Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

2025 Community Health Needs Assessment

Acknowledgments

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

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

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

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Introduction

Background

Beth Israel Deaconess Hospital–Plymouth (BID Plymouth) is Beth Israel Lahey Health's regional comprehensive provider of healthcare services in Southeastern Massachusetts. The hospital has 175 licensed inpatient beds with more than 1,700 employees and over 600 clinicians on active medical staff. BID Plymouth is among the fastest growing hospitals in New England, caring for patients across Plymouth and Barnstable Counties and with recognized centers of excellence in cardiovascular care, cancer, orthopedics and neuroscience.

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

This 2025 Community Health Needs Assessment (CHNA) report is an integral part of BID Plymouth's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BID Plymouth provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This assessment, along with the associated prioritization and planning processes, also provides a critical opportunity for BID Plymouth to engage the community and strengthen the community partnerships that are essential to BID Plymouth's success now and in the future. The assessment engaged more than 600 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, government officials, and community residents.

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

Purpose

The CHNA is at the heart of BID Plymouth's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BID Plymouth serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

Prior to this current CHNA, BID Plymouth completed its last assessment in the summer of 2022 and the report, along with the associated 2023-2025 IS, was approved by the BID Plymouth Board of Trustees on Septeber 14, 2022. The 2022 CHNA report was posted on BID Plymouth's website before September 30, 2022 and, per federal compliance requirements, made available in paper copy without charge upon request.

The assessment and planning work for this current report was conducted between June 2024 and September 2025 and BID Plymouth's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 10, 2025.

Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within BID Plymouth's CBSA.

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

Description of Community Benefits Service Area

BID Plymouth's CBSA includes the four municipalities of Duxbury, Carver, Kingston, and Plymouth located in the southeast area of Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography.

There is also diversity with respect to community needs. There are segments of the BID Plymouth's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. BID Plymouth is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in the CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. BID Plymouth is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

BID Plymouth's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within the CBSA. The activities that will be implemented as a result of this assessment will support all

of the people who live in the CBSA. However, in recognition of the health disparities that exist for some residents, BID Plymouth focuses most of its community benefits activities to improve the health status of those who face health disparities, experience poverty, or have been historically underserved. By prioritizing these cohorts, BID Plymouth is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

Assessment Approach & Methods

Approach

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

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

Equity:

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

Accountability:

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

Community Engagement:

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

Impact:

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

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

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

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

Methods

Oversight and Advisory Structures

The CBAC greatly informs BID Plymouth's assessment and planning activities. BID Plymouth's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and members of the hospital's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Local public health departments/boards of health
- Additional municipal staff (such as elected officials, planning, etc.)
- Education
- Housing (such as community development corporations, local public housing authority, etc.)
- Social services
- Regional planning and transportation agencies
- Private sectors
- Community health centers
- Community-based organizations

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

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

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

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

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, BID Plymouth collected a wide range of quantitative data to characterize the communities in the hospital's CBSA. BID Plymouth also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was also tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment, including the BID Plymouth Community Health Survey, is included in Appendix B.

Community Engagement and Qualitative Data Collection

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

To meet these standards, BID Plymouth employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Between June 2024 and February 2025, BID Plymouth conducted 15 one-on-one interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving over 500 residents, and organized a community listening session. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

15 interviews
with community leaders

564 survey respondents

5 focus groups

- Older Adults and Veterans
- Haitian Refugees
- Wampanoag Tribal Members
- Low-resourced Individuals
- Parents of School Aged Children

Inventory of Community Resources

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

- Domestic violence

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

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

Prioritization, Planning and Reporting

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

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

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

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

After the Board of Trustees formally approved the 2025 CHNA report and adopted 2026-2028 IS, these documents were posted on BID Plymouth's website, alongside the 2022 CHNA report and 2023-2025 IS, for easy viewing and download. As with all BID Plymouth CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that the hospital's Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

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

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Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, other government officials, and community residents engaged in supporting the health and well-being of residents throughout BID Plymouth's CBSA. Findings are organized into the following areas:

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

Each section begins with a highlight of key findings. This introduction is followed by graphs and other data visuals. It is important to note that these five sections do not review all the findings collected during the assessment, rather they draw out the most significant drivers of health status and health disparities. A summary of interviews, focus groups, community listening session prioritization, and a databook that includes all of the quantitative data gathered for this assessment are included in Appendices A and B.

Community Characteristics

A description of the population's demographic characteristics and trends lays the foundation for understanding community needs and health status. This information is critical to recognizing health inequities and identifying communities and population segments that are disproportionately impacted by health issues and other social, economic, and systemic factors. This information is also critical to BID Plymouth's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status, and other characteristics.

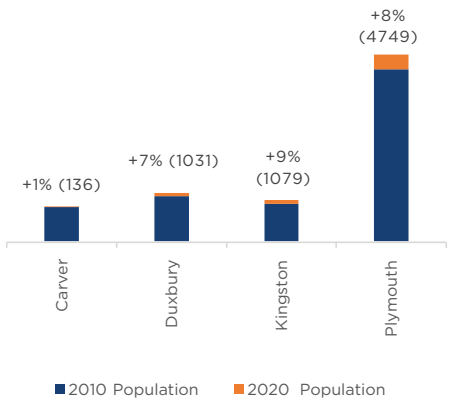
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the BID Plymouth CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were people of color, immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, non-English speakers, and individuals living with disabilities faced systemic challenges that limited their ability to access health care services. Some segments of the population were impacted by language and cultural barriers that limited access to appropriate services, 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 BID Plymouth's CBSA increased by 7%, from 95,665 to 102,660 people. Kingston saw the greatest percent increase (9%) and Carver saw the lowest (1%).

Population Changes by, Municipality, 2010 to 2020



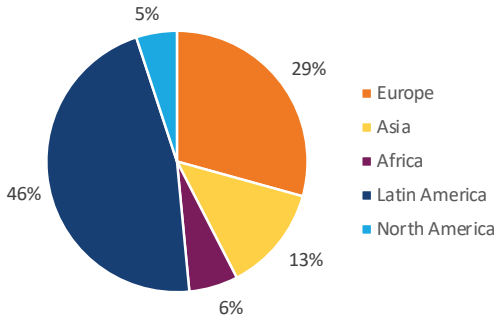
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

Nation of Origin

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

5% of the BID Plymouth 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]

6% of CBSA residents 5 years of age and older speak a language other than English at home and of those,

40% 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]

23%

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.

19%

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, socioeconomic inequality, and health disparities.[6]

7%

of adults in Massachusetts identify as LGBTQIA+.

Source: Gallup/Williams, 2023

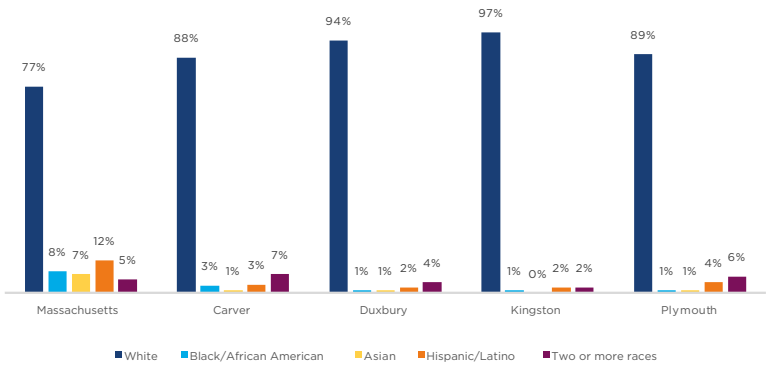
21% of LGBTQIA+ adults in Massachusetts are raising children

Source: Gallup/Williams, 2019

Race and Ethnicity

BID Plymouth's CBSA is predominantly white, though the percentage of residents who are two or more races is higher than the Commonwealth (5%) in Carver (7%) and Plymouth (6%).

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]

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

39% of BID Plymouth CBSA households included one or more people over 65 years of age.

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

Social Determinants of Health

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

Information gathered through interviews, focus groups, listening session, and the BID Plymouth Community Health Survey reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, economic insecurity, food insecurity/nutrition, transportation, and language and cultural barriers to servces.

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

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.

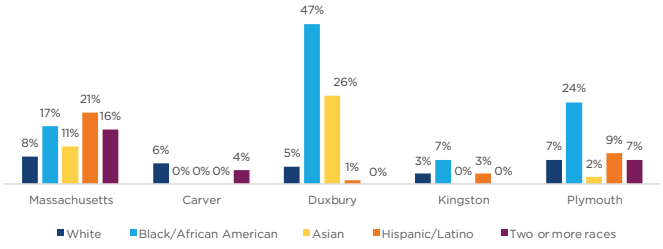
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

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]

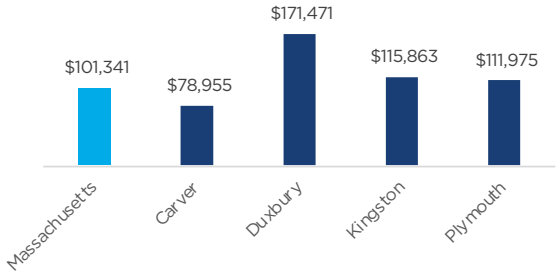
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains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

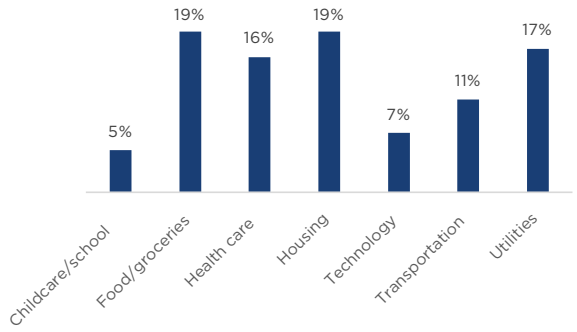


Source: US Census Bureau American Community Survey, 2019-2023

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

In the 2025 BID Plymouth Community Health Survey, survey respondents reported trouble paying for certain expenses in the past 12 months. Survey results indicate that people struggled with expenses related to food and groceries, housing, utilities, and health care.

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



Source: 2025 BID Plymouth Community Health Survey

Education

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

96% of CBSA residents 25 years of age and older have a high school degree or higher.

48% of CBSA residents 25 years of age and older have a Bachelor's degree or higher.

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

Social Determinants of Health

Food Insecurity and Nutrition

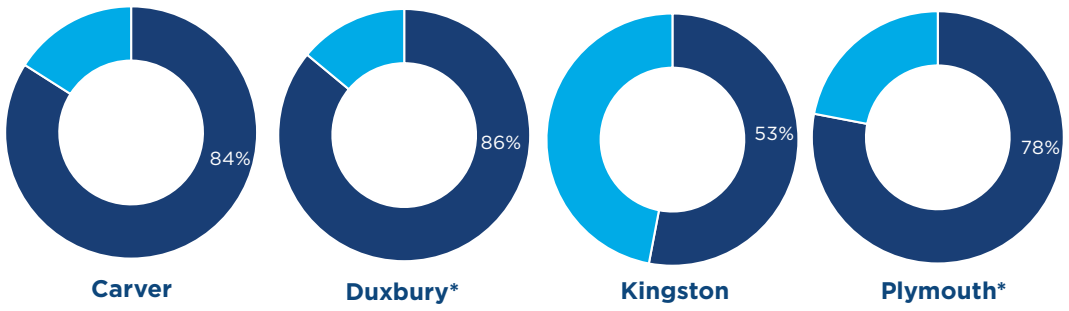
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

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

6%

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

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



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

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

Neighborhood and Built Environment

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

Housing

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

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

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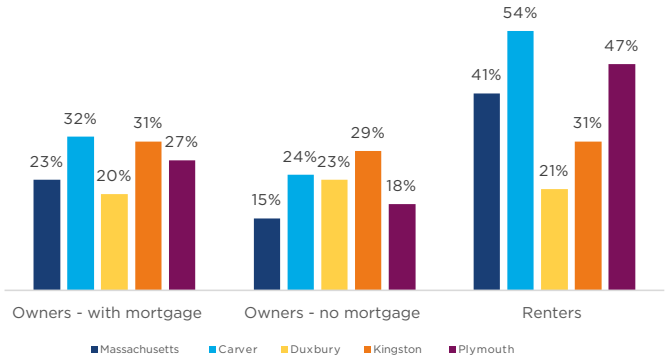
The percentage of owner-occupied housing units without a mortgage with monthly owner costs over 35% of household income was higher than the Commonwealth in all CBSA communities. Among renters, costs were higher than the Commonwealth in Carver and Plymouth.

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,

50% of 2025 BID Plymouth Community Health Survey respondents said "more affordable housing."

19% of 2025 BID Plymouth Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 BID Plymouth 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:

37% of 2025 BID Plymouth Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 BID Plymouth Community Health Survey

5% of housing units in the BID Plymouth CBSA did not have an available vehicle.

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

Roads/Sidewalks

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

35% of BID Plymouth Community Health Survey respondents identified a need for better roads.

30% of BID Plymouth Community Health Survey respondents identified a need for better sidewalks and trails.

Source: 2025 BID Plymouth 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, people whose first language is not English, foreign-born individuals, individuals living with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment reinforced the challenges that residents throughout the BID Plymouth 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

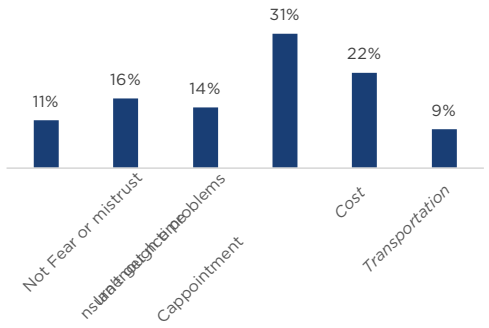
Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating th health care system. Many of these barriers were at the systen level, meaning that the issues stemmed from the ways in whi the system did or did not function. System-level issues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

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

Populations facing barriers and disparities

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

What Barriers Keep You From Getting Needed Health Care?



Source: 2025 BID Plymouth Community Health Survey

"The demand-to-access ratio is so skewed right now. I think you'll see this at any healthcare institution. I know of a clinic that is booking out until Decemer of 2025 for new patients and has a waitlist of over 100 patients seeking something sooner than that."

-Interviewee

Community Connections and Information Sharing

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

"I have worked in many amazing communities throughout my career, but I've never seen a community that has the ability to come together like Plymouth. We have such a depth and breadth of resources - it's unbelievable."
-Interviewee

Behavioral Factors

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

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

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

Nutrition

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

25% of 2025 BID Plymouth Community Health Survey respondents said they would like their community to have better access to healthy food.

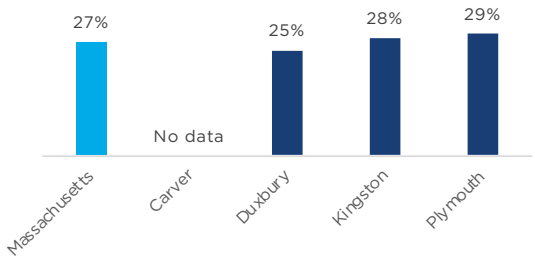
Source: 2025 BID Plymouth Community Health Survey

Physical Activity

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

The percentage of adults who were obese (with a body mass index over 30) was lower than the Commonwealth in Duxbury, but higher in Kingston and Plymouth.

Percentage of Adults Who are Obese, 2022



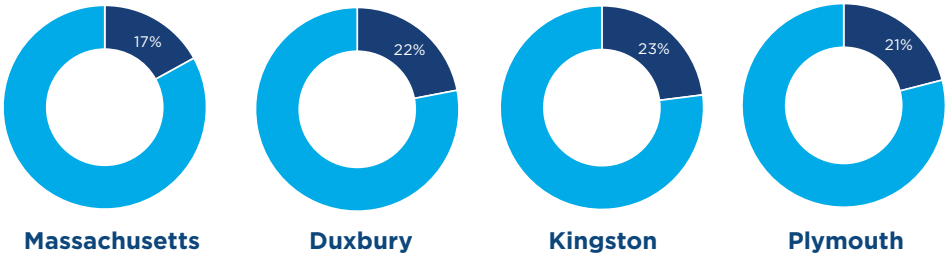
Source: CDC PLACES, 2022

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.

Interviewees reported concerns around the increase in use and normalization of alcohol and marijuana use - for the population at large, but also for youth.

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC PLACES, 2022
Data unavailable for Carver

Health Conditions

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

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

Given the limitations of the quantitative data, specifically that it was often out of date and was not stratified by age, race, or ethnicity, the qualitative information from interviews, focus groups, listening session, and the 2025 BID Plymouth 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 Interviewees also shared that they felt that stigma around behavioral health issues had improved since 2022, and that individuals, especially young adults, were more willing to share behavioral health needs and seek treatment or support.

37% of 2025 BID Plymouth Community Health Survey respondents said that health care in the community does not meet peoples mental health needs.

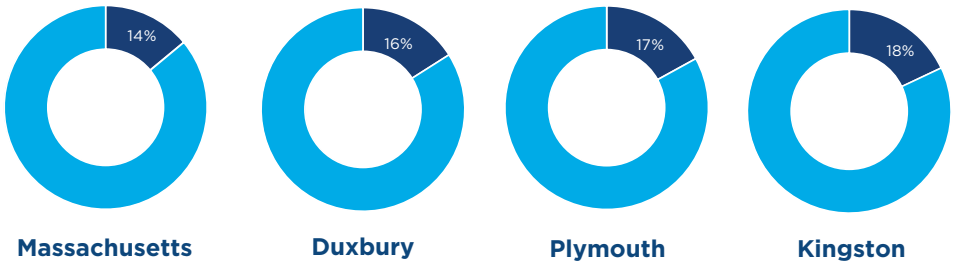
Source: 2025 BID Plymouth Community Health Survey

"I'm stunned and concerned about all of the young adults who say they have a therapist, a diagnosis, and a supportive family, and still don't feel worthy. Even with a support system, they aren't able to manage. The suicide rate scares me. We really need to pay attention to this."
-Interviewee

56%

of BID Plymouth 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
Data unavailable for Carver

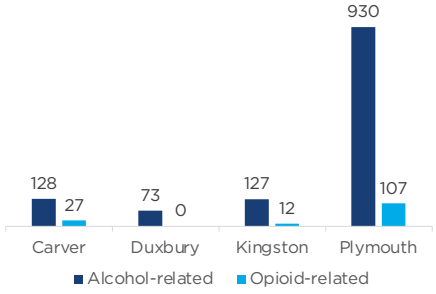
Health Conditions

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

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 Plymouth.

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



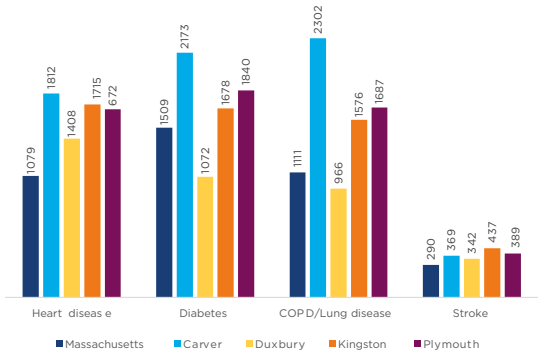
Source: MDPH Bureau of Substance Abuse Services, 2023-2024

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 for heart disease and stroke among adults 65 years and older were higher than the Commonwealth in all CBSA municipalities. Looking across other conditions, inpatient discharge rates were consistently higher than the Commonwealth in Carver, Kingston, and Plymouth.

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



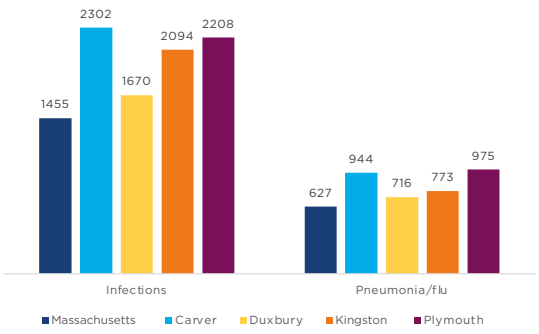
Source: Center for Health Information and Analysis, 2024

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 session and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

Data from the Center for Health Information and Analysis indicated that older adults in all CBSA communities had higher inpatient discharge rates for infections and for pneumonia/flu compared to the Commonwealth overall.

