volume rate per 100,000	1774	518	496	343	408	1267	793
FY24 Inpatient Discharges rate per 100,000	1758	1442	1211	798	796	1387	1512
Infection							
FY24 ED Volume rate per 100,000	718	396	363	394	376	471	466
FY24 Inpatient Discharges rate per 100,000	1455	1110	859	698	733	1121	1279

CHIA - Ages 65+

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Injuries							
FY24 ED Volume rate per 100,000	1257	836	870	716	596	1104	1145
FY24 Inpatient Discharges rate per 100,000	1365	1178	1096	792	806	1188	1534
Liver Disease							
FY24 ED Volume rate per 100,000	65	15	25	12	21	52	11
FY24 Inpatient Discharges rate per 100,000	421	283	259	221	260	341	349
Mental Health							
FY24 ED Volume rate per 100,000	347	169	81	133	128	202	113
FY24 Inpatient Discharges rate per 100,000	1456	1202	1055	887	790	1407	1492
Obesity							
FY24 ED Volume rate per 100,000	72	17	3	6	9	47	22
FY24 Inpatient Discharges rate per 100,000	764	400	296	265	370	551	730
Other Cancer							
FY24 ED Volume rate per 100,000	58	28	33	14	17	77	48
FY24 Inpatient Discharges rate per 100,000	285	237	262	144	145	220	324
Pneumonia/Influenza							
FY24 ED Volume rate per 100,000	79	34	25	33	29	49	28
FY24 Inpatient Discharges rate per 100,000	627	457	374	263	319	400	670

CHIA - Ages 65+

		Mount Auburn Hospital Community Benefits Service Area					
	Massachusetts	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Poisonings							
FY24 ED Volume rate per 100,000	30	19		16	8	16	11
FY24 Inpatient Discharges rate per 100,000	44	26	14	15	23	24	36
Prostate Cancer							
FY24 ED Volume rate per 100,000	62	32	18	15	13	71	39
FY24 Inpatient Discharges rate per 100,000	221	198	177	105	114	169	218
STIs							
FY24 ED Volume rate per 100,000	1	2		0			
FY24 Inpatient Discharges rate per 100,000	7		7	11	3	7	8
Stroke and Other Neurovascular Diseases							
FY24 ED Volume rate per 100,000	63	43	25	25	22	33	48
FY24 Inpatient Discharges rate per 100,000	290	226	151	133	196	202	284
Substance Use							
FY24 ED Volume rate per 100,000	391	152	81	222	169	234	196
FY24 Inpatient Discharges rate per 100,000	552	413	237	278	256	389	548
Tuberculosis							
FY24 ED Volume rate per 100,000	1			3	1		
FY24 Inpatient Discharges rate per 100,000	15	19	7	23	19	16	25
Age 65+ Total	5485	3668	3196	3139	2827	3439	4533

Community Health Survey

- FY25 MAH Community Health Survey
  - Survey output

Beth Israel Lahey Health

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

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

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

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

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

Select a language

About Your Community

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

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

Zip code: _____

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

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

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

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

Beth Israel Lahey Health

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

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

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

Health and Access to care

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

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

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

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

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

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

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

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

About You

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

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

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

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

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

11. What is your sexual orientation?

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

12. What is your current gender identity?

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

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

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

14. What is your age?

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

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

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

16. Are you currently:

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

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

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

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

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

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

May14, 2024

Beth Israel Lahey Health

Enter to Win a $100.00 Gift Card!

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

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

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

   First Name: _____

   Email: _____

   Daytime Phone #: _____

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

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

FY25 BILH CHNA Survey - Mount Auburn Hospital

Response Counts

Completion Rate:	**94%**		
	Complete		717
	Partial		46

Totals: 763

1. Select a language.

Value	Percent	Responses
Take the survey in English	75.4%	427
Մասնակցեք հարցմանը հայերեն լեզվով	2.3%	13
参加简体中文调查	9.4%	53
參加繁體中文調查	0.2%	1
Reponn sondaj la nan lang kreyòl ayisyen	0.4%	2
हिंदी में सर्वेक्षण में भाग लें	0.2%	1
Participe da pesquisa em português	0.4%	2
Пройдите анкету на русском языке	0.4%	2
Responda la encuesta en español	11.5%	65

Totals: 566

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	92.1%	696
I work in this community	23.7%	179
Other, please specify:	1.7%	13

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 %	286 38.2%	370 49.5%	51 6.8%	15 2.0%	26 3.5%	748
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 %	247 33.2%	388 52.2%	73 9.8%	21 2.8%	15 2.0%	744
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 %	244 33.1%	332 45.0%	54 7.3%	20 2.7%	88 11.9%	738
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 %	201 27.0%	358 48.1%	95 12.8%	33 4.4%	58 7.8%	745
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	160 28.6%	292 52.2%	61 10.9%	20 3.6%	26 4.7%	559
My community feels safe. Count Row %	243 32.5%	407 54.5%	64 8.6%	19 2.5%	14 1.9%	747

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	201 26.9%	379 50.7%	93 12.4%	36 4.8%	38 5.1%	747
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	118 15.9%	273 36.7%	113 15.2%	31 4.2%	208 28.0%	743
My community offers people options for staying cool during extreme heat. Count Row %	172 23.2%	372 50.1%	71 9.6%	26 3.5%	101 13.6%	742
My community has services that support people during times of stress and need. Count Row %	144 19.4%	355 47.8%	101 13.6%	28 3.8%	115 15.5%	743
I believe that all residents, including myself, can make the community a better place to live. Count Row %	315 42.5%	350 47.2%	35 4.7%	13 1.8%	29 3.9%	742
Totals Total Responses						748

