Beth Israel Lahey Health
Anna Jaques Hospital

2025 Community Health Needs Assessment

Acknowledgments

This 2025 Community Health Needs Assessment report for Anna Jaques Hospital (AJH) 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 AJH'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.

AJH 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.

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

Anna Jaques Hospital (AJH) is a community hospital located in the coastal town of Newburyport that serves Massachusetts' North Shore and Southern New Hampshire's seacoast region. Anna Jaques takes pride in its strategic partnership with Beth Israel Deaconess Medical Center in delivering a comprehensive suite of cancer services, including chemotherapy, surgical oncology, and access to clinical trials. The hospital recently added two new operating rooms and robotic surgery capabilities.

AJH 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, AJH 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. AJH, 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 AJH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that AJH 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 AJH to engage the community and strengthen the community partnerships that are essential to AJH's success now and in the future. The assessment engaged more than 1,400 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, 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 AJH's mission. Finally, this report allows AJH 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 AJH's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care, as well as the current and historical injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that AJH 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, AJH completed its last assessment in the summer of 2022 and the report, along with the associated 2023-2025 IS, was approved by the AJH Board of Trustees on September 1, 2022. The 2022 CHNA report was posted on AJH'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 AJH's Board of Trustees approved the 2025 report and adopted the 2026-2028 IS, included as Attachment E, on September 4, 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 AJH's CBSA.

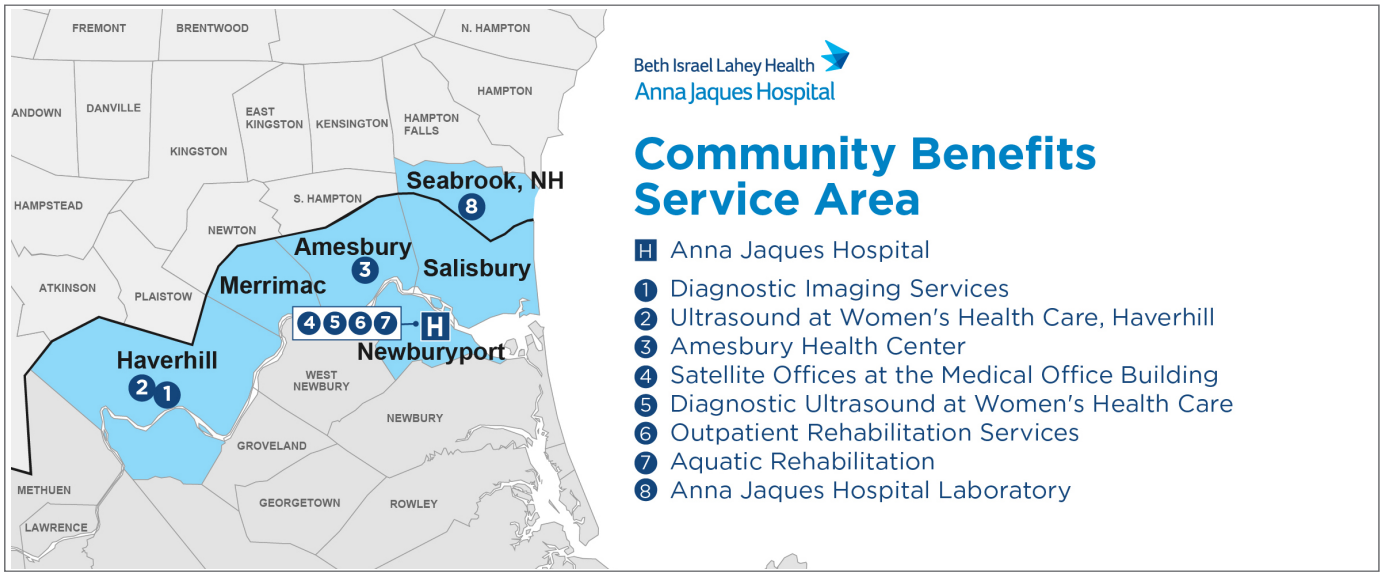
Understanding the geographic and demographic characteristics of AJH's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

Description of Community Benefits Service Area

AJH's CBSA includes the six municipalities of Amesbury, Haverhill, Merrimac, Newburyport, and Salisbury in Massachusetts and Seabrook in New Hampshire. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban).

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

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

While AJH operates a licensed facility in Seabrook, New Hampshire, this service location is in another BILH hospital's CBSA. The Town of Seabrook is located within Exeter Hospital's CBSA. As a result, the community benefits activities for the Town of Seabrook, NH have been delegated to Exeter Hospital. This helps to ensure that activities are properly coordinated and address the identified needs.

Assessment Approach & Methods

Approach

It would be difficult to overstate AJH's commitment to community engagement and a comprehensive, data driven, collaborative, and transparent assessment and planning process. AJH'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 AJH and other BILH hospitals to conduct the CHNA. AJH worked with JSI to ensure that the final AJH 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 AJH's assessment and planning activities. AJH's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and members of the hospital's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

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

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

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

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

The involvement of AJH'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 AJH'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, AJH collected a wide range of quantitative data to characterize the communities in the hospital's CBSA. AJH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was also tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment, including the 2025 AJH 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, AJH applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, AJH 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, AJH conducted 15 one-on-one and group interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,300 residents, and organized a community listening session. In total, the assessment process collected information from more than 1,400 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved, and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials.

15 interviews
with community leaders

1,354 survey respondents

5 focus groups

- Older adults
- Youth
- Low-resource individuals
- Low-resource parents and caretakers
- Low-resource adults who speak Spanish

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 AJH. Community Benefits staff reviewed AJH'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 AJH 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 AJH 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 AJH's existing IS was augmented, revised, and tailored. When developing the IS, AJH's Community Benefits staff retained community health initiatives that worked well and aligned with the priorities from the 2022 CHNA.

After drafts of the CHNA report and IS were developed, they were shared with AJH'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 AJH'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 AJH's website, alongside the 2022 CHNA report and 2023-2025 IS, for easy viewing and download. As with all AJH 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 AJH'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 AJH'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.

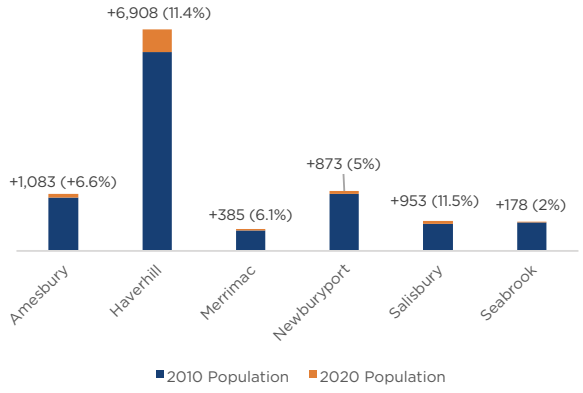
Based upon the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the AJH CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white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

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

Population Growth

Between 2010 and 2020, the population in AJH's CBSA increased by 9%, from 117,892 to 128,272 people. Salisbury saw the greatest percent increase (12%) and Seabrook saw the lowest (2%).

Population Changes by Municipality, 2010 to 2020



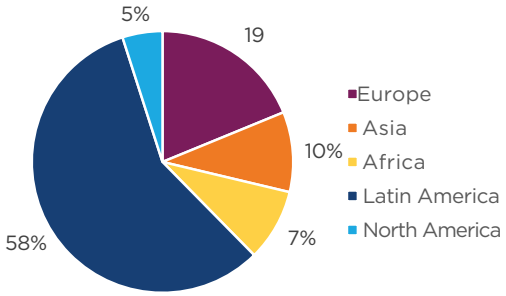
Source: US Census Bureau, 2010 and 2020 Decennial Censuses

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]

10% of the AJH 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]

17% of CBSA residents 5 years of age and older speak a language other than English at home.

Of those:

30% speak English less than "very well."

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

Age

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

17%

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

20%

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

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

Gender Identity and Sexual Orientation

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

7%

of adults in Massachusetts identify as LGBTQIA+.

Source: Gallup/Wiliams, 2023

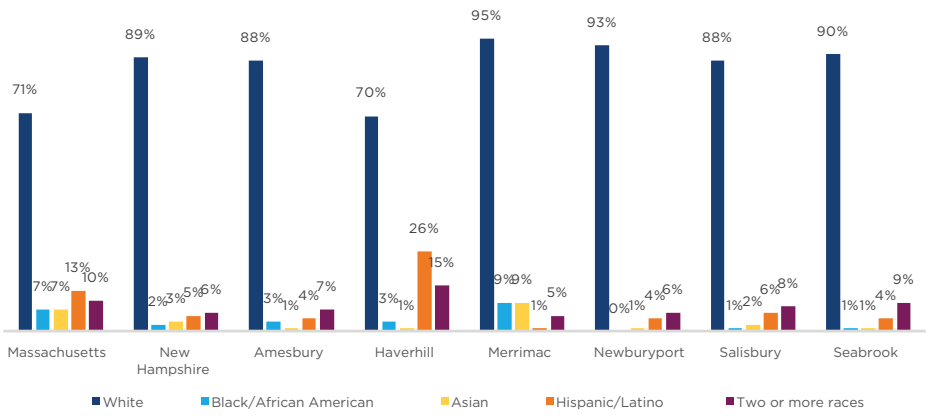
21% of LGBTQIA+ adults in Massachusetts are raising children

Source: Gallup/Williams, 2019

Race and Ethnicity

With the exception of Haverhill, all communities in the AJH CBSA have a significantly higher percentage of residents who identify as white compared to the state of Massachusetts overall. In Haverhill, 26% of residents are Hispanic/Latino (of any race), compared to 19% for the Commonwealth.

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]

29% of AJH CBSA households included one or more people under 18 years of age.

33% of AJH 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 AJH's CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities, economic insecurity, access to care/navigation issues, and other important social factors.[8]

Information gathered through interviews, focus groups, the listening session, and the 2025 AJH Community Health Survey reinforced that these issues impact health status and access to care in the region - especially issues related to housing, economic insecurity, food insecurity/ nutrition, transportation, and language and cultural barriers to services.

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

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

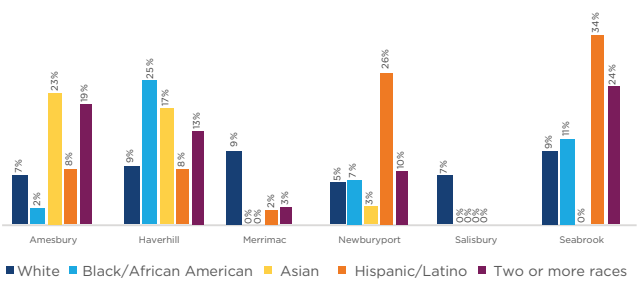
Access to public transportation was another central concern, as it directly impacts people's ability to maintain their health and reach necessary care—particularly for those without personal vehicles or support networks.

Economic Stability

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

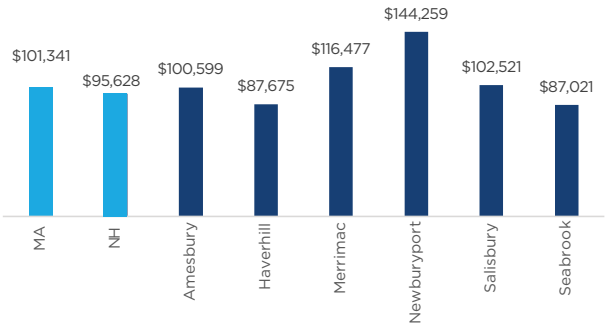
COVID-19 magnified many existing challenges related to economic stability. Though the pandemic has receded, individuals and communities continue to feel the impacts of job loss and unemployment, contributing to ongoing financial hardship. Even for those who are employed, earning a livable wage remains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

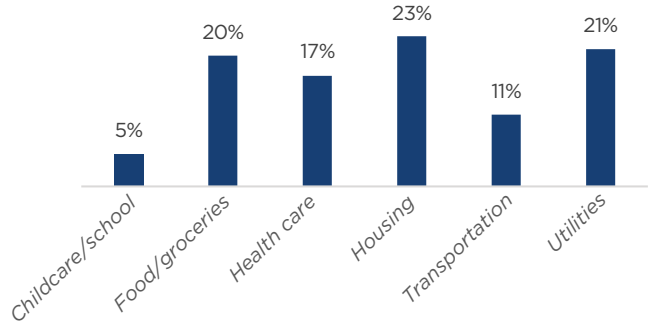


Source: US Census Bureau American Community Survey, 2019-2023

Across the AJH 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 Amesbury and Haverhill, and income was lower in Seabrook compared to New Hampshire.

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

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



Source: 2025 AJH Community Health Survey

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

-Focus Group Participant

Education

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

93% of AJH CBSA residents 25 years of age and older have a high school degree or higher.

39% of AJH CBSA residents 25 years of age and older have a Bachelor's degree or higher.

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

Social Determinants of Health

Food Insecurity and Nutrition

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

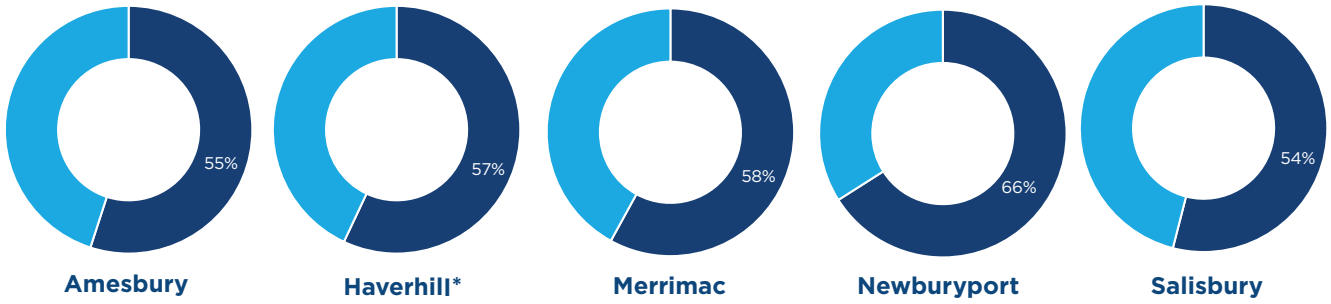
While it is important to have grocery stores placed throughout a community to promote access, there are other factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food, and cultural appropriateness of food offerings. Food pantries and community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

15%

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

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

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



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

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

Data unavailable for Seabrook, New Hampshire

Neighborhood and Built Environment

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

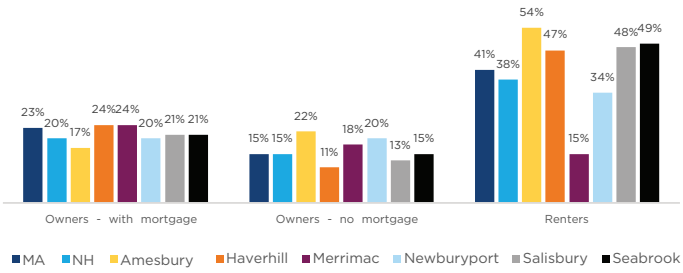
Housing

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

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

The percentage of owner-occupied housing units with housing costs in excess of 35% of household income was higher than the Commonwealth in Haverhill and Merrimac (among owners with a mortgage); and Amesbury, Merrimac, and Newburyport (among owners without a mortgage). In Seabrook, the percentage was higher than New Hampshire among owners with a mortgage. Among renters, percentages were higher than the Commonwealth in all municipalities except Merrimac and Newburyport, and higher than New Hampshire in Seabrook.

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:

54% of 2025 AJH Community Health Survey respondents said "more affordable housing."

23% of 2025 AJH Community Health Survey respondents said that they had trouble paying for housing costs in the past 12 months.

Source: 2025 AJH 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:

19% of 2025 AJH Survey Community Health Survey respondents wanted more access to public transportation.

Source: 2025 AJH Community Health Survey

7% of housing units in the AJH CBSA did not have an available vehicle.

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

Roads and Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety and increased mobility. Sidewalks and bike lanes allow more space for people to walk or bike, which increases physical activity and reduces the need for vehicles on the road.

Respondents to the AJH Community Health Survey prioritized these improvements to the built environment:

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

43% of 2025 AJH Community Health Survey respondents identified a need for better sidewalks and trails.

Source: 2025 AJH Community Health Survey

Systemic Factors

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

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of color, persons whose first language is not English, foreign-born individuals, individuals living with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment reinforced the challenges that residents throughout the AJH CBSA faced with respect to long wait-times, language and cultural barriers, and navigating a complex health care system. This was true with respect to primary care, behavioral health, and medical specialty care.

Interviewees, focus groups, and listening session participants also reflected on the high costs of care, including prescription medications, particularly for those who were uninsured or who had limited health insurance benefits.

Accessing and Navigating the Health Care System

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

> "We aren't doing enough to help patients know what they are doing with their health care. They just go back to the hospital. Having help with coordinating care would be huge."
>
> -Interviewee

Populations facing barriers and disparities

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

Community Connections and Information Sharing

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

"We have a lot of community partnerships. There are definitely silos, but we all try to communicate with one another. We're hoping that over time, we can break down the duplication of services to streamline efforts and work together."

-Interviewee

Behavioral Factors

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

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

Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being and reduces the risk of illness and death due to the chronic conditions mentioned previously. When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use, and alcohol use. Those who participated in the assessment's community engagement activities were also asked to identify the health issues that they felt were most important. The information from the assessment supports the importance of incorporating these issues into AJH'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.

20% of 2025 AJH Community Health Survey respondents said they would like their community to have better access to healthy food.

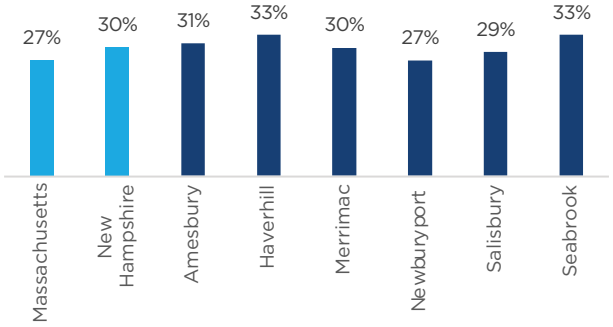
Source: 2025 AJH Community Health Survey

Physical Activity

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

The percentage of adults who were obese (with a body mass index over 30) was higher than the Commonwealth in all municipalities, with the exception of Newburyport. The percentage was higher in Seabrook compared to New Hampshire.

Percentage of Adults Who are Obese, 2022



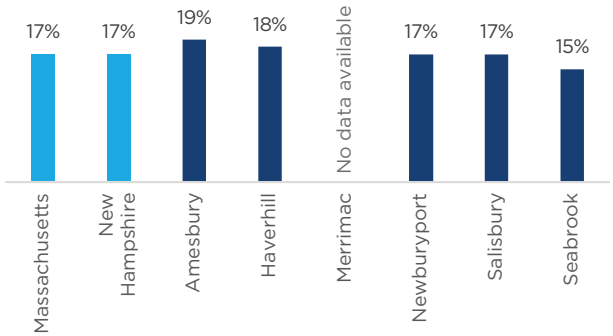
Source: CDC PLACES, 2022

Alcohol, Marijuana, and Tobacco Use

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

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

Prevalence of Binge Drinking Among Adults, 2022



Source: CDC PLACES, 2022

Health Conditions

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

Mental Health

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

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

25% of 6-12th graders in Newburyport reported feeling sad or depressed most or all of the time in the last month.

Source: 2024 Profiles of Student Life - Attitudes and Behaviors, Search Institute

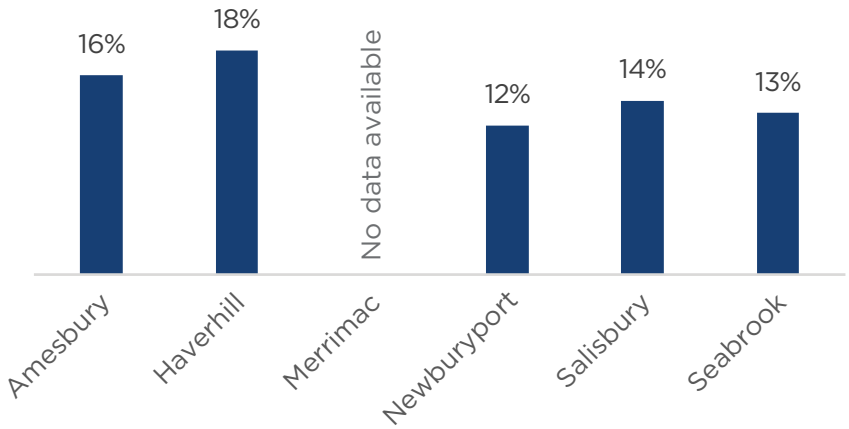
40% of high school students in Amesbury report feeling stressed fairly or very often.