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



Source: Center for Health Information and Analysis, 2024

Priorities

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

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

Massachusetts Community Health Priorities

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

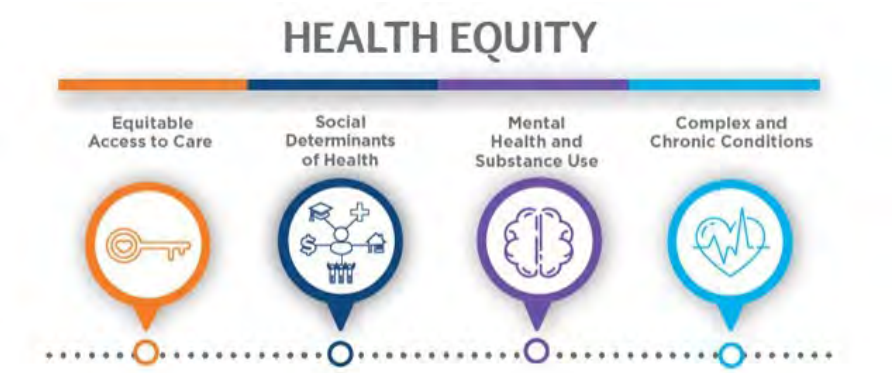
Community Health Priorities and Priority Cohorts

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

BID Plymouth Community Health Needs Assessment: Priority Cohorts

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

BID Plymouth Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BID Plymouth

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

Community Health Needs Addressed in BID Plymouth's IS

The issues that were identified in the BID Plymouth CHNA and are addressed in some way in the hospital's IS are housing issues, transportation, food insecurity, language and cultural barriers, economic insecurity, long wait times, health insurance and cost barriers, navigating a complex health care system, depression/anxiety/stress, youth mental health, social isolation among older adults, opioid use, behavioral health prevention and education, healthy eating and active living, conditions associated with aging, chronic conditions (cancer, cardiovascular disease), maternal health needs, and caregiver support.

Implementation Strategy

BID Plymouth's current 2023-2025 IS was developed in 2022 and addressed the priority areas identified by the 2022 CHNA. The 2025 CHNA provides new guidance and invaluable insight on the characteristics of BID Plymouth's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed BID Plymouth to develop its 2026-2028 IS.

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

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

Community Benefits Resources

BID Plymouth expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BID Plymouth and/or its partners to improve the health of those living in its CBSA. BID Plymouth supports residents in its CBSA by providing financial assistance to individuals who are low-resourced and are unable to pay for care and services. Moving forward, BID Plymouth will continue to provide free or discounted health services to persons who meet the organization's eligibility criteria.

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

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

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

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

Strategies to address the priority:

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

SOCIAL DETERMINANTS OF HEALTH

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

Strategies to address the priority:

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

MENTAL HEALTH AND SUBSTANCE USE

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

Strategies to address the priority:

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

CHRONIC AND COMPLEX CONDITIONS

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

Strategies to address the priority:

- Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.
- Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.
- Advocate for and support policies and systems that address those with chronic and complex conditions.

Evaluation of Impact of 2023-2025 Implementation Strategy

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

For the 2023-2025 IS process, BID Plymouth planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2022 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and financial assistance. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2023 and 2024. BID Plymouth 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	Efforts to address social determinants focused on housing, food access, transportation, and economic opportunity. BID Plymouth supported shelter services for over 150 individuals and partnered with agencies to provide rent, utility, and emergency food assistance. Nutrition education reached more than 1,700 residents across two years, while community grants funded aquaponics programs and workforce initiatives for those in recovery. Partnerships with transportation providers facilitated hundreds of rides. The hospital also supported age-friendly initiatives and regional planning for coordinated aging services.
Equitable Access to Care	BID Plymouth expanded access to care through financial assistance programs, patient navigation, and primary care enrollment. Over 4,500 patients were screened for financial support, and nearly 7,000 new patients were served in primary care settings. Interpreter services facilitated over 8,700 sessions in 39 languages. Workforce development included ESOL classes and career advising, while partnerships with local transportation services ensured mobility for older adults and individuals living with disabilities.
Mental Health and Substance Use	BID Plymouth prioritized mental health through school-based programs, MHFA training, and partnerships with local coalitions. Mental health services expanded through initiatives like Gosnold Recovery Navigators and the Behavioral Health Integrated Care Initiative, which significantly reduced anxiety and depression scores. First responders received suicide prevention training, and the hospital collaborated with Plymouth County Outreach on ED-based treatment engagement and prescription drug take-back programs. BID Plymouth also hosted grant workshops to build local capacity for behavioral health funding and program development.
Chronic and Complex Conditions	Chronic disease management included HIV care, cardiac rehab, stroke education, and extensive nutrition outreach. The ACCESS program maintained 100% viral suppression among participants, while the Keep the Beat program supported cardiac health. Community nutrition efforts reached thousands through classes, newsletters, and media, with nearly all participants reporting improved knowledge. Cancer patient support included transportation, wigs, mentoring, and wellness programs. Stroke education campaigns reached both community members and hospital staff, with high rates of increased awareness and self-efficacy.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2023-2025 Implementation Strategy

Appendix E: 2026-2028 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

BILH CHNA FY2025: Interview Guide

Interviewee:
BILH Hospital:
Interviewer:
Date/time:

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

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

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

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

Are there any questions before we begin?

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

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

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

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

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

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

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

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

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

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

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

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

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

Interviewees

- Lauren Hache, Health Agent, Town of Duxbury
- Joyce Krystofolski, Health Agent, Town of Kingston
- Karen Keane, Director of Public Health, Town of Plymouth
- Kathy LaNatra, State Representative, 12th Plymouth District
- Matt Moratore, State Representative, 1st Plymouth District
- Michelle Bratti, Commissioner of Health and Human Services, Town of Plymouth
- Meaghan Groves, Director of Practice Operations, Harbor Health Services, Inc.
- Peter Forman, President/CEO, South Shore Chamber of Commerce
- Taylor Desanty, Re-housing Manager, Father Bill's & MainSpring
- Melissa Ferretti, Chairwoman, Herring Pond Wampanoag Tribe
- Malissa Kenney, Director of Outreach and Inclusion, Cotuit Center for the Arts
- Marc Duphily, Chief of Police, Town of Carver
- Nikki Galibois, Director of Planning and Development, South Shore Community Action Council
- Stephen Cole, Executive Director, Plymouth Regional Economic Development Foundation
- Sue Giovanetti, Chief Executive Officer, Plymouth Area Coalition for the Homeless

Community Health Priority Areas

Social Determinants of Health

- Sense of Community, Support, and Tradition
    - Interviewees from the Wampanoag Tribe highlighted they often do not have the time to engage in their cultural traditions like fishing and hunting or teach skills to their children
    - The Wampanoag Tribe is working to become federally recognized, which will increase their access to funding, resources, and land protection; resources are limited for state tribes and the recognition process is expensive
    - Disconnected communities and lack of trust in the government and healthcare system
    - Community disagreement about support for migrant populations in Kingstown
- Food Insecurity
    - Food access and food availability in relation to cultural traditions
    - Increase in individuals using food pantry and food resources after COVID-19
        - The high cost of food is impacting the amount of food donations
    - Limited food access and food stores in North Plymouth
- Housing
    - Lack of safe and affordable housing, partially due to landlord negligence
    - The high cost of housing in the area makes living in place too expensive for older populations and prohibits many families from returning
    - Increase in temporary housing (hotels, shelters) and lack of resources generally
        - Shelters are unable to support people with high medical needs
    - The approval of ADUs at the state level would help improve housing access
- Transportation

    - Transportation barriers particularly impact older adults, individuals living with disabilities, and those who are low or fixed income
    - GATRA services help provide transportation, but does not include all towns
    - Organizations also use rideshare services to connect to medical appointments, but drivers are limited in the more rural towns
    - Many individuals in the community have long commutes to the Cape or Boston
- Environmental Health
    - Concerns about PFAS and lasting impacts of former landfills
    - Concerns about maintaining access to parks and recreational spaces
        - Many current bike lanes and sidewalks are seen as too dangerous to be used
- Lack of access to reliable technology impacts the ability to find resources and access telehealth
- Lack of time was noted as a barrier for prioritizing physical and mental wellness by interviewees

Access to Care

- Some interviewees noted that seeking medical care was often delayed because they felt they would not be taken seriously by providers
- Provider Access
    - Difficulty accessing mental health care, especially in-person and pediatric; long waits
    - Lack of providers who accept MassHealth; out-of-network providers are too expensive
    - Lack of pediatricians, which causes delays in school vaccinations
    - Lack of specialists; challenge to compete with higher wages in Boston and other cities
    - Urgent cares and other emergency providers are understaffed
- Language and Cultural Barriers
    - Lack of providers who can provide culturally competent care, especially for Native communities
    - Need for additional training on for all staff
    - Need for additional language and translation services
- Navigating the healthcare system is a challenge, especially for young adults and new Americans
- Need for additional adult day programs, most never reopened after COVID
- Need for additional programming on dental care and dental hygiene

Mental Health and Substance Use

- Stigma (personal and community) is a challenge
    - "Personally, take medication for their mental health. It was a hard decision. … Accepting you have a mental illness is difficult, and understanding it's not a negative thing. Forces you to reflect on things. "
- Mental Health
    - Veteran mental health
    - Native mental health
    - Youth Mental health
    - Isolation and hoarding are growing challenges in older adults
    - Impact of COVID-19
    - Impact of suicide and self-harm in communities
    - Middle aged men are a growing population with mental health needs
    - Rising anger, road rage, and bullying
- Rising impact of substance misuse, especially opioid misuse and alcohol misuse
    - Expansion of Narcan services has helped reduce overdoses

Chronic and Complex Conditions

- Cancer, obesity, poor nutrition, dementia, tick-borne diseases, diabetes, and high blood pressure were identified as common chronic conditions by interviewees
- Need for additional caregiver support and respite services
- Need for additional education on healthy habits, health prevention, and managing chronic conditions

Priority Populations

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

- Interviewees also identified concerns for individuals that identify as Native Americans, LGBTQIA+ populations, caregivers, women, and individuals who are homeless/unstably housed

Community Resources, Partnership, and Collaboration

- There are many strong organizations, partnerships, task forces, and collaboratives throughout Plymouth County
    - Specific organizations identified as critical resources: Native American Lifelines, NAICOB, Father Bill's, High Point, Senior Task Force, Council on Aging, Chambers of Commerce, South Bay Mental Health, Head Start programs, Plymouth Family Resource Center, Exchange Club, Rotary, Needham Business Alliance, Community Action Council, Mainspring House
- Municipal departments, schools, emergency services, senior centers, libraries, and veterans' groups were identified as common organizations and partnerships across interviews
- Limited funding available for organizations and partnerships to access and apply for

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

BID Plymouth
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Individuals in affordable housing
Location: Algonquin Heights (Plymouth)
Date, time: 10/8/2024
Facilitator: JSI
Approximate number of participants: 16

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?**
    i. Food expenses: Lack of resources and lack of travel access (Market Basket, Doctors)
    ii. Access to care: Appointments are hard to keep, it is difficult to find doctors, and there are long waiting lists
    iii. Obtaining a case worker/manager is challenging
    iv. Medication costs: Out of pocket or insurance
    v. Wifi access (telehealth)
    vi. Accessing a nutritionist
    vii. Education and awareness
    viii. Trouble finding a translator that speaks the same language

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?**
    a. Isolation, boredom, and social anxiety
    b. Stress around medical issues, housing, and the general state of the country
    c. Insurance for mental health
    d. Therapy waiting lists: feels as though mental care is not important
    e. Substance abuse is just equally important as mental health
    f. Need for more providers: therapists, psychiatrists, and doctors

g. Need for more programs for kids like Big Brother Big Sister, mentors, and the YMCA
h. Care navigation is difficult
i. Need for more emotional support for teens

Question 3

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. Social gatherings like the community garden, coffee hour, craft groups, and religious groups
b. Family and Friends
c. Family group nutrition
d. Toddler play groups
e. St. Vincent's
f. New Hope Chapel
g. Plymouth Coalition
h. Food pantries
i. Care works
j. St. Mary's
k. St. Peter;s
l. Plymouth recovery center
m. The library
n. Baystate
o. High point
p. Brothers Keeper
q. The Center for Active Living

BID Plymouth
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Parents in Carver
Location: Zoom
Date, time: 10/9/2024
Facilitator: JSI
Approximate number of participants: 3

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. Going to the gym
    iii. Dancing
    iv. Playing basketball
    v. Walking the dog
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Time
    ii. Fitting it into a busy family schedule

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. Going outside and connecting with nature
    b. Doing yoga
    c. Getting enough sleep
    d. Therapy for all family members
        i. Therapy for Substance Use Disorder (SUD)
b. **What stops you from being as mentally healthy as you'd like to be?**
    a. You need to schedule it so time doesn't get in the way

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. Substance Use
        - i. Vape shops
        - ii. Access to medical marijuana
        - iii. Community approval and low perception of harm
        - iv. Things are readily available for kids (substances)
            1. It is easy to purchase (substances) because of cell phones. Cell phone apps have increased the level of privacy
        - v. Long-standing heroin issue in town
            1. Generational impacts
        - vi. Vaping starts in sixth grade (in the school)
        - vii. Need education for parents to help them recognize the signs of use
        - viii. Treatment for THC addiction is different than alcohol
        - ix. A lot of family history of substance use; genetic impacts
    - b. Socioeconomic status is not an issue
    - c. Lack of face to face interactions with youth due to cell phones
- **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. Newcomers to town need help and support

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. There is a food pantry in town (Shane's) and they make packs for low-income families (weekend food)
    - b. Counseling options
    - c. Primary care providers and dentists
    - d. CVS Minute Clinic
    - e. Churches
    - f. The barber in town does back to school haircuts
    - g. Carver Recreation has activities for kids
    - h. Senior Center
    - i. Kayak rentals and pickleball

j. The track at CMHS is open to the public
k. Public library
l. Carver Cares
m. SRO - DARE Camp
    i. Police involvement in the community and with youth

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

a. Diversity
b. Affordable housing, rentals, and apartments
c. There is only one grocery store in North Carver
d. A safe space similar to a Boys and Girls Club
    i. Many youth-focused spaces have closed (Frost Dog and Supersports)
    ii. There is not a YMCA or recreational park
e. Need for a strong community for youth who ride their bikes and fish

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?

- Cancer and chemical exposure
    - Five neighbors live on bogs treated by pesticides so they cannot drink the water

BID Plymouth
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Herring Pond Wampanoag Tribe
Location: Zoom
Date, time: 10/23/2024
Facilitator: JSI
Approximate number of participants: 4

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. The family gets together and does 5Ks. Walking by the water. Drinking turmeric shakes and having turmeric in the water with lemon. We incorporate more water and healthy foods at the meals now and at holidays.
    ii. Go for a lot of walks with our three dogs. Garden, so always outside, moving a lot when transplanting things.
    iii. Do try to be mindful of walks to stay healthy. If they can't get out for a walk, they go to the gym. Utilize a lot of essential oils in their daily routine. Walking, making sure they get up and move. Kids are always out; the family is very active. Always out on the canal, fishing, and hunting. Lots of physical hunting. Can walk miles in a day. The young group does a lot more physical activity and the older folks get out for a walk.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Don't walk as often as they'd like to. Feels like they're always on her computer.
    ii. Time. I was in grad school and worked 40 hours with three kids (two who play on travel teams). It is difficult to get up at 5am to go to yoga.
    iii. Time. By the time you leave and get home, to do anything more is hard. Getting dogs fed and walked, doing schoolwork.
    iv. Time. Making healthy eating choices when you're busy from 4:30am to 8p at night, you might forget to eat. Making healthy choices when you're time constrained is hard. The healthcare system itself prevents them from being healthy. If you don't address something with your body, because of time or something else, it might be because you aren't confident you will be listened to or taken seriously.

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. Stay away from drama and toxic things. The participant has many siblings and they share books. Talk things out to work through conflict. With social media, people get worked up. Sometimes it's negative energy.
b. A lot of ceremony, a lot of clearing out, a lot of digest sessions (sitting down as a family and talking, listening, digesting). Personally, the participant takes medication for their mental health. It was a hard decision.
    i. Not one to take medication, even if they have a headache. Not a medication person.
    ii. Accepting you have a mental illness is difficult, and understanding it's not a negative thing. It forces you to reflect on things.
c. The participant's spouse is a veteran; they suffer from certain mental health issues. Medication helps. The participant does breathing exercises, embraces ceremony (not with family, but by themself). They are not good at the mental health part. The family tells them to put the phone away, but they have a hard time separating themself from their work.

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

a. Stubborn. Don't want to put the phone away. She stops herself. Finds it hard to separate herself from the work. Feels like she is her own barrier.
    i. In the past six months, has given herself permission to not always check her emails. She has started to yarn, and has beads for her kids' regalia. She feels that it is more important to get her daughter's regalia set up than to check emails. Learning new tasks.
b. Access to mental health professionals (therapists, somebody from the outside). It is tough to get into connection these days. A lot of it is online and some people need in-person connection for mental health services. It took almost 6 months to find a psychiatrist to get an appointment. And that was online, not even through the hospital.
    i. One participant talked to Native Lifelines; they have no therapists in Boston. Could be referred out to Colorado. They are constantly looking for a therapist. Feels she has to educate the therapist sometimes.
    ii. It took a long time to find their granddaughter a pediatric therapist. The participant considered getting a therapist, but waitlists are long.
    iii. When the participant had a therapist, they could only find one therapist that took military insurance.
    iv. It is difficult to get out-of-network providers

v. A lot of providers don't take MassHealth. Paying out of pocket is cost prohibitive. Connecting in person is a cultural value for many Native folks.

c. It is easier to build trust when you're in person. Technology is not always reliable.

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 challenging in your community?

a. Access to Food.
   i. Kids like sushi, soup, and lobster.
   ii. Doesn't always have time to go fishing or get fish.
   iii. One participant wants their kids to enjoy the food that they grew up with. They have a garden and access to fresh produce. If you use your time wisely, you could hunt and fish and get food for your family.
   iv. Food insecurity in relation to cultural traditions. Lost a lot of traditions, but people are busy and are trying to embrace them again. Some of their kids have never held a fishing pole, so a lot of the traditions with food no longer exist.
b. Distrust of government and within own communities. Double barrier because they're struggling to fit into society and get appropriate and equitable care (on par with federal tribes). They have their own internal healing to do.
c. Doesn't have the manpower to do it. Doesn't have the funding of the federally recognized tribes. Grants are generally restricted. Nobody just hands you money.
d. No programs that work for youth and older adult care
e. The community should have a health office to do screenings. They are working on getting these services, but they need more people and more support.
   i. Two or three people can only do so much work in the day.
   ii. Health is such a broad department, people with diabetes, and pregnant women. They are working towards it. The respondent is a social worker and they want to create departments that folks can jump into once they're educated. The respondent wants to start programs that will be there for young people after the respondent is gone. They have come a long way, but have a long way to go.
f. Funding for programs and space. They have a small meeting house. Sometimes they want to do an exercise class, but don't have the space. The meeting house is 35 minutes away.
g. Not having people that they trust. If they're not sure the provider will be able to understand them, they won't seek it out. A lot of good places like Native Lifelines and NAICOB (in Boston). If they were to walk into BID Plymouth, they wouldn't be comfortable there.

i. The problem with Native communities is that it's your auntie or uncle in the office, so they don't want to go for help because of confidentiality concerns.

b. What social factors are strengths in your community?

a. Common goal. They know where they want to be. They want to get federally recognized.
   i. Some people care about the lands. Working on learning about climate change and land rights issues. They engage in healthy lifestyles, but sometimes they don't talk about it. They go to the water and go to the beach, but are so busy with business, they don't have time to talk about it.

b. We are resilient. There is lots of healing to do internally. We all want to see healing within the community. Everybody needs to do better.

c. 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. The community is spread all over. We are disconnected.

d. What could BID do to help create a comfortable environment for folks seeking services?

a. Understand the local groups and what they value; being able to collaborate with them and putting Native folks in the hospital.
   i. The respondent is trying to bring back Indigenous birth work. A lot of this doesn't happen in hospitals.

b. The hospital in Quincy put up more inclusive artwork. The respondent donates Indigenous books for the lobby. Diversify the books available. Hang artwork that portrays Indigenous people.
   i. Lobby artwork that spoke to people, even if it was one picture. Diversify and add things from other groups.

c. Sometimes when they walk into spaces, "Native American" isn't even on the list to check off. Have more events where the Tribe and hospital get to know each other, to try to work together, diversify their staff, and get Native people in those seats at BID.

d. When you're in the ER, ask the client if they're Native. In children being sex trafficked or experiencing violence, they don't ask that question. Have resources that list Native Lifelines and NAICOB. Have brochures to give to folks in hospitals.