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	24.5%	182
Better access to health care	31.8%	236
Better access to healthy food	24.2%	180
Better access to internet	14.0%	104
Better access to public transportation	24.8%	184
Better parks and recreation	16.6%	123
Better roads	27.3%	203
Better schools	16.6%	123
Better sidewalks and trails	32.8%	244
Cleaner environment	22.1%	164
Lower crime and violence	19.1%	142
More affordable childcare	26.8%	199
More affordable housing	58.0%	431
More arts and cultural events	14.3%	106
More effective city services (like water, trash, fire department, and police)	10.8%	80
More inclusion for diverse members of the community	21.0%	156

Value	Percent	Responses
Stronger community leadership	14.8%	110
Stronger sense of community	11.8%	88
Other, please specify:	6.9%	51

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 %	85 11.7%	178 24.5%	309 42.4%	112 15.4%	44 6.0%	728
Health care in my community meets the mental health needs of people like me. Count Row %	65 9.2%	200 28.2%	254 35.8%	89 12.6%	101 14.2%	709
Totals Total Responses						728

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

Value	Percent	Responses
A doctor's or nurse's office	66.2%	361
A public health clinic or community health center	21.1%	115
Urgent care provider	4.4%	24
A hospital emergency room	3.5%	19
No usual place	3.5%	19
Other, please specify:	1.3%	7

Totals: 545

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	13.5%	72
Not enough time	19.4%	104
Insurance problems	25.8%	138
No providers or staff speak my language	10.5%	56
Can’t get an appointment	32.5%	174
Cost	26.7%	143
Concern about COVID or other disease exposure	8.8%	47
Transportation	17.2%	92
Other, please specify:	5.8%	31
No barriers	25.4%	136

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)	47.4%	246
Alcohol or drug misuse	25.2%	131
Asthma	9.2%	48
Cancer	20.2%	105
Child abuse/neglect	4.6%	24
Diabetes	19.5%	101
Domestic violence	11.2%	58
Environment (like air quality, traffic, noise)	21.8%	113
Heart disease and stroke	18.5%	96
Hunger/malnutrition	11.2%	58
Homelessness	24.9%	129
Housing	36.6%	190
Mental health (anxiety, depression, etc.)	49.7%	258
Obesity	18.1%	94
Poor diet/inactivity	13.9%	72
Poverty	13.9%	72

Value	Percent	Responses
Rape/sexual assault	3.1%	16
Smoking	7.3%	38
Suicide	3.7%	19
Trauma	5.8%	30
Underage drinking	5.2%	27
Vaping/E-cigarettes	8.1%	42
Violence	3.7%	19
Youth use of social media	16.2%	84
Infant death	1.9%	10
Sexually transmitted infections (STIs)	2.5%	13
Teenage pregnancy	2.7%	14

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

Value	Percent	Responses
12th grade or lower (no diploma)	8.8%	63
High school (including GED, vocational high school)	8.9%	64
Started college but not finished	7.2%	52
Vocational, trade, or technical program after high school	4.7%	34
Associate degree (for example, AA, AS)	6.1%	44
Bachelor's degree (for example, BA, BS, AB)	26.3%	189
Graduate degree (for example, master's, professional, doctorate)	33.7%	242
Other, please specify:	0.8%	6
Prefer not to answer	3.3%	24

Totals: 718

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

Value	Percent	Responses
American Indian or Alaska Native	1.9%	10
Asian	14.6%	78
Black or African American	9.9%	53
Hispanic or Latine/a/o	18.1%	97
Middle Eastern or North African	0.7%	4
Native Hawaiian or Pacific Islander	0.4%	2
White	53.5%	287
Other, please specify:	0.7%	4
Not sure	0.2%	1
Prefer not to answer	3.5%	19

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.3%	9
Bisexual and/or Pansexual	5.5%	38
Gay or Lesbian	3.9%	27
Straight (Heterosexual)	74.9%	514
Queer	2.0%	14
Questioning/I am not sure of my sexuality	0.9%	6
I do not understand what this question is asking	2.5%	17
I prefer not to answer	8.9%	61

Totals: 686

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	76.0%	546
Male, Man	20.3%	146
Nonbinary, Genderqueer, not exclusively male or female	1.4%	10
Questioning/I am not sure of my gender identity	0.3%	2
I do not understand what this question is asking	0.3%	2
I prefer not to answer	1.7%	12

Totals: 718

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	5.6%	39
Food or groceries	19.9%	139
Formula or baby food	1.9%	13
Health care (appointments, medicine, insurance)	20.0%	140
Housing (rent, mortgage, taxes, insurance)	26.7%	187
Technology (computer, phone, internet)	12.3%	86
Transportation (car payment, gas, public transit)	13.4%	94
Utilities (electricity, water, gas)	15.3%	107
Other, please specify:	2.6%	18
None of the above	49.7%	348

14. What is your age?

Value	Percent	Responses
Under 18	0.7%	5
18-24	5.2%	38
25-44	33.7%	245
45-64	26.7%	194
65-74	17.7%	129
75-84	12.2%	89
85 and over	2.2%	16
Prefer not to answer	1.5%	11

Totals: 727

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

Value	Percent	Responses
Armenian	3.3%	24
Cape Verdean Creole	0.3%	2
Chinese (including Mandarin and Cantonese)	8.2%	59
English	70.5%	508
Haitian Creole	3.5%	25
Hindi	0.7%	5
Khmer	0.1%	1
Portuguese	5.0%	36
Russian	1.4%	10
Spanish	14.1%	102
Vietnamese	0.3%	2
Other, please specify:	4.0%	29
Prefer not to answer	0.8%	6

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	39.0%	277
Employed part-time (Less than 40 hours per week)	14.1%	100
Self-employed (Full- or part-time)	3.5%	25
A stay-at-home parent	5.8%	41
A student (Full- or part-time)	2.8%	20
Unemployed	5.9%	42
Unable to work for health reasons	3.8%	27
Retired	21.4%	152
Other, please specify:	0.4%	3
Prefer not to answer	3.4%	24