Source: 2019 Profiles of Student Life - Attitudes and Behaviors, Search Institute

56%

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

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



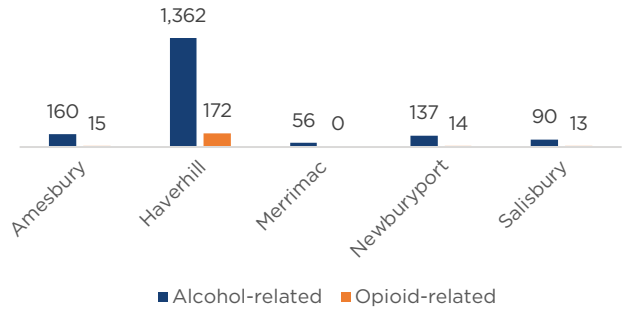
Source: CDC PLACES, 2022

Health Conditions

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

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

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



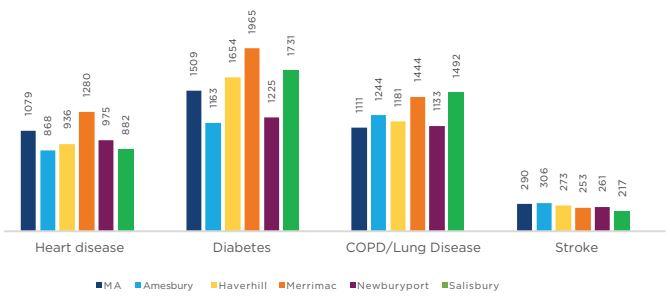
Source: MDPH Bureau of Substance Abuse Services, 2023-2024
Data unavailable for Seabrook, New Hampshire

Chronic and Complex Conditions

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

Looking across four of the more common chronic/complex conditions, inpatient discharge rates among adults 65 years of age and older were higher than the Commonwealth in Merrimac for heart disease, diabetes, and COPD/lung disease. In Newburyport, rates were lower than the Commonwealth for heart disease, diabetes, and stroke.

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



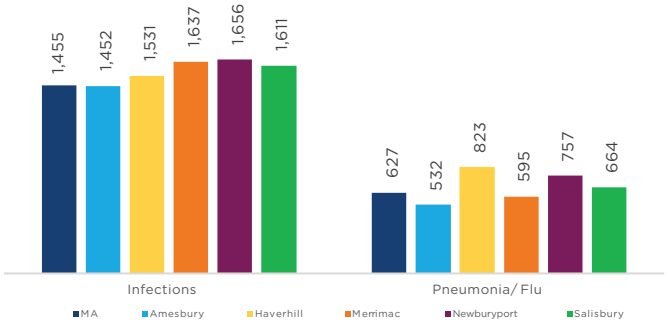
Source: Center for Health Information and Analysis, 2024
Data unavailable for Seabrook, New Hampshire

Communicable and Infectious Disease

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

Data from the Center for Health Information and Analysis indicated that older adults in Haverhill, Newburyport, and Salisbury had higher inpatient discharge rates for infections and pneumonia/flu compared to the Commonwealth.

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



Source: Center for Health Information and Analysis, 2024
Data unavailable for Seabrook, New Hampshire

Priorities

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

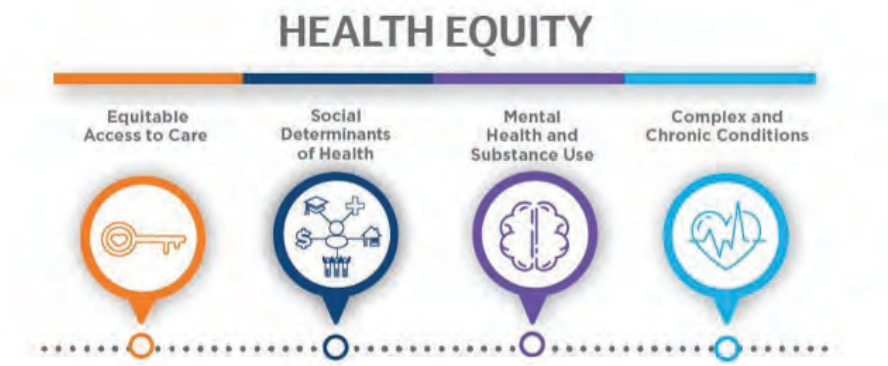
Community Health Priorities and Priority Cohorts

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

AJH Community Health Needs Assessment: Priority Cohorts

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

AJH Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by AJH

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

The issues that were identified in the AJH CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, economic insecurity, access to fresh/healthy foods, language and cultural barriers to services, long wait times, health insurance and cost barriers, depression/anxiety/stress, youth mental health, older adult loneliness and isolation, alcohol use, opioid use, navigating the behavioral health system, issues relating to aging, cardiovascular disease, chronic disease education/prevention/screening, healthy eating, caregiver resources and support, maternal health, and care navigation.

Implementation Strategy

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

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

AJH 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 AJH and/or its partners to improve the health of those living in its CBSA. AJH 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, AJH 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, AJH'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. AJH 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 AJH 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 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 by expanding access to affordable, nutritious food.
- Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.

SOCIAL DETERMINANTS OF HEALTH (continued)

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:

- Provide and promote career support services and career mobility programs to hospital employees 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 chronic and complex conditions and/or their caregivers.
- Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.
- Advocate for and support policies and systems that address those with chronic and complex conditions.

Evaluation of Impact of 2023-2025 Implementation Strategy

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

For the 2023-2025 IS process, AJH 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 Years 2023 and 2024. AJH 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	To address social determinants of health, Anna Jaques Hospital awarded community grants to organizations tackling food insecurity, housing instability, and access to healthy foods. Funded programs provided meals, fresh produce, and supportive services to low-income and unhoused individuals, including those served by Our Neighbors' Table, Nourishing the North Shore, and the Haverhill YMCA's hydroponic Freight Farm. The hospital supported housing programs through partnerships with the YWCA and Emmaus, Inc., leading to permanent housing placements for individuals experiencing homelessness. AJH also funded community-based food programs such as Common Ground Cafe and Haverhill Schools' food closet initiative. Additionally, the hospital participated in coalitions like the Our Neighbors' Table Food Security Advisory Group.
Equitable Access to Care	AJH made significant strides in improving equitable access to care by expanding financial assistance programs, transportation support, and culturally responsive services. In FY24, the hospital substantially increased the number of patients screened for financial aid and maintained transportation assistance for those with limited resources. It also launched a successful "Welcome Visit" program for expectant parents and continued to subsidize primary care access through affiliated practices. In FY24, interpreter services were expanded, with nearly 2,000 encounters,. Workforce efforts led to growth in ESOL participation, and community employment programs. AJH also partnered with Northern Essex Elder Transport and Merrimack Valley Transit to improve transportation infrastructure and access, particularly for older adults.
Mental Health and Substance Use	AJH strengthened mental health and substance use services by expanding behavioral health access, supporting youth resilience programs, and deepening community partnerships. Youth-focused grants increased therapeutic support, while the Collaborative Care Model and Patient Care Navigator programs served adults, particularly women in recovery. The hospital provided over 1,300 behavioral health crisis evaluations in FY24 and supported initiatives addressing suicide prevention and substance use recovery. It also delivered community education, including Mental Health First Aid training, and participated in regional coalitions to advocate for systemic change.
Chronic and Complex Conditions	AJH supported individuals with complex and chronic conditions by funding support groups, survivorship, and community-based wellness initiatives. The hospital offered classes to support and educate new parents in the community, while community grants fund adult day health. The hospital backed survivorship and fitness programs through the YMCA and YWCA, reaching cancer survivors and their families. Sponsorship of the Haverhill Farmers' Market provided access to healthy, fresh foods to help prevent chronic disease. Additional support included access to complementary therapies and education through support of North of Boston Cancer Resource, focused on improving cancer-related resources and advocacy.

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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?**

Anna Jaques Hospital
Summary of 2024-2025 Community Health Needs Assessment Interview Findings

Interviewees

- Kerri Perry, Community Action, Inc.
- Lyndsey Haight, Our Neighbors' Table
- Zandra Kelley and Dr. Jess Reader, Greater Lawrence Family Health Center
- Javier Bristol, Haverhill Boys & Girls Club
- Suzanne Dubois, Jeanne Geiger Crisis Center
- Chris Tardiff, AgeSpan
- Al Hanscom, Emmaus, Inc.
- Olivia White, Newburyport Housing Authority
- Nairoby Sanchez, Latino Coalition Leadership Team
- Renata Ivnitskaya, Northeast Arc
- Haverhill Municipal Leaders
- Newburyport Municipal Leaders
- Merrimac Municipal Leaders
- Salisbury Municipal Leaders
- Amesbury Municipal Leaders

Community Health Priority Areas

Social Determinants of Health

- Housing was a top concern throughout the interviews
    - Homelessness and an increase in temporary housing is a growing challenge
        - More people are sharing rooms, living in hotels, or relying on shelters
    - Housing affordability and availability are both key challenges
        - Waitlists for affordable housing units are often years long
        - Most of the new housing developments are luxury units rather than affordable or accessible units
        - Rent is increasing
    - Availability of housing (affordable, accessible) often depends on the specific neighborhood
- Food Insecurity
    - There are a lot of food resources available, but people do not have the knowledge on nutrition and its impact on health, especially chronic conditions.
        - Many communities have food pantries, churches, schools, and non-profit food deliveries that provide food resources
    - This challenge is especially relevant for the older adult population
- Transportation
    - In some communities the buses are free, but may have limited service, especially during weekdays
    - Some organizations use grant money to provide Lyft services for patients unable to get to their appointments

    - Transportation barriers impact older adults in particular who may also struggle with mobility
- Economic Insecurity
    - Rent and utilities are increasing in costs, with heat being particularly impactful
    - Earning minimum wage is not enough to support living in this area
- Social Connections
    - COVID-19 and social media negatively impacted feelings of social connection within the community
    - Many people experience chronic stress caused by housing, food, or economic insecurities

Access to Care

- Barriers to accessing medical care impact those who are low-income, those who speak a language other than English, those with a mental health diagnosis, and those who need specialty care in particular.
- Need for Additional Community Outreach
    - There is a lack of public health nursing and preventative care.
    - Screening and preventative care services should be available at community events
    - Basic medical appointments should be provided at community centers and senior centers rather than having patients wait for a primary care or urgent care appointment
    - Community health fairs, mobile flu shot clinics, and mobile prevention vans models should be expanded
    - There are opportunities for additional outreach through local cable television stations and town websites
- Lack of Providers
    - Many providers have moved away from the region, leaving gaps in primary care, mental health care, and specialty care
        - Individuals often have to go to Boston to receive care
    - There are limited providers outside of Boston, who accept public health insurance like MassHealth
- Lack of Navigation and Financial Support Services
    - Individuals are worried about the high costs of hospitalization and other more intensive levels of care
    - Individuals have trouble meeting their co-pays or incur additional changes during appointments if elements of a visit are not covered by insurance
    - Looking for health insurance and learning about each insurance network is challenging
    - Community health workers who could assist with care and medical system navigation would be helpful
- Language/Cultural Barriers
    - There is a lack of culturally and linguistically diverse providers, especially for specialty care
    - Newcomer groups are unaware of the healthcare and other resources available to them; need for additional service navigation support
- There is a lack trust between hospitals, patients, and medical providers

- While bus routes do help connect patients with medical care, including care in Boston, transportation is still a challenge.
- Providers are often unaware of the resources available to their parents

Mental Health and Substance Use

- Access to mental health resources and care was a major theme in almost all interviews
- Substance Use
    - Increase in male patients who are experiencing homelessness and have mental health needs. Often patients use substances to self-medicate or cope with stress.
    - Alcohol, opioid, and prescription medication misuse
    - Increase of usage requiring Narcan intervention – increase in clinics providing access
    - Youth Vaping
- Lack of providers and in-patient programs
    - Patients have to travel further to access care due the limited number of providers.
        - The development of Community Behavioral Health Centers is helpful but is too far away for many patients
    - Lack of mental health providers in the emergency rooms
    - Need for partial hospitalization program and intensive outpatient programs
    - Current services are for emergency intervention and evaluation rather than recovery or longer-term care
        - "To bridge the gap, we're using the anonymous hotlines; significant delay in getting the intake done for a mental health agency to begin working with patient"
    - Limited services available aimed at youth mental health
    - Long wait times for existing mental health services
- Social isolation and addressing stigma are challenges among older adult populations
    - There is a lack of mental health resources and programming for older adults, especially people who are homebound.
- Increase in calls to law enforcement and need for additional training for law enforcement on mental health interventions
- Often overlapping challenge between housing insecurity, economic insecurity, and mental health
- There are many resources so it can be a challenge to navigate them all
    - Need for more health advocates

Chronic and Complex Conditions

- Managing diabetes can be a challenge for many, especially older adults. The diagnosis is life-long and requires a lot of attention.
- Lack of coordinated care, timeliness of access, and continuity of care
- There is a lack of focus on preventative measures like screening, health education, medication management, and nutrition
- Chronic conditions prevalent in the community include diabetes, heart disease, lung conditions (including COPD), and high blood pressure

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
    - Low-resourced/low-income populations
    - Racially/ethnically/linguistically diverse populations
    - Individuals living with disabilities
- Interviewees also identified concerns for middle-aged men with chronic mental health conditions and pregnant individuals.
    - Need to address disparities in maternal health outcomes
- Interviewees specifically noted that youth engagement in community was a barrier
    - There is a lack of accessible spaces, mentoring, and afterschool care or programming
    - Youth don't feel like they belong or are wanted in the community

Community Resources, Partnership, and Collaboration

- Collaboration with community safety organizations (police, fire, etc.) schools, religious organizations, and community-based organizations is common
    - Specific organizations identified as key resources: Lion's Club, Pettengill House, Lawrence Partnership, YMCA, Boys and Girls Club, Community Action of Greater Haverhill, Newburyport Society for Relief for Older Women, St. Vincent DePaul, Partnership of Amesbury Community Youth Teams (PACT), Our Neighbor's Table, Council on Aging (COA), Essex Outreach, Latino Coalition, Food Council Task Force
- Organizations are working to address siloed work and improve cross-communication but the lack of financial resources and changes in town leadership can slow momentum

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Focus Group Guide

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

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

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

Opening Script

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

Question 1

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

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

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

Question 2

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

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

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

Question 3

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

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

Summarize:

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

Question 4

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

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

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

Question 5

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

Thank you

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

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

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

Anna Jaques Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Older adults
Location: Salisbury Senior Center
Date, time: 9/19/2024
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?**
    i. Walks - walking the dog, early morning walks, and participating in the walking group twice a week at the senior center
    ii. Yoga - including chair yoga at the senior center
    iii. Swimming
    iv. Yard work and gardening
    v. Diet and nutrition - limiting meat in their diet; eating more fruits and vegetables; drinking more electrolytes to stay hydrated
    vi. Exercise
    vii. Seeing a doctor regularly
    viii. Golf
    ix. Pickleball
    x. Trying to be active and do something every day
    xi. Social activities like trivia, cards, and cornhole

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Aches and pains
    ii. Injuries
    iii. Fear of falling - in general and on specific terrains like ice
    iv. Dependent on oxygen assistance
    v. Lack of motivation - need for more self-confidence
    vi. Feeling disconnected since COVID
    vii. Depression, loneliness - including the loss of loved ones
    viii. Poor time management
    ix. Perception of ability has changed - now that individuals are older they believe they cannot do the same activities as before
    x. Need for additional mental health and mindfulness programs

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. Get support from family
    b. Volunteer
    c. Reach out to past friendships - vent to friends
    d. Set goals for themself - including setting small daily goals
    e. Maintain a positive attitude and spend time with positive people
    f. Allow themselves to feel sad for limited periods of time, rather than ignoring the emotion
    g. Listen to music - especially music related to their current mood
    h. Make art and quilt
    i. Care for their pets
    j. Embrace their freedom
b. **What stops you from being as mentally healthy as you'd like to be?**
    a. Lack of mental health providers and facilities
    b. Lack of access and knowledge about zoom
    c. Challenges getting appointments
    d. Long wait times for care
    e. Challenges accessing the care portal
    f. Doctors do not spend enough time with patients during appointments
    g. Doctors are not prepared for patient visits and haven't reviewed the patient file
    h. Poor relationships with medical providers
    i. Lack of follow-up and communication from providers
    j. Challenges sharing information between providers
    k. Lack of care coordination support

Question 3

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

a. **What social factors are most problematic in your community?**
    a. Lack of affordable housing, especially for seniors
    b. Need for more social activities, like a low-cost gym membership
    c. Challenges accessing food
b. **Are there certain segments of the community (by geography, language, age, etc.) that struggle to get their needs met more than others? What sorts of barriers do they face in getting the resources they need?**

Question 4

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

a. **Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?**
    a. Salisbury has plenty of food resources, including food pantries, the Brown Bag: Food for Elders program, the harvest program, and SNAP
    b. Merrimack Valley Transit (MeVA)
    c. Council on Aging
    d. Some restaurants in the community provide deals or discounts
    e. Walking groups
    f. Choice Fitness
    g. Coffee Hour
    h. Weekly blood pressure screening
    i. Lazy J Ranch hosts mental health and well-being events where people can engage with horses
b. **What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. Discounted chiropractor and massage appointments
    b. Need for additional patient advocate support to help clients decipher prescriptions, doctor's advice, appointments, etc.

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?

- Resources to help someone get a new surgeon or doctor when their past provider retires
- Lack of rheumatologists in the area
- Long emergency room wait times
- Community hospital no longer provides level 1 trauma care
- Want to organize a group to meet directly with the hospital to address concerns

Anna Jaques Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Youth in Newburyport
Date, time: 10/2/24
Facilitator: JSI, in partnership with Newburyport Youth Services
Approximate number of participants: 12

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Eat healthy - eat two meals a day and access locally grown produce
    ii. Play sports - swimming, fencing, archery
    iii. Drink water
    iv. Take their vitamins and medications
    v. Keep a healthy sleep schedule
    vi. Help their younger siblings
    vii. Go to the doctor for regular checkups
    viii. Avoid vaping, drugs, and other harmful substances
    ix. Connect with family about their health
    x. Reduce caffeine intake
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Lack of time - busy school and afterschool schedules
    ii. Being scared to ask for help
    iii. Poor mental health
    iv. Feeling unworthy
    v. Addiction to harmful substances
    vi. Forgetfulness

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. Refocus on a different thing when upset
    b. Watch nostalgic television shows
    c. Watch funny videos or shows

d. Read
e. Scroll through the internet or social media
f. Sleep
g. Reach out to their doctor
h. Reach out to their parents
i. Pay attention to patterns in their mental health
j. Try to stay positive
k. Practice staying grounded
l. Practice positive self talk
m. Set boundaries
n. Do something special for themself
o. Paint, write, and draw
p. Listen to music
q. Talk to friends
r. Journal
s. Facetime loved ones
t. Redirect anger towards their pillow
u. Remove themself from stressful situations
v. Take a break to go for a walk
w. Look at happy photos
x. Go for a run or walk outside
y. Distract themself
z. Eat chocolate
aa. Play video games

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

a. Difficulty getting a diagnosis
b. Challenges with parents
c. Spending too much time scrolling the internet
d. Comparing themself to others
e. Lack of schedule flexibility
f. Pressure to succeed
g. Being in activities that are beyond their ability and being told they are not trying hard enough
h. Financial challenges
i. Lack of understanding from adults
j. Lack of validation for their feelings
k. Having to do things they don't want to do

Question 3

We know that health and wellness are heavily impacted by people's ability to access the things they need to live comfortably – access to housing that is affordable, access to transportation, access to

food, and living in a community that feels safe and welcoming. These are sometimes called the "social factors that impact health."

- **a. What social factors are most problematic in your community?**
    a. Access to food
    b. Feeling safe and welcome in the community - people who look different are singled out
    c. Community stability
    d. Bullying
    e. Feeling isolated
    f. Lack of education in older generations
- **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. No response

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. Youth Services
    b. NYS lunches
    c. High School and Nock GSA
    d. Medical resources - hospitals, doctors, therapists
    e. Helpline and hotline access
- **b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?**
    a. Not enough places for teenagers to go and feel safe - especially with the loss of the Brown school, NYS students do not have their own space
    b. Education materials for adults
    c. Dedicated spaces for LGBTQ+ individuals (of all ages)
    d. Community Center
    e. Dedicated safe spaces

Question 5

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

No responses

Anna Jaques Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Low-resource adults
Location: Pettengill House
Date, time: 10/25/2024
Facilitator: JSI
Approximate number of participants: 6

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Go for a walk
    ii. Swim and do aqua therapy - at Port Plaza and the YMCA
    iii. Embrace humor
    iv. Attend doctors appointments
    v. Participate in faith-based activities
    vi. Work in the garden
    vii. Take vitamins and eat healthy
b. **What stops you from being as physically healthy as you'd like to be?**

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. Participate in faith-based activities
    b. Embrace humor
    c. Figure out who they are and act on their needs
    d. Connect with social workers when they need help
    e. Connect with people in their life who support them
    f. Write, play games, and read books
b. **What stops you from being as mentally healthy as you'd like to be?**
    a. Many therapists do not take their insurance
    b. Pain and stress are barriers to getting out and doing activities

c. Long wait times for mental health supports
d. Loneliness

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. Politics, especially after the presidential election
   b. Pads and pull-ups are expensive and difficult to find
   c. Aggressive drivers in the community
   d. Lack of spaces for kids to hang out

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

Question 4

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

a. Tell me about the resources in your community – which organizations and places help people to stay physically and mentally healthy, and get the basic things they need (e.g., housing, food, transportation, etc.)?
   a. Lots of food is available at the community food pantries
   b. Bus and transportation resources for individuals without cars
   c. Police and fire departments are involved in the community and conduct wellness checks
   d. Salisbury beach is a popular and safer place
   e. Hilton Resource Center
   f. Medical resources - Seabrook emergency room, Anna Jaques emergency room, Seabrook urgent care
      i. The emergency room in Seabrook is incredible; you don't have to wait long to be seen and they don't hesitate to call specialists.
   g. St. Vincent De Paul
   h. Salvation Army

b. What kind of resources are <u>not</u> available in your community, but you'd like them to be?
   a. Lack of language resources and resources for immigrants
      i. One client at their agency said it was hard to communicate and they did not have any language resources to refer them to.

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?