Question 4

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

- **a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    a. We have to rely on organizations like Native American Lifelines, NAICOB (in Boston). They bring services to them, but sometimes they have to go to Boston.
- **b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. There are no services. We are trying to fight to be recognized. Other tribal communities get assistance.
        i. One respondent saw a grant that would have allowed for fuel assistance, but they didn't have time to write it.
        ii. The lands were taken, the community was displaced, and folks were split up.
        iii. The community was supposed to get food from the pantry in Plymouth, but couldn't get it anymore. The respondent would rather provide the community with fresh produce and meats. There are always barriers for them.
    b. You are almost forced to go for recognition, even if you don't want it. It's the only option, because they're denied services and put in a category along with fake tribes.
        i. If they don't get recognition, artisans can't even sell their jewelry without fear of prosecution (for violating the Indian Arts and Crafts Act).
    c. We get denied a lot of things; we can't apply for USDA grants, for HUD, or for the Workforce Investment Act that helps young people go to schools.
    d. We would love to see Tribal recognition happen in 4 years.

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?

- BID has reached out more than once. Keep doing what they're doing.
- Kathy and Jill do health fairs.

BID Plymouth
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Older adults in Kingston
Location: Kingston Council on Aging
Date, time: 11/15/2024
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. Walking (+4)
        1. One person said it relieves her of anxiety and gives her time to think
        2. Need to keep walking due to osteoarthritis
    ii. Yard work, gardening (+1)
    iii. Drinking water
    iv. Bowling
    v. Turning off the TV
    vi. Self motivation
    vii. Getting help from others
    viii. Medical help (+2)
        1. Cancer treatment at hospital
        2. Trial medication made by a Boston hospital helped someone's friend with a rare health condition

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Difficult to exercise due to bad leg
    ii. One woman had a bad experience at BIDH. She had a bad fall, went to the emergency department and there was only 1 doctor in the entire emergency department.
        1. They spent too much money on fancy renovations and don't have enough doctors
    iii. Lack of motivation (+4)
        1. Laziness or relaxing
        2. Being in a rut
        3. People get sedimentary
        4. People get stubborn and don't want to do what they're supposed to
    iv. Taking care of others makes it hard to take care of yourself, especially sick and dying family members (+2)

v. Not wanting to burden their family with problems.
vi. There isn't enough support for older people

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 (+7)
    i. Talking to people outside of family
    ii. Easier to talk to people our age than burden family
b. Community (+4)
    i. Making time for friends
    ii. The Council on Aging has free meals to encourage people to come in.
    iii. One woman started driving the van here and has made many friends
    iv. Going to lunch with old friends consistently
c. Medication for some people
d. Especially for men, doing activities and walking together helps them open up
e. Recognizing that you need something and figuring out what you need

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

a. Men are more reluctant to get therapy (+2)
b. Stigma around mental health (+3)
c. Depression. Feeling alone even when being with people.
d. Isolation (+3)
    i. Covid made isolation worse
    ii. "People don't drop by anymore. We've all gotten so busy."
    iii. One woman said she can't drive which makes it harder
e. Technology (+2)
    i. It's hard to trust others. Easy to get scammed by phone calls.
    ii. More difficult to connect with people via text than over the phone
    iii. Don't like cell phones
f. Difficult to make new friends in old age (+3)
    i. Hard to step out of comfort zone and make new friends because "we're set in our ways"
g. Deaths of friends and family members (+3)
    i. "Most of us are widows"
    ii. The Council on Aging used to have a bereavement program, but they discontinued it.
h. Doctors visits are becoming texts or Telehealth (+1)
    i. Doctors used to come to your house

Question 3

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

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

a. The cost of housing is a big issue. (+4)
    i. When you're older, you can't afford to buy a house or take care of one
    ii. The senior housing has lots of infections
    iii. Cost of housing for seniors.
    iv. "There is no affordable housing for seniors"
    v. "The nursing home is really bad. You get people who don't speak the same language"
b. Multiple people spoke highly of the residential area town and country
c. The last Council on Aging director was not good (+2)
    i. "She took everything away from us" including bereavement program
    ii. They should be able to vote for who becomes the director, but the town chooses who it will be.
d. Wish they could have more groups like this to discuss issues

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. Social workers and counselors can help with insurance
b. Church (+1)
c. A housing complex organized covid shots
d. One woman likes Atrius because she gets her results online
e. Council on aging (+5)
    i. "It's our center"
f. Southshore medical or kingston

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

a. Wish they could have a doctor at the Council on Aging (+2)
b. Readily available appointments with primary care providers. (+1)
    i. Doctors are booking two months out. She needs to go to the emergency room or urgent care to get primary care.
    ii. "In Ireland, if something was wrong, you'd go to a pharmacist and they'd give you something"
c. Lack of communication in healthcare system (+3)

i. “Doctors don't talk to each other”
ii. People are not aware of the seriousness of issues when you call the office
iii. One woman said she got labs run and they didn’t call her back with results.
iv. “You need to go through so many people and repeat yourself so much”

d. Poor quality doctors (+1)
    i. “They don't listen anymore”
    ii. “Theyre jaded”
e. You need to be your own advocate and an advocate for your partner (+1)
    i. “If you're not your own advocate, you wont get the help you need”
    ii. “We need to monitor ourselves at home”

BID Plymouth
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Haitian Refugees
Location: Plymouth Salvation Army
Date, time: 11/21/2024
Facilitator: 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. We have two groups that meet here, one on Parkinson's and one for weight, but they are more for the senior population
    iii. Pickleball is free and open to the public
    iv. Retired boys and girls director runs things for youth
    v. They have a person who comes in and mentors youth here
    vi. One group is interested in using facilities for other young people
    vii. Swimming at the YMCA
    viii. A lot of healthy food donations at Salvation Army
    ix. People come here (Salvation Army)
    x. The Council on Active Living has several programs
    xi. Planet Fitness

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Laziness
    ii. Cost is a factor, gyms are expensive
        1. Opportunities for those that can't afford it are minimal, that's why they try and open up the building
    iii. People with chronic health issues
    iv. Quality of foods being consumed
        1. A lot of cheaper foods are unhealthy, which is what a lot of folks are eating who are low income
    v. Food insecurity is a big thing in general
    vi. Transportation a barrier to get to some places in town to be physically healthy

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. Geting exercise
b. Some people use faith
c. Social interactions is a big one, especially for the youth and elderly

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

a. Isolation and loneliness
b. Barriers to internet to feel connected; need more resources
c. Cost is a factor in some regards

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. Some people are afraid to get services because of documentation, or just being vulnerable
b. Some people feel nervous to utilize services because of a distrust of the system in general
c. Transportation to get to some services
d. Some people feel there's a stigma to who they are, what they look like, having an accent
e. Coming out of COVID and people that owe a lot of money because of it, couldn't make ends meet and now are homeless/evicted, or they can't owe/pay back people, just getting a vehicle is tough
f. Barriers for the elderly to get places
    i. "Invisible generation," meaning the elderly, just a big life for them to get things
g. A lot of elderly people are taking care of their own grandchildren
h. People coming out of recovery, they have to jump through hoops just to get to things they need, and try to build themselves back up
i. Getting out of prison is very challenging too
j. Young adults are finding it hard to grasp all the responsibilities they have to accomplish
k. Starting ESOL classes here
l. Some people don't want them to learn English so certain employers can keep ahold and control them
m. Some Asian families have come here and are very shy, never ask for help unless they have someone that knows their language
n. Disabilities in general, especially speech language ones

o. People in the Latino community don't want to go to the hospital because of being afraid of payment and not being able to make things work
p. Certain people of color feel uncomfortable going to the hospital, especially Latinos/Haitians, whether they're undocumented or not, or newly arrived

b. Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others?

a. Newly arrived communities feel like they have a target on their back
    i. Dominican and Haitians feel somewhat like outsiders
b. People who are postpartum
c. Single mothers
d. The elderly. They don't know where to go for help; they have a good Council on Active Living that deals with a lot problems they face, but not everyone utilizes it

c. What sorts of barriers do they face in getting the resources they need?

a. Housing in general is the biggest issue for everyone, to get it for anyone is hard
    i. Hard to maintain a place to live for most low income people, and some middle income people
    ii. Not a lot of places for transitional housing, if any. There's one shelter
b. Food insecurity is very high. The pantry is very busy, but some things are better. The schools don't charge for lunch; most schools will send some food home to get kids through the weekend
c. Transportation again tough, there is nothing to Boston
d. Access to getting jobs can be a challenge
e. Unless you have someone to help, navigation is challenging, not just for immigrants

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. Council on Active Living
b. Salivation Army
c. South Shore Community Action Council, they work very closely with the families, they have a lot of activities to bring them together as a group, help to meet their needs as well
d. Urgent care

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

a. There is a barrier to interpreter services at urgent cares
b. Women's shelter
c. More public transportation
    i. Re-open the commuter rail

d. Cheaper services to somewhere like the YMCA, another one that's closer
e. Make the boys and girls club more accessible
f. More affordable childcare
g. More language services, a language czar
h. More navigation services
    i. More community navigators not online, but a telephone number for older folks

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 summary for new folks that are here from the shelter
    - Childcare is a challenge when trying to work
        - Not that difficult to find a job, but hard to find childcare
    - Transportation challenges
        - Transportation is okay when trying to get from the shelter to the hospital
    - MassHealth navigation challenges
        - Navigation can be a challenge
    - If funding for the shelter ends, what happens?
        - They would have to rent a place on their own, and if they don't have a job it can be tough
    - Okay to get some healthy foods, or food in general
    - Mental/physical health is okay overall, but not great
    - More resources for housing, daycare, transportation, and care navigation

Community Listening Sessions

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

Beth Israel Lahey Health

JSI

TRAINING FOR COMMUNITY FACILITATORS

BILH Community Listening Sessions 2025

TRAINING AGENDA

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

WHAT IS A COMMUNITY LISTENING SESSION?

90-minute sessions

Open to anyone in the community who would like to attend

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

Goals:

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

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

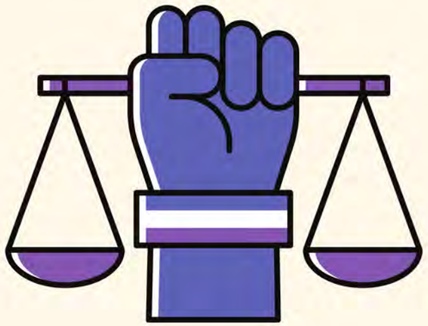
Be sure to register for your Listening Session (both in-person and virtual). For Zoom meetings, registration is required to join and you will be sent your link to join the meeting after you register

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."

Beth Israel Deaconess Hospital-Plymouth Community Listening Session

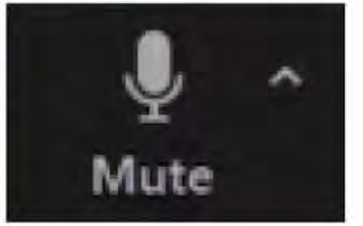
February 13, 2025 | 3:00-4:30pm

Beth Israel Lahey Health

BID Plymouth Community Listening Session

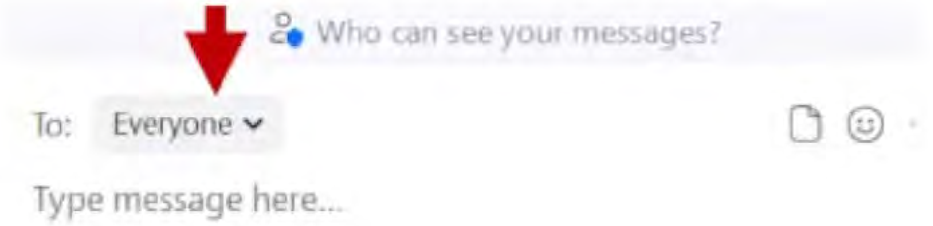
Meeting Guidelines

- Please remain on **mute** until we move to Breakout Sessions



- Start your **video** if possible

- **Tech Support** is available – chat with “Tech Support” in Chat



BID Plymouth Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

BID Plymouth Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
3:00-3:05	Room orientation and Welcome	JSI
3:05-3:10	Overview of assessment purpose, process, and guiding principles	Karen Peterson, Community Benefits & Community Relations Manager, BID Plymouth
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	Karen Peterson

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Assessment Purpose and Process

Beth Israel Lahey Health

Assessment Purpose and Process

Purpose

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

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

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

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

Community Benefits Service Area

H Beth Israel Deaconess Hospital-Plymouth
1 Beth Israel Deaconess
2 Beth Israel Deaconess-Plymouth Rehabilitation Center

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.

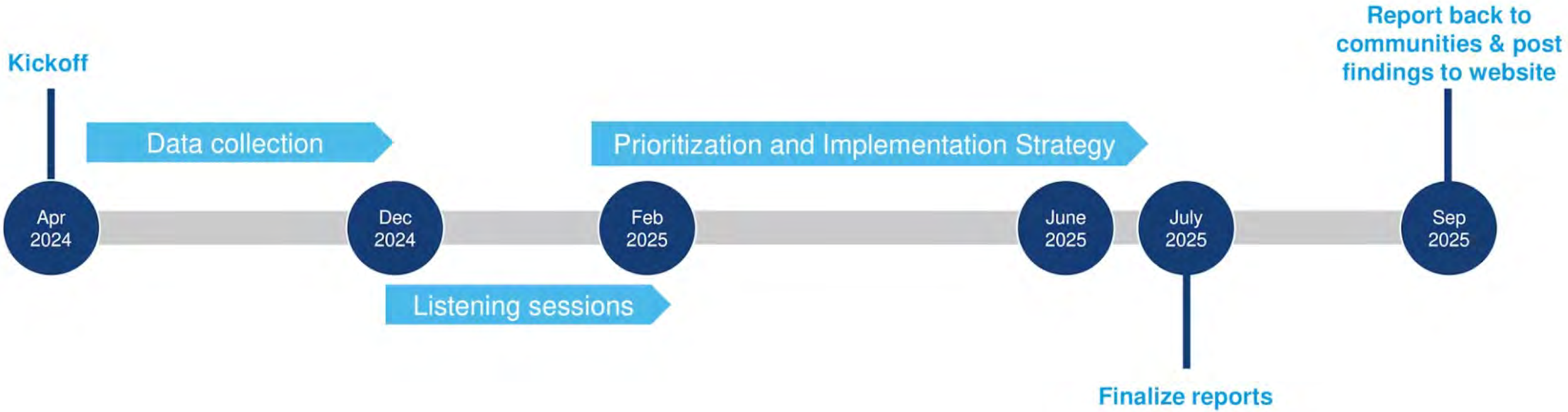
Community Engagement: Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

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 BID Plymouth
- Present data for prioritization
- Identify opportunities for ***community-driven/led solutions and collaboration***

We want to hear from you.
Please share when we get to Breakout Sessions

Mentimeter

Key Themes & Data Findings

Beth Israel Lahey Health

FY25 CHNA Progress

Activities to date

Collection of secondary data, e.g.:

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

15 Interviews

564 BID PlymouthFY25 Community Health Survey Respondents

5 Focus Groups

- Seniors and veterans *(Kingston Council on Aging)*
- Haitian refugees (*Plymouth Salvation Army)*
- Wampanoag Tribal Members (*Herring Pond*)
- Low-resourced individuals (*Algonquin Heights*) conducted in Spanish
- Parents of school-aged children *(Carver Cares Coalition)*

FY25 CHNA Progress

FY25 BID Plymouth Community Health Survey Responses

564 responses

(Represents a 23% increase from 460 responses FY22)

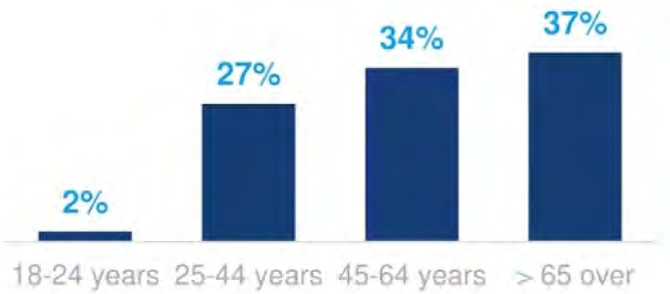
8% of respondents report a language other than English as the primary language spoken in their home **(up from 5% in FY22)**

81% of the respondents are women **(down from 82% in FY22)**

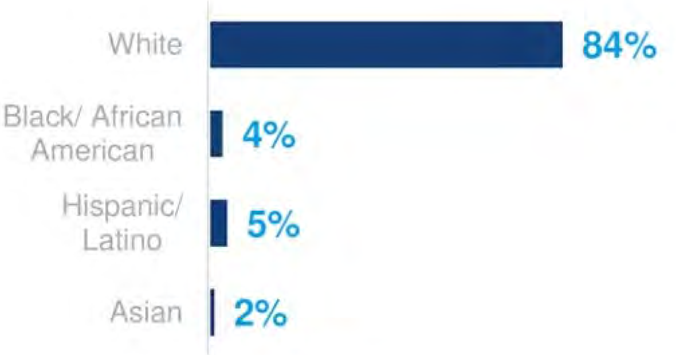
18% of the respondents identify as living with a disability **(up from 11% in FY22)**

6% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(up from 5% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 20 in FY25 compared to only 1 in FY22
- **Hispanic respondents:** 5% in FY25 compared to 1% in FY22
- **Asian respondents:** 2% in FY25 compared to 1% in FY22
- **Black/African American respondents:** 4% in FY25 compared to 1% in FY22

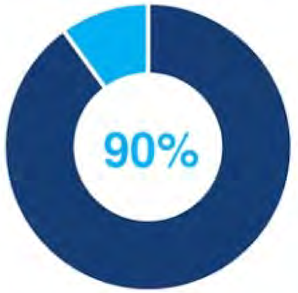
FY25 CHNA Progress

Community Benefits Service Area Strengths

FROM INTERVIEWS & FOCUS GROUPS:

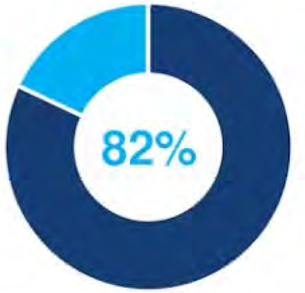
- Collaborative nature among municipal leadership, community organizations, and private businesses
- High levels of civic engagement

FROM FY25 BID PLYMOUTH 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 90% in FY22)



said the community **has good access to resources**
(compared to 85% in FY22)

FY25 CHNA Progress

Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

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

FY25 CHNA Progress

Preliminary Themes: Social Determinants of Health

Primary concerns:

- Housing issues (affordability, displacement, homelessness)
- Transportation
- Food insecurity
- Language and cultural barriers to services
- Economic insecurity and high cost of living
- Environmental health/exposure to toxins

"We do have a growing homeless population, but we have an even larger population of people that want to move to Plymouth, or return to Plymouth, but the cost of housing is prohibitive. This also dovetails with people's ability to stay here and age in place. People want to stay where they've been their entire adult lives, and they can't anymore." ***– Interviewee***

When asked what they'd like to improve in their community, **50%** of FY25 Community Health Survey respondents reported **more affordable housing – the #1 response (up from 44% in FY22)**

When asked what they'd like to improve in their community, **37%** of FY25 Community Health Survey respondents reported **better access to public transportation (down from 49% in FY22)**

19% of FY25 Community Health Survey respondents reported that they had **trouble paying for food or groceries** sometime in the past 12 months

FY25 CHNA Progress

Preliminary Themes: Equitable Access to Care

Primary concerns:

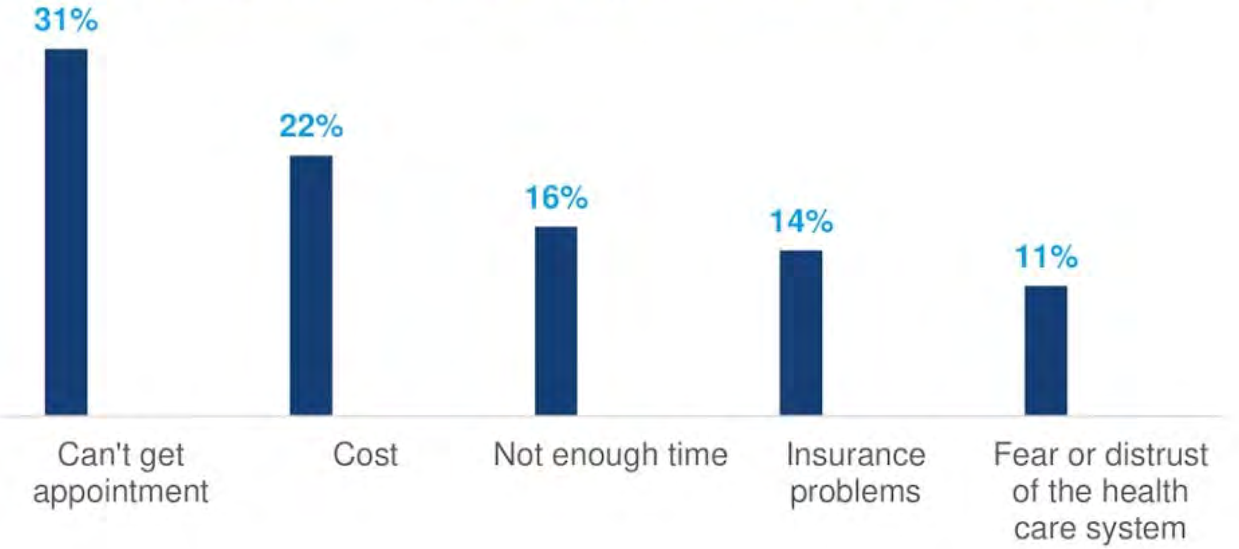
- Long wait times for primary care and behavioral health care (acknowledging that workforce was identified as an issue among providers)
- Health insurance and cost barriers
- Language and cultural barriers to care
- Navigating a complex health care system

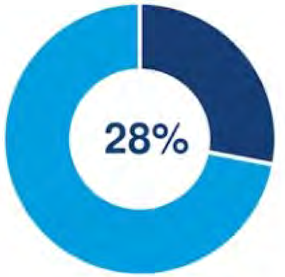
"The demand-to-access ratio is so skewed right now. I think you'll see this at any healthcare institution. I know of a clinic that is booking out until December of 2025 for new patients and has a waitlist of over 100 patients seeking something sooner than that."