Totals: 711

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

Value	Percent	Responses
Yes	19.3%	137
No	74.8%	530
Prefer not to answer	5.9%	42

Totals: 709

18. I currently:

Value	Percent	Responses
Rent my home	43.3%	299
Own my home (with or without a mortgage)	36.3%	251
Live with parent or other caretakers who pay for my housing	2.6%	18
Live with family or roommates and share costs	4.9%	34
Live in a shelter, halfway house, or other temporary housing	0.4%	3
Live in senior housing or assisted living	8.1%	56
I do not currently have permanent housing	1.9%	13
Other	2.5%	17

Totals: 691

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

Value	Percent	Responses
I have always lived in the United States	60.0%	429
Less than one year	2.5%	18
1 to 3 years	4.2%	30
4 to 6 years	4.6%	33
More than 6 years, but not my whole life	27.4%	196
Prefer not to answer	1.3%	9

Totals: 715

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	53.1%	355
Faith community (such as a church, mosque, temple, or faith-based organization)	27.7%	185
School community (such as a college or education program that you attend or a school that your child attends)	16.6%	111
Work community (such as your place of employment or a professional association)	35.4%	237
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)	20.9%	140
A shared interest group (such as a club, sports team, political group, or advocacy group)	30.6%	205
Another city or town where I do not live	9.0%	60
Other, please feel free to share:	7.3%	49

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	42.5%	107
No	57.5%	145

Totals: 252

Appendix C:
Resource Inventory

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Statewide Resources	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
	Executive Office of Aging & Independence	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	Find Help	Provides resources for financial assistance, food pantries, medical care, and other free or reduced-cost help.			www.findhelp.org
	Mass 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Behavioral Health Help Line	Available 24 hours a day, 7 days a week, connects individuals and families to the full range of treatment services for mental health and substance use.		833.773.2445	www.masshelpline.com
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 10th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-aging-independence
	Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program?
	MassOptions	Provides connection to services for older adults and persons with disabilities.		800.243.4636	www.massoptions.org
	Massachusetts Behavioral Health Help Line (BHHL) Treatment Connection	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.		833.773.2445	www.masshelpline.com/MABHHLTreatmentConnectionResourceDirectory
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for substance use treatment, recovery, and problem gambling services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		988	www.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	Boston Area Rape Crisis Center-Family Justice Center	Provides free, confidential support and services to survivors of sexual violence.	99 Bishop Allen Dr Cambridge	617.492.8306 24/7 Hotline: 800.841.8371	www.barcc.org
	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
	RESPOND	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 555 Somerville	617.623.5900	www.respondinc.org

	Transition House	Offers help and resources to survivors of domestic violence, intimate partner abuse, dating violence and family violence.	PO Box 392016 Cambridge	617.661.7203	www.transitionhouse.org
Food Assistance	Arlington EATS Market	Provides food assistance to residents of Arlington.	117 Broadway Arlington	339.707.6757	www.arlingtoneats.org
	Belmont Food Pantry	Provides food assistance to residents of Belmont.	455 Concord Ave Belmont		www.belmontfoodpantry.org
	Cambridge Community Center	Provides food assistance to residents of Cambridge.	5 Callender St Cambridge	617.547.6811	www.cambridgecc.org/pantry.html
	Cambridge Economic Opportunity Committee	Provides food assistance to residents of Cambridge.	11 Inman St Cambridge	617.868.2900	www.ceoccambridge.org/food-pantry
	East End House	Provides food assistance to residents of Cambridge and greater Boston area.	105 Spring St Cambridge	617.876.4444	www.eastendhouse.org/programs-and-services/emergency-food-program/
	Healthy Waltham	Provides food assistance to residents of Waltham.	510 Moody St Waltham	781.314.5647	www.healthywaltham.org/food-pantries/
	Project Soup	Provides food assistance to residents of Somerville.	165 Broadway Somerville	617.776.7687	www.somervillehomelesscoalition.org/food security
	Watertown Food Pantry	Provides food assistance to residents of Watertown.	80 Mount Auburn St Watertown	617.972.6490	www.watertown-ma.gov/330/Watertown-Food-Pantry
	Arlington Housing Authority	Provides housing assistance programs to low-resource individuals and families.	4 Winslow St	781.646.3400	www.arlingtonhousing.org
	Belmont Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults, veterans and persons with disabilities.	59 Pearson Rd Belmont	617.484.2160	www.belmontha.org
Housing Support	Cambridge Community Development Department	Provides affordable housing opportunities for those who qualify.	344 Broadway Cambridge	617.349.4600	www.cambridgema.gov/CDD/housing.aspx
	Cambridge Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	362 Green St 3rd Floor Cambridge	617.864.3020	www.cambridge-housing.org
	Cambridge Multi Service Center	Provides information and resources for low and moderate resource individuals in Cambridge.	362 Green St 1st Floor Cambridge	617.349.6340	www.cambridgema.gov/Services/HomelessandEvictionPreventionServices
	Community Action Agency of Somerville	Provides access to resources and services for residents of Somerville.	66-70 Union Sq. Ste 104 Somerville	617.623.7370	www.caasomerville.org/housing-advocacy-program
	Homeowners Rehab Inc.	Provides affordable housing units, housing stabilization programs, economic resiliency programs, and youth development programs.	280 Franklin St Cambridge	617.868.4858	www.homeownersrehab.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
	Jump-A-Start Corporation	Provides affordable housing, education and job training, and support services.	1035 Cambridge St Cambridge	617.494.0444	www.justastart.org
	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
	Middlesex Human Service Agency	Provides community-based shelter, nutrition and recovery programs throughout Greater Boston to individuals and families.	50 Prospect St Ste 300 Waltham	781.894.6110	www.MHSAinc.org
	Somerville Homeless Coalition	Provides information and resources for low and moderate resource families and individuals.	1 Davis Sq. Somerville	617.623.6111	www.somervillehomelesscoalition.org
	Somerville Housing Authority	Provides affordable, subsidized rental housing for low-resource families and older adults.	30 Memorial Rd Somerville	617.625.1152	www.sha-web.org
	Waltham Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	110 Pond St Waltham	781.894.3357	www.walhouse.org
	Watch CDC	Provides information and resources for low and moderate resource families and	24 Crescent St Ste	781.891.6689	www.watchcdc.org
	Watertown Housing Authority	Provides affordable, subsidized rental housing for residents of Watertown.	55 Waverley Ave Watertown	617.923.3950	www.watertownha.org
	YWCA Cambridge	Provides safe, affordable accommodations for women and families.	7 Temple St Cambridge	617.491.6050	www.ywcacam.org