- Haven't had good luck with Anna Jaques Hospital
    - She was cut open without anesthesia, sent home with appendicitis, and her appendix burst. The sheets and gowns didn't get changed during the days that she spent there.
    - Other clients agreed that their experiences with Anna Jaques Hospital were insufficient.
    - The people that ran Anna Jaques before Covid were better than those running it post-Covid.
- Need for additional money toward the mall in Newburyport
- Need for additional bible study programs in Newburyport to help with mental health
- Many nurses and other hospital workers left during the pandemic and didn't come back. Bedside manner has gone "right out the window" since staff started returning to work after the pandemic
- Most people don't know what services are available

Anna Jaques Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Spanish speakers
Location: Community Action, Inc. (Haverhill)
Date, time: 10/28/2024
Facilitator: JSI in collaboration with Community Action Inc.
Language: Spanish
Approximate number of participants: 15

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. I have found that I need hot showers to be able to function, I have arthritis and I wake up very stiff. Once I take a very hot shower, I am able to go about my day.
    ii. I need to be very active and move around in order to feel fine. Being busy helps me avoid the pain that my body feels.
    iii. Be physically active
    iv. Attending physical therapy helps with backaches and arthritis pain
    v. Nutrition and healthy eating have helped me so much! I have suffered from constipation and increasing my fiber intake has even helped me lose thirty pounds.
    vi. I need to check my food intake because I used to be very thin.

b. **What stops you from being as physically healthy as you'd like to be?**
    i. Cold weather makes their arthritis pain worse and wearing a lot of clothing makes them feel suffocated.
    ii. Chronic pain
    iii. Stress can have a big impact. We are always on the go and forget to take care of ourselves. I feel like stress impacts your mental and physical health
    iv. Stress is something that has affected me. I have had many headaches that were due to stress. Half of my face has gone numb due to stress headaches.
    v. There were many times that I went to the hospital and had multiple exams, but they never found anything. I feel like our physical health problems are affected by our mental health. It starts with mental health challenges than it turns into something physical.

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. Seeing a therapist can help with feelings of burnout
- **b. What stops you from being as mentally healthy as you'd like to be?**
    - a. Personally, I do not feel comfortable talking to someone, especially a stranger about what I feel.
    - b. Stress

Question 3

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

- **a. What social factors are most problematic in your community?**
    - a. I am having a hard time with housing. When you find an apartment, they have so many requirements. You have to have good credit, savings, and be able to pay the security deposits; it is very expensive. It feels like I am purchasing a home. I have a child with autism and am having a hard time finding housing. It has been very stressful. When I am looking for an apartment, I also look for first-floor apartments because my son likes to run around.
    - b. Just like we all have stress as tenants, the landlords also have stress. The landlords have a mortgage to pay. They want to make sure the tenants are going to pay.
        - i. I have family members that own houses and they want the tenants to pay the mortgage and the mortgage of their other house so that they can live for free.
            1. That is something that homeowners think is going to happen, but with the interest rates today that is not possible.
    - c. I also have a child with autism. I go to work and have to come home on time because I don't have anyone to care for my child with special needs.
    - d. Another thing is that the economy is very unstable. My husband could lose his job at any point. He can get his hours cut and that causes me stress.
    - e. I work with WIC and have seen that the voucher waitlist is one to two years long. Another way to get assistance is through DTA, which is an accelerated process. Head Start has a waitlist for their half-day program. I was a teacher and a mom and I had to talk to my supervisor, because I needed more hours and I needed childcare. There is also Family Child Care which may be more affordable, but I am not sure. I tell my participants to take care of their voucher as if it was gold.
        - i. That is true. I have been on a voucher waitlist for a very long time, and I still do not have a voucher.

f. I have not had any good experiences with therapists or specialists who work with children with special needs.
g. Unfortunately, we do not have many services for children with special needs. I believe in Haverhill we only have one school for children with special needs.
h. The therapist that we saw did not do anything with my child. The Early Intervention Specialist came three times in six months.
    i. The Early Intervention Specialists are trained in this. They should be able to work with the child's needs.
i. There are family members that are trained to care for older adults, maybe this is something that can be done with children.
    i. They don't have that program with children. I tried to receive support for my child that has special needs, and I feel like I need to be reimbursed for caring for my child, because the child does not talk and is very aggressive, but they do not want parents to be reimbursed. My child once left the house and DCYF was informed. I was assigned a social worker, but they did not do anything; they only took notes.

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. Children with special needs

Question 4

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

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

a. The Child Care Circuit should be able to provide information to individuals with childcare vouchers.
b. Family Child Care
c. Public transportation is working well.
d. Community Action, Inc. provides many services
    i. Yes, Community Action, Inc. has helped me so much. I received two months of rent assistance because my husband had an accident at work. I have also received diapers

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

a. Need for more translation resources
    i. Lawrence does a great job of translating. Haverhill, Salem and Danvers do not have a lot of translation services available.
    ii. I feel like it also depends on the staff person. I went to Pentucket Medical, and a receptionist who speaks Spanish did not want to speak to me in Spanish. It was clear that she knew the language.

b. The hospitals do not have enough staff.
c. I went to the Emergency Department and I had to wait 12 hours for the ambulance to come and transfer my daughter to Boston. They did not let me take my child myself.

Question 5

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

No responses

Anna Jaques Hospital
Focus Group Notes for FY2025 Community Health Needs Assessment

Focus Group Information

Name of group: Community Action Inc. Parents and Caregivers
Location: Zoom
Date, time: 11/4/2024
Facilitator: JSI
Approximate number of participants: 12

Question 1

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay physically healthy?**
    i. Stay busy and active
    ii. Keep to a routine
    iii. Do a quick workout for 15 minutes three times a week
    iv. Go for walks after meals
    v. Go to the gym at Planet Fitness
    vi. Exercise every morning. When I started doing this it was hard to stick to it but now I am used to it.
b. **What stops you from being as physically healthy as you'd like to be?**
    i. Financial limitations
    ii. Attending to children
    iii. Depression, isolation, and poor mental health - when my mental health is low, I am not as willing to walk
    iv. Lack of knowledge about what is healthy
    v. The area where they live is not supportive
    vi. Time - I work two jobs and go to school while parenting
    vii. Convenience
    viii. Food is a source of comfort - it is easy to eat and not think about health

Question 2

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

a. **Think about yourself, your family, and your loved ones. What sort of things do you and the people you know do to stay mentally healthy?**
    a. I see a therapist once a week
    b. I like to dress up and look nice - hygiene, hair, makeup, and clothes

c. I try to focus on my son, he needs us to be healthy
d. Good communication in my relationship helps us not get too stressed

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

a. We're not always thinking about our mental health
b. Thinking about finances has a big toll on my mental health
    i. Lately it has been a struggle with money to look nice
    ii. Financial instability is the source of many arguments
    iii. It is difficult as a single person to pay for bills - it takes a lot out of you
    iv. I don't know how anyone does it as a single parent
    v. As a single parent, something I pull up to work and wonder why I'm there.
    vi. I work two jobs and am in school. Some days I feel like giving up; my son keeps me going.
c. Feeling like I am by myself. I am trying to set boundaries with my kids.
    i. It is so difficult to set boundaries. I live in my house and it can get very isolating and depressing
    ii. Yes it is very hard when there is no one around to help and your spouse works all day. It is just you with four children. The dishes are piled up and there is a mess in every room; I clean and then there is a mess everywhere again.
d. I am struggling with school and it is taking a toll on my mental health. Sometimes I get discouraged and I want to give up.
e. Wanting to avoid confrontation
f. Others may not be as willing to have a conversation about mental health
g. Having kids with special needs is challenging

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. Financial Insecurity
    i. I am on social security. I can't afford to go out or eat at a restaurant; there aren't fun things in my life anymore.
    ii. It is hard to live on a budget and put food on the table. I like to look and dress nice. Money is a big stressor, but it is hard for me to stop spending money.
b. Jealousy - especially from social media
c. I lived in East Boston where there are a lot of trains and buses, but here it is a lot harder to get around without buses. It can be a struggle to get to medical appointments and it feels very isolating.
d. A lot of people do not have support systems and are trying to do it all alone.

i. It is hard to find social support. When I was younger I was very social, but now I don't have many friends. Social media and being on my phone takes me away from reality. People do not have respect for each other.
ii. There is not a sense of community. I am from a small town in New Hampshire where everyone knows each other, but it is a different vibe here. It is everyone for themselves.

e. People are mean, bitter, and angry; it makes me not want to talk to anyone.
    i. People do not have respect for each other.
f. Daycare is very expensive

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

a. There are not a lot of resources for single dads in the community. It is hard for single dads to get into a shelter with kids. Single dads do not get talked about enough in the community. There is a focus on women and children but not on single fathers.
    i. I have run into obstacles where places will not accept me and my three kids. I used to work 65 hours per week but now I can only work part time.

Question 4

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

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

a. I belong to an organization in Haverhill and Lawrence. I go three times per week. They do activities, host trips, provide lunches, and have meetings about mental health. It is a place to get people off the streets and give them something to do. Other days I go to school.
b. Salvation army and food pantries
c. There are a lot of resources in the community, you just have to know about them.
    i. If you are not looking for it, you are not going to find it.
d. The pregnancy care center offers food, clothes,and diapers. The center has been a huge help for me.
e. Mental Health Counseling at the YW
f. The library has activities and provides discounted tickets

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

a. The community does not have enough veteran resources, especially for veterans with mental health issues.
b. There are not a lot of places for older kids to hang out; there is nothing for them to do and they are losing out.
    i. Kids are out on the street and are vaping

ii. Sports are expensive
iii. Kids are getting into trouble for their ADHD

c. I have two autistic children, both are non-verbal, and we could really use some sports for them.

Question 5

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

- We need easier housing resources; I have been on the waiting list since 2017. It is hard to get housing resources like Section 8 or RAFT. I struggle to talk with people and start the application. It is very stressful and they are not making it any easier.
    - Once you get a voucher, they still don't rent to Section 8 vouchers. You have a month to find housing with the voucher.
    - The cost of rent is skyrocketing; nobody can afford rent
    - There is definitely a housing crisis right now
    - My kids need a stable place to live, but we have been waiting for years.
- I have spent two years on the childcare voucher waiting list. I want to get back to work full time.

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."

Mentimeter

Anna Jaques Hospital Community Listening Session

February 12, 2022 | 11:00am-12:30pm

Beth Israel Lahey Health

Anna Jaques Hospital Community Listening Session

Join a language channel

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

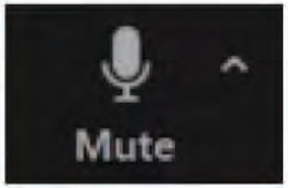
2. Choose your preferred language

3. Mute original audio to only hear the interpreted audio

Mentimeter

Anna Jaques Hospital 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

Anna Jaques Hospital Community Listening Session

Beth Israel Lahey Health

Beth Israel Lahey Health
Anna Jaques Hospital

Mentimeter

Anna Jaques Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
11:00-11:05	Zoom orientation and Welcome	JSI
11:05-11:10	Overview of assessment purpose, process, and guiding principles	Tom Sands, Market President – North Shore Janel D'Agata-Lynch, Community Benefits & Community Relations Manager, Anna Jaques Hospital
11:10-11:25	Presentation of preliminary themes and data findings	JSI
11:25-11:30	Transition to Breakout Groups	JSI
11:30-12:25	Breakout Groups: Prioritization and Discussion	Community Facilitators
12:25-12:30	Wrap up and Next Steps	Janel D'Agata-Lynch

Mentimeter

Assessment Purpose and Process

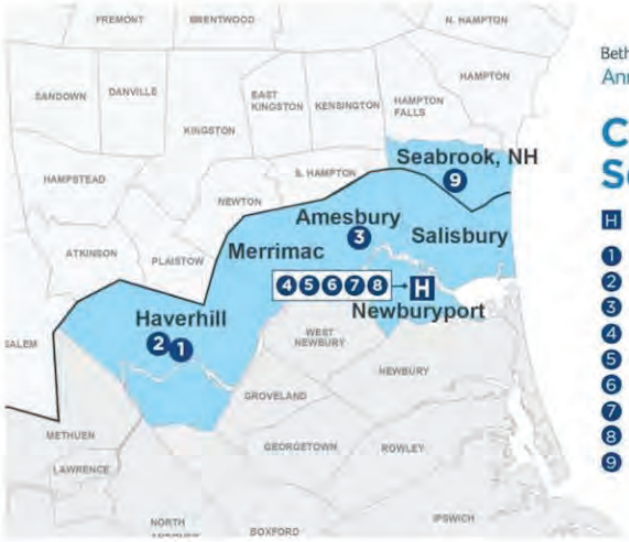
Assessment Purpose and Process

Purpose

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

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

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



Beth Israel Lahey Health
Anna Jaques Hospital

Community Benefits Service Area

- H Anna Jaques Hospital
- 1 Diagnostic Imaging Services
- 2 Ultrasound at Women's Health Care, Haverhill
- 3 Amesbury Health Center
- 4 Satellite Offices at the Medical Office Building
- 5 Cancer Center
- 6 Diagnostic Ultrasound at Women's Health Care
- 7 Outpatient Rehabilitation Services
- 8 Aquatic Rehabilitation
- 9 Anna Jaques Hospital Laboratory

Community Benefits and Community Relations
Guiding Principles

Beth Israel Lahey Health

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

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

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

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

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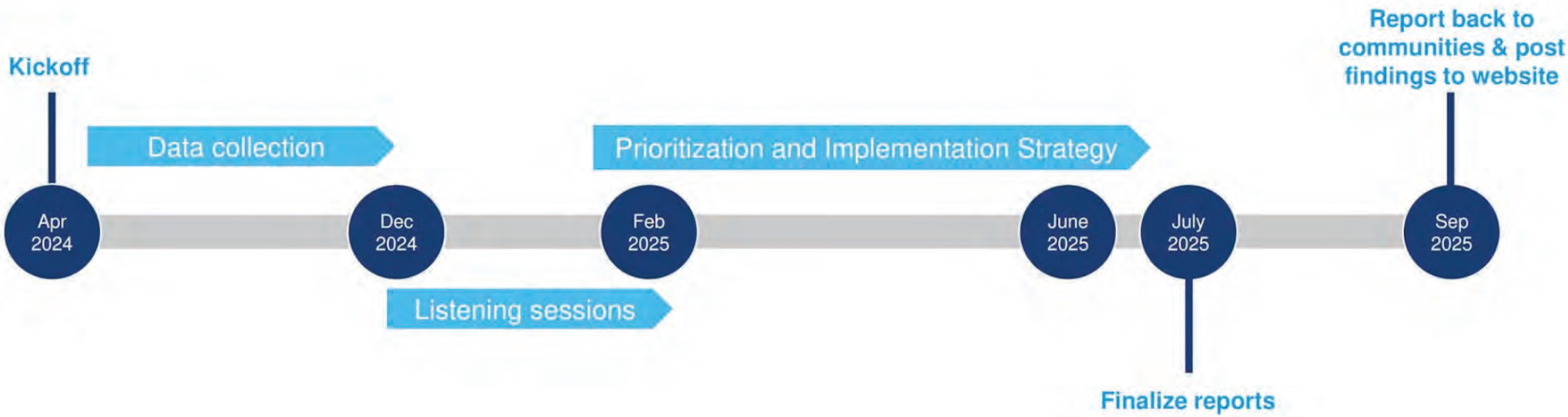
Assessment Purpose and Process

FY25 CHNA and Implementation Strategy Process



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Assessment Purpose and Process

Meeting goals

Goals:

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

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

Key Themes & Data Findings

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
- MA Community Health Equity Survey
- Other local sources of data

15 Interviews

1,354 FY25 AJH Community Health Survey Respondents

5 Focus Groups

- Older adults (*Salisbury Council on Aging*)
- LGBTQIA+ youth (*Newburyport Youth Services*)
- Low resource individuals (*Pettengill House*)
- Low resource parents/caretakers (*Community Action Inc*)
- Low resource adults who speak Spanish (*Community Action Inc*)

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FY25 CHNA Progress

FY25 AJH Community Health Survey Responses

1,354 responses
(Represents a 75% increase from 773 responses in FY22)

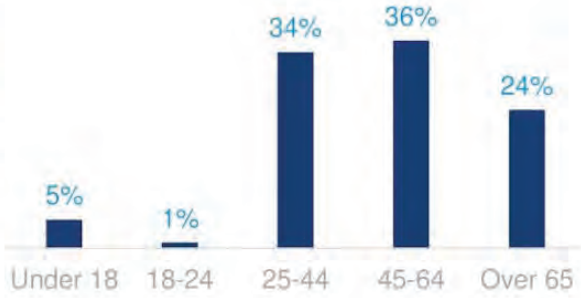
10% of respondents report a language other than English as the primary language spoken in their home **(up from 5% in FY22)**

80% of the respondents are women **(same as FY22)**

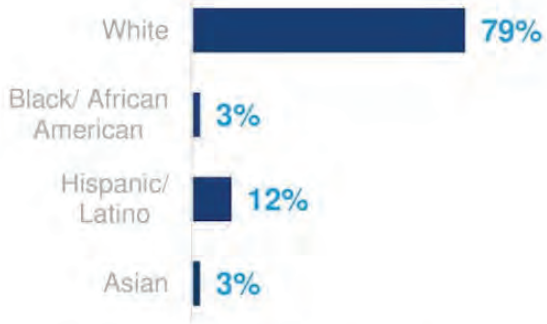
12% of the respondents identify as living with a disability **(up from 10% in FY22)**

8% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning **(up from 6% in FY22)**

Age



Race/Ethnicity



Key Accomplishments

- **Surveys taken in a language other than English:** 122 in FY25 compared to 7 in FY22
- **Hispanic respondents:** 12% in FY25 compared to 4% in FY22
- **Asian respondents:** 3% in FY25 compared to less than 1% in FY22
- **Black/African American respondents:** 3% in FY25 compared to 1% in FY22

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FY25 CHNA Progress

Community Benefits Service Area Strengths and Opportunities for AJH

FROM INTERVIEWS & FOCUS GROUPS:

- Organizations willing to work together across sectors to address community issues
- Strong, active network of community services for youth
- Continue to build partnerships and bring services and support to community spaces (e.g., community centers, Councils on Aging)
- Continue communication and collaboration with other clinical providers to improve care transitions

FROM FY25 AJH COMMUNITY HEALTH SURVEY:

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

said the community is **a good place to raise children**
(up from 80% in FY22)

said the community **has good access to resources**
(down from 87% in FY22)

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FY25 CHNA Progress
Preliminary priorities and key themes

Social Determinants of Health

Equitable Access to Care

Mental Health and Substance Use

Complex and Chronic Conditions

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

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FY25 CHNA Progress

Preliminary Priority: Social Determinants of Health

Primary concerns:

- Lack of affordable housing
- Economic insecurity/high cost of living
- Access to fresh/healthy foods
- Access to transportation
- Language and cultural barriers to services

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

– Focus group participant

When asked what they'd like to improve in their community, **54%** of FY25 AJH Community Health Survey respondents reported

"more affordable housing"
(#1 response)

20% of FY25 AJH Community Health Survey respondents said they had trouble paying for food or groceries sometime within the past year

19% of FY25 AJH Community Health Survey respondents said better access to public transportation is one of the top 5 things they'd like to improve in their community

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FY25 CHNA Progress

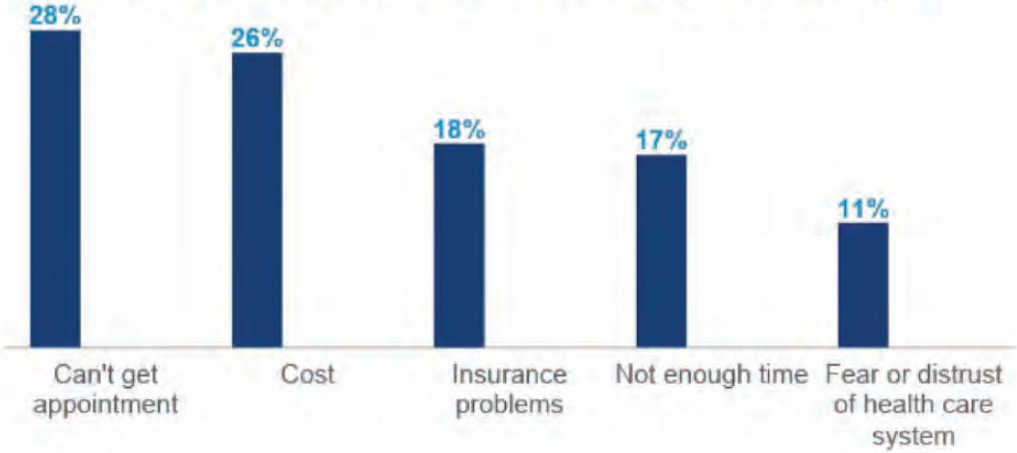
Preliminary Priority: Equitable Access to Care

Primary concerns:

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

What barriers keep you from getting needed health care?

(Top 5 responses from FY25 AJH Community Health Survey)



"We aren't doing enough to help patients know what they are doing with their health care. They just go back to the hospital. Having help with coordinating care would be huge."

*- **Interviewee***

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FY25 CHNA Progress

Preliminary Priority: Mental Health and Substance Use

Primary Concerns:

- Chronic depression, anxiety, and stress
- Youth mental health issues
- Older adult loneliness and isolation
- Alcohol use
- Opioid use
- Lack of providers
- Navigating the behavioral health system

"We have a substantial aging population. We recently had a mental health forum where a lot of elderly folks made their voices heard. They said there is nothing for the elderly. A lot of things are put into youth mental health. But a person isolated at home? There isn't much for them."