- ***Interviewee***

What barriers keep you from getting needed health care?

(Top 5 responses from FY25 BID Plymouth Community Health Survey)





28% of FY25 BID Plymouth 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

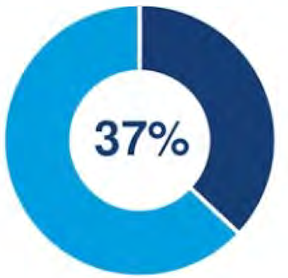
Primary Concerns:

- Depression, anxiety, and stress
- Youth mental health
- Social isolation and mental health issues among older adults
- Opioid use
- Lack of providers
- Need for more prevention and education

"I'm stunned and concerned about all of the young adults who say they have a therapist, a diagnosis, and a supportive family, and still don't feel worthy. Even kids with support systems say they aren't able to manage. The suicide rate scares me. We really need to pay attention to this." ***- Interviewee***

AMONG FY25 BID PLYMOUTH COMMUNITY HEALTH SURVEY RESPONDENTS:

56% identified mental health as a heath issue that matters most in their community (#1 response)



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

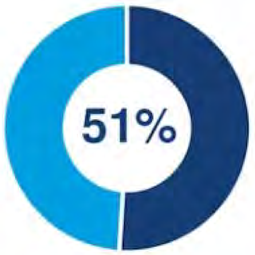
FY25 CHNA Progress

Preliminary Themes: Complex and Chronic Conditions

Primary Concerns:

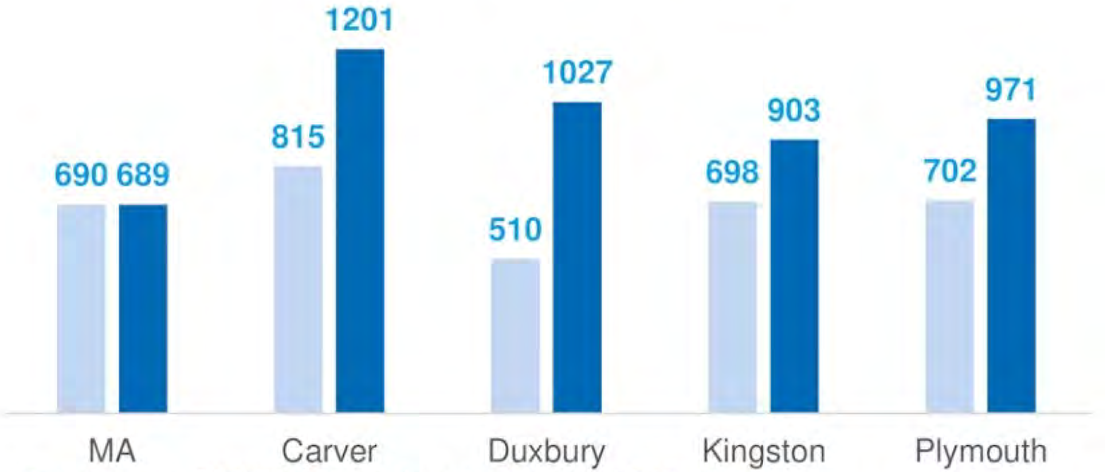
- Healthy eating/active living
- Conditions associated with aging (e.g., mobility, Alzheimer's and dementia)
- Cancer
- Cardiovascular disease
- Caregiver support
- Tick-borne illnesses

AMONG FY25 BID PLYMOUTH COMMUNITY HEALTH SURVEY RESPONDENTS:



51% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community (#2 response)

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



Data Source: MDPH, Massachusetts Deaths, 2019, 2021

"Patients coming to us are way sicker than they were before. We aren't getting the 35 year-old-male coming in for their yearly physical – we're getting new patient requests for people with multiple serious co-morbidities. Patient volume has generally increased, and we really feel this in the midst of workforce shortages." ***- Interviewee***

Instructions

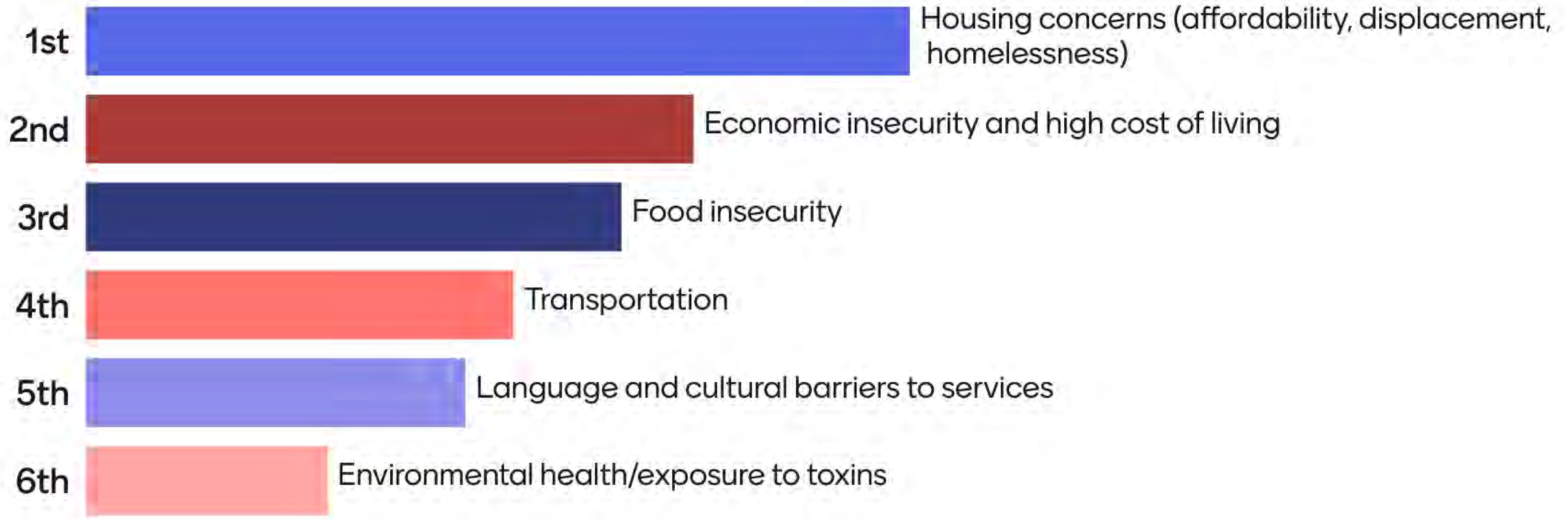
Mentimeter

Breakout Sessions

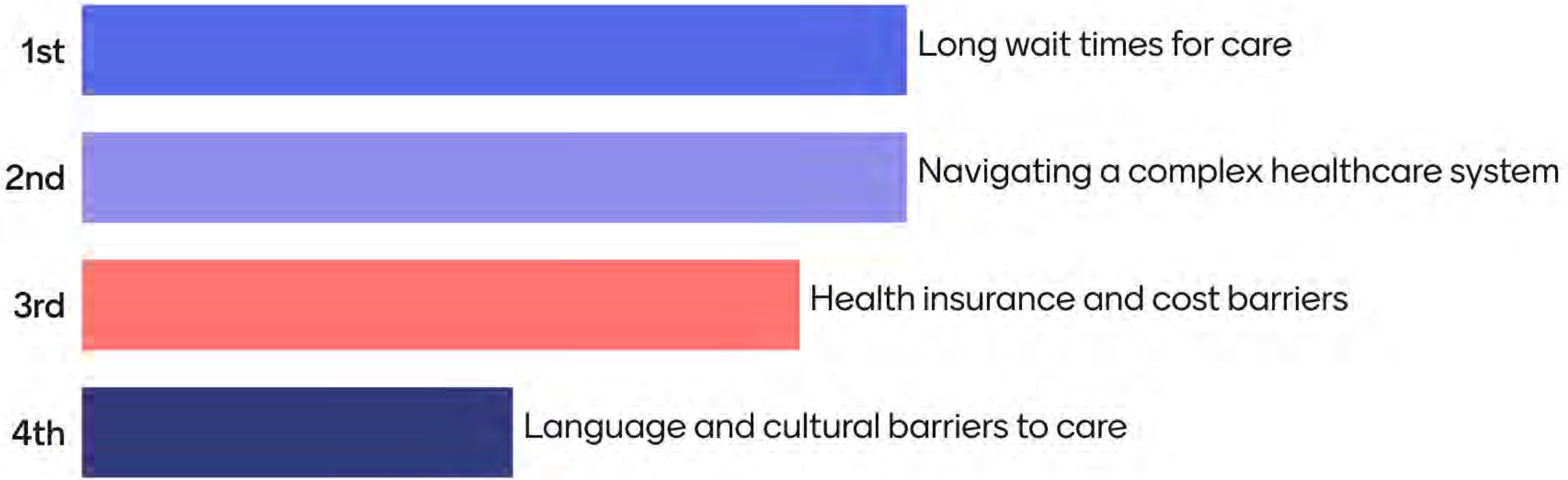
Beth Israel Lahey Health

2

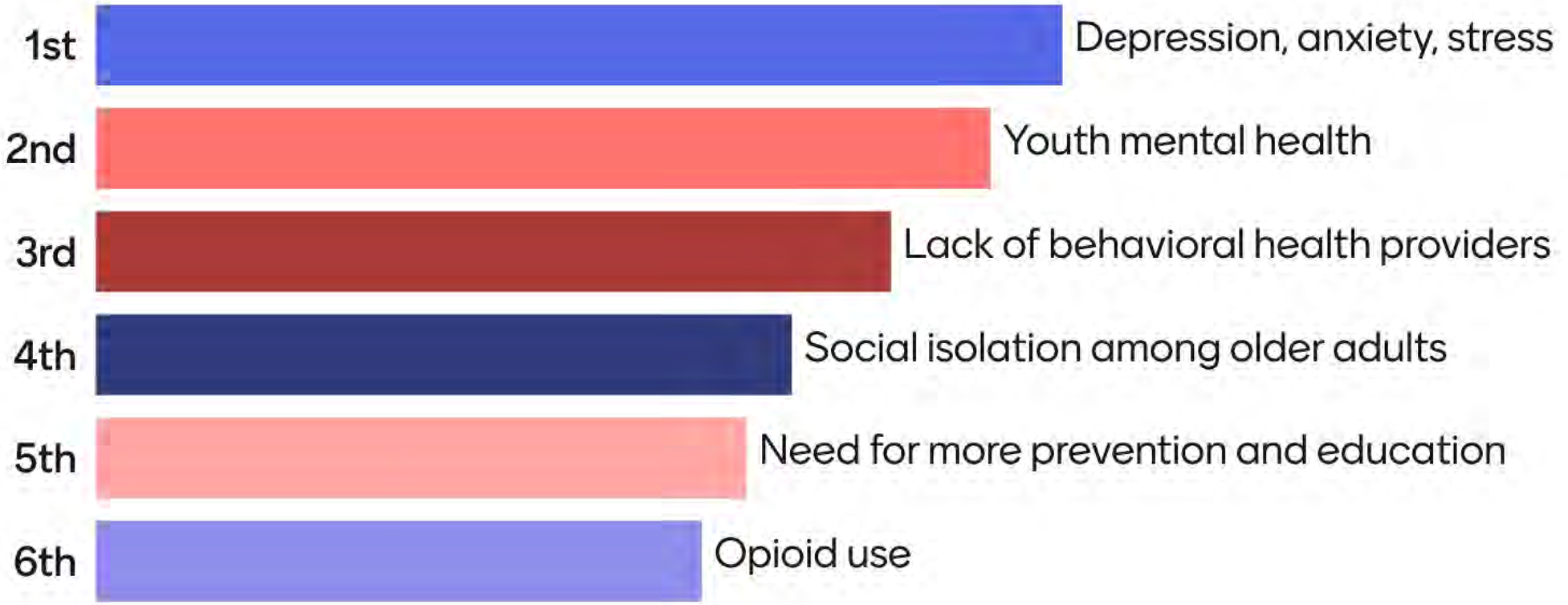
Social Determinants: Rank the following in order of what you feel should be the highest priority, based on needs in your community



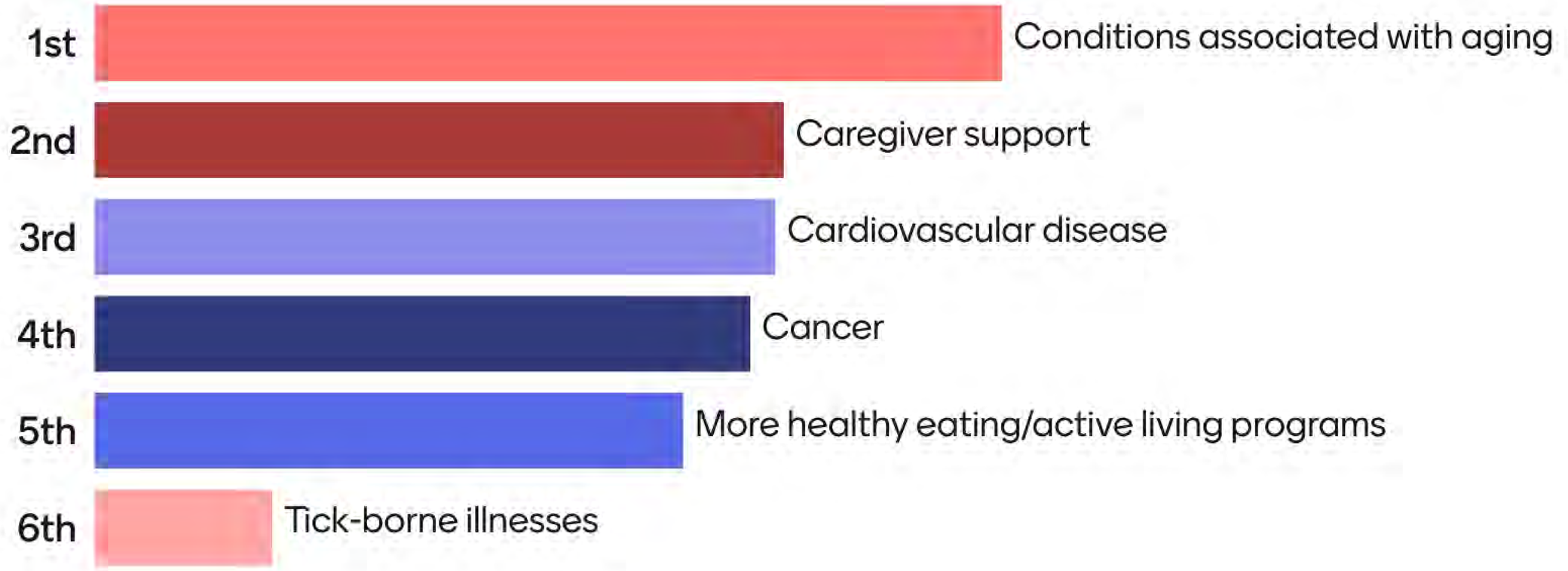
Access to Care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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



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



Mentimeter

Reconvene

Next Steps

Karen Peterson

Manager, Community Benefits & Community Relations || BID Plymouth

kpeterson@bilh.org

Community Health & Community Benefits Information:

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

Community Benefits Annual Meeting in September (More info TBD)