	Adolescent Consulting Services	Supports and empowers court-involved children and families by providing mental health prevention and intervention services with access to direct, no-cost MH care and assistance navigating the juvenile justice and child welfare systems.	189 Cambridge St Cambridge	617.494.0135	www.acskids.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	781.893.2003	www.advocates.org/services/cbhc
	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
	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
	Cambridge Community Behavioral Health Center	Provides treatment for mental health and substance use disorders.	1493 Cambridge St Cambridge	833.222.2030	www.challiance.org/services-programs/mental-health-and-substance-use/psychiatry-crisis-services
	DeNovo Center for Justice and Healing	Provides access to mental health counseling and forensic psychological evaluations to survivors of torture, violence, abuse and poverty.	47 Thorndike St Cambridge	617.661.1010	www.denovo.org
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
	Greater Boston PFLAG	Provide support groups for LGBTQ+ people, and caregivers, family members and allies of LGBTQ+ people.	85 River St Waltham	781.891.5966	www.gbpflag.org
	Jewish Family & Children's Services	Provides direct services and advancing best practices that support the resilience and well-being of its target populations: new parents and their children, older adults and family caregivers, children and adults with disabilities, and people experiencing poverty, hunger, or domestic abuse.	1430 Main St Waltham	781.647.5327	www.jfcsboston.org
	LifeStance Health	Provides mental health treatment services for patients of all ages with telehealth and in-person appointments.	22 Mill St Arlington	781.646.6432	www.lifestance.com/welcome/child-and-family-psychological-services/
	Neighborhood Counseling and Community Services, Inc.	Provides community wellness, mental health, and support services to groups across their lifespan.	403 Highland Ave Somerville	781.600.6074	www.neighborhoodcounselingservices.org
	Riverside Outpatient Center	Offers comprehensive mental health services for children and families.	117 Summer St Somerville	617.354.2275	www.riversidecc.org
	Samaritans	Provides lifesaving suicide prevention services in Massachusetts.	41 West St. 4th Floor Boston	617.536.2460	www.samaritanshope.org
	Spectrum Outpatient Treatment Center	Provides Medication-Assisted Treatment via Methadone and naltrexone.	210 Bear Hill Rd Waltham	781.290.4970	www.spectrumhealthsystems.org
	Wayside Watertown	Offers a comprehensive array of services, ranging from outpatient counseling to in-home family therapy and emergency mental health services.	127 N Beacon St Watertown	781.891.0555	www.waysideyouth.org
	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
Senior Services	Cambridge Senior Center	Provides services for older adults in Cambridge including fitness, education, social services, and recreation.	806 Massachusetts Ave Cambridge	617.349.6060	www.cambridgema.gov/Departments/humanserviceprograms/COA
	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
	North Cambridge Senior Center	Provides services for older adults in Cambridge including fitness, education, social services, and recreation.	2050 Massachusetts Ave Cambridge	617.349.6320	www.cambridgema.gov/Departments/humanserviceprograms/COA

	Somerville Cambridge Elder Services	Provides programs for older adults or people with disabilities and caregivers.	61 Medford St Somerville	617.628.2601	www.eldercare.org
	Somerville Senior Center	Provides comprehensive services that enhance the lives of the older adult population and enriches the community at large.	167 Holland St. Somerville	617.625.6600	www.somervillema.gov/departments/health-and-human-services/council-aging
	Springwell Elder Services	Provide supportive services for older adults and persons with disabilities.	307 Waverley Oaks Rd Ste 205 Waltham	617.926.4100	www.springwell.com
	Waltham Council On Aging	Provides services for older adults in Waltham including fitness, education, social services, and recreation.	488 Main St Waltham	781.314.3499	www.city.waltham.ma.us/council-on-aging
	Watertown Council On Aging	Provides services for older adults in Watertown including fitness, education, social services, and recreation.	31 Marshall St Watertown	617.972.6490	www.watertown- ma.gov/284/Council-on-Aging-Senior-Center
	MBTA	Provides transportation thru out Boston and surrounding communities.			www.mbta.com
Transportation	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
	SCM Transportation	Provides local transportation and medical escorts	167 Holland St Somerville	617.625.1191 ext. 103	www.scmtransportation.org
	African Cultural Services, Inc.	Helps African immigrant youth and their families to succeed in life through provision of a safe space, educational and mental health support, visual and performing arts, and cultural connections.	PO Box 540325 Waltham	781.298.1545	www.africanowaltham.org
	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
Additional Resources	Somerville YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	101 Highland Ave Somerville	617.625.5050	www.somervilleymca.org
	Waltham 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.	20 Exchange St Waltham	781.893.6620	www.walthambgc.org
	Waltham YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	725 Lexington St Waltham	781.894.5295	www.ymcaboston.org