– Interviewee

AMONG FY25 AJH COMMUNITY HEALTH SURVEY RESPONDENTS:

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

25% of 6-12th graders in Newburyport reported feeling sad or depressed most or all of the time in the last month; **17%** reported having attempted suicide one or more times

Data source: 2024 Profiles of Student Life – Attitudes and Behaviors, Search Institute

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FY25 CHNA Progress

Preliminary Priority: Complex and Chronic Conditions

Primary Concerns:

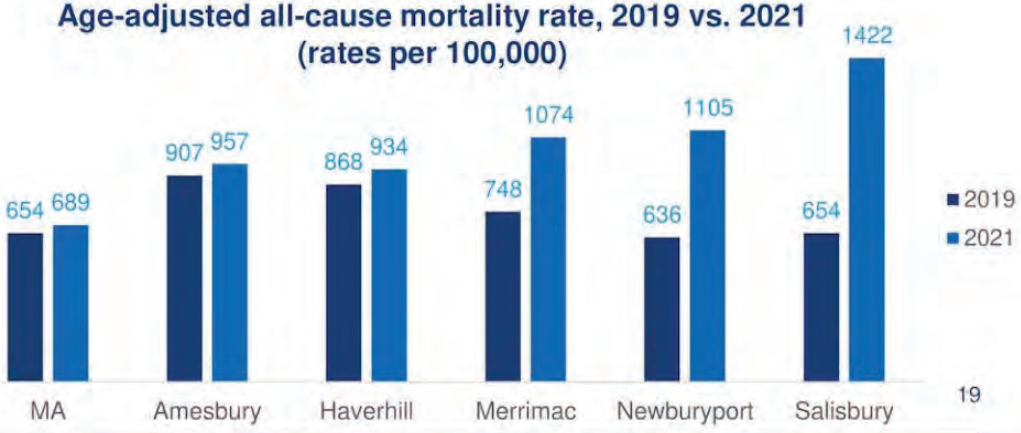
- Issues related to aging (e.g., mobility, Alzheimer's, dementia)
- Diabetes
- Cardiovascular disease
- Chronic disease education, prevention, and screening
- Healthy eating/active living programming
- Caregiver resources and support
- Care navigation

"We need to meet people where they're at. We would love to see more mobile clinics and more mobile prevention efforts coming to this area." -Interviewee

AMONG AJH FY25 COMMUNITY HEALTH SURVEY RESPONDENTS:

39% identified aging issues (e.g., arthritis, falls, hearing/vision loss) as a heath issue that matters most in their community (#3 response)

Age-adjusted all-cause mortality rate, 2019 vs. 2021 (rates per 100,000)



Data source: MDPH, Massachusetts Deaths, 2019 and 2021

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Anna Jaques Hospital

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Instructions

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Breakout Sessions

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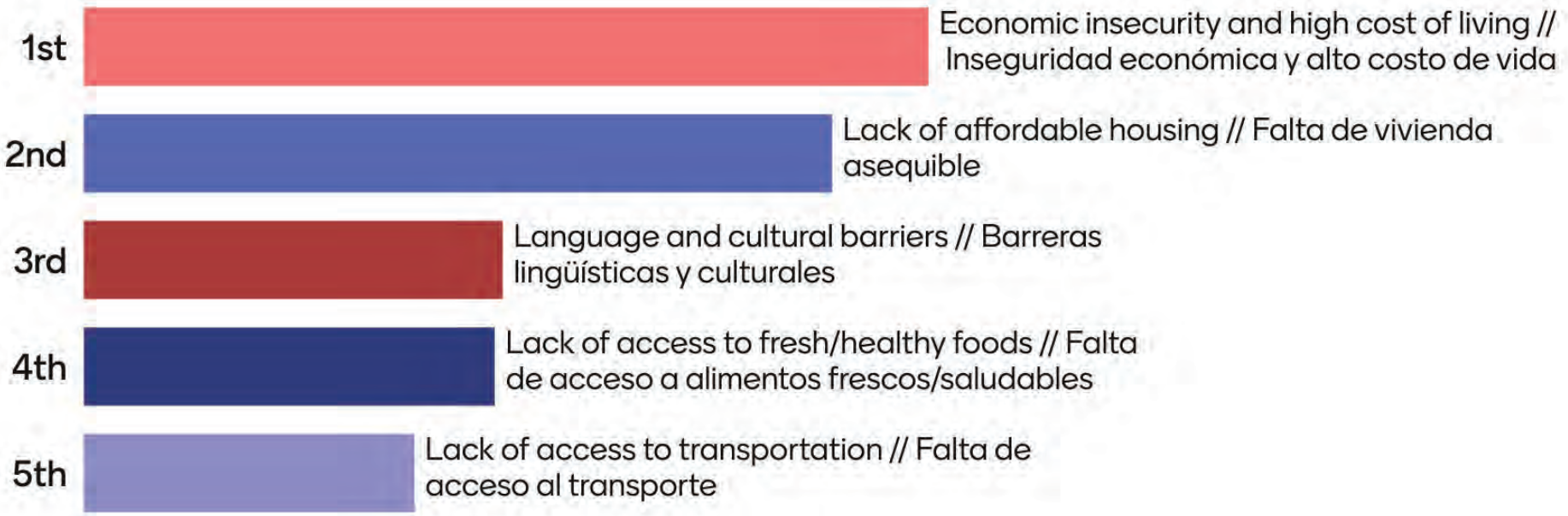
Social Determinants: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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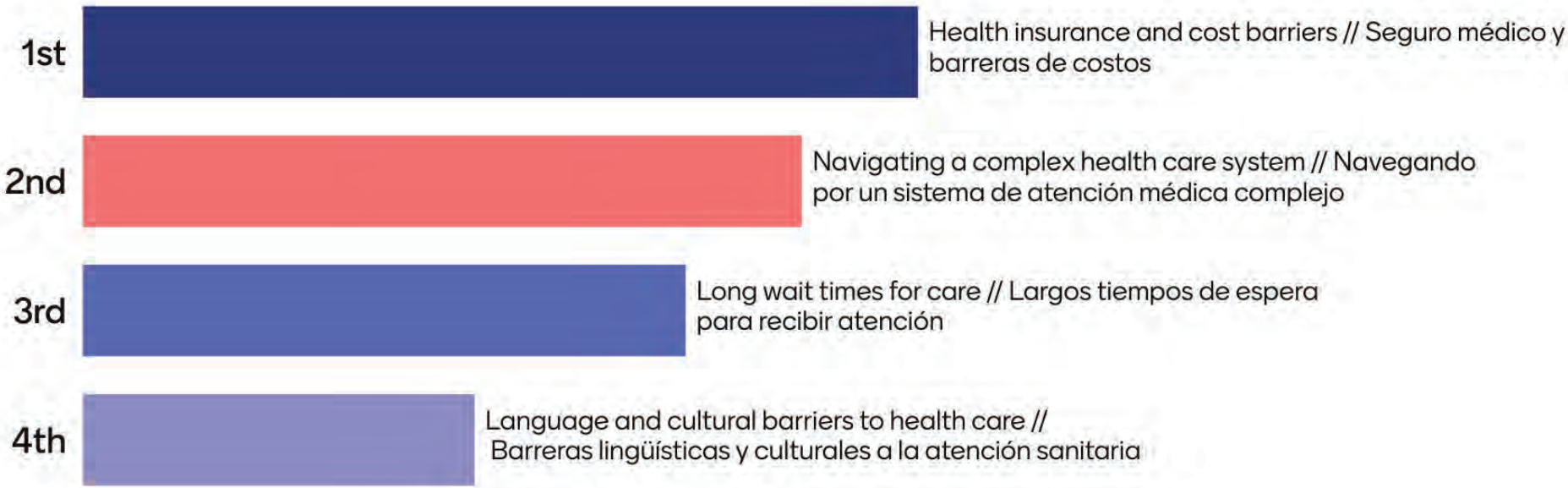
Access to care: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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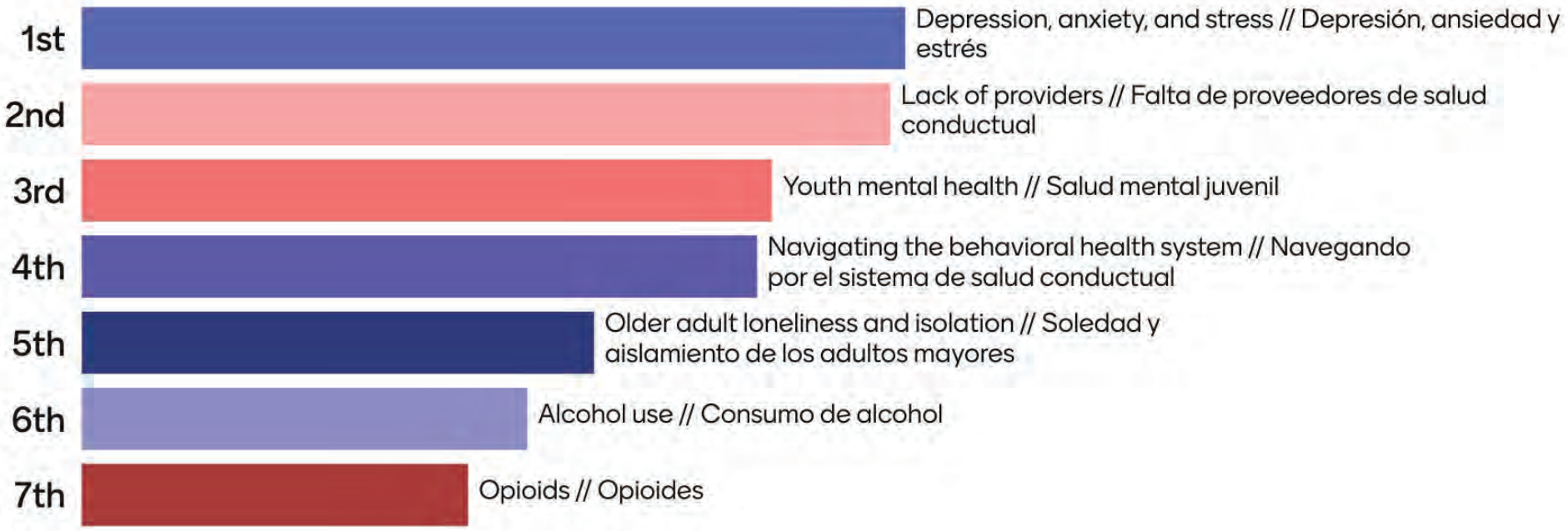
Mental Health and Substance Use: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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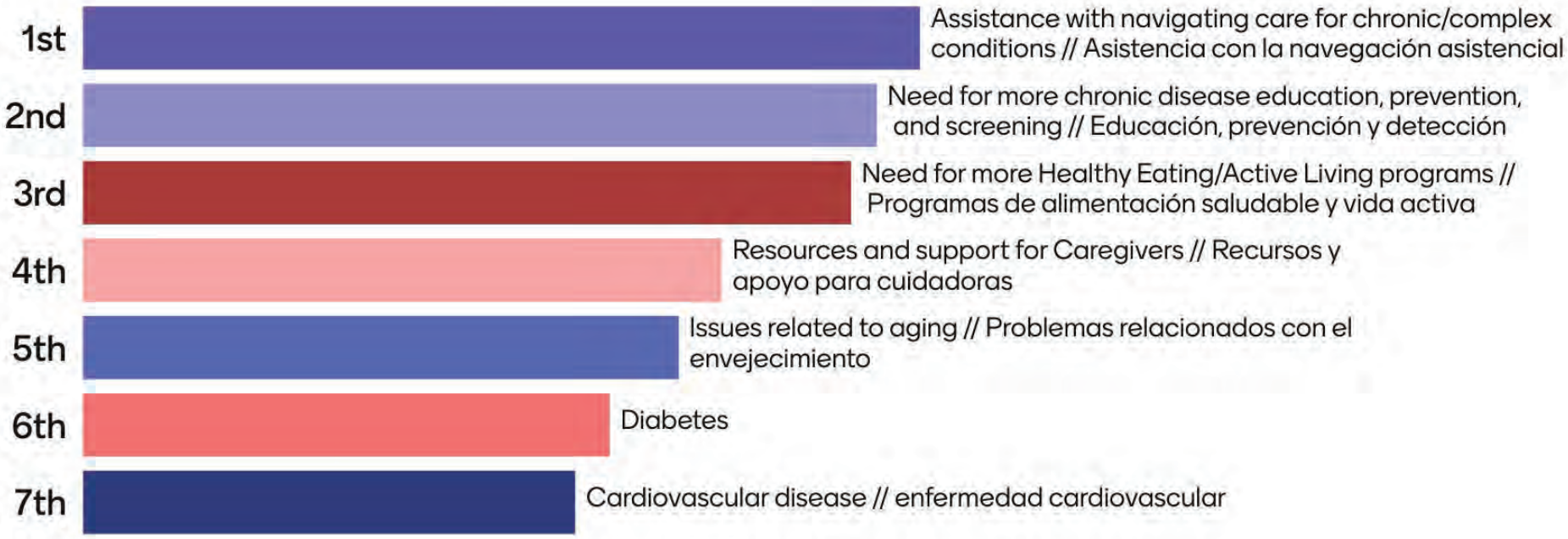
Chronic and complex conditions: Rank the following in order of what you feel should be the highest priority, based on needs in your community



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Reconvene

Next Steps

Janel D'Agata-Lynch

Manager, Community Benefits & Community Relations || Anna Jaques Hospital

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Community Health & Community Benefits Information:

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

Community Benefits Annual Meeting in September (date TBD)

Appendix B:
Data Book

Secondary Data

Demographics

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Amesbury - Merrimac

					Areas of Interest			
	Massachusetts	New Hampshire	Essex County, MA	Rockingham County, NH	Amesbury, MA	Haverhill, MA	Merrimac, MA	Source
Demographics								
Population								US Census Bureau, American Community Survey 2019-2023
Total population	6992395	1,387,834	807258	317,163	17277	67387	6707	
Male	48.9%	49.9%	48.6%	49.8%	48.8%	48.5%	55.3%	
Female	51.1%	50.1%	51.4%	50.2%	51.2%	51.5%	44.7%	
Age Distribution								US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	4.6%	5.4%	4.5%	4.9%	5.5%	5.7%	
5 to 9 years	5.2%	4.9%	5.6%	5.2%	4.4%	5.4%	7.1%	
10 to 14 years	5.7%	5.5%	6.2%	5.4%	6.5%	6.7%	2.7%	
15 to 19 years	6.5%	6.1%	6.4%	5.6%	5.3%	6.4%	3.9%	
20 to 24 years	6.8%	6.2%	6.2%	5.2%	3.2%	6.3%	5.5%	
25 to 34 years	14.1%	12.7%	12.5%	11.9%	12.9%	14.7%	11.1%	
35 to 44 years	12.9%	12.1%	12.6%	12.4%	14.0%	12.1%	8.4%	
45 to 54 years	12.6%	12.8%	12.8%	13.6%	15.2%	13.0%	14.7%	
55 to 59 years	7.0%	7.8%	7.3%	8.3%	8.4%	7.7%	10.1%	
60 to 64 years	6.8%	7.9%	7.0%	8.4%	7.2%	6.8%	7.2%	
65 to 74 years	10.3%	11.9%	10.7%	12.1%	11.3%	9.2%	13.8%	
75 to 84 years	4.9%	5.5%	5.0%	5.7%	4.9%	4.2%	8.3%	
85 years and over	2.2%	2.0%	2.4%	1.8%	1.8%	2.0%	1.6%	
Under 18 years of age	19.6%	18.5%	21.0%	18.8%	19.0%	21.5%	17.4%	
Over 65 years of age	17.5%	19.5%	18.0%	19.5%	18.0%	15.4%	23.7%	

Key

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Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
Race/Ethnicity								US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.70%	88.9%	70.3%	91.4%	87.7%	69.9%	94.90%	
Black or African American alone (%)	7.0%	1.5%	4.1%	0.9%	3.3%	3.1%	0.0%	
American Indian and Alaska Native (%) alone	0.2%	0.1%	0.3%	0.1%	0.0%	0.2%	0.0%	
Asian alone (%)	7.1%	2.6%	3.5%	2.1%	1.1%	1.3%	0.0%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	1.3%	12.1%	1.1%	1.4%	10.2%	0.0%	
Two or More Races (%)	9.5%	5.5%	9.7%	4.4%	6.5%	15.3%	5.0%	
Hispanic or Latino of Any Race (%)	12.9%	4.5%	23.2%	3.5%	3.8%	26.4%	0.6%	
Foreign-born								US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	86,095	151,560	16,655	1,523	9,023	275	
Naturalized U.S. citizen	54.5%	59.9%	56.4%	66.2%	53.4%	58.7%	85.1%	
Not a U.S. citizen	45.5%	40.1%	43.6%	33.8%	46.6%	41.3%	14.9%	
Region of birth: Europe	18.1%	23.8%	13.4%	32.1%	26.0%	11.4%	94.5%	
Region of birth: Asia	30.5%	33.1%	14.5%	35.6%	20.2%	7.1%	0.0%	
Region of birth: Africa	9.5%	8.2%	5.5%	2.9%	23.8%	5.0%	0.0%	
Region of birth: Oceania	0.3%	0.7%	0.2%	0.6%	0.9%	0.1%	0.0%	
Region of birth: Latin America	39.4%	25.3%	64.4%	21.9%	13.1%	73.4%	0.0%	
Region of birth: Northern America	2.2%	8.9%	2.0%	7.0%	16.0%	3.0%	5.5%	

Key

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Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
Language								US Census Bureau, American Community Survey 2019-2023
English only	75.2%	92.0%	71.6%	93.7%	91.7%	74.5%	93.6%	
Language other than English	24.8%	8.0%	28.4%	6.3%	8.3%	25.5%	6.4%	
Speak English less than "very well"	9.7%	2.4%	12.2%	1.3%	2.9%	7.5%	1.3%	
Spanish	9.6%	2.7%	18.8%	2.0%	2.3%	20.0%	0.8%	
Speak English less than "very well"	4.1%	0.9%	8.8%	0.4%	1.0%	6.0%	0.0%	
Other Indo-European languages	9.2%	3.4%	6.4%	2.7%	3.1%	4.1%	5.6%	
Speak English less than "very well"	3.2%	0.8%	2.2%	0.4%	1.2%	1.1%	1.3%	
Asian and Pacific Islander languages	4.4%	1.4%	2.0%	1.2%	0.5%	0.7%	0.0%	
Speak English less than "very well"	1.9%	0.5%	0.9%	0.4%	0.1%	0.2%	0.0%	
Other languages	1.6%	0.6%	1.2%	0.4%	2.4%	0.7%	0.0%	
Speak English less than "very well"	0.4%	0.2%	0.4%	0.1%	0.6%	0.1%	0.0%	
Employment								US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	3.4%	5.1%	3.5%	3.9%	5.9%	1.6%	
Unemployment rate by race/ethnicity								
White alone	4.5%	3.3%	4.3%	3.4%	3.5%	4.6%	1.7%	
Black or African American alone	7.9%	5.1%	4.6%	13.6%	0.0%	13.0%	-	
American Indian and Alaska Native alone	6.9%	1.6%	1.8%	0.0%	-	0.0%	-	

Key

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Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
Asian alone	4.0%	3.3%	3.3%	2.8%	0.0%	13.8%	-	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	0.0%	0.0%	0.0%	-	-	
Some other race alone	8.0%	4.7%	7.9%	3.9%	0.0%	7.4%	-	
Two or more races	7.9%	4.2%	8.6%	3.3%	12.7%	9.2%	0.0%	
Hispanic or Latino origin (of any race)	8.1%	5.4%	8.0%	3.7%	0.0%	7.9%	100.0%	
Unemployment rate by educational attainment								
Less than high school graduate	9.1%	8.1%	10.0%	7.6%	0.0%	9.5%	0.0%	
High school graduate (includes equivalency)	6.4%	3.7%	5.3%	4.2%	8.4%	6.7%	9.3%	
Some college or associate's degree	5.2%	2.6%	4.8%	2.5%	2.7%	6.0%	2.3%	
Bachelor's degree or higher	2.7%	2.0%	3.1%	2.4%	2.1%	3.0%	0.0%	
Income and Poverty								US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	95,628	99,431	113,927	100,599	87,675	116,477	
Population living below the federal poverty line in the last 12 months								
Individuals	10.0%	7.2%	9.4%	4.8%	7.0%	10.6%	8.3%	
Families	6.6%	4.4%	4.4%	3.1%	3.1%	5.9%	1.0%	
Individuals under 18 years of age	11.8%	7.8%	12.1%	5.1%	7.9%	13.9%	23.7%	
Individuals over 65 years of age	10.2%	7.4%	10.8%	5.6%	7.5%	11.0%	4.3%	
Female head of household, no spouse	19.1%	15.4%	18.2%	14.9%	10.3%	19.1%	39.2%	
White alone	7.6%	6.9%	7.2%	4.6%	5.6%	8.8%	8.6%	
Black or African American alone	17.1%	11.2%	14.1%	6.3%	23.1%	25.3%	-	