Appendix B:
Data Book

Secondary Data

Demographics

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Demographics							
Population							US Census Bureau, American Community Survey 2019-2023
Total population	6992395	531889	11645	16110	13782	62656	
Male	48.9%	48.9%	47.8%	49.3%	51.1%	48.7%	
Female	51.1%	51.1%	52.2%	50.7%	48.9%	51.3%	
Age Distribution							US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.1%	3.6%	4.6%	5.3%	4.3%	
5 to 9 years	5.2%	5.7%	6.1%	6.1%	6.7%	5.0%	
10 to 14 years	5.7%	6.0%	5.5%	7.4%	5.5%	4.4%	
15 to 19 years	6.5%	6.4%	5.0%	6.7%	6.7%	5.0%	
20 to 24 years	6.8%	6.0%	6.2%	5.3%	2.5%	5.1%	
25 to 34 years	14.1%	11.1%	10.5%	6.2%	9.8%	11.9%	
35 to 44 years	12.9%	12.0%	11.4%	8.9%	13.2%	11.9%	
45 to 54 years	12.6%	13.3%	14.5%	16.4%	14.3%	12.0%	
55 to 59 years	7.0%	7.5%	6.8%	9.0%	5.4%	8.0%	
60 to 64 years	6.8%	7.6%	8.6%	6.2%	8.5%	8.3%	
65 to 74 years	10.3%	11.5%	13.9%	13.8%	11.8%	14.4%	
75 to 84 years	4.9%	5.6%	6.5%	6.9%	7.5%	7.3%	
85 years and over	2.2%	2.1%	1.6%	2.5%	2.7%	2.4%	
Under 18 years of age	19.6%	20.9%	17.3%	22.7%	22.1%	16.9%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Over 65 years of age	17.5%	19.2%	22.0%	23.3%	22.0%	24.1%	
Race/Ethnicity							US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.70%	78.0%	87.8%	93.7%	96.9%	89.1%	
Black or African American alone (%)	7.0%	8.8%	2.7%	0.7%	0.7%	1.2%	
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.0%	0.1%	0.0%	0.2%	
Asian alone (%)	7.1%	1.7%	0.7%	0.9%	0.4%	1.1%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	
Some Other Race alone (%)	5.4%	3.9%	1.6%	0.9%	0.3%	2.8%	
Two or More Races (%)	9.5%	7.5%	7.2%	3.8%	1.7%	5.5%	
Hispanic or Latino of Any Race (%)	12.9%	4.7%	2.6%	1.9%	1.8%	3.6%	
Foreign-born							US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	57,268	434	592	393	4,003	
Naturalized U.S. citizen	54.5%	62.5%	68.9%	58.1%	86.8%	49.5%	
Not a U.S. citizen	45.5%	37.5%	31.1%	41.9%	13.2%	50.5%	
Region of birth: Europe	18.1%	14.5%	37.3%	52.7%	43.3%	22.6%	
Region of birth: Asia	30.5%	11.4%	16.8%	15.9%	15.5%	12.5%	
Region of birth: Africa	9.5%	27.9%	0.5%	0.0%	8.4%	6.6%	
Region of birth: Oceania	0.3%	0.2%	0.0%	1.7%	0.0%	1.2%	
Region of birth: Latin America	39.4%	43.9%	38.5%	21.5%	28.0%	52.6%	
Region of birth: Northern America	2.2%	2.2%	6.9%	8.3%	4.8%	4.4%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Language							US Census Bureau, American Community Survey 2019-2023
English only	75.2%	85.7%	96.2%	95.9%	94.8%	92.5%	
Language other than English	24.8%	14.3%	3.8%	4.1%	5.2%	7.5%	
Speak English less than "very well"	9.7%	5.8%	1.4%	1.1%	0.6%	3.5%	
Spanish	9.6%	3.0%	1.6%	1.9%	1.3%	1.9%	
Speak English less than "very well"	4.1%	1.1%	0.8%	0.9%	0.0%	0.6%	
Other Indo-European languages	9.2%	9.8%	1.9%	2.1%	3.5%	4.4%	
Speak English less than "very well"	3.2%	4.2%	0.5%	0.1%	0.6%	2.3%	
Asian and Pacific Islander languages	4.4%	0.9%	0.2%	0.2%	0.1%	1.0%	
Speak English less than "very well"	1.9%	0.4%	0.1%	0.2%	0.0%	0.4%	
Other languages	1.6%	0.6%	0.1%	0.0%	0.4%	0.3%	
Speak English less than "very well"	0.4%	0.1%	0.0%	0.0%	0.0%	0.1%	
Employment							US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	5.1%	2.9%	3.3%	2.2%	6.0%	
Unemployment rate by race/ethnicity							
White alone	4.5%	4.5%	2.0%	3.2%	2.2%	6.0%	
Black or African American alone	7.9%	8.6%	0.0%	0.0%	6.3%	5.3%	
American Indian and Alaska Native alone	6.9%	4.5%	-	-	-	0.0%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Asian alone	4.0%	2.0%	0.0%	0.0%	0.0%	0.0%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	-	-	-	-	
Some other race alone	8.0%	7.1%	0.0%	0.0%	0.0%	12.4%	
Two or more races	7.9%	7.8%	15.0%	8.0%	0.0%	3.2%	
Hispanic or Latino origin (of any race)	8.1%	8.0%	0.0%	15.5%	0.0%	0.9%	
Unemployment rate by educational attainment							
Less than high school graduate	9.1%	8.4%	0.0%	0.0%	0.0%	10.2%	
High school graduate (includes equivalency)	6.4%	6.4%	0.5%	7.5%	2.1%	6.0%	
Some college or associate's degree	5.2%	4.9%	1.0%	3.1%	4.6%	6.5%	
Bachelor's degree or higher	2.7%	2.2%	0.8%	2.6%	2.2%	4.0%	
Income and Poverty							US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	109,698	78,955	171,471	115,863	111,975	
Population living below the federal poverty line in the last 12 months							
Individuals	10.0%	7.1%	6.6%	5.1%	2.9%	6.1%	
Families	6.6%	4.2%	3.3%	4.9%	4.6%	1.0%	
Individuals under 18 years of age	11.8%	8.1%	8.9%	3.8%	0.5%	6.4%	
Individuals over 65 years of age	10.2%	8.5%	4.1%	8.5%	7.6%	5.7%	
Female head of household, no spouse	19.1%	14.1%	7.1%	22.0%	2.7%	14.6%	
White alone	7.6%	5.6%	5.9%	4.8%	2.7%	5.6%	
Black or African American alone	17.1%	15.3%	0.0%	46.9%	7.1%	23.5%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
American Indian and Alaska Native alone	19.1%	6.2%	-	0.0%	0.0%	0.0%	
Asian alone	11.0%	5.3%	0.0%	26.4%	0.0%	1.8%	
Native Hawaiian and Other Pacific Islander alone	21.7%	64.4%	-	-	-	100.0%	
Some other race alone	20.1%	12.1%	70.3%	2.1%	57.1%	15.3%	
Two or more races	15.7%	10.5%	3.9%	0.0%	0.0%	6.8%	
Hispanic or Latino origin (of any race)	20.6%	14.8%	0.0%	1.0%	2.8%	8.5%	
Less than high school graduate	24.4%	19.8%	6.6%	5.1%	44.1%	23.7%	
High school graduate (includes equivalency)	12.7%	9.7%	10.2%	14.3%	2.8%	8.1%	
Some college, associate's degree	9.2%	6.5%	5.2%	7.2%	1.1%	5.9%	
Bachelor's degree or higher	4.0%	3.1%	1.3%	3.0%	4.8%	3.2%	
With Social Security	29.8%	34.3%	40.2%	40.3%	40.0%	38.0%	
With retirement income	22.9%	27.4%	34.7%	31.5%	34.1%	31.8%	
With Supplemental Security Income	5.6%	4.9%	6.8%	4.4%	1.5%	2.7%	
With cash public assistance income	3.5%	3.4%	3.2%	1.2%	3.9%	2.6%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	12.1%	9.2%	3.8%	4.0%	6.9%	
Housing							US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	92.8%	93.7%	94.3%	98.0%	90.3%	
Owner-occupied	62.6%	77.6%	88.7%	90.0%	83.7%	79.8%	
Renter-occupied	37.4%	22.4%	11.3%	10.0%	16.3%	20.2%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Lacking complete plumbing facilities	0.3%	0.4%	0.3%	0.2%	0.0%	1.0%	
Lacking complete kitchen facilities	0.8%	0.5%	0.3%	0.7%	0.9%	0.6%	
No telephone service available	0.8%	0.5%	0.7%	0.3%	0.0%	0.4%	
Monthly housing costs <35% of total household income							
Among owner-occupied units with a mortgage	22.7%	24.6%	32.2%	20.0%	31.0%	26.9%	
Among owner-occupied units without a mortgage	15.4%	16.6%	23.5%	22.8%	28.7%	18.3%	
Among occupied units paying rent	41.3%	46.5%	53.9%	51.8%	30.7%	46.8%	
Access to Technology							US Census Bureau, American Community Survey 2019-2023
Among households							
Has smartphone	89.2%	89.2%	85.4%	92.3%	91.1%	91.0%	
Has desktop or laptop	83.2%	83.9%	87.1%	91.5%	82.6%	87.9%	
With a computer	95.1%	95.6%	96.0%	97.9%	95.8%	97.0%	
With a broadband Internet subscription	91.8%	92.0%	92.6%	97.6%	86.1%	94.3%	
Transportation							US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	71.8%	80.5%	69.9%	69.1%	68.4%	
Car, truck, or van -- carpooled	6.9%	7.0%	5.9%	3.5%	9.2%	9.0%	
Public transportation (excluding taxicab)	7.0%	3.3%	1.5%	4.9%	2.3%	1.3%	
Walked	4.2%	1.6%	0.2%	0.6%	0.2%	2.0%	

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Other means	2.5%	1.6%	0.0%	0.9%	0.6%	2.7%	
Worked from home	16.7%	14.7%	12.0%	20.2%	18.5%	16.5%	
Mean travel time to work (minutes)	29.3	32.9	33.1	34.2	36.3	30.4	
Vehicles available among occupied housing units							
No vehicles available	11.8%	6.2%	3.0%	4.0%	6.4%	5.2%	
1 vehicle available	35.8%	29.6%	31.8%	17.6%	28.4%	30.0%	
2 vehicles available	35.8%	41.4%	35.4%	48.1%	41.7%	47.1%	
3 or more vehicles available	16.6%	22.9%	29.8%	30.3%	23.5%	17.8%	
Education							US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older							
Less than 9th grade	4.2%	3.1%	0.9%	0.2%	0.4%	1.2%	
9th to 12th grade, no diploma	4.4%	3.6%	4.2%	3.6%	0.9%	2.9%	
High school graduate (includes equivalency)	22.8%	26.5%	38.2%	9.5%	20.2%	24.1%	
Some college, no degree	14.4%	16.6%	17.3%	9.3%	20.6%	16.9%	
Associate's degree	7.5%	9.0%	12.1%	4.0%	9.2%	9.9%	
Bachelor's degree	25.3%	25.6%	15.1%	39.4%	32.3%	27.9%	
Graduate or professional degree	21.4%	15.6%	12.1%	34.1%	16.4%	17.1%	
High school graduate or higher	91.4%	93.2%	94.9%	96.3%	98.7%	95.9%	
Bachelor's degree or higher	46.6%	41.2%	27.2%	73.5%	48.7%	45.0%	
Educational attainment by race/ethnicity							
White alone	(X)	(X)	(X)	(X)	(X)	(X)	

Key

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Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
High school graduate or higher	94.6%	95.8%	94.5%	96.5%	99.1%	96.5%	
Bachelor's degree or higher	49.4%	44.5%	26.7%	74.3%	49.3%	46.3%	
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	87.1%	84.4%	100.0%	97.5%	85.2%	79.9%	
Bachelor's degree or higher	30.7%	23.5%	45.3%	95.0%	22.2%	18.4%	
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	75.2%	84.0%	-	100.0%	100.0%	76.1%	
Bachelor's degree or higher	24.4%	28.0%	-	100.0%	0.0%	38.1%	
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	86.7%	100.0%	84.0%	69.0%	80.3%	
Bachelor's degree or higher	64.0%	55.1%	30.6%	75.0%	47.6%	40.6%	
Native Hawaiian and Other Pacific Islander alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	86.6%	63.0%	-	-	-	100.0%	
Bachelor's degree or higher	40.0%	3.5%	-	-	-	0.0%	
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	71.6%	74.1%	85.9%	97.5%	59.5%	87.8%	
Bachelor's degree or higher	20.0%	19.6%	9.1%	34.4%	16.7%	18.0%	
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	80.6%	82.5%	100.0%	91.7%	100.0%	96.4%	
Bachelor's degree or higher	33.6%	28.4%	29.8%	56.1%	28.2%	40.9%	
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	
High school graduate or higher	73.4%	82.7%	93.8%	98.3%	100.0%	89.9%	
Bachelor's degree or higher	23.3%	28.2%	17.2%	70.7%	9.6%	39.8%	

Key

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Significantly high compared to Massachusetts overall based on margin of error

			Area of Interest				
	Massachusetts	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
Health insurance coverage among civilian noninstitutionalized population (%)							US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	97.5%	97.9%	97.5%	97.9%	97.5%	
With private health insurance	73.8%	75.5%	81.7%	88.3%	85.6%	77.7%	
With public coverage	37.1%	37.7%	39.3%	28.7%	28.9%	40.1%	
No health insurance coverage	2.6%	2.5%	2.1%	2.5%	2.1%	2.5%	
Disability							US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	11.7%	14.6%	7.8%	13.0%	12.3%	
Under 18 with a disability	4.9%	4.3%	8.8%	2.2%	7.1%	2.7%	
18-64	9.4%	9.3%	10.6%	3.4%	6.6%	10.2%	
65+	30.2%	27.6%	30.2%	23.8%	36.0%	24.4%	

Health Status

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
Access to Care							
Ratio of population to primary care physicians	103.5	63.2	63.2	63.2	63.2	63.2	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	161.3	162.4	161.5	161.9	161.3	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	36.2	0.0	12.4	7.3	68.6	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health							
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	13.8	Data unavailable	no data	9.9	11.5	13.4	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	992.5					CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	360.3					Massachusetts Death Report, 2021
Risk Factors							
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	2.7	0.0	0.0	0.0	0.0	USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	8.5	10.4	1.9	8.4	7.7	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	41.7	40.0	88.8	74.5	47.4	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	no data	25.4	27.6	28.7	BRFSS, 2022

			Areas of Interest				
	MA	**Plymouth County**	**Carver**	**Duxbury**	**Kingston**	**Plymouth**	**Source**
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	no data	20.4	22.8	24.9	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	no data	28.6	29.2	29.9	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	no data	14.4	17	18.5	BRFSS, 2022
Chronic Conditions							
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	no data	11.1	11.2	11.7	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	no data	5.7	6.7	7.3	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	no data	3.8	5	5.7	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	no data	4.5	5.3	5.5	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	no data	1.9	2.4	2.6	BRFSS, 2022
Cancer							
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	no data	85.7	86.1	81.2	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	no data	71.2	68	64.6	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)							
All sites	449.4	484.7	487.1	484.1	485.4	484.3	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	67.0	67.9	67.0	68.1	66.9	State Cancer Profiles, 2016-2020

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
Prostate Cancer	113.2	116.4	112.9	111.8	119.3	117.3	State Cancer Profiles, 2016-2020
Prevention and Screening							
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	no data	77.6	77.1	77.6	Behavioral Risk Factor Surveillance System, 2022
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	no data	89.6	87.4	85.6	Behavioral Risk Factor Surveillance System, 2021
Communicable and Infectious Disease							
STI infection cases (per 100,000)							
Chlamydia	385.8	807.8	358.2	358.2	358.2	358.2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	9.6	9.6	9.6	9.6	9.6	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	93.2	93.3	93.3	93.3	93.3	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	250.6	250.6	250.6	250.6	250.6	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	1.3	1.3	1.3	1.3	1.3	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022
COVID-19							

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
Percent of Adults Fully Vaccinated	78.1	80.9	79.4	79.4	79.4	79.4	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	4.9	4.9	4.9	4.9	4.9	
Vaccine Coverage Index	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use							
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	no data	9.3	11.4	12.5	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	Data unavailable	no data	21.7	22.5	21.1	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	41.7	41.7	41.6	41.6	41.6	CDC- National Vital Statistics System, 2016-2020
Male Drug Overdose Mortality Rate (per 100,000)	48.3	62.3					
Female Drug Overdose Mortality Rate (per 100,000)	17.6	21.4					
Substance-related deaths (Age-adjusted rate per 100k)							
Any substance	61.9	63.2	94.8	*	*	66.7	
Opioid-related deaths	33.7	38.1	66.6	*	*	39.8	
Alcohol-related deaths	29.1	29.0	37.0	*	0.0	32.6	
Stimulant-related deaths	23.0	25.2	44.3	*	*	35.1	
Substance-related ER visits (age-adjusted rate per 100K)							
Any substance-related ER visits	1605.7	1568.6	1197.9	708.8	1169.1	17728.0	
Opioid-related ER visits	169.3	150.3	91.0	*	102.1	160.2	
Opioid-related EMS Incidents	248.8	208.7	77.3	62.2	124.0	225.5	
Alcohol-related ER visits	1235.6	1212.8	973.9	523.9	911.4	1373.1	
Stimulant-related ER visits	15.7	15.3	*	0.0	0.0	12.7	
Substance Addiction Services							

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
Individuals admitted to BSAS services (crude rate per 100k)	588.4	612.8	583.9	236.2	561.7	743.3	
Number of BSAS providers		90.0	0.0	0.0	0.0	21.0	
Number of clients of BSAS services (residents)		2054.0	47.0	25.0	51.0	303.0	
Avg. distance to BSAS provider (miles)	17.0	24.0	19.0	31.0	27.0	24.0	
Buprenorphine RX's filled	9982.0	11921.2	15775.0	633.0	9483.5	13775.6	
Individuals who received buprenorphine RX's		964.4	1399.7	58.0	766.0	1275.8	
Naloxone kits received		22315.0	81.0	53.0	50.0	6021.0	
Naloxone kids: Opioid deaths Ratio		117.0	9.0	*	*	269.0	
Fentanyl test strips received		25900.0	500.0	600.0	1400.0	8500.0	
Environmental Health							
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6	18.9	0.0	0.0	0.0	0.0	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		67.0	84.0	77.0	68.0	MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP), 2021Percentage of children age 9-47

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
							months screened for lead in 2021
Prevalence of Blood Lead Levels (per 1,000)	13.6		5.3	1.1	4.2	3.8	UMass Donahue Institute (UMDI), 2017 population estimates, 2021 5-year annual average rate (2017-2021) for children age 9-47 months with an estimated confirmed blood lead level ≥ 5 µg/dL
% of houses built before 1978	67.0		48.0	57.0	46.0	49.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6		34.6	13.8	27.9	24.2	Massachusetts Center for Health Information and Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9		5.5	8.1	7.5	9.5	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	8.9	0.0	0.0	NS	NS	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3	0.2					EPA - National Air Toxics Assessment, 2018
Mental Health							
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	62.0	62.0	62.0	62.0	62.0	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	no data	23.6	23.7	24.4	Behavioral Risk Factor Surveillance System, 2022

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	no data	29.2	30.1	31.4	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	no data	20.2	22	24.2	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	no data	15.9	17	17.6	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	0.1	0.1	0.0	0.0	0.1	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	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.2	7.2	7.2	7.2	County Health Rankings, 2016-2022
Safety/Crime							
Property Crimes Offenses (#)							Massachusetts Crime Statistics, 2023
Burglary	10028.0		3.0	2.0	5.0	63.0	
Larceny-theft	60647.0		37.0	31.0	43.0	472.0	
Motor vehicle theft	7224.0		4.0	1.0	1.0	29.0	
Arson	377.0		3.0	0.0	2.0	2.0	
Crimes Against Persons Offenses (#)							
Murder/non-negligent manslaughter	162.0		0.0	0.0	1.0	0.0	
Sex offenses	4365.0		5.0	5.0	9.0	59.0	
Assaults	72086.0		65.0	47.0	51.0	614.0	

			Areas of Interest				
	MA	Plymouth County	Carver	Duxbury	Kingston	Plymouth	Source
Human trafficking	0.0		0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)							
Race/Ethnicity/Ancestry Bias	222.0					2.0	
Religious Bias	88.0					0.0	
Sexual Orientation Bias	80.0					1.0	
Gender Identity Bias	22.0					1.0	
Gender Bias	2.0					0.0	
Disability Bias	0.0					0.0	

Community Health Equity Survey (CHES) – Youth

CHES – Youth

Data Notes:

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

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

			MASSACHUSETTS		Plymouth County		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	1908	1.30%	*	*	*	*
		Worried about losing	1908	2.60%	*	*	*	*
Housing	Current living situation	Steady place	1908	95.10%	181	97.80%	109	98.20%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	175	14.30%	107	16.80%
		Never	1963	87.80%	187	93.00%	111	94.60%
		Sometimes	1963	9.90%	187	6.40%	111	5.40%
Basic Needs	Food insecurity, past month	A lot	1963	2.30%	*	*	*	*
		No internet	1938	1.30%	*	*	*	*
		Does not work well	1938	6.60%	184	3.80%	109	4.60%
Basic Needs	Current internet access	Works well	1938	92.20%	184	95.10%	109	93.60%
		Somewhat or strongly disagree	1864	2.50%	*	*	*	*
		Somewhat agree	1864	14.60%	178	9.60%	108	11.10%
Neighborhood	Able to get where you need to go	Strongly agree	1864	82.80%	178	90.40%	108	88.90%
		Never	1833	65.00%	176	81.30%	108	81.50%
		Rarely	1833	22.80%	176	15.30%	108	17.60%
		Somewhat often	1833	8.50%	176	2.80%	*	*
Neighborhood	Experienced neighborhood violence, lifetime	Very often	1833	3.70%	*	*	*	*
		No	1739	3.90%	170	2.90%	*	*
		Yes, adult in home	1739	80.50%	170	84.70%	104	83.70%
		Yes, adult outside home	1739	37.30%	170	40.00%	104	50.00%
Safety & Support	Have someone to talk to if needed help	Yes, friend or non-adult family	1739	43.00%	170	47.60%	104	58.70%
	Feel safe with my family/caregivers	Not at all	1768	1.00%	*	*	*	*

			MASSACHUSETTS		Plymouth County		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support		Somewhat	1768	7.70%	175	6.90%	108	6.50%
		Very much	1768	91.30%	175	93.10%	108	93.50%
Safety & Support	Feel I belong at school	Not at all	1760	5.90%	*	*	*	*
		Somewhat	1760	29.10%	175	19.40%	108	17.60%
		Very much	1760	65.00%	175	79.40%	108	81.50%
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	*	*	*	*
		Somewhat	1745	17.10%	172	11.00%	106	12.30%
		Very much	1745	80.50%	172	87.80%	106	86.80%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	171	65.50%	105	66.70%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	171	5.30%	105	6.70%
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	171	24.00%	105	26.70%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	171	12.30%	105	11.40%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	171	5.30%	105	4.80%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	171	11.70%	105	13.30%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	171	70.20%	105	73.30%
Safety & Support	Experienced intimate partner violencea	Ever	1589	13.10%	157	8.90%	99	8.10%
		In past year	1567	7.80%	155	4.50%	98	5.10%
Safety & Support	Experienced household violenceb	Ever	1536	14.20%	153	15.00%	97	15.50%
		In past year	1519	5.50%	*	*	*	*
Safety & Support	Experienced sexual violencec	Ever	1558	9.20%	156	7.10%	99	8.10%
		In past year	1551	3.10%	*	*	*	*
Safety & Support	Experienced discrimination	Ever	1674	45.20%	164	27.40%	106	27.40%
		In past year	1674	19.60%	164	13.40%	106	14.20%
Employment	Worked for pay, past year	No	1652	51.50%	161	44.10%	106	42.50%
		Yes, <10 hours per week	1652	18.10%	161	21.70%	106	21.70%