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

Mount Auburn Hospital

Evaluation of 2023-2025 Implementation Strategy

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

Priority: Equitable Access to Care

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and 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**
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Provide and promote career support services and career mobility programs to hospital employees.	● Career and academic advising ● Hospital-sponsored community college courses ● Hospital-sponsored English Speakers of Other Languages (ESOL) classes	● # of events Workforce Development team attended and hosted and gave presentations about employment opportunities to (FY23: 67; FY24: 33) Workforce Development will offer internships in BILH hospitals to community members over the age of 18. MAH participated in offering these internships. (FY23: 54; FY24: 107) ● MAH provided career development and health care training information to college level students and high schools students (FY24: new program – 225 students; 40 high school students). ● Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. (Citizenship classes, FY23: 20; FY:24 14;

			Career development workshops, FY23:135; FY24: 15; Financial literacy classes FY23: 189; FY24: 207. (Mount Auburn Hospital employees participated in these offerings). ● Workforce Development offered English for Speakers of Other Languages (ESOL) classes to BILH employees. (FY 23: 45; FY24: 82 MAH employees participated in these classes). ● Workforce Development will encourage community referrals and hires. (FY 23: 225 referrals and 70 hires; FY 24: 412 referrals and 111 hires. MAH participated in these hirings). ● Workforce Development will hire interns after internships and place in BILH hospitals. (FY 24: 37 interns were hired permanently in BILH hospitals. MAH participated in these hirings.) ● Workforce Development will offer employees career development services. (FY 24: 1,044 BILH employees received career development services). ● Workforce Development will offer paid trainings for community members across BILH. (FY 23: 89; FY 24: 99. MAH participated in offering these trainings). ● Through a partnership with More than Words (MTW) in Waltham helped fund the Social Enterprise Youth Development Program:

			○ Provided job training, youth development programming, intensive case management education and employment coaching and individual advocacy to young people in Waltham. (FY 23: 110; FY 24: 105,) ○ At least 90% of graduates of the youth development program will have or be on track to earn their high school diploma or HiSet certification (high school equivalency. (FY 23: 96%; FY 24: 98%).
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Promote access to healthcare, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.	● Financial counselors	● MAH financial counselors assisted individuals with government application forms including help with health insurance applications and or referring them to government programs at both MAH and Charles River Community Health locations.(FY23: 954; FY 24: 3,922).
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.	● Transportation Program ● Cambridge Transportation Advisory Committee ● Alewife Transportation Management Association	● Facilitate the connection to health care by providing transportation connections at no cost when transportation is a barrier to medical care. (FY23: Approximately 1,609; FY24: Approximately 897).
● Racially, ethnically and linguistically diverse populations	Promote equitable care, health equity, and health literacy for patients	● Health Equity programs	●

● Low-resourced populations ● LGBTQIA+	especially those who face cultural and linguistic barriers.	● Interpreter Services ● Health Literacy and Education Program	● Provide free, timely, medical professional interpreter services for patients of all cultural and linguistic backgrounds with limited English proficiency, non-English speaking, and deaf or hard of hearing patients (ASL). (FY23:18,899; FY24: 23,345). ● Provide health literacy education programs in the community for those who are English language learners: (FY23: 7 programs, 143 people attended; FY24: 7 programs, 172 people attended). ○ 90% (FY23) and 96% (FY24) of participants reported increasing their knowledge about navigating our health care system. ○ 77% (FY23) 96% (FY24) reported they increased their knowledge on how to prepare for their doctors appointment.
● Racially, ethnically and linguistically diverse populations ● Low-resourced populations	Promote resiliency for new moms.	● Pre/post-natal outreach worker program ● Doula Program	● A community outreach worker is available to prenatal and postpartum patients to provide accessibility help with resources and to provide emotional support.in the community. ○ Provided over 280 women with navigational and emotional support as well as referrals to community resources (FY23)

			○ Provided over 250 women with navigational and emotional support as well as referrals to community resources (FY24) ● Provide a doula for populations who request this support during birth. ○ 21 births (FY 23) ○ 14 births (FY 24) ● Provide infant car seats to women who are in need of transporting their newborn home after delivery. ○ 18 new infant car seats (FY 23) ○ 40 new infant car seats (FY 24)
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Support cities/towns to promote resilience, emergency care and emergency preparedness.	● Emergency Services training ● Serve as Emergency Medical Services (EMS) Medical Directors for Cambridge, Arlington and Belmont Medical Dispatchers, MIT EMS and Harvard University Emergency Medical Services (EMS) ● Serve on State and regional Emergency Medical Services (EMS) advisory boards to lend medical oversight to the region	● The Emergency Department provided 12 education sessions and case review sessions to Cambridge, Arlington, Belmont, Cambridge and Watertown (Fire and Police) departments. ○ An average of 25 staff attended each month (all towns) (FY 23). ● The Emergency Department provided 6 education and case review sessions to Cambridge, Arlington, Belmont Watertown Fire departments. ○ An average of 25 staff in attendance (FY 24). ● MAH Emergency Physicians will provide at least 2 "Life Threatening Emergency - what to do" classes to community organizations who are requesting training.

			○ In 6 sessions, 165 people were trained (FY 23). ○ In 6 sessions, 120 people were trained (FY 24).