Key

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Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
American Indian and Alaska Native alone	19.1%	14.1%	19.0%	4.0%	0.0%	8.2%	-	
Asian alone	11.0%	6.1%	9.3%	8.6%	2.1%	3.9%	-	
Native Hawaiian and Other Pacific Islander alone	21.7%	19.6%	0.0%	23.1%	0.0%	-	-	
Some other race alone	20.1%	11.7%	19.0%	6.3%	2.1%	15.9%	100.0%	
Two or more races	15.7%	10.0%	11.1%	5.5%	19.2%	13.0%	3.0%	
Hispanic or Latino origin (of any race)	20.6%	13.8%	17.1%	6.6%	8.4%	17.0%	2.4%	
Less than high school graduate	24.4%	20.4%	22.8%	13.1%	15.7%	25.4%	9.1%	
High school graduate (includes equivalency)	12.7%	9.5%	11.8%	6.8%	8.0%	12.4%	14.4%	
Some college, associate's degree	9.2%	6.4%	8.6%	5.1%	7.8%	8.3%	2.6%	
Bachelor's degree or higher	4.0%	2.9%	3.5%	2.3%	2.3%	3.9%	2.6%	
With Social Security	29.8%	34.3%	31.4%	33.4%	28.6%	28.5%	44.0%	
With retirement income	22.9%	27.2%	22.5%	28.1%	20.8%	20.3%	30.5%	
With Supplemental Security Income	5.6%	4.1%	5.8%	3.2%	4.8%	7.9%	7.8%	
With cash public assistance income	3.5%	2.4%	4.6%	1.7%	4.8%	8.0%	6.5%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	6.0%	16.0%	3.5%	9.7%	20.9%	11.5%	
Housing								US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	551,186	94.9%	126,588	96.4%	95.3%	95.1%	
Owner-occupied	62.6%	72.5%	64.0%	78.6%	68.3%	61.3%	79.0%	
Renter-occupied	37.4%	27.5%	36.0%	21.4%	31.7%	38.7%	21.0%	
Lacking complete plumbing facilities	0.3%	0.5%	0.4%	0.6%	0.1%	0.4%	1.8%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Amesbury - Merrimac

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
Lacking complete kitchen facilities	0.8%	0.7%	0.9%	0.7%	0.3%	1.5%	1.8%	
No telephone service available	0.8%	0.6%	0.8%	0.5%	0.2%	0.7%	1.0%	
Monthly housing costs <35% of total household income								
Among owner-occupied units with a mortgage	22.7%	20.1%	24.6%	19.7%	17.3%	23.9%	23.7%	
Among owner-occupied units without a mortgage	15.4%	15.0%	16.6%	15.4%	21.6%	11.3%	17.7%	
Among occupied units paying rent	41.3%	37.9%	46.3%	37.7%	53.7%	47.0%	14.5%	
Access to Technology								US Census Bureau, American Community Survey 2019-2023
Among households								
Has smartphone	89.2%	88.6%	88.7%	91.2%	93.1%	88.7%	87.3%	
Has desktop or laptop	83.2%	84.8%	81.0%	88.3%	86.5%	82.6%	88.6%	
With a computer	95.1%	95.6%	94.8%	96.8%	97.5%	95.9%	95.1%	
With a broadband Internet subscription	91.8%	91.8%	91.4%	94.4%	93.8%	91.2%	91.4%	
Transportation								US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	73.7%	69.3%	73.9%	74.1%	77.0%	82.2%	
Car, truck, or van -- carpooled	6.9%	7.1%	7.0%	5.5%	6.3%	6.6%	3.8%	
Public transportation (excluding taxicab)	7.0%	0.6%	3.7%	0.6%	1.3%	1.7%	0.0%	
Walked	4.2%	2.2%	2.8%	1.5%	2.0%	1.6%	1.3%	
Other means	2.5%	1.3%	2.6%	1.2%	0.9%	1.5%	2.8%	
Worked from home	16.7%	15.1%	14.6%	17.2%	15.4%	11.6%	9.8%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
Mean travel time to work (minutes)	29.3	26.8	28.9	29.1	30.6	26.8	30.3	
Vehicles available among occupied housing units								
No vehicles available	11.8%	4.5%	9.6%	3.0%	6.1%	7.9%	4.9%	US Census Bureau, American Community Survey 2019-2023
1 vehicle available	35.8%	31.0%	34.6%	27.2%	36.7%	34.7%	27.5%	
2 vehicles available	35.8%	40.8%	37.4%	43.3%	42.5%	39.7%	49.4%	
3 or more vehicles available	16.6%	23.6%	18.4%	26.5%	14.7%	17.8%	18.2%	
Education								
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	1.9%	5.2%	1.2%	0.9%	3.9%	1.3%	
9th to 12th grade, no diploma	4.4%	4.1%	4.7%	2.7%	3.8%	5.5%	3.9%	
High school graduate (includes equivalency)	22.8%	27.0%	24.4%	25.0%	22.3%	30.2%	22.5%	
Some college, no degree	14.4%	17.3%	15.2%	16.8%	18.2%	18.6%	24.3%	
Associate's degree	7.5%	10.0%	8.2%	9.5%	12.4%	10.1%	11.2%	
Bachelor's degree	25.3%	24.1%	24.9%	27.8%	26.6%	21.0%	26.1%	
Graduate or professional degree	21.4%	15.7%	17.5%	17.0%	15.9%	10.6%	10.8%	
High school graduate or higher	91.4%	94.1%	90.1%	96.1%	95.3%	90.5%	94.8%	
Bachelor's degree or higher	46.6%	39.8%	42.3%	44.8%	42.5%	31.6%	36.8%	
Educational attainment by race/ethnicity								
White alone								
High school graduate or higher	94.6%	94.6%	94.7%	96.1%	96.2%	93.5%	94.6%	
Bachelor's degree or higher	49.4%	39.8%	47.7%	44.4%	43.1%	35.4%	38.3%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
Black alone								
High school graduate or higher	87.1%	87.0%	85.3%	98.8%	79.8%	80.9%	-	
Bachelor's degree or higher	30.7%	29.3%	31.0%	37.0%	29.1%	19.1%	-	
American Indian or Alaska Native alone								
High school graduate or higher	75.2%	76.9%	85.2%	79.7%	100.0%	86.8%	-	
Bachelor's degree or higher	24.4%	18.8%	19.7%	12.6%	0.0%	0.0%	-	
Asian alone								
High school graduate or higher	86.6%	91.5%	83.9%	97.6%	91.4%	70.9%	-	
Bachelor's degree or higher	64.0%	61.8%	55.0%	67.7%	70.4%	37.1%	-	
Native Hawaiian and Other Pacific Islander alone								
High school graduate or higher	86.6%	96.1%	100.0%	100.0%	100.0%	-	-	
Bachelor's degree or higher	40.0%	41.7%	95.2%	52.4%	0.0%	-	-	
Some other race alone								
High school graduate or higher	71.6%	83.6%	67.5%	93.3%	78.0%	77.4%	100.0%	
Bachelor's degree or higher	20.0%	28.2%	12.9%	39.8%	7.1%	14.1%	0.0%	
Two or more races								
High school graduate or higher	80.6%	89.2%	81.1%	95.5%	93.3%	85.5%	100.0%	
Bachelor's degree or higher	33.6%	34.6%	29.6%	45.0%	41.0%	24.1%	0.0%	
Hispanic or Latino Origin								
High school graduate or higher	73.4%	80.4%	71.1%	90.6%	87.6%	79.9%	100.0%	
Bachelor's degree or higher	23.3%	26.4%	16.9%	37.3%	36.6%	16.5%	0.0%	
Health insurance coverage among civilian noninstitutionalized population (%)								US Census Bureau, American Community Survey 2019-2023

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Amesbury - Merrimac

			Areas of Interest					
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Amesbury, MA**	**Haverhill, MA**	**Merrimac, MA**	**Source**
With health insurance coverage	97.4%	94.5%	97.2%	95.6%	97.3%	96.4%	97.8%	US Census Bureau, American Community Survey 2019-2023
With private health insurance	73.8%	76.2%	71.0%	82.0%	78.2%	68.0%	78.6%	
With public coverage	37.1%	32.4%	39.9%	28.3%	33.7%	41.6%	38.9%	
No health insurance coverage	2.6%	5.5%	2.8%	4.4%	2.7%	3.6%	2.2%	
Disability								
Percent of population With a disability	12.1%	13.0%	12.1%	11.3%	12.5%	14.8%	11.8%	
Under 18 with a disability	4.9%	4.9%	5.0%	5.0%	6.3%	4.6%	2.9%	
18-64	9.4%	10.7%	9.1%	8.5%	9.8%	13.2%	6.4%	
65+	30.2%	28.6%	31.0%	26.3%	29.3%	36.2%	31.9%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Demographics								
Population								US Census Bureau, American Community Survey 2019-2023
Total population	6992395	1,387,834	807258	317,163	18444	9217	8,427	
Male	48.9%	49.9%	48.6%	49.8%	44.3%	50.8%	51.2%	
Female	51.1%	50.1%	51.4%	50.2%	55.7%	49.2%	48.8%	
Age Distribution								US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	4.6%	5.4%	4.5%	3.4%	3.6%	2.7%	
5 to 9 years	5.2%	4.9%	5.6%	5.2%	6.8%	1.9%	4.2%	
10 to 14 years	5.7%	5.5%	6.2%	5.4%	8.9%	4.3%	4.0%	
15 to 19 years	6.5%	6.1%	6.4%	5.6%	4.2%	6.4%	5.8%	
20 to 24 years	6.8%	6.2%	6.2%	5.2%	2.9%	7.1%	3.3%	
25 to 34 years	14.1%	12.7%	12.5%	11.9%	9.6%	14.1%	11.4%	
35 to 44 years	12.9%	12.1%	12.6%	12.4%	10.9%	8.7%	9.1%	
45 to 54 years	12.6%	12.8%	12.8%	13.6%	12.2%	12.4%	12.8%	
55 to 59 years	7.0%	7.8%	7.3%	8.3%	8.1%	9.5%	7.1%	
60 to 64 years	6.8%	7.9%	7.0%	8.4%	10.0%	7.6%	8.3%	
65 to 74 years	10.3%	11.9%	10.7%	12.1%	13.1%	13.6%	16.2%	
75 to 84 years	4.9%	5.5%	5.0%	5.7%	6.5%	8.8%	12.9%	
85 years and over	2.2%	2.0%	2.4%	1.8%	3.3%	2.0%	2.1%	
Under 18 years of age	19.6%	18.5%	21.0%	18.8%	21.8%	13.2%	14.1%	
Over 65 years of age	17.5%	19.5%	18.0%	19.5%	22.9%	24.3%	31.2%	
Race/Ethnicity								US Census Bureau, American Community Survey 2019-2023
White alone (%)	70.70%	88.9%	70.3%	91.4%	92.7%	87.7%	89.5%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Black or African American alone (%)	7.0%	1.5%	4.1%	0.9%	0.4%	1.2%	0.8%	
American Indian and Alaska Native (%) alone	0.2%	0.1%	0.3%	0.1%	0.0%	0.1%	0.0%	
Asian alone (%)	7.1%	2.6%	3.5%	2.1%	0.7%	1.9%	0.7%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	1.3%	12.1%	1.1%	0.7%	0.7%	0.0%	
Two or More Races (%)	9.5%	5.5%	9.7%	4.4%	5.5%	8.3%	9.1%	
Hispanic or Latino of Any Race (%)	12.9%	4.5%	23.2%	3.5%	4.0%	5.9%	3.6%	
Foreign-born								US Census Bureau, American Community Survey 2019-2023
Foreign-born population	1,236,518	86,095	151,560	16,655	1,168	393	228	
Naturalized U.S. citizen	54.5%	59.9%	56.4%	66.2%	59.5%	72.0%	35.5%	
Not a U.S. citizen	45.5%	40.1%	43.6%	33.8%	40.5%	28.0%	64.5%	
Region of birth: Europe	18.1%	23.8%	13.4%	32.1%	47.4%	34.4%	15.4%	
Region of birth: Asia	30.5%	33.1%	14.5%	35.6%	11.0%	43.5%	31.6%	
Region of birth: Africa	9.5%	8.2%	5.5%	2.9%	2.9%	0.0%	7.9%	
Region of birth: Oceania	0.3%	0.7%	0.2%	0.6%	3.3%	0.0%	0.0%	
Region of birth: Latin America	39.4%	25.3%	64.4%	21.9%	29.7%	19.8%	45.2%	
Region of birth: Northern America	2.2%	8.9%	2.0%	7.0%	5.7%	2.3%	0.0%	
Language								US Census Bureau, American Community Survey 2019-2023
English only	75.2%	92.0%	71.6%	93.7%	93.3%	92.8%	95.3%	
Language other than English	24.8%	8.0%	28.4%	6.3%	6.7%	7.2%	4.7%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Speak English less than "very well"	9.7%	2.4%	12.2%	1.3%	1.8%	1.7%	2.7%	
Spanish	9.6%	2.7%	18.8%	2.0%	2.6%	2.3%	1.1%	
Speak English less than "very well"	4.1%	0.9%	8.8%	0.4%	0.6%	0.3%	1.1%	
Other Indo-European languages	9.2%	3.4%	6.4%	2.7%	3.6%	1.9%	2.6%	
Speak English less than "very well"	3.2%	0.8%	2.2%	0.4%	1.2%	0.2%	0.9%	
Asian and Pacific Islander languages	4.4%	1.4%	2.0%	1.2%	0.2%	1.8%	0.7%	
Speak English less than "very well"	1.9%	0.5%	0.9%	0.4%	0.0%	1.1%	0.5%	
Other languages	1.6%	0.6%	1.2%	0.4%	0.3%	1.2%	0.2%	
Speak English less than "very well"	0.4%	0.2%	0.4%	0.1%	0.0%	0.0%	0.2%	
Employment								US Census Bureau, American Community Survey 2019-2023
Unemployment rate	5.1%	3.4%	5.1%	3.5%	5.8%	7.0%	8.5%	
Unemployment rate by race/ethnicity								
White alone	4.5%	3.3%	4.3%	3.4%	5.5%	7.2%	8.1%	
Black or African American alone	7.9%	5.1%	4.6%	13.6%	0.0%	6.4%	0.0%	
American Indian and Alaska Native alone	6.9%	1.6%	1.8%	0.0%	-	0.0%	-	
Asian alone	4.0%	3.3%	3.3%	2.8%	0.0%	0.0%	72.1%	
Native Hawaiian and Other Pacific Islander alone	4.8%	0.0%	0.0%	0.0%	-	-	-	
Some other race alone	8.0%	4.7%	7.9%	3.9%	0.0%	0.0%	-	
Two or more races	7.9%	4.2%	8.6%	3.3%	14.0%	9.1%	0.0%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Hispanic or Latino origin (of any race)	8.1%	5.4%	8.0%	3.7%	13.3%	10.5%	0.0%	
Unemployment rate by educational attainment								
Less than high school graduate	9.1%	8.1%	10.0%	7.6%	8.2%	0.0%	0.0%	
High school graduate (includes equivalency)	6.4%	3.7%	5.3%	4.2%	11.9%	4.3%	9.5%	
Some college or associate's degree	5.2%	2.6%	4.8%	2.5%	2.6%	3.3%	15.6%	
Bachelor's degree or higher	2.7%	2.0%	3.1%	2.4%	5.4%	5.8%	7.6%	
Income and Poverty								US Census Bureau, American Community Survey 2019-2023
Median household income (dollars)	101,341	95,628	99,431	113,927	144,259	102,521	87,021	
Population living below the federal poverty line in the last 12 months								
Individuals	10.0%	7.2%	9.4%	4.8%	5.1%	4.9%	11.0%	
Families	6.6%	4.4%	4.4%	3.1%	7.8%	0.0%	9.3%	
Individuals under 18 years of age	11.8%	7.8%	12.1%	5.1%	5.1%	0.6%	13.0%	
Individuals over 65 years of age	10.2%	7.4%	10.8%	5.6%	4.5%	6.0%	10.7%	
Female head of household, no spouse	19.1%	15.4%	18.2%	14.9%	10.0%	2.5%	24.4%	
White alone	7.6%	6.9%	7.2%	4.6%	4.7%	5.6%	9.1%	
Black or African American alone	17.1%	11.2%	14.1%	6.3%	6.8%	0.0%	89.1%	
American Indian and Alaska Native alone	19.1%	14.1%	19.0%	4.0%	-	0.0%	-	
Asian alone	11.0%	6.1%	9.3%	8.6%	3.1%	0.0%	0.0%	

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Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Native Hawaiian and Other Pacific Islander alone	21.7%	19.6%	0.0%	23.1%	-	-	-	
Some other race alone	20.1%	11.7%	19.0%	6.3%	18.0%	0.0%	-	
Two or more races	15.7%	10.0%	11.1%	5.5%	9.9%	0.0%	23.6%	
Hispanic or Latino origin (of any race)	20.6%	13.8%	17.1%	6.6%	26.2%	0.0%	34.1%	
Less than high school graduate	24.4%	20.4%	22.8%	13.1%	17.2%	13.4%	10.2%	
High school graduate (includes equivalency)	12.7%	9.5%	11.8%	6.8%	12.9%	5.6%	8.3%	
Some college, associate's degree	9.2%	6.4%	8.6%	5.1%	8.1%	6.0%	13.2%	
Bachelor's degree or higher	4.0%	2.9%	3.5%	2.3%	2.9%	4.0%	12.9%	
With Social Security	29.8%	34.3%	31.4%	33.4%	33.4%	39.9%	48.8%	
With retirement income	22.9%	27.2%	22.5%	28.1%	30.4%	30.0%	33.8%	
With Supplemental Security Income	5.6%	4.1%	5.8%	3.2%	2.1%	5.3%	5.2%	
With cash public assistance income	3.5%	2.4%	4.6%	1.7%	2.1%	2.0%	3.7%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	6.0%	16.0%	3.5%	6.4%	9.1%	8.3%	
Housing								US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	551,186	94.9%	126,588	93.9%	81.0%	3,773	
Owner-occupied	62.6%	72.5%	64.0%	78.6%	76.2%	74.7%	71.8%	
Renter-occupied	37.4%	27.5%	36.0%	21.4%	23.8%	25.3%	28.2%	
Lacking complete plumbing facilities	0.3%	0.5%	0.4%	0.6%	0.0%	0.0%	0.6%	

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Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Lacking complete kitchen facilities	0.8%	0.7%	0.9%	0.7%	0.2%	0.0%	0.7%	
No telephone service available	0.8%	0.6%	0.8%	0.5%	0.0%	0.0%	0.8%	
Monthly housing costs <35% of total household income								
Among owner-occupied units with a mortgage	22.7%	20.1%	24.6%	19.7%	20.3%	21.4%	20.9%	
Among owner-occupied units without a mortgage	15.4%	15.0%	16.6%	15.4%	19.9%	12.6%	15.2%	
Among occupied units paying rent	41.3%	37.9%	46.3%	37.7%	34.1%	47.8%	48.6%	
Access to Technology								US Census Bureau, American Community Survey 2019-2023
Among households								
Has smartphone	89.2%	88.6%	88.7%	91.2%	89.5%	90.1%	81.0%	
Has desktop or laptop	83.2%	84.8%	81.0%	88.3%	87.6%	83.7%	74.7%	
With a computer	95.1%	95.6%	94.8%	96.8%	95.7%	96.4%	90.8%	
With a broadband Internet subscription	91.8%	91.8%	91.4%	94.4%	93.2%	90.4%	89.9%	
Transportation								US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	73.7%	69.3%	73.9%	63.1%	78.4%	82.7%	
Car, truck, or van -- carpooled	6.9%	7.1%	7.0%	5.5%	3.9%	4.0%	4.0%	
Public transportation (excluding taxicab)	7.0%	0.6%	3.7%	0.6%	3.0%	0.5%	1.0%	
Walked	4.2%	2.2%	2.8%	1.5%	4.6%	0.1%	2.3%	
Other means	2.5%	1.3%	2.6%	1.2%	1.8%	0.4%	2.2%	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Worked from home	16.7%	15.1%	14.6%	17.2%	23.6%	16.6%	7.9%	
Mean travel time to work (minutes)	29.3	26.8	28.9	29.1	32.3	28.5	23.3	
Vehicles available among occupied housing units								
No vehicles available	11.8%	4.5%	9.6%	3.0%	5.2%	4.3%	5.2%	
1 vehicle available	35.8%	31.0%	34.6%	27.2%	35.9%	39.0%	34.2%	
2 vehicles available	35.8%	40.8%	37.4%	43.3%	44.0%	34.4%	39.5%	
3 or more vehicles available	16.6%	23.6%	18.4%	26.5%	14.9%	22.4%	21.1%	
Education								US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older								
Less than 9th grade	4.2%	1.9%	5.2%	1.2%	0.8%	1.1%	2.8%	
9th to 12th grade, no diploma	4.4%	4.1%	4.7%	2.7%	1.5%	4.7%	6.2%	
High school graduate (includes equivalency)	22.8%	27.0%	24.4%	25.0%	11.9%	25.5%	40.3%	
Some college, no degree	14.4%	17.3%	15.2%	16.8%	13.4%	14.2%	15.1%	
Associate's degree	7.5%	10.0%	8.2%	9.5%	6.4%	10.7%	9.5%	
Bachelor's degree	25.3%	24.1%	24.9%	27.8%	37.5%	27.6%	19.1%	
Graduate or professional degree	21.4%	15.7%	17.5%	17.0%	28.4%	16.3%	7.0%	
High school graduate or higher	91.4%	94.1%	90.1%	96.1%	97.6%	94.2%	90.9%	
Bachelor's degree or higher	46.6%	39.8%	42.3%	44.8%	65.9%	43.9%	26.1%	
Educational attainment by race/ethnicity								

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
White alone								
High school graduate or higher	94.6%	94.6%	94.7%	96.1%	97.9%	94.3%	90.6%	
Bachelor's degree or higher	49.4%	39.8%	47.7%	44.4%	66.0%	42.5%	26.0%	
Black alone								
High school graduate or higher	87.1%	87.0%	85.3%	98.8%	90.4%	100.0%	100.0%	
Bachelor's degree or higher	30.7%	29.3%	31.0%	37.0%	9.6%	82.5%	89.1%	
American Indian or Alaska Native alone								
High school graduate or higher	75.2%	76.9%	85.2%	79.7%	-	100.0%	-	
Bachelor's degree or higher	24.4%	18.8%	19.7%	12.6%	-	0.0%	-	
Asian alone								
High school graduate or higher	86.6%	91.5%	83.9%	97.6%	100.0%	100.0%	100.0%	
Bachelor's degree or higher	64.0%	61.8%	55.0%	67.7%	95.3%	87.8%	98.4%	
Native Hawaiian and Other Pacific Islander alone								
High school graduate or higher	86.6%	96.1%	100.0%	100.0%	-	-	-	
Bachelor's degree or higher	40.0%	41.7%	95.2%	52.4%	-	-	-	
Some other race alone								
High school graduate or higher	71.6%	83.6%	67.5%	93.3%	74.1%	50.0%	-	
Bachelor's degree or higher	20.0%	28.2%	12.9%	39.8%	33.6%	0.0%	-	