			MASSACHUSETTS		Plymouth County		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		Yes, 11-19 hours per week	1652	13.30%	161	16.80%	106	13.20%
		Yes, 20-34 hours per week	1652	10.30%	161	13.00%	106	17.00%
		Yes, >35 hours per week	1652	6.80%	161	4.30%	106	5.70%
		None of these	1484	66.80%	150	68.70%	101	66.30%
		Frequent absences	1484	7.60%	150	7.30%	101	8.90%
		Needed more support in school	1484	7.00%	150	5.30%	101	5.90%
		Needed more support outside school	1484	6.30%	150	7.30%	101	7.90%
		Safety concerns	1484	5.10%	150	4.70%	*	*
Education	Educational challenges, past year	Temperature in classroom	1484	18.50%	150	15.30%	101	12.90%
		Never	1503	87.70%	152	92.10%	103	93.20%
		Once or twice	1503	9.10%	152	7.20%	103	6.80%
		Monthly	1503	1.60%	*	*	*	*
Education	Hurt or harrassed by school staff, past year	Daily	1503	1.60%	*	*	*	*
		College-preparation	1459	57.90%	149	70.50%	103	75.70%
		Extracurricular activities	1459	74.40%	149	91.30%	103	90.30%
		Guidance conselour	1459	58.80%	149	67.80%	103	68.00%
Education	Helpful school resources provided	Programs to reduce bullying, violence, etc.	1459	19.10%	149	18.10%	103	13.60%
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	*	*	*	*
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	*	*	*	*

			MASSACHUSETTS		Plymouth County		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
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%	105	7.60%	*	*
Mental Health	Psychological distress, past month	Low	1376	22.10%	143	22.40%	98	18.40%
		Medium	1376	33.00%	143	36.40%	98	36.70%
		High	1376	18.40%	143	16.80%	98	18.40%
		Very high	1376	26.60%	143	24.50%	98	26.50%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	151	12.60%	104	12.50%
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%	138	8.00%	94	8.50%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	147	4.80%	102	5.90%
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	147	6.80%	101	6.90%
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	*	*	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	*	*	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	148	6.10%	102	6.90%
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%	*	*	*	*

			MASSACHUSETTS		Plymouth County		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	142	7.70%	96	6.30%
		Not sure	1445	5.70%	142	4.90%	96	5.20%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%	82	30.50%	53	22.60%
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%	*	*	*	*
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%	82	24.40%	53	26.40%
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%	82	34.10%	53	30.20%
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%	82	45.10%	53	45.30%
Emerging Issues	Unable to work due to weather, past 5 years1	Yes	767	7.60%	*	*	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years1	Yes	767	33.30%	82	35.40%	53	24.50%
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%	82	63.40%	53	58.50%

Community Health Equity Survey (CHES) – Adult

			MASSACHUSETTS		PLYMOUTH		Duxbury		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	*	*	*	*	*	*
		Worried about losing	14888	8.00%	766	8.10%	*	*	*	*
Housing	Current living situation	Steady place	14888	89.30%	766	91.10%	32	90.60%	106	96.20%
Housing	Issues in current housing2	Yes, at least one	11103	37.00%	571	35.90%	*	*	77	27.30%
Basic Needs	Trouble paying for childcare/school1	Yes	7486	4.60%	385	3.90%	*	*	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food)1	Yes	7486	18.80%	385	15.30%	*	*	56	16.10%
Basic Needs	Trouble paying for health care1	Yes	7486	15.00%	385	14.00%	*	*	56	12.50%
Basic Needs	Trouble paying for housing1	Yes	7486	19.40%	385	16.60%	*	*	56	17.90%
Basic Needs	Trouble paying for technology1	Yes	7486	8.40%	385	8.10%	*	*	56	10.70%
Basic Needs	Trouble paying for transportation1	Yes	7486	12.60%	385	7.50%	*	*	56	12.50%
Basic Needs	Trouble paying for utilities1	Yes	7486	17.20%	385	17.70%	*	*	56	17.90%
Basic Needs	Trouble paying for ANY basic needs1	Yes	7486	35.20%	385	29.60%	*	*	56	28.60%
Basic Needs	Applied for/received economic assisstance	Yes	14928	20.30%	771	15.20%	32	15.60%	108	13.00%
		Not enough money	13814	16.50%	675	15.40%	*	*	101	9.90%
		Just enough money	13814	31.10%	675	32.60%	*	*	101	32.70%
Basic Needs	End of month finances	Money left over	13814	52.40%	675	52.00%	*	*	101	57.40%
		No internet	11425	3.00%	585	2.40%	*	*	*	*
		Does not work well	11425	9.30%	585	9.20%	*	*	*	*
Basic Needs	Current internet access2	Works well	11425	87.70%	585	88.40%	*	*	79	94.90%
		Somewhat or strongly disagree	11064	7.00%	558	7.30%	*	*	*	*
	Able to get where you need to	Somewhat agree	11064	22.00%	558	22.00%	*	*	74	17.60%
Neighborhood	go2	Strongly agree	11064	71.00%	558	70.60%	*	*	74	78.40%
		Never	11008	58.60%	564	67.60%	*	*	75	69.30%
	Experienced neighborhood	Rarely	11008	28.90%	564	24.50%	*	*	75	20.00%
Neighborhood	violence, lifetime2	Somewhat often	11008	9.10%	564	6.60%	*	*	75	9.30%

			MASSACHUSETTS		PLYMOUTH		Duxbury		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		Very often	11008	3.40%	564	1.40%	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	735	79.70%	*	*	102	91.20%
		Not sure	14393	6.50%	735	7.20%	*	*	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	735	72.90%	*	*	102	86.30%
		Not sure	14366	10.20%	735	10.70%	*	*	*	*
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	730	64.40%	*	*	101	75.20%
		Not sure	14325	12.90%	730	13.70%	*	*	101	13.90%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	735	76.70%	*	*	102	87.30%
		Not sure	14336	7.00%	735	9.00%	*	*	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	728	59.30%	*	*	101	67.30%
		Not sure	14247	16.30%	728	18.40%	*	*	101	15.80%
Safety & Support	Experienced intimate partner violencea	Ever	13621	29.70%	684	30.80%	*	*	98	31.60%
		In past year	13359	4.50%	668	4.00%	*	*	*	*
Safety & Support	Experienced sexual violenceb	Ever	13628	21.00%	686	22.30%	*	*	95	25.30%
		In past year	13593	1.40%	685	1.00%	*	*	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	724	46.80%	*	*	99	37.40%
		In past year	14130	18.00%	724	16.20%	*	*	99	16.20%
Employment	Have multiple jobs (among all workers)2	Yes	6896	20.90%	313	14.70%	*	*	47	19.10%
Employment	Location of work (among all workers)	At home only	9173	7.50%	446	8.30%	*	*	64	7.80%
		Outside home only	9173	54.60%	446	57.40%	*	*	64	51.60%
		Both at home/outside home	9173	37.40%	446	34.30%	*	*	64	40.60%
Employment	Paid sick leave at work (among all workers)2	Yes	6903	75.30%	320	78.40%	*	*	47	66.00%
		Not sure	6903	4.20%	320	3.40%	*	*	*	*
Healthcare Access	Reported chronic condition 1	Yes	6821	65.20%	348	63.20%	*	*	46	73.90%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care)2	Yes	3455	7.60%	150	7.30%	*	*	*	*

			MASSACHUSETTS		PLYMOUTH		Duxbury		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for injury care (among those who needed this care)2	Yes	1674	9.00%	79	8.90%	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	158	10.80%	*	*	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	84	23.80%	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)2	Yes	998	7.00%	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care)2	Yes	109	13.90%	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	37	18.90%	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)2	Yes	6941	15.20%	312	15.10%	*	*	49	16.30%
Healthcare Access	Telehealth visit, past year1	One or more visit	6747	51.20%	342	46.20%	*	*	48	52.10%
		Offered, didn't have	6747	7.00%	342	5.60%	*	*	*	*
		Not offered	6747	22.10%	342	27.80%	*	*	48	27.10%
		No healthcare visits	6747	20.30%	342	21.60%	*	*	48	16.70%
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	181	19.30%	*	*	*	*
		Not sure	4184	3.80%	*	*	*	*	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	649	42.80%	*	*	96	44.80%
		Medium	13267	32.00%	649	32.00%	*	*	96	29.20%

			MASSACHUSETTS		PLYMOUTH		Duxbury		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
		High	13267	13.90%	649	12.50%	*	*	96	13.50%
		Very high	13267	17.30%	649	12.60%	*	*	96	12.50%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	519	9.20%	*	*	69	13.00%
Mental Health	Suicide ideation, past yearc	Yes	13036	7.40%	640	4.20%	*	*	94	6.40%
Substance Use	Tobacco use, past month2	Yes	10305	14.10%	511	11.90%	*	*	78	11.50%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	668	50.90%	*	*	95	58.90%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	684	5.70%	*	*	98	8.20%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	684	6.90%	*	*	98	9.20%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	684	11.30%	*	*	98	13.30%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	684	13.30%	*	*	98	16.30%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	*	*	*	*	*	*
Substance Use	Fentanyl use, pasy year	Yes	13626	0.60%	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	684	0.70%	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	13626	0.60%	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	684	1.00%	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	684	1.20%	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	684	0.90%	*	*	*	*
Emerging Issues	COVID-19 vaccinatination, past year1	Yes	6729	67.80%	339	60.50%	*	*	47	59.60%
		Not sure	6729	3.60%	339	2.70%	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)2	Yes	6196	22.00%	304	26.00%	*	*	43	16.30%

			MASSACHUSETTS		PLYMOUTH		Duxbury		Plymouth	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years2	Yes	10422	37.40%	516	35.10%	*	*	78	38.50%
Emerging Issues	Flooding in home or on street, past 5 years2	Yes	10422	11.00%	516	9.90%	*	*	78	6.40%
Emerging Issues	More ticks or mosquitoes, past 5 years2	Yes	10422	32.20%	516	27.70%	*	*	78	29.50%
Emerging Issues	Power outages, past 5 years2	Yes	10422	24.50%	516	31.20%	*	*	78	30.80%
Emerging Issues	School cancellation due to weather, past 5 years2	Yes	10422	17.60%	516	15.30%	*	*	78	12.80%
Emerging Issues	Unable to work due to weather, past 5 years2	Yes	10422	14.80%	516	14.90%	*	*	78	16.70%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years2	Yes	10422	28.30%	516	22.50%	*	*	78	28.20%
Emerging Issues	Other climate impact, past 5 years2	Yes	10422	1.70%	516	2.10%	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years2	Yes	10422	67.20%	516	65.50%	*	*	78	65.40%

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

CHIA Ages 0-17

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
All Causes					
FY24 ED Volume (all cause) rate per 100,000	4923	3350	3092	3729	3891
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1262	1066	1306	1147
Allergy					
FY24 ED Volume rate per 100,000	293	60	112	160	146
FY24 Inpatient Discharges rate per 100,000	29	8	24	29	24
Asthma					
FY24 ED Volume rate per 100,000	347	137	199	277	254
FY24 Inpatient Discharges rate per 100,000	67	51	49	80	37
Attention Deficit Hyperactivity Disorder					
FY24 ED Volume rate per 100,000	77	34	68	21	47
FY24 Inpatient Discharges rate per 100,000	27	8	6	7	17
Complication of Medical Care					
FY24 ED Volume rate per 100,000	33	25	56	21	37
FY24 Inpatient Discharges rate per 100,000	49	51	37	36	38
Diabetes					
FY24 ED Volume rate per 100,000	21		18		14
FY24 Inpatient Discharges rate per 100,000	8				3
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	859	685	715	840
FY24 Inpatient Discharges rate per 100,000	131	120	143	72	73
Injuries					
FY24 ED Volume rate per 100,000	922	953	903	846	819
FY24 Inpatient Discharges rate per 100,000	49	8	24	29	34
Learning Disorders					

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 ED Volume rate per 100,000	22		6	21	17
FY24 Inpatient Discharges rate per 100,000	24	17	18	14	12
Mental Health					
FY24 ED Volume rate per 100,000	292	171	124	204	199
FY24 Inpatient Discharges rate per 100,000	75	42	49	29	53
Obesity					
FY24 ED Volume rate per 100,000	7			7	1
FY24 Inpatient Discharges rate per 100,000	12				3
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	150	34	49	102	128
FY24 Inpatient Discharges rate per 100,000	32	25	37	36	25
Poisonings					
FY24 ED Volume rate per 100,000	59	25	43	21	42
FY24 Inpatient Discharges rate per 100,000	6				9
STIs					
FY24 ED Volume rate per 100,000	4			7	4
FY24 Inpatient Discharges rate per 100,000	1				
Substance Use					
FY24 ED Volume rate per 100,000	48	8	12	29	38
FY24 Inpatient Discharges rate per 100,000	11	8		7	12
Age 0-17 Total	4923	3350	3092	3729	3891

CHIA Ages 18-44

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
All Causes					
FY24 ED Volume (all cause) rate per 100,000	11106	7911	3653	7159	8249
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	2379	1234	1977	1913
Allergy					
FY24 ED Volume rate per 100,000	952	377	199	415	343
FY24 Inpatient Discharges rate per 100,000	206	231	112	153	167
Asthma					
FY24 ED Volume rate per 100,000	552	420	143	386	410
FY24 Inpatient Discharges rate per 100,000	266	274	112	175	223
Breast Cancer					
FY24 ED Volume rate per 100,000	7		6		4
FY24 Inpatient Discharges rate per 100,000	9		6		11
CHF					
FY24 ED Volume rate per 100,000	14	8			6
FY24 Inpatient Discharges rate per 100,000	50	34	6	7	24
Complication of Medical Care					
FY24 ED Volume rate per 100,000	120	120	49	109	77
FY24 Inpatient Discharges rate per 100,000	645	738	448	569	606
COPD and Lung Disease					
FY24 ED Volume rate per 100,000	30	34	12	29	37
FY24 Inpatient Discharges rate per 100,000	40	51	31	21	29
Diabetes					
FY24 ED Volume rate per 100,000	309	223	74	116	137
FY24 Inpatient Discharges rate per 100,000	173	283	12	94	124
GYN Cancer					
FY24 ED Volume rate per 100,000	2				3
FY24 Inpatient Discharges rate per 100,000	4	8	12		11
Heart Disease					

		BID Plymouth Hospital Community Benefits Service Area			
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 ED Volume rate per 100,000	12	8	12	14	12
FY24 Inpatient Discharges rate per 100,000	56	25	6	7	32
Hepatitis					
FY24 ED Volume rate per 100,000	26				25
FY24 Inpatient Discharges rate per 100,000	70	51	24	36	82
HIV/AIDS					
FY24 ED Volume rate per 100,000	24	17			4
FY24 Inpatient Discharges rate per 100,000	14				4
Hypertension					
FY24 ED Volume rate per 100,000	447	223	87	284	283
FY24 Inpatient Discharges rate per 100,000	210	163	99	197	189
Infection					
FY24 ED Volume rate per 100,000	1595	1090	423	883	1092
FY24 Inpatient Discharges rate per 100,000	338	489	118	262	308
Injuries					
FY24 ED Volume rate per 100,000	1775	1357	623	1145	1343
FY24 Inpatient Discharges rate per 100,000	237	309	124	145	225
Liver Disease					
FY24 ED Volume rate per 100,000	99	51	18	43	82
FY24 Inpatient Discharges rate per 100,000	191	231	62	182	201
Mental Health					
FY24 ED Volume rate per 100,000	1310	601	405	605	561
FY24 Inpatient Discharges rate per 100,000	834	850	361	671	684
Obesity					
FY24 ED Volume rate per 100,000	135	51	43	80	60
FY24 Inpatient Discharges rate per 100,000	324	292	74	167	228
Other Cancer					
FY24 ED Volume rate per 100,000	12	8	12	7	22
FY24 Inpatient Discharges rate per 100,000	23	68		21	14
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	122	85	37	51	102

		BID Plymouth Hospital Community Benefits Service Area			
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 Inpatient Discharges rate per 100,000	85	111	24	43	92
Poisonings					
FY24 ED Volume rate per 100,000	182	154	43	197	178
FY24 Inpatient Discharges rate per 100,000	33	34		29	38
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		18	21	29
FY24 Inpatient Discharges rate per 100,000	37	17	37	65	27
Stroke and Other Neurovascular Dis.					
FY24 ED Volume rate per 100,000	8	17			12
FY24 Inpatient Discharges rate per 100,000	19	34			16
Substance Use					
FY24 ED Volume rate per 100,000	2079	1185	361	737	900
FY24 Inpatient Discharges rate per 100,000	588	463	168	335	545
Tuberculosis					
FY24 ED Volume rate per 100,000	2				
FY24 Inpatient Discharges rate per 100,000	8				1
Age 18–44 Total	11106	7911	3653	7159	8249

CHIA– Ages 45-64

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
All Causes					
FY24 ED Volume (all cause) rate per 100,000	6844	5437	2905	4867	6169
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	2869	1234	1861	2742
Allergy					
FY24 ED Volume rate per 100,000	797	128	199	189	270
FY24 Inpatient Discharges rate per 100,000	330	498	174	372	475
Asthma					
FY24 ED Volume rate per 100,000	299	146	31	131	184
FY24 Inpatient Discharges rate per 100,000	254	266	143	80	256
Breast Cancer					
FY24 ED Volume rate per 100,000	40	60	56	29	51
FY24 Inpatient Discharges rate per 100,000	57	42	24	131	64
CHF					
FY24 ED Volume rate per 100,000	78	8	31	29	35
FY24 Inpatient Discharges rate per 100,000	344	369	118	175	352
Complication of Medical Care					
FY24 ED Volume rate per 100,000	100	77	37	94	85
FY24 Inpatient Discharges rate per 100,000	428	532	274	357	507
COPD and Lung Disease					
FY24 ED Volume rate per 100,000	239	223	43	72	181
FY24 Inpatient Discharges rate per 100,000	415	463	87	291	528
Diabetes					
FY24 ED Volume rate per 100,000	759	377	118	313	433
FY24 Inpatient Discharges rate per 100,000	688	773	205	561	702
GYN Cancer					
FY24 ED Volume rate per 100,000	4	8			6

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 Inpatient Discharges rate per 100,000	16	8	18	7	19
Heart Disease					
FY24 ED Volume rate per 100,000	37	51	12	29	30
FY24 Inpatient Discharges rate per 100,000	280	446	149	284	348
Hepatitis					
FY24 ED Volume rate per 100,000	23	8			8
FY24 Inpatient Discharges rate per 100,000	83	103	24	51	115
HIV/AIDS					
FY24 ED Volume rate per 100,000	34			14	6
FY24 Inpatient Discharges rate per 100,000	34		24	7	21
Hypertension					
FY24 ED Volume rate per 100,000	1377	979	398	810	1124
FY24 Inpatient Discharges rate per 100,000	918	1194	423	904	1171
Infection					
FY24 ED Volume rate per 100,000	813	695	268	569	653
FY24 Inpatient Discharges rate per 100,000	627	970	305	459	817
Injuries					
FY24 ED Volume rate per 100,000	1351	1314	648	1102	1255
FY24 Inpatient Discharges rate per 100,000	534	644	305	394	722
Liver Disease					
FY24 ED Volume rate per 100,000	113	137	31	116	105
FY24 Inpatient Discharges rate per 100,000	383	489	137	299	561
Mental Health					
FY24 ED Volume rate per 100,000	703	231	211	291	337
FY24 Inpatient Discharges rate per 100,000	1042	996	455	802	1296
Obesity					
FY24 ED Volume rate per 100,000	138	94	43	87	71
FY24 Inpatient Discharges rate per 100,000	619	824	180	423	649
Other Cancer					

		BID Plymouth Hospital Community Benefits Service Area			
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 ED Volume rate per 100,000	30	25	37	51	30
FY24 Inpatient Discharges rate per 100,000	100	171	149	145	108
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	73	51	24	51	66
FY24 Inpatient Discharges rate per 100,000	228	292	87	124	300
Poisonings					
FY24 ED Volume rate per 100,000	82	103	43	51	73
FY24 Inpatient Discharges rate per 100,000	36	42	12	29	40
Prostate Cancer					
FY24 ED Volume rate per 100,000	12			21	3
FY24 Inpatient Discharges rate per 100,000	28	8	43	58	51
STIs					
FY24 ED Volume rate per 100,000	10				3
FY24 Inpatient Discharges rate per 100,000	6			7	6
Stroke and Other Neurovascular Diseases					
FY24 ED Volume rate per 100,000	24	25	6	14	27
FY24 Inpatient Discharges rate per 100,000	92	137	37	102	77
Substance Use					
FY24 ED Volume rate per 100,000	1492	627	174	284	592
FY24 Inpatient Discharges rate per 100,000	858	1013	230	576	1139
Tuberculosis					
FY24 ED Volume rate per 100,000	1				
FY24 Inpatient Discharges rate per 100,000	11	51			4
Age 45-64 Total	6844	5437	2905	4867	6169