Priority: Social Determinants of Health

Goal: Enhance the built, social, and economic environment where people live, work, play, and learn in order to improve health and quality-of-life outcomes.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Older adults ● Youth ● Linguistically, ethnically and racially diverse populations ● Low-resourced populations ● LGBTQIA+	Provide community health grants to support impactful programs that address issues associated with the social determinants of health.	● Community Health Grant Program - Grant funding program for community organizations and municipalities	● Provide organizations funding to continue their work on identified projects which reflect the health priorities identified in our most recent Community Health Needs Assessment. ○ 11 organizations; $150,000 total funds dispersed (FY23) ○ 5 organizations; $40,000 total funds dispersed (FY24)
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.	● Join and support multi-sector community coalitions which convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health	● MAH staff attend community coalitions, community building and or community task force meetings in its service area ○ 52 meetings, $20,000 funding for community coalitions (FY23) ○ 43 meetings, $20,000 funding for community coalitions (FY24)

● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	● Community Food Distribution Program ● Food Access Program	● Using the hospital's purchasing power, purchase food and deliver to food insecure families throughout the year. ○ Provided 9 deliveries containing 900 dozen eggs and 900 loaves of fresh bread (FY23) ○ Provided 9 deliveries containing 900 dozen eggs and 900 loaves of fresh bread (FY24) ● Through a partnership with Waltham Fields Community Farm, Community Supported Agriculture (CSA) purchase/provide shares to low income medically identified families weekly for 20 weeks ○ 30 households were provided a CSA share representing 4,861 pounds of produce (FY23) ○ 30 households, representing 6,561 pounds of fresh produce (FY24) ● Collaborated with local farmers markets to help support access to fresh produce for those who are low resourced. Included a new partnership this year with Somerville Winter farmers' market. In (FY23, 3 markets; FY24, 4 markets). ○ SNAP Match customers increased by 25% at the Watertown Farmers Market as

			compared to the previous year (FY23). ○ SNAP Match customers increased by 15% at the Watertown Farmers Market as compared to the previous year (FY24). ○ Fresh Bucks (food voucher program) customers increased by 40% (FY 23) at the Arlington Farmer's Market as compared to the previous year. 43% (FY 24) of those using the Fresh Bucks (food voucher program) at the Arlington Farmer's Market were new to the program. ○ In Belmont, SNAP Match shoppers increased by 12% from the previous year (FY23). 48% of the SNAP shoppers were either new to the market or were people who had gone off the program and were incentivized to return to the program (FY 24).

● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Screen, assess, and connect patients with health-related social needs.	● Social Determinants of Health Screening Program	● Through a partnership with Housing Corporation of Arlington (HCA): ○ Support households in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to partner agencies as needed to create more stable tenancies for at least 45 families. (FY23: 39 households : FY24: 48 households). ○ Engage tenants and social service clients in advocacy. (FY23: 26 tenants engaged in advocacy : FY24: over 25 tenants engaged in advocacy). Examples of engagement include tenants in advocating for several housing related bills at the state level including MBTA Communities draft maps, funding for energy retrofit improvements for their housing, tenant Opportunity to Purchase Act (TOPA), and the Zero Carbon Renovation Fund.

			● Through a partnership with Somerville Homeless Coalition: ○ Provide funding to support moving individuals/families into stable housing. (FY23 - FY 24: 46 individuals and 4 children). ○ Provide funding to support people experiencing homelessness wishing to access support services. (FY23 - FY24: approximately 535 people/6,306 monthly visits).
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Support programs that stabilize or create access to affordable housing.	● Metro Housing Boston (MHB) Program	● Provide a dedicated case worker who will meet with patients and community members and provide assistance and referrals to community programs and governmental assistance programs. ○ 95 individuals (FY23) ○ 45 individuals (FY24) ○ 6 individuals received a consultation that resulted in avoiding eviction from their home (FY23) ○ Over 60% of participants who received services were able to stabilize their housing situation and reported an increased knowledge of the housing search process (FY24) ● Through a partnership with Housing Corporation of Arlington (HCA):

			o Support households in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to partner agencies as needed to create more stable tenancies for at least 45 families. o 39 households (FY23). o 48 households (FY24). o Engage tenants and social service clients in advocacy. o 26 tenants engaged in advocacy (FY 23). o Over 25 tenants engaged in advocacy (FY 24). ● Through a partnership with Somerville Homeless Coalition: o Provide funding to support moving individuals/families into stable housing. 46 individuals and 4 children (FY 23 - FY 24) o Provide funding to support people experiencing homelessness wishing to access support services. Approximately 535 people/6,306 monthly visits (FY23 – FY 24).

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 ● LGBTQIA+ ● Racially, ethnically and linguistically diverse populations	Address the unique mental health needs of historically underserved youth.	● Community Health Grant Program - Provide an opportunity for grant funding for community organizations and municipalities	● Culturally Informed Psychological Counseling with De Novo Center for Justice and Healing: ○ Provide specialized services through the Torture Treatment Program to survivors of torture, gender-based violence, war crimes or other human rights violations (FY23: 90 survivors; FY24: 117 survivors). ○ Provide forensic psychological evaluations, and in-court testimony as needed, to support their humanitarian relief applications. (FY23: 27 clients; FY24: 32 clients). ○ Provide case management supports, such as safety planning, food or clothing assistance, housing navigation, technology assistance, help completing paperwork, referral for legal or medical services, and accompaniment to court hearings, among other services. (FY23: 159 clients; FY24: 62 clients).
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	● Emergency Department social work navigator to support the START program (Substance Treatment and Referral Team)	● Provided bereavement support group, eight week long sessions for community members. (FY23; 2 support groups with 23 community members; FY24, 3 support groups with 26 community members). ● Provided an ongoing support group for new parents increasing access by 2 weekly options both in person and/or virtual groups (FY23, 125

		● Provide support groups ● BILH Collaborative Care model	community members; FY24, 138 community members). ○ 100% of participants reported that they gained confidence in caring for themselves and their baby as a result of their participation in the postpartum support group (FY23, FY24). ○ 100% of participants reported that they felt supported and it felt like a safe space for them to share their feelings and experiences (FY23, FY24). ● Provided a substance use navigator in the Emergency Department (ED) to provide support and care to those patients in the ED who show signs of substance use disorder and to help with continuity of care. ● Increase access to behavioral health services through our Collaborative Care Model (FY23: 1,308 patients across twelve sites; FY24: 1,395 patients across twelve sites). ● Subsidized inpatient and outpatient behavioral health services.
● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Promote collaboration, share knowledge, and coordinate activities internally at MAH and externally with community partners.	● Social Work Community Support	● Offered Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area. (FY24: More than 350 community residents and BILH staff attended one of the 21 MHFA trainings).