Key

Significantly low compared to Massachusetts and New Hampshire based on margin of error

Significantly high compared to Massachusetts and New Hampshire overall based on margin of error

Demographics: Newburyport-Seabrook

					Areas of Interest			
	Massachusetts	**New Hampshire**	**Essex County, MA**	**Rockingham County, NH**	**Newburyport, MA**	**Salisbury, MA**	**Seabrook, NH**	**Source**
Two or more races								
High school graduate or higher	80.6%	89.2%	81.1%	95.5%	96.8%	93.5%	94.2%	
Bachelor's degree or higher	33.6%	34.6%	29.6%	45.0%	69.8%	46.1%	0.0%	
Hispanic or Latino Origin								
High school graduate or higher	73.4%	80.4%	71.1%	90.6%	93.3%	84.3%	100.0%	
Bachelor's degree or higher	23.3%	26.4%	16.9%	37.3%	57.6%	33.0%	0.0%	
Health insurance coverage among civilian noninstitutionalized population (%)								US Census Bureau, American Community Survey 2019-2023
With health insurance coverage	97.4%	94.5%	97.2%	95.6%	99.1%	97.0%	93.5%	
With private health insurance	73.8%	76.2%	71.0%	82.0%	86.7%	75.1%	71.2%	
With public coverage	37.1%	32.4%	39.9%	28.3%	28.0%	39.6%	45.3%	
No health insurance coverage	2.6%	5.5%	2.8%	4.4%	0.9%	3.0%	6.5%	
Disability								US Census Bureau, American Community Survey 2019-2023
Percent of population With a disability	12.1%	13.0%	12.1%	11.3%	10.6%	14.4%	17.9%	
Under 18 with a disability	4.9%	4.9%	5.0%	5.0%	2.6%	4.8%	8.7%	
18-64	9.4%	10.7%	9.1%	8.5%	7.0%	10.6%	12.4%	
65+	30.2%	28.6%	31.0%	26.3%	27.6%	29.3%	31.7%	

Health Status

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
Access to Care											
Ratio of population to primary care physicians	103.5		73.3		73.3	73.3	73.3	73.3	73.3		County Health Rankings, 2021
Ratio of population to mental health providers	135.7		151.7		151.8	151.8	152.3	151.9	150.9		County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3		26.9		23.0	13.3	0.0	10.9	0.0		CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health											
Adults age 18+ with self-reported fair or poor general health (%), age-adjusted	13.8	No data	Data unavailable	12.9	12.9	16.9	No data	9.1	11.2	11.80	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	738.6	948.4	676.2							CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	315.0	291.1	263.0							Massachusetts Death Report, 2021
Risk Factors											
Farmers Markets Accepting SNAP, Rate per 100,00 low income population	1.8	No data	1.2		0.0	0.0	0.0	0.0	0.0		USDA - Agriculture Marketing Service, 2023
SNAP-Authorized Retailers, Rate per 10,000 population	9.6	No data	8.6		5.9	7.7	3.0	5.6	11.7		USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	No data	30.1		71.7	39.0	100.0	9.6	60.5		USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	No data	Data unavailable	31.8	29.9	32.4	No data	26.3	28.3	31.5	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	No data	Data unavailable	29.4	25.9	28.0	No data	24.7	25.8	24.5	BRFSS, 2021

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
High cholesterol among adults who have been screened (%)	No data	No data	Data unavailable	34.0	30.4		No data	30.1	30.5	28.3	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	No data	Data unavailable	18.4	17.8	22.3	No data	13.0	15.6	16.6	BRFSS, 2022
Chronic Conditions											
Current asthma (adults) (%) age-adjusted prevalence	11.3	No data	Data unavailable	11.1	12.0	12.0	No data	11.0	11.6	11.2	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	No data	Data unavailable	9.4	7.6	9.2	No data	6.3	7.0	7.40	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	No data	Data unavailable	6.1	5.6	6.2	No data	3.9	4.8	4.90	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	No data	Data unavailable	6.4	5.9	6.3	No data	4.8	5.4	5.1	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	No data	Data unavailable	2.9	2.6	2.9	No data	2.0	2.3	2.4	BRFSS, 2022
Cancer											
Mammography screening among women 50-74 (%), age-adjusted	84.9	No data	Data unavailable	78.8	84.1	82.5	No data	85.5	83.8	77	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	No data	Data unavailable	70.9	64.9	62.4	No data	68.4	67.0	63	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)											
All sites	449.4	472.5	453.1	475.6	455.3	453.5	451.2	454.0	449.6		State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	59.3	58.9	58.2	57.1	58.4	56.7	58.3	57.7		State Cancer Profiles, 2016-2020

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
Prostate Cancer	113.2	116.3	109.8	122.0	111.3	110.9	116.9	108.8	104.6		State Cancer Profiles, 2016-2020
Prevention and Screening											
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	No data	Data unavailable	75.9	79.3	79.1	No data	80.2	79.5	73.2	Behavioral Risk Factor Surveillance System, 2022
Cholesterol screening within past 5 years (%) (adults)	No data	No data	Data unavailable	88.3	87.9	86.6		89.4		85.1	Behavioral Risk Factor Surveillance System, 2021
Communicable and Infectious Disease											
STI infection cases (per 100,000)											
Chlamydia	385.8	395.2	293.2	358.2	424.5	424.5	424.5	424.5	424.5	392.4	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Syphilis	10.6	12.2	6.7	10.6	6.7	6.7	6.7	6.7	6.7	11.6	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Gonorrhea	214.0	220.1	90.7	214	118.0	90.7	90.7	90.7	90.7	229.3	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
HIV prevalence	385.8	282.3	289.6	234.1	289.6	289.6	289.6	289.6	289.6	243.7	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.5	2.9	1.7	2.9	2.9	2.9	2.9	2.9	2	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2022

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
COVID-19											
Percent of Adults Fully Vaccinated	78.1	78.1	83.9	87.8	82.0	82.0	82.0	82.0	82.0	90.4	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-19 Vaccination	4.5	No data	4.5		4.5	4.5	4.5	4.5	4.5		
Vaccine Coverage Index	0.0	No data	0.0		0.0	0.0	0.0	0.0	0.0		
Substance Use											
Current cigarette smoking (%), age-adjusted	10.4	No data	Data unavailable	12.1	11.6	13.3	No data	7.0	9.7	11.6	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	No data	Data unavailable	19.2	20.8	19.2	No data	21.2	21.1	21.3	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	29.4	39.3	19.7	39.3	39.3	39.3	39.3	39.3		CDC- National Vital Statistics System, 2016-2020; NH DHHS2024
Male Drug Overdose Mortality Rate (per 100,000)	48.3	41.6	59.8	28.4							MA BSAS, 2023; NH DHHS 2023
Female Drug Overdose Mortality Rate (per 100,000)	17.6	16.7	20.1	10.9							MA BSAS, 2023; NH DHHS 2019-2023
Substance-related deaths (Age-adjusted rate per 100k)											
Any substance	61.9		59.8		54.2	78.1	96.3	46.5	42.2		MA BSAS, 2023
Opioid-related deaths	33.7		32.4		*	39.8	*	*	*		
Alcohol-related deaths	29.1		26.7		38.9	38.1	74.0	26.5	*		
Stimulant-related deaths	23.0		22.4		*	31.0	*	*	*		
Substance-related ER visits (age-adjusted rate per 100K)											
Any substance-related ER visits	1605.7		1421.3		1197.5	2268.0	769.9	842.4	1357.3		MA BSAS, 2023
Opioid-related ER visits	169.3		144.9		78.0	268.9	*	61.7	198.0		
Opioid-related EMS Incidents	248.8		244.2		109.4	312.7	*	76.5	259.9		

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
Alcohol-related ER visits	1235.6		1059.7		957.8	1769.9	642.6	630.1	927.3		
Stimulant-related ER visits	15.7		13.8		*	25.3	0.0	*	*		
Substance Addiction Services											
Individuals admitted to BSAS services (crude rate per 100k)	588.4		608.6		472.2	848.2	386.7	514.0	1028.6		MA BSAS, 2023
Number of BSAS providers			140.0		3.0	18.0	0.0	0.0	-		
Number of clients of BSAS services (residents)			3092.0		47.0	381.0	10.0	*	46.0		
Avg. distance to BSAS provider (miles)	17.0		18.0		26.0	22.0	26.0	26.0	27.0		
Buprenorphine RX's filled	9982.0		8521.4		9628.0	11254.4	5146.5	3411.9	16078.4		
Individuals who received buprenorphine RX's			756.5		869.5	1150.7	461.1	399.1	1375.1		
Naloxone kits received			23764.0		355.0	2209.0	23.0	48.0	413.0		
Naloxone kids: Opioid deaths Ratio			73.0		*	52.0	*	*	*		
Fentanyl test strips received			42200.0		1000.0	2500.0	0.0	1700.0	1000.0		
											Environmental Health
Environmental Justice (%) (Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry. Accessed via CDC National Environmental Public Health Tracking. 2022.)	56.6		71.8		77.9	89.5	100.0	61.8	100.0		Population in Neighborhoods Meeting Environmental Justice Health Criteria , Centers for Disease Control and Prevention, CDC - Agency for Toxic Substances and Disease Registry, 2022
Lead screening %	68.0	76.0		72.0	63.0	60.0	88.0	61.0	60.0		MDPH BCEH Childhood Lead Poisoning Prevention Program (CLPPP),

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
											2021Percentage of children age 9-47 months screened for lead in 2021; NH DHHS 2024
Prevalence of Blood Lead Levels (per 1,000)	13.6	No data			13.6	14.6	10.8	10.8	-	8.0	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; NH DHHS, 2024
% of houses built before 1978	67.0				65.0	63.0	39.0	74.0	45.0		ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6	23.2		25.7	17.3	42.0	13.2	10.2	14.7		Massachusetts Center for Health Information and Analysis (CHIA), 2020; NH DHHS 2017-2021
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8 students)	9.9	9.8			4.4	12.0	7.2	5.4	3.6		MDPH BCEH, 2022-2023 school year; NH DHHS 2023
Age Adjusted Rates of Emergency Department Visit for Heat Stress per 100,00 people for males and females combined by county	7.6	14.6	8.1	12.2	NS	17.3	0.0	0.0	NS		Center for Health Information and Analysis, 2020; NH DHHS 2017-2021

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
Air Quality Respiratory Hazard Index (EPA - National Air Toxics Assessment, 2018)	0.3		0.3								EPA - National Air Toxics Assessment, 2018
											Mental Health
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	11.8	57.4		57.4	57.4	57.4	57.4	57.4		CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	No data	Data unavailable		25.6	24.6	No data	23.5	24.7	25	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	No data	Data unavailable		34.3	34.9	No data	32.5	32.5	31.7	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	No data	Data unavailable		21.7	23.3	No data	19.0	18.9	22.4	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	No data	Data unavailable		17.6	18.3	No data	14.2	16.2	16.7	Behavioral Risk Factor Surveillance System, 2022
Youth experiences of harassment or bullying (allegations, rate per 1,000)	0.1	No data	0.1		0.0	0.1	0.0	0.0	0.0		U.S. Department of Education - Civil Rights Data Collection, 2020-2021
Maternal and Child Health/Reproductive Health											
Infant Mortality Rate (per 1,000 live births)	4.0		4.0		4.0	4.0	4.0	4.0	4.0		County Health Rankings, 2015-2021
Low birth weight (%)	7.6		7.0		7.4	7.4	7.4	7.4	7.4		County Health Rankings, 2016-2022
Safety/Crime											
Property Crimes Offenses (#)											Massachusetts Crime Statistics, 2023; NH Crime Statistics, 2024

					Areas of interest						
	MA	NH	Essex County	Rockingham County	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury	Seabrook, NH	Source
Burglary	10028.0	684			11.0	69.0	3.0	5.0	13.0	6	
Larceny-theft	60647.0	11525			120.0	491.0	17.0	80.0	58.0	195	
Motor vehicle theft	7224.0	918			5.0	47.0	1.0	11.0	12.0	6	
Arson	377.0	83			2.0	4.0	0.0	0.0	1.0	0	
Crimes Against Persons Offenses (#)											
Murder/non-negligent manslaughter	162.0	14			0.0	0.0	0.0	0.0	0.0	0	
Sex offenses	4365.0	477			13.0	4.0	6.0	16.0	13.0	4	
Assaults	72086.0	893.0			117.0	1525.0	33.0	74.0	102.0	7	
Human trafficking	0.0				0.0	0.0	0.0	0.0	0.0		
Hate Crimes Offenses (#)											
Race/Ethnicity/Ancestry Bias	222.0				0.0	1.0		1.0			
Religious Bias	88.0				1.0	0.0		0.0			
Sexual Orientation Bias	80.0				0.0	0.0		0.0			
Gender Identity Bias	22.0				0.0	0.0		0.0			
Gender Bias	2.0				0.0	0.0		0.0			
Disability Bias	0.0				0.0	0.0		0.0			

Community Health Equity Survey (CHES) – Youth

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

			MASSACHUSETTS		no county or town data
Topic	**Question**	**Response**	**N**	**%**	
Housing	Current living situation	No steady place	1908	1.30%	
		Worried about losing	1908	2.60%	
		Steady place	1908	95.10%	
Housing	Issues in current housing	Yes, at least one	1830	24.50%	
Basic Needs	Food insecurity, past month	Never	1963	87.80%	
		Sometimes	1963	9.90%	
		A lot	1963	2.30%	
Basic Needs	Current internet access	No internet	1938	1.30%	
		Does not work well	1938	6.60%	
		Works well	1938	92.20%	
Neighborhood	Able to get where you need to go	Somewhat or strongly disagree	1864	2.50%	
		Somewhat agree	1864	14.60%	
		Strongly agree	1864	82.80%	
Neighborhood	Experienced neighborhood violence, lifetime	Never	1833	65.00%	
		Rarely	1833	22.80%	
		Somewhat often	1833	8.50%	
		Very often	1833	3.70%	
Safety & Support	Have someone to talk to if needed help	No	1739	3.90%	
		Yes, adult in home	1739	80.50%	
		Yes, adult outside home	1739	37.30%	
		Yes, friend or non-adult family	1739	43.00%	
Safety & Support	Feel safe with my family/caregivers	Not at all	1768	1.00%	
		Somewhat	1768	7.70%	
		Very much	1768	91.30%	
	Feel I belong at school	Not at all	1760	5.90%	

			MASSACHUSETTS		no county or town data
Topic	**Question**	**Response**	**N**	**%**	
Safety & Support		Somewhat	1760	29.10%	
		Very much	1760	65.00%	
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	
		Somewhat	1745	17.10%	
		Very much	1745	80.50%	
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	
Safety & Support	Experienced intimate partner violencea	Ever	1589	13.10%	
		In past year	1567	7.80%	
Safety & Support	Experienced household violenceb	Ever	1536	14.20%	
		In past year	1519	5.50%	
Safety & Support	Experienced sexual violencec	Ever	1558	9.20%	
		In past year	1551	3.10%	
Safety & Support	Experienced discrimination	Ever	1674	45.20%	
		In past year	1674	19.60%	
Employment	Worked for pay, past year	No	1652	51.50%	
		Yes, <10 hours per week	1652	18.10%	
		Yes, 11-19 hours per week	1652	13.30%	
		Yes, 20-34 hours per week	1652	10.30%	
		Yes, >35 hours per week	1652	6.80%	
Education	Educational challenges, past year	None of these	1484	66.80%	

			MASSACHUSETTS		no county or town data
Topic	**Question**	**Response**	**N**	**%**	
		Frequent absences	1484	7.60%	
		Needed more support in school	1484	7.00%	
		Needed more support outside school	1484	6.30%	
		Safety concerns	1484	5.10%	
		Temperature in classroom	1484	18.50%	
		Never	1503	87.70%	
		Once or twice	1503	9.10%	
		Monthly	1503	1.60%	
Education	Hurt or harrassed by school staff, past year	Daily	1503	1.60%	
		College-preparation	1459	57.90%	
		Extracurricular activities	1459	74.40%	
		Guidance conselour	1459	58.80%	
Education	Helpful school resources provided	Programs to reduce bullying, violence, etc.	1459	19.10%	
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	
Healthcare Access	Unmet need for substance use or addiction treatment (among those needing care)	Yes	*	*	
Healthcare Access	Unmet need for other type of care (among those needing care)	Yes	62	7.90%	
Healthcare Access	ANY unmet heath care need, past year (among those needing any care)	Yes	857	10.30%	
		Low	1376	22.10%	
Mental Health	Psychological distress, past month	Medium	1376	33.00%	

			MASSACHUSETTS		no county or town data
Topic	**Question**	**Response**	**N**	**%**	
		High	1376	18.40%	
		Very high	1376	26.60%	
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%	
Substance Use	Tobacco use, past month	Yes	1499	8.00%	
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	
Substance Use	Medical cannabis use, past month	Yes, past month	1486	0.80%	
Substance Use	Medical cannabis use, past year	Yes, past year	1487	1.90%	
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	1487	0.70%	
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	
Substance Use	Heroin use, past year	Yes	1487	0.30%	
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%	
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	

			MASSACHUSETTS		no county or town data
Topic	**Question**	**Response**	**N**	**%**	
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	
		Not sure	1445	5.70%	
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%	
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%	
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%	
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%	
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%	
Emerging Issues	Unable to work due to weather, past 5 years1	Yes	767	7.60%	
Emerging Issues	Extreme temperatures at home, work, school, past 5 years1	Yes	767	33.30%	
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%	
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%	

Community Health Equity Survey (CHES) – Adult

			MASSACHUSETTS		ESSEX		Haverhill	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
		No steady place	14888	2.50%	773	1.90%	*	*
		Worried about losing	14888	8.00%	773	10.20%	50	10.00%
Housing	Current living situation	Steady place	14888	89.30%	773	87.50%	50	86.00%
Housing	Issues in current housing2	Yes, at least one	11103	37.00%	571	37.30%	39	28.20%
Basic Needs	Trouble paying for childcare/school1	Yes	7486	4.60%	374	5.90%	*	*
Basic Needs	Trouble paying for food or groceries (including formula or baby food)1	Yes	7486	18.80%	374	20.10%	*	*
Basic Needs	Trouble paying for health care1	Yes	7486	15.00%	374	17.40%	*	*
Basic Needs	Trouble paying for housing1	Yes	7486	19.40%	374	22.70%	*	*
Basic Needs	Trouble paying for technology1	Yes	7486	8.40%	374	8.00%	*	*
Basic Needs	Trouble paying for transportation1	Yes	7486	12.60%	374	14.20%	*	*
Basic Needs	Trouble paying for utilities1	Yes	7486	17.20%	374	19.80%	*	*
Basic Needs	Trouble paying for ANY basic needs1	Yes	7486	35.20%	374	43.60%	*	*
Basic Needs	Applied for/received econimic assisstance	Yes	14928	20.30%	768	18.00%	50	20.00%
		Not enough money	13814	16.50%	703	18.90%	46	15.20%
		Just enough money	13814	31.10%	703	32.70%	46	43.50%
Basic Needs	End of month finances	Money left over	13814	52.40%	703	48.40%	46	41.30%
		No internet	11425	3.00%	588	1.70%	*	*
		Does not work well	11425	9.30%	588	9.00%	*	*
Basic Needs	Current internet access2	Works well	11425	87.70%	588	89.30%	40	92.50%
		Somewhat or strongly disagree	11064	7.00%	572	5.90%	*	*
	Able to get where you need to	Somewhat agree	11064	22.00%	572	22.40%	36	19.40%
Neighborhood	go2	Strongly agree	11064	71.00%	572	71.70%	36	72.20%
		Never	11008	58.60%	566	55.80%	34	50.00%
		Rarely	11008	28.90%	566	29.20%	34	35.30%
	Experienced neighborhood	Somewhat often	11008	9.10%	566	11.50%	*	*
Neighborhood	violence, lifetime2	Very often	11008	3.40%	566	3.50%	*	*

			MASSACHUSETTS		ESSEX		Haverhill	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	734	78.10%	46	82.60%
		Not sure	14393	6.50%	734	7.90%	*	*
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	736	71.30%	46	73.90%
		Not sure	14366	10.20%	736	10.90%	46	15.20%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	735	60.50%	46	54.30%
		Not sure	14325	12.90%	735	13.60%	46	21.70%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	730	78.60%	46	89.10%
		Not sure	14336	7.00%	730	6.40%	*	*
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	731	57.70%	46	60.90%
		Not sure	14247	16.30%	731	17.60%	46	15.20%
Safety & Support	Experienced intimate partner violence	Ever	13621	29.70%	693	34.20%	45	37.80%
		In past year	13359	4.50%	677	5.00%	*	*
Safety & Support	Experienced sexual violence	Ever	13628	21.00%	697	23.70%	43	34.90%
		In past year	13593	1.40%	695	1.20%	*	*
Safety & Support	Experienced discrimination	Ever	14130	55.20%	725	56.30%	46	58.70%
		In past year	14130	18.00%	725	18.90%	46	15.20%
Employment	Have multiple jobs (among all workers)2	Yes	6896	20.90%	388	21.60%	*	*
Employment	Location of work (among all workers)	At home only	9173	7.50%	527	5.30%	*	*
		Outside home only	9173	54.60%	527	56.50%	39	64.10%
		Both at home/outside home	9173	37.40%	527	38.00%	39	33.30%
Employment	Paid sick leave at work (among all workers)2	Yes	6903	75.30%	394	78.20%	*	*
		Not sure	6903	4.20%	394	4.10%	*	*
Healthcare Access	Reported chronic condition 1	Yes	6821	65.20%	365	60.50%	*	*
Healthcare Access	Unmet need for short-term illness care (among those who needed this care)2	Yes	3455	7.60%	171	9.90%	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care)2	Yes	1674	9.00%	88	10.20%	*	*