CHIA– Ages 65+

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
All Causes					
FY24 ED Volume (all cause) rate per 100,000	5485	5463	4139	4678	6055
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	6391	4787	5429	6169
Allergy					
FY24 ED Volume rate per 100,000	798	274	187	189	350
FY24 Inpatient Discharges rate per 100,000	671	1168	735	1021	1184
Asthma					
FY24 ED Volume rate per 100,000	155	77	99	80	176
FY24 Inpatient Discharges rate per 100,000	314	395	268	291	332
Breast Cancer					
FY24 ED Volume rate per 100,000	69	60	93	80	85
FY24 Inpatient Discharges rate per 100,000	216	283	374	284	342
CHF					
FY24 ED Volume rate per 100,000	270	231	180	226	201
FY24 Inpatient Discharges rate per 100,000	1445	1786	1327	1802	1828
Complication of Medical Care					
FY24 ED Volume rate per 100,000	158	206	143	182	193
FY24 Inpatient Discharges rate per 100,000	809	1237	916	1175	1299
COPD and Lung Disease					
FY24 ED Volume rate per 100,000	350	481	187	364	347
FY24 Inpatient Discharges rate per 100,000	1111	2302	966	1576	1687
Diabetes					
FY24 ED Volume rate per 100,000	860	738	380	525	657
FY24 Inpatient Discharges rate per 100,000	1509	2173	1072	1678	1840
GYN Cancer					
FY24 ED Volume rate per 100,000	7		18	7	4

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 Inpatient Discharges rate per 100,000	27	17	18	36	55
Heart Disease					
FY24 ED Volume rate per 100,000	90	128	99	21	73
FY24 Inpatient Discharges rate per 100,000	1079	1812	1408	1715	1672
Hepatitis					
FY24 ED Volume rate per 100,000	7	8			3
FY24 Inpatient Discharges rate per 100,000	51	111	49	29	37
HIV/AIDS					
FY24 ED Volume rate per 100,000	7				3
FY24 Inpatient Discharges rate per 100,000	14				16
Hypertension					
FY24 ED Volume rate per 100,000	1774	1829	1464	1481	1846
FY24 Inpatient Discharges rate per 100,000	1758	2748	2032	2277	2631
Infection					
FY24 ED Volume rate per 100,000	718	798	517	642	739
FY24 Inpatient Discharges rate per 100,000	1455	2302	1670	2094	2208
Injuries					
FY24 ED Volume rate per 100,000	1257	1108	1072	1138	1385
FY24 Inpatient Discharges rate per 100,000	1365	1992	1739	1831	1966
Liver Disease					
FY24 ED Volume rate per 100,000	65	25	62	43	69
FY24 Inpatient Discharges rate per 100,000	421	730	436	554	678
Mental Health					
FY24 ED Volume rate per 100,000	347	85	162	131	204
FY24 Inpatient Discharges rate per 100,000	1456	2138	1514	2138	2201
Obesity					
FY24 ED Volume rate per 100,000	72	34	43	58	40
FY24 Inpatient Discharges rate per 100,000	764	1082	504	700	812
Other Cancer					

	BID Plymouth Hospital Community Benefits Service Area				
	MA	Carver	Duxbury	Kingston	Plymouth
FY24 ED Volume rate per 100,000	58	94	68	43	58
FY24 Inpatient Discharges rate per 100,000	285	515	392	459	514
Pneumonia/Influenza					
FY24 ED Volume rate per 100,000	79	77	68	58	105
FY24 Inpatient Discharges rate per 100,000	627	944	716	773	975
Poisonings					
FY24 ED Volume rate per 100,000	30	51	6	51	30
FY24 Inpatient Discharges rate per 100,000	44	103	49	109	79
Prostate Cancer					
FY24 ED Volume rate per 100,000	62	68	56	58	55
FY24 Inpatient Discharges rate per 100,000	221	352	243	240	371
STIs					
FY24 ED Volume rate per 100,000	1				
FY24 Inpatient Discharges rate per 100,000	7		6	7	9
Stroke and Other Neurovascular Diseases					
FY24 ED Volume rate per 100,000	63	34	43	65	68
FY24 Inpatient Discharges rate per 100,000	290	369	342	437	389
Substance Use					
FY24 ED Volume rate per 100,000	391	171	49	124	180
FY24 Inpatient Discharges rate per 100,000	552	1030	430	802	864
Tuberculosis					
FY24 ED Volume rate per 100,000	1				
FY24 Inpatient Discharges rate per 100,000	15	17		14	9
Age 65+ Total	5485	6391	4787	5429	6169

Community Health Survey

- FY25 BID Plymouth 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 - BID Plymouth

Response Counts

Completion Rate:	**91%**		
	Complete		513
	Partial		51

Totals: 564

1. Select a language.

Value	Percent	Responses
Take the survey in English	96.4%	536
参加简体中文调查	0.7%	4
Reponn sondaj la nan lang kreyòl ayisyen	0.9%	5
Participe da pesquisa em português	0.5%	3
Responda la encuesta en español	1.4%	8

Totals: 556

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	91.8%	516
I work in this community	36.3%	204
Other, please specify:	2.1%	12

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 %	186 33.5%	315 56.7%	28 5.0%	8 1.4%	19 3.4%	556
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 %	148 26.8%	327 59.1%	54 9.8%	12 2.2%	12 2.2%	553
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 %	141 25.5%	286 51.8%	32 5.8%	11 2.0%	82 14.9%	552
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 %	127 22.7%	296 53.0%	93 16.6%	18 3.2%	25 4.5%	559
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	122 21.8%	335 59.9%	73 13.1%	14 2.5%	15 2.7%	559
My community feels safe. Count Row %	159 28.6%	351 63.2%	28 5.0%	9 1.6%	8 1.4%	555

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	131 23.6%	323 58.3%	54 9.7%	15 2.7%	31 5.6%	554
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	65 11.6%	237 42.5%	91 16.3%	12 2.2%	153 27.4%	558
My community offers people options for staying cool during extreme heat. Count Row %	74 13.3%	251 45.1%	73 13.1%	8 1.4%	151 27.1%	557
My community has services that support people during times of stress and need. Count Row %	58 10.4%	260 46.5%	81 14.5%	16 2.9%	144 25.8%	559
I believe that all residents, including myself, can make the community a better place to live. Count Row %	218 38.9%	301 53.7%	16 2.9%	9 1.6%	17 3.0%	561
Totals Total Responses						561

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

Value	Percent	Responses
Better access to good jobs	19.2%	107
Better access to health care	31.5%	175
Better access to healthy food	24.8%	138
Better access to internet	7.4%	41
Better access to public transportation	37.1%	206
Better parks and recreation	12.1%	67
Better roads	35.1%	195
Better schools	16.5%	92
Better sidewalks and trails	30.0%	167
Cleaner environment	14.0%	78
Lower crime and violence	13.5%	75
More affordable childcare	23.9%	133
More affordable housing	50.4%	280
More arts and cultural events	12.8%	71
More effective city services (like water, trash, fire department, and police)	15.5%	86
More inclusion for diverse members of the community	19.6%	109

Value	Percent	Responses
Stronger community leadership	18.3%	102
Stronger sense of community	12.4%	69
Other, please specify:	6.7%	37

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 %	42 7.8%	106 19.8%	298 55.6%	74 13.8%	16 3.0%	536
Health care in my community meets the mental health needs of people like me. Count Row %	43 8.2%	153 29.0%	208 39.5%	31 5.9%	92 17.5%	527
Totals Total Responses						536

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

Value	Percent	Responses
A doctor's or nurse's office	85.3%	465
A public health clinic or community health center	6.2%	34
Urgent care provider	4.2%	23
A hospital emergency room	2.2%	12
No usual place	1.1%	6
Other, please specify:	0.9%	5

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	10.6%	57
Not enough time	16.1%	87
Insurance problems	14.4%	78
No providers or staff speak my language	1.7%	9
Can’t get an appointment	30.6%	165
Cost	21.5%	116
Concern about COVID or other disease exposure	5.0%	27
Transportation	8.5%	46
Other, please specify:	8.0%	43
No barriers	38.9%	210

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

Value	Percent	Responses
Aging problems (like arthritis, falls, hearing/vision loss)	51.0%	272
Alcohol or drug misuse	38.1%	203
Asthma	7.5%	40
Cancer	27.0%	144
Child abuse/neglect	8.1%	43
Diabetes	13.9%	74
Domestic violence	6.6%	35
Environment (like air quality, traffic, noise)	15.0%	80
Heart disease and stroke	20.6%	110
Hunger/malnutrition	8.8%	47
Homelessness	23.8%	127
Housing	33.0%	176
Mental health (anxiety, depression, etc.)	55.7%	297
Obesity	15.9%	85
Poor diet/inactivity	15.9%	85
Poverty	9.4%	50

Value	Percent	Responses
Smoking	5.3%	28
Suicide	8.3%	44
Trauma	7.5%	40
Underage drinking	3.4%	18
Vaping/E-cigarettes	12.4%	66
Violence	3.9%	21
Youth use of social media	23.3%	124
Infant death	1.1%	6
Rape/sexual assault	1.1%	6
Sexually transmitted infections (STIs)	1.9%	10
Teenage pregnancy	0.6%	3

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

Value	Percent	Responses
12th grade or lower (no diploma)	3.5%	19
High school (including GED, vocational high school)	8.7%	47
Started college but not finished	8.4%	45
Vocational, trade, or technical program after high school	7.1%	38
Associate degree (for example, AA, AS)	11.0%	59
Bachelor's degree (for example, BA, BS, AB)	30.7%	165
Graduate degree (for example, master's, professional, doctorate)	27.3%	147
Other, please specify:	1.1%	6
Prefer not to answer	2.2%	12

Totals: 538

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

Value	Percent	Responses
American Indian or Alaska Native	2.0%	11
Asian	1.9%	10
Black or African American	3.7%	20
Hispanic or Latine/a/o	5.2%	28
Middle Eastern or North African	0.4%	2
Native Hawaiian or Pacific Islander	0.4%	2
White	84.4%	453
Other, please specify:	0.4%	2
Not sure	0.6%	3
Prefer not to answer	4.8%	26

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	2.3%	12
Bisexual and/or Pansexual	1.3%	7
Gay or Lesbian	1.7%	9
Straight (Heterosexual)	86.7%	462
Queer	0.8%	4
I use a different term, please specify:	0.2%	1
I do not understand what this question is asking	0.6%	3
I prefer not to answer	6.6%	35

Totals: 533

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	81.3%	435
Male, Man	16.3%	87
Nonbinary, Genderqueer, not exclusively male or female	0.4%	2
I do not understand what this question is asking	0.2%	1
I prefer not to answer	1.9%	10

Totals: 535

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

Value	Percent	Responses
Childcare or school	4.8%	25
Food or groceries	19.2%	101
Formula or baby food	1.7%	9
Health care (appointments, medicine, insurance)	16.2%	85
Housing (rent, mortgage, taxes, insurance)	19.0%	100
Technology (computer, phone, internet)	7.2%	38
Transportation (car payment, gas, public transit)	11.0%	58
Utilities (electricity, water, gas)	17.0%	89
Other, please specify:	2.7%	14
None of the above	57.7%	303

14. What is your age?

Value	Percent	Responses
18-24	1.9%	10
25-44	27.1%	146
45-64	33.5%	180
65-74	20.8%	112
75-84	13.4%	72
85 and over	2.6%	14
Prefer not to answer	0.7%	4

Totals: 538

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

Value	Percent	Responses
Armenian	3.5%	19
Cape Verdean Creole	0.2%	1
Chinese (including Mandarin and Cantonese)	0.4%	2
English	92.8%	499
Haitian Creole	1.3%	7
Portuguese	1.1%	6
Russian	0.2%	1
Spanish	1.9%	10
Vietnamese	0.2%	1
Other, please specify:	0.6%	3
Prefer not to answer	0.7%	4

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	42.6%	229
Employed part-time (Less than 40 hours per week)	13.6%	73
Self-employed (Full- or part-time)	5.0%	27
A stay-at-home parent	2.0%	11
A student (Full- or part-time)	0.4%	2
Unemployed	2.0%	11
Unable to work for health reasons	4.3%	23
Retired	27.7%	149
Other, please specify:	1.5%	8
Prefer not to answer	0.9%	5

Totals: 538

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

Value	Percent	Responses
Yes	18.2%	97
No	78.9%	420
Prefer not to answer	2.8%	15

Totals: 532

18. I currently:

Value	Percent	Responses
Rent my home	14.3%	76
Own my home (with or without a mortgage)	66.8%	356
Live with parent or other caretakers who pay for my housing	1.9%	10
Live with family or roommates and share costs	3.9%	21
Live in a shelter, halfway house, or other temporary housing	0.9%	5
Live in senior housing or assisted living	10.3%	55
I do not currently have permanent housing	0.4%	2
Other	1.5%	8

Totals: 533

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

Value	Percent	Responses
I have always lived in the United States	91.2%	486
Less than one year	0.8%	4
1 to 3 years	1.3%	7
4 to 6 years	1.3%	7
More than 6 years, but not my whole life	4.3%	23
Prefer not to answer	1.1%	6

Totals: 533

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	61.1%	316
Faith community (such as a church, mosque, temple, or faith-based organization)	19.0%	98
School community (such as a college or education program that you attend or a school that your child attends)	18.2%	94
Work community (such as your place of employment or a professional association)	40.8%	211
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)	5.4%	28
A shared interest group (such as a club, sports team, political group, or advocacy group)	27.1%	140
Another city or town where I do not live	13.0%	67
Other, please feel free to share:	6.0%	31

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

Value	Percent	Responses
Yes	31.9%	66
No	68.1%	141

Totals: 207

Appendix C:
Resource Inventory

Beth Israel Deaconess Plymouth Community Resource List

Community Benefits Service Area includes: Carver, Duxbury, Kingston and Plymouth

Health Issue	Organization	Brief Description	Address	Phone	Website
	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
Statewide Resources	Executive Office of Aging & Independence	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	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	South Shore Resource and Advocacy Center	Provides comprehensive services for intimate partner and familial violence, as well as victim services and prevention for survivors and loved ones of impaired driving crashes, and loved ones who have lost someone to homicide.	PO Box 6237 North Plymouth	508.746.2664	www.hptc.org/service-provider/ssrac/
Food Assistance	Christ Church Outreach Plymouth	Provides food assistance to residents of Plymouth.	149 Court St Plymouth	508.746.4959	www.christchurchplymouth.org/ministries/outreach/food-pantry/
	Duxbury Lions Club Pantry	Provides food assistance to residents of Duxbury and the surrounding communities.	136 Summer St Duxbury		www.duxburylionsclub.org/about-us
	Pilgrims Hope Kingston	Provides food assistance to residents of the Greater South Shore.	149 Bishop's Highway Kingston	781.582.2010	www.plymouthareacoalition.org/food-pantry
	Salvation Army Plymouth	Provides food assistance to residents of Plymouth.	52 Long Pond Rd Plymouth	508.746.1559	easternusa.salvationarmy.org/massachusetts/plymouth/
	Shane Gives Thanks	Provides food assistance to residents of Carver.	128 Main St Bld 2 Unit H Carver	508.866.7673	www.shanegivesthanks.com
	St. Joseph's Church Kingston	Provides food assistance to residents of Kingston.	272 Main St Kingston	781.585.6679	www.stsmaryjoseph.org/food-pantry

Housing Support	Carver Housing Authority	Provides affordable, subsidized rental housing for low-resource families, older adults and persons with disabilities.	108 Main St Carver		www.carverma.gov/carver-housing-authority
	Duxbury Housing Authority	Provides affordable, subsidized rental housing for low-resource families.	59 Chestnut St Duxbury	781.934.6618	www.duxburyha.org
	Father Bill's & Mainspring	Provides shelter, job support and case management for people without housing.	39 Broad St Quincy	617.770.3314	www.helpfbms.org
	Habitat for Humanity-Greater Plymouth	Provides affordable homeownership opportunities to help local hard-working, low-income families find a path to strength, stability and self-reliance	160 North Main St Carver	508.866.4188	www.hfhplymouth.org
	Kingston Housing Authority	Provides affordable, subsidized rental housing for low-resource families.	15 Hillcrest Rd Kingston	781.585.8028	www.kingstonha.org
	Neighborworks Housing Solutions	Provides housing resource assistance.	169 Summer St Kingston	781.422.4200	www.nhsmass.org
	Pilgrims Hope Family Shelter	Provides safe temporary shelter, professional case management, and support services.	149 Bishop's Highway Kingston	781.582.2010	www.plymouthareacoalition.org
	Plymouth Housing Authority	Provides affordable, subsidized rental housing for low-resource families.	130 Court St Plymouth	508.746.2105	www.plymha.org
	Advocates-Outpatient Counseling Clinic Plymouth	Provides evidence-based, best practice therapies for individuals and families.	118 Long Pond Rd Ste 106 Plymouth	508.747.6762	www.advocates.org
	Aspire Health Alliance	Provides early intervention and mental health treatment and recovery programs.	64 Industrial Park Rd Plymouth	800.852.2844	www.aspirehealthalliance.org
	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.bilhbehavioral.org
	Child and Family Services, Inc.	Provides psychiatric assessment and intervention to people of any age who are in a crisis situation.	61 Industrial Park Rd Plymouth	877.996.3154	www.cfservices.org/services-cbhc.php
	High Point Treatment Center Plymouth	Provides a broad range of evidence-based treatment programs for individuals recovering from substance use disorders and co-occurring disorders.	1233 State Rd Plymouth	508.224.7701	www.hptc.org/service/plymouth-campus/
	NAMI Plymouth Area	Provides support, education and advocacy throughout the Plymouth MA area on behalf of individuals and families affected by mental illness.	PO Box 1398 Marshfield	781.934.5086	www.namiplymoutharea.org

Mental Health and Substance Use	Plymouth Center for Behavioral Health	Provides mental health and behavioral support services to children and adults throughout the South Shore and Cape Cod area of Massachusetts.	34 Main St Ext Ste 103 Plymouth	508.830.0012	www.plymouthbehavioralhealth.com
	Plymouth Community Behavioral Health Center	Provides mental health and behavioral support services to adolescents and adults throughout Bristol and Plymouth counties.	61 Industrial Park Rd Ste 1 Plymouth	508.830.1234	www.hptc.org/service/plymouth-multi-service-site-outpatient/
	Plymouth Family Resource Center	Provides community-based, multi-cultural, support groups, parenting programs, assessment services, information and referral resources, and education for families whose children range in age from birth to 18.	430-3 Court St Plymouth	774.283.6531	www.plymouthfamilyrc.org
	Plymouth Recovery Center	Provide peer facilitated groups, sober social events, computers for job search activities, advocacy, coaching, and family-led support groups.	5 Main St Ext Plymouth	774.776.3515	www.gandaracenter.org/plymouth-recovery-center
	South Bay Community Services Plymouth Outpatient and Community Behavioral Health Clinic	Provides continuum of services including adult behavioral health, substance use disorder counseling, children's behavioral health, day services, autism services and early childhood services.	50 Aldrin Rd Plymouth	508.521.2200	www.southbaycommunityservices.com
Senior Services	Carver Council on Aging	Provides services for older adults in Carver including fitness, education, social services, and recreation.	48 Lakeview St South Carver	508.866.4698	www.carverma.gov/council-aging
	Duxbury Senior Center	Provides services for older adults in Duxbury including fitness, education, social services, and recreation.	10 Mayflower St Duxbury	781.934.5774	www.town.duxbury.ma.us/senior-center
	Kingston Council on Aging	Provides services for older adults in Kingston including fitness, education, social services, and recreation.	30 Evergreen St Kingston	781.585.0511	www.kingstonma.gov/292/Council-on-Aging
	Old Colony Elder Services Regional	Provide supportive services for older adults and persons with disabilities.	144 Main St Brockton	508.584.1561	www.ocesma.org
	Plymouth Center for Active Living	Provides services for older adults in Plymouth including fitness, education, social services, transportation and recreation.	44 Nook Rd Plymouth	508.830.4230	www.plymouth-ma.gov/245/Center-for-Active-Living
Transportation	GATRA (Greater Attleboro Transportation Authority)	Provides bus service in Plymouth, Carver, Kingston, and Duxbury.	10 Oak St Taunton	1.800.483.2500	www.gatra.org