● Youth ● Older adults ● Racially, ethnically and linguistically diverse populations ● Low-resourced populations ● LGBTQIA+	Advocate for and support policies and systems that improve behavioral health services.	● Support relevant policies when proposed	● BILH Government Affairs advocated, directly or through the state hospital association or community coalitions, for bills supporting access to mental health and substance use services for all Massachusetts residents (FY24: 8).

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	Ensure older adults have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.	• Healthy Aging Program	• Coordinate and provide presentations geared towards educating older adults on health topics. (Baseline(FY23): 4 presentations, 152 older adults in attendance. Presentation topics included: Brain Health, Healthy Eating/Healthy Aging, and Heart Health including stroke awareness. Year 1(FY24): 4: 9 presentations, 179 older adults attended. Presentation topics included: Fall Prevention, Healthy Eating/Healthy Aging, and Heart Health including stroke awareness). ○ Brain Health (Baseline only(FY23)): ▪ 83% of participants reported they will take lessons and skills learned and incorporate them into their weekly routine. ▪ 87% of participants reported learning new information about keeping their brains healthy. ▪ 93% of participants reported that they learned strategies to help them make choices that will positively impact their overall health. ○ Healthy Eating/Healthy Aging

			▪ Baseline(FY23): 87% of participants reported learning new tips and ideas they will use when they go grocery shopping; Year 1(FY24): 100% of participants reported learning some new healthy tips and ideas they will use when they go grocery shopping. ▪ Baseline(FY23): 87% of participants reported learning new tips or ideas about how to substitute healthier foods in their diet. Year 1(FY24): 80% of participants reported learning new tips or ideas about how to substitute foods in their diet with healthier foods. ○ Heart Health (FY23 and FY24): ▪ FY23: 73% of participants reported increased knowledge of the risks of heart disease. FY24: 94% of participants reported they increased their knowledge of the risks of heart disease. ▪ FY23: 73% of participants reported increasing their knowledge of the signs and symptoms of heart disease. FY 24: 94% of participants reported increasing their knowledge of the signs and symptoms of heart disease

			○ Fall Prevention (FY24 only): ▪ 94% of participants reported they learned some new information on how to help themselves prevent a fall ▪ 98% of participants reported they would be able to take what they learned from the presentation and improve their own health and well-being.
• Older adults • Racially, ethnically and linguistically diverse populations • Low-resourced populations • LGBTQIA+	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.	• Survivorship Day Event • Stroke Nurse Navigator Program • Breast Cancer Support Group • Caregiver's Support Group	• Provided stroke education and support to patients and families by stroke nurse coordinator (FY23, 225 patients and their family members; FY24, 240 patients and their family members) ○ Conduct a stroke awareness campaign • Created and developed a public service announcement (video), distributed stroke education materials and conducted stroke awareness presentations for community members (FY23) ○ Distributed over 2,000 stroke educational materials ○ Provided eight stroke awareness presentations with 127 people in attendance. ▪ 98% of presentation participants reported an increase in their knowledge of the risks of having a stroke. ▪ 89% of presentation participants reported an increase in their knowledge of the signs and symptoms of stroke.

			• Distributed over 5,000 stroke educational materials (FY24)
			  ○ Provided 9 stroke awareness presentations with 110 people in attendance.
			  ▪ 98% of presentation participants reported an increase in their knowledge of the risks of having a stroke.
			  ▪ 97% of presentation participants reported an increase of their knowledge of the signs and symptoms of stroke.
			• Provided a free breast cancer support group to those who have completed treatment, this group met twice a month throughout the year. (FY23, 24 sessions; FY24, 24 sessions)
			• Organize a Survivorship Day event
			  ○ FY23, event completed in June 2023 with 48 people attending
			  o 97% of participants reported learning something of lasting value.
			  o 95% of participants reported they would be able to take what they learned and apply it to improve their own health and wellbeing.
			  ○ FY24, event completed with 60 people attending
			  o 100% of those participating reported they learned something of lasting value by participating in the event.

			o 100% of those participating reported they would be able to take what they learned or a skill they practice and use it to improve their own health and wellbeing.

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Mount Auburn Hospital

FY26-FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Mount Auburn Hospital (MAH) is a Harvard Medical School-affiliated teaching hospital located in Cambridge, Massachusetts. Mount Auburn has 217 licensed inpatient beds with more than 2,100 employees and over 650 clinicians on active medical staff. With comprehensive services and expertise in obstetrics and gynecology and cardiovascular and digestive care, Mount Auburn provides advanced care in a community setting.

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 MAH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. MAH'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 MAH'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 langu age other than English, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

MAH collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). MAH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed Implementation Strategy (IS).