			MASSACHUSETTS		ESSEX		Haverhill	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	154	9.10%	*	*
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	129	20.90%	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)2	Yes	998	7.00%	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care)2	Yes	109	13.90%	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	48	10.40%	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)2	Yes	6941	15.20%	360	15.80%	*	*
Healthcare Access	Telehealth visit, past year1	One or more visit	6747	51.20%	364	51.10%	*	*
		Offered, didn't have	6747	7.00%	364	5.20%	*	*
		Not offered	6747	22.10%	364	21.40%	*	*
		No healthcare visits	6747	20.30%	364	23.10%	*	*
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	237	19.80%	*	*
		Not sure	4184	3.80%	237	5.10%	*	*
Mental Health	Psychological distress, past month	Low	13267	36.80%	689	33.50%	44	27.30%
		Medium	13267	32.00%	689	32.50%	44	38.60%
		High	13267	13.90%	689	14.70%	44	13.60%
		Very high	13267	17.30%	689	19.30%	44	20.50%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	524	13.70%	*	*
Mental Health	Suicide ideation, past year	Yes	13036	7.40%	674	6.20%	*	*

			MASSACHUSETTS		ESSEX		Haverhill	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Substance Use	Tobacco use, past month2	Yes	10305	14.10%	520	10.80%	*	*
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	701	49.90%	45	48.90%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	707	6.40%	*	*
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	707	7.10%	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	707	9.90%	*	*
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	707	14.30%	45	11.10%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	707	0.80%	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	*	*	*	*
Substance Use	Fentanyl use, pasy year	Yes	13626	0.60%	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	13626	0.60%	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	707	1.30%	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	707	1.60%	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	707	2.30%	*	*
Emerging Issues	COVID-19 vaccinatination, past year1	Yes	6729	67.80%	360	61.10%	*	*
		Not sure	6729	3.60%	360	5.00%	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)2	Yes	6196	22.00%	335	30.10%	*	*

			MASSACHUSETTS		ESSEX		Haverhill	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years2	Yes	10422	37.40%	523	39.00%	31	38.70%
Emerging Issues	Flooding in home or on street, past 5 years2	Yes	10422	11.00%	523	9.40%	31	19.40%
Emerging Issues	More ticks or mosquitoes, past 5 years2	Yes	10422	32.20%	523	24.10%	31	16.10%
Emerging Issues	Power outages, past 5 years2	Yes	10422	24.50%	523	19.70%	31	25.80%
Emerging Issues	School cancellation due to weather, past 5 years2	Yes	10422	17.60%	523	14.70%	*	*
Emerging Issues	Unable to work due to weather, past 5 years2	Yes	10422	14.80%	523	13.40%	31	16.10%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years2	Yes	10422	28.30%	523	24.50%	31	29.00%
Emerging Issues	Other climate impact, past 5 years2	Yes	10422	1.70%	523	1.90%	*	*
Emerging Issues	ANY climate impact, past 5 years2	Yes	10422	67.20%	523	65.60%	31	61.30%

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

CHIA Ages 0-17

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
All Causes						
FY24 ED Volume (all cause) rate per 100,000	4923	3651	6909	2977	2827	2755
FY24 Inpatient Discharges (all cause) rate per 100,000	1396	1255	1550	937	844	1034
Allergy						
FY24 ED Volume rate per 100,000	293	306	350	297	245	239
FY24 Inpatient Discharges rate per 100,000	29	11	29	29	5	43
Asthma						
FY24 ED Volume rate per 100,000	347	266	471	282	207	315
FY24 Inpatient Discharges rate per 100,000	67	40	78	44	16	32
Attention Deficit Hyperactivity Disorder						
FY24 ED Volume rate per 100,000	77	11	203	14	16	21
FY24 Inpatient Discharges rate per 100,000	27	28	41	89	43	76
Complication of Medical Care						
FY24 ED Volume rate per 100,000	33	28	63		5	
FY24 Inpatient Discharges rate per 100,000	49	23	52	29	70	43
Diabetes						
FY24 ED Volume rate per 100,000	21		40	14	10	21
FY24 Inpatient Discharges rate per 100,000	8		16		16	
HIV/AIDS						
FY24 ED Volume rate per 100,000	0		2			
FY24 Inpatient Discharges rate per 100,000	0					
Infection						
FY24 ED Volume rate per 100,000	1314	949	1647	699	588	718
FY24 Inpatient Discharges rate per 100,000	131	115	169	89	70	76
Injuries						
FY24 ED Volume rate per 100,000	922	729	1132	655	664	479

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
FY24 Inpatient Discharges rate per 100,000	49	28	59	14	16	43
Learning Disorders						
FY24 ED Volume rate per 100,000	22	5	17	14		
FY24 Inpatient Discharges rate per 100,000	24	11	13	14		
Mental Health						
FY24 ED Volume rate per 100,000	292	231	664	253	174	337
FY24 Inpatient Discharges rate per 100,000	75	121	124	119	87	196
Obesity						
FY24 ED Volume rate per 100,000	7		26			10
FY24 Inpatient Discharges rate per 100,000	12		14			10
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	150	69	212	29	136	76
FY24 Inpatient Discharges rate per 100,000	32	5	22	44	16	
Poisonings						
FY24 ED Volume rate per 100,000	59	11	83	29	16	10
FY24 Inpatient Discharges rate per 100,000	6	5	4	14		
STIs						
FY24 ED Volume rate per 100,000	4		2			
FY24 Inpatient Discharges rate per 100,000	1		2			
Substance Use						
FY24 ED Volume rate per 100,000	48	34	175	104	38	21
FY24 Inpatient Discharges rate per 100,000	11	34	17	59	5	32
Age 0-17 Total	4923	3651	6909	2977	2827	2755

CHIA Ages 18-44

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
All Causes						
FY24 ED Volume (all cause) rate per 100,000	11106	7292	15652	6654	5687	7819
FY24 Inpatient Discharges (all cause) rate per 100,000	2251	1967	2796	1563	1220	1633
Allergy						
FY24 ED Volume rate per 100,000	952	1510	1285	1191	904	1208
FY24 Inpatient Discharges rate per 100,000	206	109	405	133	65	152
Asthma						
FY24 ED Volume rate per 100,000	552	804	1022	610	457	947
FY24 Inpatient Discharges rate per 100,000	266	138	337	74	81	185
Breast Cancer						
FY24 ED Volume rate per 100,000	7	5	14	14		
FY24 Inpatient Discharges rate per 100,000	9	11	13	14	5	
CHF						
FY24 ED Volume rate per 100,000	14	23	26		5	
FY24 Inpatient Discharges rate per 100,000	50	5	78	59		
Complication of Medical Care						
FY24 ED Volume rate per 100,000	120	75	185	74	38	43
FY24 Inpatient Discharges rate per 100,000	645	555	713	521	354	468
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	30	34	209	29	5	108
FY24 Inpatient Discharges rate per 100,000	40	11	74		21	76
Diabetes						
FY24 ED Volume rate per 100,000	309	243	548	148	152	381
FY24 Inpatient Discharges rate per 100,000	173	98	263		21	141
GYN Cancer						
FY24 ED Volume rate per 100,000	2					
FY24 Inpatient Discharges rate per 100,000	4					
Heart Disease						

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
FY24 ED Volume rate per 100,000	12	17	32			
FY24 Inpatient Discharges rate per 100,000	56	5	81	59	5	10
Hepatitis						
FY24 ED Volume rate per 100,000	26		47	14	16	32
FY24 Inpatient Discharges rate per 100,000	70	46	80	44	38	76
HIV/AIDS						
FY24 ED Volume rate per 100,000	24		29			
FY24 Inpatient Discharges rate per 100,000	14	11	25			
Hypertension						
FY24 ED Volume rate per 100,000	447	329	659	133	239	370
FY24 Inpatient Discharges rate per 100,000	210	150	283	74	49	152
Infection						
FY24 ED Volume rate per 100,000	1595	1082	2296	923	958	1274
FY24 Inpatient Discharges rate per 100,000	338	266	414	282	163	294
Injuries						
FY24 ED Volume rate per 100,000	1775	1001	2440	1042	773	1154
FY24 Inpatient Discharges rate per 100,000	237	156	301	148	125	141
Liver Disease						
FY24 ED Volume rate per 100,000	99	40	99	14	16	21
FY24 Inpatient Discharges rate per 100,000	191	167	214	89	81	76
Mental Health						
FY24 ED Volume rate per 100,000	1310	781	2210	789	621	1045
FY24 Inpatient Discharges rate per 100,000	834	810	1149	714	457	718
Obesity						
FY24 ED Volume rate per 100,000	135	5	222	44	16	10
FY24 Inpatient Discharges rate per 100,000	324	318	619	193	87	130
Other Cancer						
FY24 ED Volume rate per 100,000	12		10			
FY24 Inpatient Discharges rate per 100,000	23	23	26		5	10
Pneumonia/Influenza						
FY24 ED Volume rate per 100,000	122	98	170	59	70	65
FY24 Inpatient Discharges rate per 100,000	85	28	89	44	27	21

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
Poisonings						
FY24 ED Volume rate per 100,000	182	214	254	74	87	130
FY24 Inpatient Discharges rate per 100,000	33	28	35	14	10	
Prostate Cancer						
FY24 ED Volume rate per 100,000	0					
FY24 Inpatient Discharges rate per 100,000	0					
STIs						
FY24 ED Volume rate per 100,000	77	17	63		5	54
FY24 Inpatient Discharges rate per 100,000	37	34	26		5	10
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	8		13		5	
FY24 Inpatient Discharges rate per 100,000	19	5	31		5	
Substance Use						
FY24 ED Volume rate per 100,000	2079	1533	3664	967	1067	2352
FY24 Inpatient Discharges rate per 100,000	588	590	801	342	288	555
Tuberculosis						
FY24 ED Volume rate per 100,000	2		2			
FY24 Inpatient Discharges rate per 100,000	8		10			
Age 18-44 Total	11106	7292	15652	6654	5687	7819

CHIA Ages 45-64

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
All Causes						
FY24 ED Volume (all cause) rate per 100,000	6844	6672	9938	6371	5780	7961
FY24 Inpatient Discharges (all cause) rate per 100,000	2291	2083	2971	1890	1656	3528
Allergy						
FY24 ED Volume rate per 100,000	797	1655	1152	1295	1258	1546
FY24 Inpatient Discharges rate per 100,000	330	127	811	267	179	424
Asthma						
FY24 ED Volume rate per 100,000	299	619	584	327	359	544
FY24 Inpatient Discharges rate per 100,000	254	219	269	163	141	424
Breast Cancer						
FY24 ED Volume rate per 100,000	40	5	28		21	
FY24 Inpatient Discharges rate per 100,000	57	75	53	29	59	98
CHF						
FY24 ED Volume rate per 100,000	78	52	123	29	76	87
FY24 Inpatient Discharges rate per 100,000	344	318	535	163	130	424
Complication of Medical Care						
FY24 ED Volume rate per 100,000	100	86	159	59	70	76
FY24 Inpatient Discharges rate per 100,000	428	451	459	223	321	533
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	239	254	526	282	81	392
FY24 Inpatient Discharges rate per 100,000	415	416	703	238	217	729
Diabetes						
FY24 ED Volume rate per 100,000	759	665	1370	669	730	849
FY24 Inpatient Discharges rate per 100,000	688	561	982	535	392	947
GYN Cancer						
FY24 ED Volume rate per 100,000	4		14	14	5	

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
FY24 Inpatient Discharges rate per 100,000	16	5	25	29	5	10
Heart Disease						
FY24 ED Volume rate per 100,000	37	46	71	29	10	21
FY24 Inpatient Discharges rate per 100,000	280	266	350	133	163	511
Hepatitis						
FY24 ED Volume rate per 100,000	23		50			
FY24 Inpatient Discharges rate per 100,000	83	34	87	14	59	76
HIV/AIDS						
FY24 ED Volume rate per 100,000	34	23	47			
FY24 Inpatient Discharges rate per 100,000	34	17	29			21
Hypertension						
FY24 ED Volume rate per 100,000	1377	1429	2191	1384	1127	2167
FY24 Inpatient Discharges rate per 100,000	918	798	1123	625	539	1165
Infection						
FY24 ED Volume rate per 100,000	813	908	1095	684	648	1110
FY24 Inpatient Discharges rate per 100,000	627	619	844	476	528	849
Injuries						
FY24 ED Volume rate per 100,000	1351	1261	1859	1205	1035	1513
FY24 Inpatient Discharges rate per 100,000	534	486	662	401	359	675
Liver Disease						
FY24 ED Volume rate per 100,000	113	28	145	89	49	108
FY24 Inpatient Discharges rate per 100,000	383	376	435	253	283	980
Mental Health						
FY24 ED Volume rate per 100,000	703	538	1514	595	294	468
FY24 Inpatient Discharges rate per 100,000	1042	1099	1409	789	659	1655
Obesity						
FY24 ED Volume rate per 100,000	138	46	173	59	16	76
FY24 Inpatient Discharges rate per 100,000	619	393	1159	401	294	947
Other Cancer						
FY24 ED Volume rate per 100,000	30	11	28		10	32
FY24 Inpatient Discharges rate per 100,000	100	69	109	89	114	250
Pneumonia/Influenza						

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
FY24 ED Volume rate per 100,000	73	52	120	44	76	65
FY24 Inpatient Discharges rate per 100,000	228	196	337	208	185	228
Poisonings						
FY24 ED Volume rate per 100,000	82	69	98	59	81	130
FY24 Inpatient Discharges rate per 100,000	36	28	50	14	27	32
Prostate Cancer						
FY24 ED Volume rate per 100,000	12		19		5	
FY24 Inpatient Discharges rate per 100,000	28		41	14	21	76
STIs						
FY24 ED Volume rate per 100,000	10		11			
FY24 Inpatient Discharges rate per 100,000	6		8			10
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	24	17	20		10	10
FY24 Inpatient Discharges rate per 100,000	92	63	121	74	54	130
Substance Use						
FY24 ED Volume rate per 100,000	1492	1423	2949	1324	811	2112
FY24 Inpatient Discharges rate per 100,000	858	891	1209	789	522	1568
Tuberculosis						
FY24 ED Volume rate per 100,000	1		1			
FY24 Inpatient Discharges rate per 100,000	11					
Age 45-64 Total	6844	6672	9938	6371	5780	7961

CHIA Ages 65+

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
All Causes						
FY24 ED Volume (all cause) rate per 100,000	5485	5341	6213	5955	8035	6490
FY24 Inpatient Discharges (all cause) rate per 100,000	4476	4056	4502	5106	5093	4715
Allergy						
FY24 ED Volume rate per 100,000	798	1371	682	1310	2151	1786
FY24 Inpatient Discharges rate per 100,000	671	358	1294	729	490	522
Asthma						
FY24 ED Volume rate per 100,000	155	266	237	178	348	326
FY24 Inpatient Discharges rate per 100,000	314	196	254	163	234	381
Breast Cancer						
FY24 ED Volume rate per 100,000	69	11	56		10	10
FY24 Inpatient Discharges rate per 100,000	216	115	191	223	315	163
CHF						
FY24 ED Volume rate per 100,000	270	208	341	312	392	196
FY24 Inpatient Discharges rate per 100,000	1445	1093	1480	1607	1193	1274
Complication of Medical Care						
FY24 ED Volume rate per 100,000	158	98	157	253	294	261
FY24 Inpatient Discharges rate per 100,000	809	833	664	1027	887	1078
COPD and Lung Disease						
FY24 ED Volume rate per 100,000	350	561	469	521	506	642
FY24 Inpatient Discharges rate per 100,000	1111	1244	1181	1444	1133	1492
Diabetes						
FY24 ED Volume rate per 100,000	860	873	1317	1101	877	1187
FY24 Inpatient Discharges rate per 100,000	1509	1163	1654	1965	1225	1731
GYN Cancer						
FY24 ED Volume rate per 100,000	7		2	14		

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
FY24 Inpatient Discharges rate per 100,000	27	23	38	74	43	43
Heart Disease						
FY24 ED Volume rate per 100,000	90	17	101	14	43	32
FY24 Inpatient Discharges rate per 100,000	1079	868	936	1280	975	882
Hepatitis						
FY24 ED Volume rate per 100,000	7		4			
FY24 Inpatient Discharges rate per 100,000	51	17	50	14	10	32
HIV/AIDS						
FY24 ED Volume rate per 100,000	7					
FY24 Inpatient Discharges rate per 100,000	14		10			32
Hypertension						
FY24 ED Volume rate per 100,000	1774	2239	2491	2248	3432	2395
FY24 Inpatient Discharges rate per 100,000	1758	1689	1764	1935	2200	1916
Infection						
FY24 ED Volume rate per 100,000	718	810	881	908	969	1056
FY24 Inpatient Discharges rate per 100,000	1455	1452	1531	1637	1656	1611
Injuries						
FY24 ED Volume rate per 100,000	1257	1047	1322	1057	1743	1208
FY24 Inpatient Discharges rate per 100,000	1365	1238	1287	1592	1579	1481
Liver Disease						
FY24 ED Volume rate per 100,000	65	17	50		59	43
FY24 Inpatient Discharges rate per 100,000	421	312	370	476	310	359
Mental Health						
FY24 ED Volume rate per 100,000	347	243	588	282	386	294
FY24 Inpatient Discharges rate per 100,000	1456	1290	1380	1399	1514	1383
Obesity						
FY24 ED Volume rate per 100,000	72	5	72	44		
FY24 Inpatient Discharges rate per 100,000	764	584	1299	1086	419	577
Other Cancer						
FY24 ED Volume rate per 100,000	58	11	69		16	10
FY24 Inpatient Discharges rate per 100,000	285	243	221	521	365	413
Pneumonia/Influenza						

	Anna Jaques Hospital Community Benefits Service Area					
	MA	Amesbury	Haverhill	Merrimac	Newburyport	Salisbury
FY24 ED Volume rate per 100,000	79	57	135	104	114	108
FY24 Inpatient Discharges rate per 100,000	627	532	823	595	757	664
Poisonings						
FY24 ED Volume rate per 100,000	30	23	34	29	21	10
FY24 Inpatient Discharges rate per 100,000	44	34	47	133	32	54
Prostate Cancer						
FY24 ED Volume rate per 100,000	62	5	57	14	27	10
FY24 Inpatient Discharges rate per 100,000	221	104	199	119	266	315
STIs						
FY24 ED Volume rate per 100,000	1	5	1			
FY24 Inpatient Discharges rate per 100,000	7	11	8			
Stroke and Other Neurovascular Diseases						
FY24 ED Volume rate per 100,000	63	52	49	59	65	
FY24 Inpatient Discharges rate per 100,000	290	306	273	253	261	217
Substance Use						
FY24 ED Volume rate per 100,000	391	329	612	565	375	533
FY24 Inpatient Discharges rate per 100,000	552	526	658	535	517	729
Tuberculosis						
FY24 ED Volume rate per 100,000	1		1			
FY24 Inpatient Discharges rate per 100,000	15		17		16	
Age 65+ Total	5485	5341	6213	5955	8035	6490

Community Health Survey

- FY25 AJH Community Health Survey
  - Survey output

Beth Israel Lahey Health

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

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

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

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

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

Select a language

About Your Community

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

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

Zip code: _____

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

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

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

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

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

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

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

Health and Access to care

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

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

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

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

Beth Israel Lahey Health

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

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

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

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

About You

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

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

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

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

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

11. What is your sexual orientation?

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

12. What is your current gender identity?

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

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

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

14. What is your age?

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

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

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

16. Are you currently:

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

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

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

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

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

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

May14, 2024

Beth Israel Lahey Health

Enter to Win a $100.00 Gift Card!