	MBTA	Provides transportation thru out Plymouth and surrounding communities.			www.mbta.com
Additional Resources	BID Plymouth ACCESS Program	Provides primary care services including physical examinations; treatment services and planning; laboratory testing; immunizations and screening; antiviral medications; referrals to specialty care and clinical trials as well as medical case management.	275 Sandwich St Plymouth	508.732.8981	www.bidplymouth.org/services/infectious-diseases
	Boys and Girls Club Plymouth	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	9 Resnik Rd Plymouth	508.746.6070	www.bgcplymouth.org
	Harbor Community Health Center – Plymouth	Provides medical, behavioral health, dental, and support services	10 Cordage Park Circle Ste 115 Plymouth	508.778.5470	www.hhsi.us/locations/harbor-community-health-center-plymouth/
	Old Colony YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	2 Greenside Way Plymouth	508.927.3100	www.oldcolonyymca.org/locations/plymouth-branch
	South Shore Community Action Council	Provides programs in the areas of Youth and Family Development, Income Maintenance, Nutrition, Emergency Assistance, Self-Sufficiency, Energy Assistance, Employment, and Transportation Assistance.	71 Obery St Plymouth	508.747.7575	www.sscac.org

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

Beth Israel Deaconess Hospital-Plymouth

Evaluation of 2023-2025 Implementation Strategy

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

Priority: Equitable Access to Care

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations ● Racially, ethnically & linguistically diverse populations	Promote access to health care, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.	● BID Plymouth's Financial Assistance Program ● BID Plymouth's Enrollment Counseling/ Assistance & Patient Navigation Support ● Primary Care Support	● 4,582 patients screened for financial assistance (FY23) ● 140 patients enrolled in State Assistance Program and 235 uninsured patients enrolled in Health Safety Net (FY23) ● 6,899 new patients in primary care offices in CBSA (FY23)
● Racially, ethnically & linguistically diverse populations	Promote equitable care, health equity and hhealthh literacyy for patients, especially those who face cultural and linguistic barriers.	● Interpreter Services	● 8,723 interpreter sessions provided in 39 different languages (FY23)

Priority: Social Determinants of Health

Goal: Enhance the built, social, and economic environments where people live, work, play and learn in order to improve health and quality-of-life outcomes.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Low-resourced populations	Support impactful programs that stabilize or create access to affordable housing.	● Grant support for Father Bill's Mainspring for temporary shelter	● Provided 72 unique individuals with shelter services (FY23) ● 98% of residents maintained housing (FY23) ● Provided 84 unique individuals with shelter services (FY24) ● 99% of residents maintained housing (FY24)
● Low-resourced populations	Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	● Nutrition education and cooking tips in the community through BID Plymouth Registered Dietician (RD)	● FY23 o 18 recipes developed o 889 participants and their demographics o 25 nutrition programs for adults and families living in the CBSA and presenting with food insecurity o 25 programs for youth and families living in the CBSA seeking access to healthy and affordable food options o All participants reported an increased confidence in preparing healthy food on a budget ● FY24 o 17 recipes were shared o 858 participants attended

			○ 20 nutrition programs for adults and families living in the CBSA and presenting with food insecurity ○ 20 programs for youth and families living in the CBSA seeking access to healthy and affordable food options ○ All participants reported an increased confidence in preparing healthy food on a budget
● Older adults ● Individuals with disabilities ● Low-resourced populations	Support existing partnerships and explore new ones with regional transportation providers and community partners to enhance access to affordable and safe transportation.	● Taking People Places (TPP) ● The CAL Express through the Plymouth Center for Active Living	● 388 rides provided of which were for adults aged 60 and older and 305 were for those with a disability (FY23) ● 345 rides provided of which 117 were for adults aged 60 and older and 228 were for those with a disability (FY24) ● No data for CAL Express as their program is now supported through Taking People Places
● Youth ● Older adults ● Racially, ethnically & linguistically diverse populations ● Individuals with disabilities ● Low-resourced populations	Provide community health grants to support evidence-based programs.	● Community Health Grant Program - Grant funding program for community organizations and municipalities	● South Shore Community Action Council – housing assistance and emergency food ○ FY23: provided referrals, case management, and financial assistance with rent or mortgage arrearages for 61 households (181 household members), with 14 households (37 household

			members) avoiding eviction, 58 households receiving financial assistance with rent or mortgage maintaining stable housing for 3 months, 4 households (11 household members) receiving financial assistance with utility bills and avoiding a utility shut-off, 34 households (51 household members) accessing emergency food o FY24: provided referrals, case management, and financial assistance with rent or mortgage arrearages for 63 households with 25% of applicants avoiding eviction, 27 households receiving financial assistance with rent or mortgage maintaining stable housing for 3 months, 1 household receiving financial assistance with utility bills and avoiding a utility shut-off, 36 households accessing emergency food

			● NeighborWorks Housing Solutions - Family Self Sufficiency Program and Family Shelter Program o FY23: 29 families accumulated an average savings of $7,446, with 2 families no longer needing Housing Assistance payments and were paying market rent; 30 families received weekly one- on-one case management and assistance in accessing health benefits, health care, school enrollment, transportation, as well as ESOL and budgeting classes o FY24: no data as this was a one-year funded program) ● Plymouth County Sheriff's Department – Aquaponics/Hydroponics Program: o FY23: 21,629 lbs. of food donated and a new Environmental Justice Education Center education and training program developed on Aquaponics ~ Hydroponics ~ Vertical Growing Systems o FY24: no data as this was a one-year funded program

			● Greater Plymouth Community Health Network Alliance (CHNA): Organizational Support provided o FY24: 8 education & skill-building sessions served an average of 28 participants per session, 4 mini-grants were provided to area non-profits, the steering committee represents 12 Community & Municipal organizations. ● Directors of Personal Economy: o FY24: Funding was provided to support workforce development for those in recovery
● Low resourced populations	Support impactful programs and evidence-based strategies to increase employment and earnings and increase financial security.	● Provide opportunities for grant funding ● Career and academic advising ● Hospital-sponsored community college courses ● Hospital-sponsored English Speakers of Other Language (ESOL) classes	● Community Grant Workshops o FY23:118 participants o FY24: 19 community organizations represented ● Grant Consultation Services o FY23: 2 organizations – one who provides access to food and one who provides transportation services to 11 social service organizations o FY24: 2 organizations – one provides free or low-cost mobile dental hygiene services and one offers

			mental health and wellness programs for low-resourced individuals experiencing trauma and addiction ● Number of people trained: o FY23: 89 community members trained across BILH - BID-Plymouth participated in these trainings o FY24:1,044 BILH employees received career development services ● Number of people served: o FY23: no data for community college courses o FY24: no data for community college courses) ● Number of people served: o FY23: 20 participants per weekly ESOL class o FY24: 82 BILH employees were enrolled in ESOL classes. BID Plymouth employees participated in these classes.

• Older adults	Collaborate to enhance access to coordinated health and support services and resources to support overall health and aging in place.	• Plymouth Senior Task Force: Age & Dementia Friendly designation process	• FY23: 10 sectors represented, 3 new partnerships and Age & Dementia Friendly needs assessment completed • FY24: 10 sectors represented, 2 new partnerships and working towards sustainability for the Greater Plymouth CHNA

Priority: Mental Health and Substance Use

Goal: Promote social & 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 and families	Enhance and explore relationships with schools, youth-serving organizations, and other community partners to build resiliency, coping and prevention skills.	• Plymouth Schools PreVenture Program	• PreVenture program is sustained through school funding

		● Provide an opportunity for grant funding ● PCO Hope: Hidden in Plain Site mobile display ● Adult and Youth Mental Health First Aid	● Number of participants, percent reporting increased skills and confidence in applying skills: o FY23: 5 organizations who provide services to individuals experiencing mental health and substance use issues; 100% reported improved skills in becoming grant ready and grant writing, as well as a significant increase in confidence in using these skills o FY24: 8 Community Based organizations participating in grant workshops reported a significant increase in confidence using these skills ● Number of participants and demographics, number screened and results and number completing program: o FY23: PCO Hope Hidden in Plain Site no longer collaborating with BID-Plymouth o FY24: PCO Hope is no longer in operation ● Number of participants and demographics, increased skills and increased confidence in using skills: o FY23: no data available for Mental Health First Aid o FY24: 24 participants attended Adult MHFA
● Youth ● Older adults	Participate in multi-sector community coalitions to identify and advocate for policy, systems and environmental	● Member of many community initiatives	● Sectors represented, number of resources obtained, number of partnerships

● Racially, ethnically & linguistically diverse populations ● Individuals with disabilities ● Low-resourced populations	changes to increase resiliency, reduce substance use, overdoses & deaths	and outreach programs	developed, and skill-building/education shared: o FY23: 5 sectors represented, 6 new partnerships developed, multiple resources and education gained and shared o FY24: 8 sectors represented, 2 new partnerships developed, multiple resources and education gained and shared
● Youth ● Older adults ● Racially, ethnically & linguistically diverse populations ● Individuals with disabilities ● Low-resourced populations	Build the capacity of community members and emergency services to understand the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.	● Resiliency Library ● Grant funded training for Emergency Medical Service (EMS) providers to identify and intervene around suicide and suicidal ideation	● Number of community members trained/educated, increased skills and increased confidence in the ability to use skills: o FY23: Resiliency Library no longer collaborating with BID-Plymouth o FY24 Resiliency Library no longer collaborating with BID-Plymouth ● Number of community members trained/educated, increased skills and increased confidence in the ability to use skills: o FY23: 38 first responders were trained on suicide preventions o FY24: 57 first responders were trained on suicide prevention, intervention and post-vention
● Youth ● Older adults ● Racially, ethnically & linguistically diverse populations	Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	● Gosnold Recovery Navigators ● Explore other potential hospital-based programming	● FY23: no data available for Gosnold as funding is through a third party, this will be evaluated in FY24 and potentially added in ● FY24: 2,074 consults in the ED resulted in 1,277 referrals to treatment and 1,659 consults on medical floors resulted in 892 referrals to treatment

● Individuals with disabilities ● Low-resourced populations			● Behavioral Health Integrated Care Initiative o FY23: 1,478 with depressive symptoms (PHQ9) decreasing by 59% and anxiety score (GAD7) decreasing by 66% o FY24: PHQ9 scores decreased by 59% and GAD7 scores decreased by 60% ● Plymouth County Outreach o FY23: 960 with 58% of patients accepting treatment in the Emergency Department and 48% patients accepting treatment who were admitted to inpatient beds o FY24: 60% of patients in ED accepted treatment and 76% of friends and family accepted support services ● Plymouth County Outreach Hope o FY23: 958 people were trained in how to administer Narcan and 366 gallons of unused prescription drugs were collected o FY24: PCO Hope is no longer in operation. Prescription Drug Takeback resulted in 395 gallons of unused prescription drugs collected ● Plymouth County Outreach HUB o FY23: 50% of referrals through a were closed due to connection to services o FY24: BID Plymouth did not participate in HUB meetings due to a staffing change

Priority: 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.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● All priority cohorts with identified chronic disease risk	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.	● BID Plymouth AIDS Comprehensive, Care, Education and Support Services (ACCESS) program for HIV/AIDS ● Keep the Beat Post-Cardiac Program ● Chronic Disease & Nutrition Education ● House Calls program ● Stroke education	● FY23: 14 clients were enrolled in ACCESS care, with 100% taking antiretroviral treatment (ART) and 100% virally suppressed ● FY24: 15 clients were enrolled in ACCESS care, with 100% taking antiretroviral treatment (ART) and 100% virally suppressed) ● FY23: 11 participants in Keep the Beat Post-Cardiac Program ● FY24: 17 participants in Keep the Beat Post-Cardiac Program ● FY23: 1,428 participants attended nutrition programs; 2,663 people were reached indirectly through video and radio; 22 agencies serving received nutrition notes for their newsletters and 32 vendors educated 250 participants through a health & wellness fair supported by BID-Plymouth ● FY24: 1,407 participants attended nutrition programs; 20 agencies serving the community received nutrition notes for their newsletters and sent them out to over 15,000 constituents, and 35 vendors educated 300 participants through a health & wellness fair supported by BID-Plymouth ● FY23: 2 programs educated 47 older adults around joint health and 65 participants educated on behavioral health and community programs

			• FY24: 3 programs educated a total of 120 older adults around joint health, the future of healthcare on the South Shore and the need for expanded emergency services • FY23: 29 participants were educated through 2 community events on stroke symptoms and early notification • FY24: Stroke education was shared with staff and visitors at the hospital on the TV monitors for stroke awareness, a PSA on how to recognize and treat a stroke was taped and shown in Plymouth, and 25 older adults were educated at the Plymouth Health & Safety Fair
• Patients diagnosed with cancer and their families/ caregivers	Ensure cancer patients and their families have access to coordinated health & support services and resources to support them	• Cancer Patient Support Program	• FY23: 400 rides were given to patients needing rides to and from treatment 50 wigs were provided to patients, 35 participants took part in the Bridge to Wellness program and 4 cancer survivors were trained to work with patients as mentors to provide support through the treatment process • FY24: 610 rides were given to patients needing rides to and from treatment 45 wigs were provided to patients, 19 participants took part in the Bridge to Wellness program and 4 cancer survivors were trained to work with patients as mentors to provide support through the treatment process

● All priority cohorts with identified chronic disease risk	Address chronic disease management through health and nutrition education	● Healthy recipes for food pantries ● Nutrition education at local Councils on Aging (COAs), libraries and schools ● Nutrition articles distributed to area newsletters ● Nutrition education and cooking tips	● FY23: 8 Delicious & Nutritious shows were aired with recipe demonstrations, over 4,000 community participants were reached directly and indirectly with nutrition education, 12 nutrition articles were sent out the community and 99% of participants surveyed reported that their knowledge had increased ● FY24: 9 Delicious & Nutritious shows were aired with recipe demonstrations, over 2,663 community participants were reached directly and indirectly with nutrition education, 12 nutrition articles were sent out the community and 99% of participants surveyed reported that their knowledge had increased

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

FY26–FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Hospital–Plymouth is Beth Israel Lahey Health's regional comprehensive provider of healthcare services in Southeastern Massachusetts. The hospital has 175 licensed inpatient beds with more than 1,700 employees and over 600 clinicians on active medical staff. BID Plymouth is among the fastest growing hospitals in New England, caring for patients across Plymouth and Barnstable Counties and with recognized centers of excellence in cardiovascular care, cancer, orthopedics and neuroscience.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. It would be difficult to overstate BID Plymouth's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. BID Plymouth's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage BID Plymouth's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

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

Prioritization and Implementation Strategy Process

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

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

BID Plymouth'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 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, BID Plymouth's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. BID Plymouth is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

BID Plymouth's CBSA includes the four municipalities of Duxbury, Carver, Kingston, and Plymouth located in the southeast area of Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography. There is also diversity with respect to community needs. There are segments of BID Plymouth's CBSA population that are healthy and have limited unmet health needs and other segments that face significant disparities in access, underlying social determinants, and health outcomes. BID Plymouth is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. BID Plymouth is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

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

Prioritized Community Health Needs and Cohorts

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

BID Plymouth Priority Cohorts

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

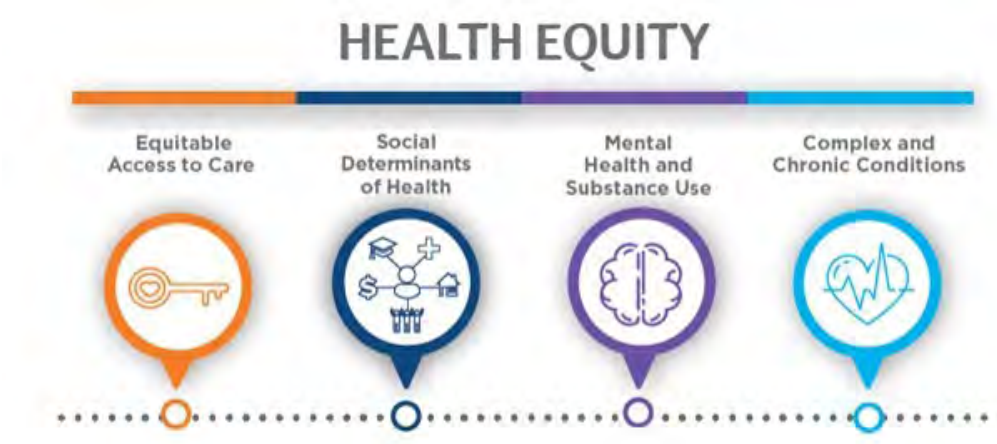
Community Health Needs Not Prioritized by BID Plymouth

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

Community Health Needs Addressed in BID Plymouth's IS

The issues that were identified in the BID Plymouth CHNA and are addressed in some way in the hospital's IS are housing issues, transportation, food insecurity, language and cultural barriers economic insecurity, long wait times, health insurance and cost barriers, navigating a complex health care system, depression, anxiety, stress, youth mental health, social isolation among older adults, opioid use, lack of behavioral health providers, behavioral health prevention and education, health eating and active living, conditions associated with aging, cancer, cardiovascular disease, maternal health needs, and caregiver support.

BID Plymouth Community Health Priority Areas



Implementation Strategy Details

Priority: Equitable Access to Care

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

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

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

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

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

Priority: Social Determinants of Health

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

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• All priority populations	• Food access, nutrition support, and education programs and activities	• # of programs • # of attendees • # of mobile food markets • Pounds of food distributed	• Private, non-profit, and health-related agencies
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• Low-resourced populations	• Housing assistance, navigation, and resident support activities • Community investment and affordable housing initiatives	• # of unique individuals served • % of residents maintaining housing for one year • # of individuals connected to case management	• Housing support and community development agencies
Support programs and activities that foster social connections and strengthen community cohesion and resilience.	• Older adults • Low-resoured populations	• Community connection and social engagement activities	• # of volunteers • # of hours served	• Older adult services agencies • Private, non-profit, health-related agencies

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support community/ regional programs and partnerships to enhance access to affordable and safe transportation.	• All priority populations	• Transortation and ride share assistance programs • Public transit and mobility enhancement programs	• # of people served • # of rides provided	• Private, non-profit, health-related agencies • Local/regional public transportation agencies
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 who participated • # hired by hospital • # of programs • # of participants • # of employees served by hospital	• 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: BID-Plymouth expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BID-Plymouth and/or its partners to improve the health of those living in its CBSA. Additionally, BID Plymouth works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BID Plymouth supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BID Plymouth 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 • Medication disposal programs	• # of people served • # of referrals made • Pounds of medication disposed	• 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	• Programs and activities with community health workers, recovery coaches, and peer support workers • Outreach, support, and navigation programs and activities • Expand access to mental health and substance use services for individuals and families • Primary care and behavioral health integration and collaborative care programs • Health education, awareness, and wellness activities • Crisis intervention and early response programs and activities • Participation in community coalitions	• # of people served • # of referrals made • # of classes, trainings, and activities organized • # of community meetings attended • Increased knowledge about how to support people experiencing mental health challenges	• Clinical service providers • First responders • Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Chronic and Complex Conditions

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

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

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with chronic and complex conditions and/or their caregivers.	• All priority populations	• Chronic disease management, treatment, and self-care support programs • HIV/AIDS care, education, and support programs • Education, wellness, navigation, and peer support programs and activities • Fitness, nutrition, and healthy living programs and activities • Cancer education, wellness, navigation, and survivorship support programs	• # of new clients • # of patients taking ART • # of patients virally suppressed • # of meetings attended • # of new programs • # of attendees • # of educational materials distributed • # of referrals to community programs • # of wigs provided • # of peer supporters trained	• Older adult services agencies • Private, non-profit, health-related agencies • Community-based agencies • Hospital-based activities
Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.	• Racially, ethnically, and linguistically diverse populations	• Culturally responsive prenatal/postnatal case management and care coordination programs	• # of people served • # of referrals made and received • # of classes, support groups, or sessions organized	• Non-profit community-based agencies

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
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:	Karen Peterson, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 10, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 10, 2025
Date written plan was required to be adopted:	February 15, 2026
Authorized governing body that adopted the written plan:	Beth Israel Deaconess Hospital-Plymouth 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 14, 2022
Name and EIN of hospital organization operating hospital facility:	Beth Israel Deaconess Hospital-Plymouth: 22-2667354
Address of hospital organization:	275 Sandwich St. Plymouth, MA 02360

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

bidplymouth.org