Between June 2024 and February 2025, MAH conducted 15 one-on-one interviews with key collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 700 residents, and organized a community listening session. In total, the assessment process collected information from more than 800 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

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

MAH'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:

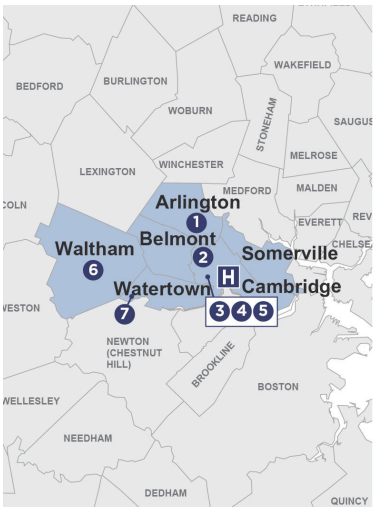
- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the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

Community Benefits Service Area

MAH's CBSA includes the six municipalities of Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown to the west of the City of Boston. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs. There are segments of MAH'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. MAH 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. MAH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

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



Beth Israel Lahey Health
Mount Auburn Hospital

Community Benefits Service Area

- H Mount Auburn Hospital
- 1 Mount Auburn Hospital Radiology at Arlington
- 2 Mount Auburn Hospital MRI Center
- 3 Mount Auburn Hospital Rehabilitation Services; Outpatient Physical & Occupational Therapy
- 4 Mount Auburn Hospital Mobile PET Unit
- 5 Mount Auburn Hospital Employee Assistance Program, Occupational Health & Rehabilitation Services
- 6 Mount Auburn Hospital Imaging and Specimen Collection
- 7 Mount Auburn Hospital Radiology at Watertown

Prioritized Community Health Needs and Cohorts

MAH 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.

MAH Priority Cohorts

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+

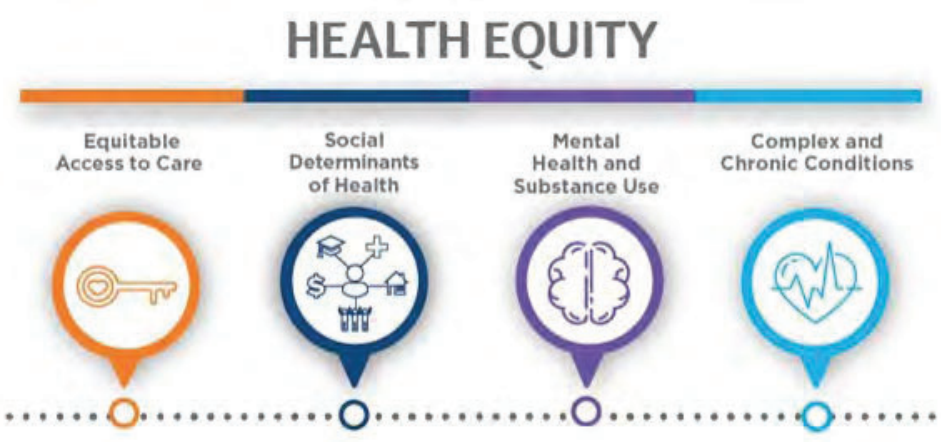
Community Health Needs Not Prioritized by MAH

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Health insurance eligibility and enrollment assistance services • Financial counseling activities • Programs and activities to support culturally/ linguistically competent care and interpreter services • Expanded primary care and medical specialty care services for Medicaid-covered, insured, and underinsured populations	• # of people served • # of patients enrolled • # of referrals made • # of clinical practices supported	• Community health centers • Hospital-based activities
Support cities/ towns to promote resilience, emergency care, and emergency preparedness	• All priority populations	• Emergency medical services, training, leadership, and community preparedness activities	• # of people served • # of classes/ trainings organized • # of towns serving as Medical Director	• Private, non-profit, health-related agencies • First responders
Advocate for and support policies and systems that improve access to care	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

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
Support community/regional programs and partnerships to enhance access to affordable and safe transportation.	• All priority populations	• Public transit and mobility enhancement programs • Transportation and ride share assistance programs	• # of people served • # of rides provided • # of community meetings attended	• Private, non-profit, health-related agencies • Hospital-based activities

Priority: Social Determinants of Health

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

Information gathered through interviews, focus groups, listening session, and the 2025 MAH 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: MAH 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 MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH 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, MAH will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• Low-resourced populations	• Food access, nutrition support, and educational programs and activities	• # of people served • # of pantries/ farmers markets • # of classes organized	• Private, non-profit, and health-related agencies • Community-based organizations
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• Low-resourced populations	• Housing assistance, navigation, and resident support activities • Community investment and affordable housing initiatives	• # of people/ families served • # of people who secured housing	• Housing support and community development agencies • Community-based organizations

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	• # of employees served • # of people hired • # of classes/ programs organized	• Cultural, linguistic, and community advocacy programs • Hospital-based activities
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• All priority populations	• Health education, awareness, and wellness activities for all age groups • Support groups (peer and professional-led)	• # of people served • # of classes organized • # of encounters	• Private, non-profit, health-related agencies • Hospital-based activities
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Primary care and behavioral health integration and collaborative care programs • Outreach, support, and navigation programs and activities • Substance use and mental health screening, monitoring, counseling, and referral programs • Crisis intervention and early response programs and activities • Health education, awareness, and wellness activities	• # of people served • # of encounters • # of referrals made • # of classes/ programs organized • # of clinical practices supported	• Private, non-profit, health related agencies • Hospital-based activities
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital -based activities

Priority: Chronic and Complex Conditions

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

Resources/Financial Investment: MAH 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 MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH 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, MAH 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 • Cancer education, wellness, navigation, and survivorship programs • Chronic disease management, treatment and self-care support programs	• # of people served • # of classes organized	• Private, non-profit, and health-related agencies
Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.	• All priority populations	• Care navigation, case management, and referral programs • Support groups (peer and professional-led)	• # of people served • # of classes/ groups organized	• Hospital-based activities
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

General Regulatory Information

Contact Person:	Mary DeCourcey, Community Benefits Director
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 9, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 9, 2025
Date written plan was required to be adopted	February 15, 2026
Authorized governing body that adopted the written plan:	Mount Auburn Hospital 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 13, 2022
Name and EIN of hospital organization operating hospital facility:	Mount Auburn Hospital: 04-2103606
Address of hospital organization:	330 Mt. Auburn Street Cambridge, MA 02138

Beth Israel Lahey Health

Mount Auburn Hospital