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

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

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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 - Anna Jaques Hospital

Response Counts

Completion Rate:	**90.3%**		
	Complete		1,222
	Partial		132

Totals: 1,354

1. Select a language.

Value	Percent	Responses
Take the survey in English	90.9%	1,214
Faze es Piskiza na Kriolu di Kabu Verdi	0.1%	1
参加简体中文调查	1.6%	21
Reponn sondaj la nan lang kreyòl ayisyen	0.7%	9
Participe da pesquisa em português	0.7%	10
Responda la encuesta en español	6.1%	81

Totals: 1,336

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	95.2%	1,280
I work in this community	27.4%	369
Other, please specify:	2.9%	39

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 %	544 40.7%	660 49.4%	73 5.5%	21 1.6%	39 2.9%	1,337
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 %	406 30.6%	718 54.1%	138 10.4%	36 2.7%	30 2.3%	1,328
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 %	429 32.1%	651 48.7%	125 9.3%	37 2.8%	95 7.1%	1,337
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 %	317 23.7%	664 49.7%	203 15.2%	59 4.4%	92 6.9%	1,335
My community has good access to resources. *(Think about organizations, agencies, healthcare, etc.)* Count Row %	344 25.8%	756 56.7%	138 10.3%	30 2.2%	66 4.9%	1,334
My community feels safe. Count Row %	511 38.3%	660 49.4%	103 7.7%	32 2.4%	29 2.2%	1,335

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Responses
My community has housing that is safe and of good quality. Count Row %	326 24.5%	738 55.5%	134 10.1%	53 4.0%	79 5.9%	1,330
My community is prepared for climate disasters like flooding, hurricanes, or blizzards. Count Row %	133 10.0%	547 41.2%	248 18.7%	46 3.5%	355 26.7%	1,329
My community offers people options for staying cool during extreme heat. Count Row %	203 15.3%	617 46.4%	156 11.7%	28 2.1%	327 24.6%	1,331
My community has services that support people during times of stress and need. Count Row %	192 14.5%	630 47.5%	164 12.4%	42 3.2%	297 22.4%	1,325
I believe that all residents, including myself, can make the community a better place to live. Count Row %	614 46.1%	641 48.1%	37 2.8%	19 1.4%	21 1.6%	1,332
Totals Total Responses						1337

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	20.9%	280
Better access to health care	28.3%	379
Better access to healthy food	19.9%	266
Better access to internet	14.9%	200
Better access to public transportation	18.5%	247
Better parks and recreation	14.8%	198
Better roads	33.1%	443
Better schools	27.6%	369
Better sidewalks and trails	42.9%	574
Cleaner environment	14.9%	199
Lower crime and violence	15.8%	211
More affordable childcare	27.1%	362
More affordable housing	53.9%	721
More arts and cultural events	11.7%	157
More effective city services (like water, trash, fire department, and police)	12.3%	164
More inclusion for diverse members of the community	20.6%	276

Value	Percent	Responses
Stronger community leadership	11.2%	150
Stronger sense of community	9.5%	127
Other, please specify:	6.4%	86

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	102 7.9%	201 15.7%	726 56.5%	186 14.5%	69 5.4%	1,284
Health care in my community meets the mental health needs of people like me. Count Row %	124 9.8%	324 25.6%	450 35.6%	114 9.0%	253 20.0%	1,265
Totals Total Responses						1284

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

Value	Percent	Responses
A doctor's or nurse's office	84.3%	1,085
A public health clinic or community health center	6.7%	86
Urgent care provider	3.7%	47
A hospital emergency room	0.9%	12
No usual place	2.6%	33
Other, please specify:	1.9%	24

Totals: 1,287

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

Value	Percent	Responses
Fear or distrust of the health care system	11.0%	140
Not enough time	16.9%	215
Insurance problems	17.9%	227
No providers or staff speak my language	2.4%	31
Can’t get an appointment	27.7%	352
Cost	26.4%	335
Concern about COVID or other disease exposure	3.4%	43
Transportation	6.4%	81
Other, please specify:	7.6%	96
No barriers	36.0%	457

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)	38.8%	477
Alcohol or drug misuse	30.8%	378
Asthma	4.1%	50
Cancer	19.7%	242
Child abuse/neglect	8.9%	109
Diabetes	9.4%	115
Domestic violence	11.2%	137
Environment (like air quality, traffic, noise)	15.8%	194
Heart disease and stroke	13.5%	166
Hunger/malnutrition	12.8%	157
Homelessness	21.7%	266
Housing	39.8%	489
Mental health (anxiety, depression, etc.)	56.3%	691
Obesity	12.9%	158
Poor diet/inactivity	13.1%	161
Poverty	12.5%	154

Value	Percent	Responses
Smoking	7.9%	97
Suicide	9.0%	111
Trauma	7.8%	96
Underage drinking	6.8%	83
Vaping/E-cigarettes	17.9%	220
Violence	6.4%	78
Youth use of social media	30.2%	371
Infant death	1.2%	15
Rape/sexual assault	2.9%	36
Sexually transmitted infections (STIs)	2.4%	30
Teenage pregnancy	2.8%	34

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

Value	Percent	Responses
12th grade or lower (no diploma)	7.2%	91
High school (including GED, vocational high school)	7.8%	99
Started college but not finished	10.3%	130
Vocational, trade, or technical program after high school	3.2%	41
Associate degree (for example, AA, AS)	9.0%	113
Bachelor's degree (for example, BA, BS, AB)	28.3%	357
Graduate degree (for example, master's, professional, doctorate)	30.7%	387
Other, please specify:	1.6%	20
Prefer not to answer	1.9%	24

Totals: 1,262

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

Value	Percent	Responses
American Indian or Alaska Native	1.2%	15
Asian	2.7%	34
Black or African American	2.5%	32
Hispanic or Latine/a/o	12.1%	153
Middle Eastern or North African	0.4%	5
White	79.3%	1,001
Other, please specify:	1.0%	13
Not sure	0.5%	6
Prefer not to answer	3.7%	47

11. What is your sexual orientation?

Value	Percent	Responses
Asexual	1.5%	19
Bisexual and/or Pansexual	3.5%	44
Gay or Lesbian	2.6%	33
Straight (Heterosexual)	83.6%	1,052
Queer	0.4%	5
Questioning/I am not sure of my sexuality	0.3%	4
I use a different term, please specify:	0.3%	4
I do not understand what this question is asking	1.0%	13
I prefer not to answer	6.8%	85

Totals: 1,259

12. What is your current gender identity?

Value	Percent	Responses
Female, Woman	79.9%	1,004
Male, Man	16.0%	201
Nonbinary, Genderqueer, not exclusively male or female	0.6%	7
I use a different term, please specify:	0.2%	2
I do not understand what this question is asking	0.2%	2
I prefer not to answer	3.2%	40

Totals: 1,256

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

Value	Percent	Responses
Childcare or school	5.1%	63
Food or groceries	20.3%	252
Formula or baby food	1.4%	17
Health care (appointments, medicine, insurance)	17.4%	216
Housing (rent, mortgage, taxes, insurance)	22.7%	282
Technology (computer, phone, internet)	9.1%	113
Transportation (car payment, gas, public transit)	11.3%	140
Utilities (electricity, water, gas)	20.6%	256
Other, please specify:	1.8%	22
None of the above	56.5%	700

14. What is your age?

Value	Percent	Responses
Under 18	4.5%	57
18-24	0.9%	11
25-44	34.4%	436
45-64	35.7%	453
65-74	14.6%	185
75-84	7.4%	94
85 and over	1.7%	21
Prefer not to answer	0.9%	11

Totals: 1,268

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

Value	Percent	Responses
Armenian	2.9%	37
Cape Verdean Creole	0.2%	2
Chinese (including Mandarin and Cantonese)	1.6%	20
English	89.5%	1,129
Haitian Creole	1.2%	15
Hindi	0.1%	1
Khmer	0.1%	1
Portuguese	1.7%	21
Spanish	8.7%	110
Vietnamese	0.1%	1
Other, please specify:	1.0%	13
Prefer not to answer	0.8%	10

16. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	44.8%	568
Employed part-time (Less than 40 hours per week)	14.4%	182
Self-employed (Full- or part-time)	5.7%	72
A stay-at-home parent	4.3%	55
A student (Full- or part-time)	3.4%	43
Unemployed	2.8%	36
Unable to work for health reasons	2.4%	31
Retired	19.1%	242
Other, please specify:	1.7%	22
Prefer not to answer	1.3%	17

Totals: 1,268

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

Value	Percent	Responses
Yes	12.3%	155
No	84.3%	1,061
Prefer not to answer	3.3%	42

Totals: 1,258

18. I currently:

Value	Percent	Responses
Rent my home	17.7%	223
Own my home (with or without a mortgage)	67.5%	848
Live with parent or other caretakers who pay for my housing	5.4%	68
Live with family or roommates and share costs	3.3%	42
Live in a shelter, halfway house, or other temporary housing	0.8%	10
Live in senior housing or assisted living	3.4%	43
I do not currently have permanent housing	0.6%	7
Other	1.3%	16

Totals: 1,257

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

Value	Percent	Responses
I have always lived in the United States	82.3%	1,035
Less than one year	1.0%	12
1 to 3 years	2.6%	33
4 to 6 years	1.6%	20
More than 6 years, but not my whole life	12.1%	152
Prefer not to answer	0.5%	6

Totals: 1,258

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	60.5%	737
Faith community (such as a church, mosque, temple, or faith-based organization)	20.4%	249
School community (such as a college or education program that you attend or a school that your child attends)	26.1%	318
Work community (such as your place of employment or a professional association)	40.2%	490
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)	7.9%	96
A shared interest group (such as a club, sports team, political group, or advocacy group)	31.5%	384
Another city or town where I do not live	12.6%	153
Other, please feel free to share:	5.3%	64

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	25.6%	186
No	74.4%	540

Totals: 726

Appendix C:
Resource Inventory

Anna Jaques Hospital Community Resource List

Community Benefits Service Area includes: Amesbury, Haverhill, Merrimac, Newburyport, Salisbury, and Seabrook, NH

Health Issue	Organization	Brief Description	Address	Phone	Website
	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.		833.773.2445	www.handholdma.org
	Executive Office of Aging & Independence	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 10th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-aging-independence
	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

Statewide Resources	Massachusetts Behavioral Health Help Line (BHHL) Treatment Connection	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.		833.773.2445	www.masshelpline.com/MABHHLTreatmentConnectionResourceDirectory
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for substance use treatment, recovery, and problem gambling services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		988	www.suicidepreventionlifeline.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	Jeanne Geiger Crisis Center	Provides support in Survivor Services, including advocacy, counseling, legal assistance, support groups and 24/7 Confidential Hotline.	2 Harris St Newburyport	978.465.0999 24/7 Confidential Hotline is available at 978.388.1888	www.jeannegeigercrisiscenter.org

	YWCA Northeastern Massachusetts	Provides support in Survivor Services, including advocacy, counseling, legal assistance, support groups and 24/7 Confidential Hotline.	107 Winter St Haverhill	978.374.6121 24-hour hotline 844.372.9922	www.ywcanema.org/survivor-services/
Food Assistance	All Saints Parish Food Pantry	Provides food assistance to residents of Haverhill.	120 Bellevue Ave Haverhill	978.372.7721 ext. 30	www.allsaintshaverhill.org/food-pantry
	Changing Lives Christian Church	Provides food assistance to residents of Haverhill.	17 Newcomb St Haverhill	978.373.7373	www.changingliveschristianchurch.com/food_pantry.htm
	Community Action, Inc.	Provides food assistance to residents of Amesbury, Merrimac, Salisbury, Newburyport, Newbury and West Newbury.	44A Friend St Amesbury	978.388.2570	www.communityactioninc.org/cai-amesbury-center/
	Liz Murphy Open Hand Pantry	Provides food assistance to residents of Haverhill.	16 Ashland St Haverhill	978.372.0260	www.stjamesandjohnhaverhill.org/87
	MA Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program
	Our Neighbors' Table	Provides food assistance to residents of Amesbury, Boxford, Byfield, Georgetown, Groveland, Merrimac, Newbury, Newburyport, Rowley, Salisbury, and West Newbury.	P.O. Box 592 Amesbury	978.388.1907	www.ourneighborstable.org
	The Pettengill House, Inc.	Provides food assistance to residents of Amesbury, Groveland, Merrimac, Newbury, Newburyport, and Rowley.	13 Lafayette Rd Salisbury	978.463.8801	www.pettengillhouse.org
	Project Bread Foodsource Hotline	Provides information about resources in your community as well as assist with SNAP applications over the phone.		1.800.645.8333	www.projectbread.org/get-help
	Sacred Hearts Food Pantry	Provides food assistance to residents of Haverhill.	13 Carleton Ave Bradford	508.542.0698	www.sacredheartsparish.com/serving-our-neighbors
	Salvation Army Haverhill	Provides food assistance to residents of Haverhill.	395 Main St Haverhill	978.420.4192	easternusa.salvationarmy.org/massachusetts/haverhill/
	Somebody Cares New England Food Pantry	Provides food assistance to residents of Haverhill.	358 Washington St Haverhill	978.912.7626	www.somebodycaresne.org/food-pantry/

	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
Housing Support	Amesbury Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	180 Main St Amesbury	978.388.2022	www.amesburyha.com
	Community Action, Inc.	Provides social service programs and housing resource assistance.	3 Washington Sq. Haverhill	978.373.1971	www.communityactioninc.org
	Emmaus	Provides services and programs that assist with family and children, finances, education and job training, food and nutrition, and housing and utilities.	127 How St Haverhill	978.241.3400	www.emmausinc.org
	Haverhill Housing Authority	Provides affordable, subsidized rental housing for residents of Haverhill.	25-C Washington Sq. Haverhill	978.372.6761	www.haverhillhousing.com
	Merrimac Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	180 Main St Amesbury	978.388.2022	www.merrimacha.com
	Newburyport Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families.	25 Temple St Newburyport	978.465.7216	www.nhahousing.com
	Salisbury Housing Authority	Provides affordable, subsidized rental housing for residents of Salisbury.	23 Beach Rd Salisbury	978.462.8600	www.salisburyhousing.org
	YWCA of Newburyport	Provides safe, affordable and supportive child care and youth development, housing and wellness opportunities.	13 Market St Newburyport	978.465.9922	www.ywcanewburyport.org
	Arbour Counseling Services	Provides behavioral health and substance use treatment programs to individuals of all ages, groups, families, and couples.	116 Summer St Haverhill	978.373.7010	www.arbourhealth.com
	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

Mental Health and Substance Use	Eliot Community Behavioral Health Centers	Provides substance use and mental health treatment programs including urgent and emergency services, crisis stabilization, individual and family therapy services and care coordination for youth, families and adults.	10 Harbor St Danvers	888.769.5201	www.eliotchs.org/cbhc/
	Eliot Community Human Services	Provides services for people of all ages throughout Massachusetts through a continuum of services includes diagnostic evaluation, 24-hour emergency services, and crisis stabilization, outpatient and court-mandated substance-use prevention services; individual, group and family outpatient counseling, early intervention, specialized psychological testing; day, residential, social and vocational programs for individuals with developmental disabilities, outreach and support services for people experiencing homelessness.	125 Hartwell Ave Lexington	781.861.0890	www.eliotchs.org
	Family Continuity	Provides evidence-based, best practice therapies for individuals and families.	360 Merrimack St Bldg. 9 3rd Floor Lawrence	978.687.1617	www.familycontinuity.org
	Link House, Inc.	Provides residential programs in Salisbury, Newburyport, and Amesbury for men and women who struggle with substance use disorders.	110 Haverhill Rd Amesbury	978.462.0787	www.linkhouseinc.org
	AgeSpan	Provides programs and services which are available and accessible to meet the diverse needs and changing lifestyles of older adults.	280 Merrimack St Ste 400 Lawrence	978.683.7747	www.agespan.org
	Amesbury Council on Aging	Provides services for older adults in Amesbury including fitness, education, social services, and recreation.	68 Elm St Amesbury	978.388.8138	www.amesburyma.gov/323/Council-on-Aging
	Haverhill Council on Aging	Provides services for older adults in Haverhill including fitness, education, social services, and recreation.	10 Welcome St Haverhill	978.374.2390	www.cityofhaverhill.com/departments/human_services1/council_on_aging/index.php

Senior Services	Merrimac Senior Center	Provides services for older adults in Merrimac including fitness, education, social services, and recreation.	100 East Main St Merrimac	978.346.9549	www.townofmerrimac.com/council-on-aging/
	Newburyport Council on Aging	Provides services for older adults in Newburyport including fitness, education, social services, and recreation.	331 High St Newburyport	978.462.0430	www.cityofnewburyport.com/council-on-aging
	Salisbury Council on Aging	Provides services for older adults in Salisbury including fitness, education, social services, and recreation.	43 Lafayette Rd Salisbury	978.462.2412	www.salisburyma.gov/council-on-aging
	MBTA Commuter Rail Service	Provides service to Newburyport and Haverhill.			www.mbta.com
Transportation	Merrimack Valley Regional Transit Authority	Serves the northeast corner of Massachusetts with scheduled bus routes and older adults/people with disabilities transportation.	85 Railroad Ave Haverhill	978.469.6878	www.mvrta.com
Additional Resources	Boys & Girls Club of Greater Haverhill	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	55 Emerson St Haverhill	978.374.6171	www.haverhillbgc.org
	211 NH	Available 24 hours a day, 7 days a week, 211 NH provides help with housing, utilities, food, mental health, health care and so much more.		211	www.211nh.org
	Boys & Girls Club of Lower Merrimack Valley	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	18 Maple St Salisbury	978.462.7003	www.bgclmv.org
	YMCA Haverhill	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	81 Winter St Haverhill	978.374.0506	www.northshoreymca.org/locations/haverhill-ymca

Appendix D:

Evaluation of 2023-2025 Implementation Strategy

Anna Jaques Hospital (AJH)

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**
● Older adults ● Low-resourced populations	Promote access to health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.	● Patient Financial Services ● Transportation Services	● Significant segments of the community population living within the hospital's CBSA, particularly low-resourced populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs. o # of patients screened for state assistance (Baseline(FY23): 156; Year 1(FY24): 622) ● AJH provides transportation assistance to patients who have limited resources and social support. This program is offered to any patient who meets the

			criteria of need decided by a social worker. o Amount distributed to patients (Baseline(FY23): $7,200; Year 1(FY24): $7,400) o Transportation assistance for patients (Baseline(FY23): 240 patients; Year 1(FY24): 189 rides) ● To orient and support expectant patients, especially those deemed "high-risk," by preparing them for hospital delivery and initial newborn care, AJH started a "Welcome Visit" program in January 2023. The visit is free, and outreach is done to ensure the most at-risk patients attend the visit. o Welcome visits completed (Baseline(FY23): 130; Year 1(FY24): 206) ● Throughout Anna Jaques Hospital's Community Benefits Service Area, AJH subsidizes primary care services provided by the hospital's Affiliated Physician's Group. o # of practices providing primary care: (Baseline(FY23): 5; Year 1(FY24): 5)
● Older adults ● Low-resourced populations ● Racially, ethnically, and linguistically diverse populations	Promote equitable care and support for those who face cultural and linguistic barriers	● Interpreter Services	● Anna Jaques Hospital offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. Professional interpretation services in hundreds of languages are available 24/7. o AJH Interpreter encounters (Baseline(FY23): 1,487, top languages being Spanish and

			Portuguese; Year 1(FY24): 1,953, top languages being Spanish and Portuguese)

			● BILH is strongly committed to workforce development programs that enhance the skills of its employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate's degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs. o Community events and presentations conducted (Baseline(FY23): 67; Year 1(FY24): 33) o Interns hired after internships (Baseline(FY23): 22; Year 1(FY24): 37) o Employees engage in ESOL classes (Baseline(FY23): 45; Year 1(FY24): 82) o Internships offered to adult community members (Baseline(FY23): 54; Year 1(FY24): 107)

			○ Community members referred to BILH (Baseline(FY23): 225; Year 1(FY24): 412) ○ Community members hired by BILH (Baseline(FY23): 70; Year 1(FY24): 111) ○ BILH employees engaged in citizenship classes (Year 1(FY24): 14) ○ BILH employees engaged in career development classes (Year 1(FY24): 15) ○ BILH employees engaged in financial literacy classes (Year 1(FY24): 207) ○ BILH employees engage in career development services (Year 1(FY24): 1,044)
● Older adults ● Low-resourced populations	Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation to healthcare services.	● Provide an opportunity for grant funding	● In Year 1, AJH released a competitive Request for Proposal for community grants to support the FY23-FY25 Implementation Strategy. Northern Essex Elder Transport (NEET) was awarded funding for Year 1 and Year 2 to assist with transportation to medical appointments. ● To support older adults' access to vital medical appointments, AJH supported Northern Essex Elder Transport, Inc. (NEET). NEET provides free transportation to and from healthcare appointments for those over the age of 60. ○ Unique individuals receiving transportation to medical care (Baseline(FY23): 436) ○ New volunteers recruited (Year 1(FY24):12) ● In Year 1(FY24), Anna Jaques Hospital strengthened its partnership with the Merrimack Valley Transit (MeVa), the operator of the bus system throughout the Community Benefits

			Service Area. In the spring 2024, MeVa and AJH worked together to move the public bus stop to the main entrance to the hospital from a non-handicap-accessible location. In addition, AJH supported MeVa's application for funding to increase free bus service between Lawrence, Haverhill, and Newburyport. This funding was approved and the bus service began in September 2024.

Priority: Social Determinants of Health

Goal: Enhance the built, social, and economic environment where people live, work, play, and learn in order to improve health and quality-of-life outcomes.			
Priority Cohorts	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Youth • Older adults • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	Provide community health grants to support impactful programs that address issues associated with the social determinants of health	• Community health grants and trainings	• Anna Jaques Hospital Community Benefits and Community Relations staff implemented effective and efficient programs through community health grants that support the community health needs of the Community Benefits Service Area (CBSA). o # of programs supported and implemented (Baseline(FY23): 18; Year 1(FY24): 15) • Anna Jaques Hospital, in collaboration with Beth Israel Lahey Health, regularly convenes community trainings to increase the capacity of the external organizations o # of community capacity building trainings offered (Baseline(FY23): 4; Year 1(FY24): 2 evaluation workshops to 30 organizations and grantees)
• Youth • Older adults • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	Support programs and initiatives that stabilize or create access to affordable housing.	• YWCA Newburyport: Roof Over Head Program • Emmaus, Inc. • Mitch's Place Emergency Shelter	• Anna Jaques Hospital supported the YWCA of Newburyport's Affordable Housing residents with a grant to purchase healthy, fresh produce. All households are below 60% of the Area Median Income. Households with incomes below 80% AMI are considered low income. At the Residences at Salisbury Square (RSS) site, 20 of 42 units are currently housing families whose income is at or below 30% of Area Median (which is considered extremely low income. o Tenants assisted with food (Baseline(FY23): 100)

			○ Status: Program was funded for Baseline Year(FY23) only. ● AJH supported Emmaus, Inc. "Mitch's Place" emergency shelter that provides overnight shelter, nutritious meals, and needed support services year-round, including during extreme conditions, to homeless men and women that may otherwise spend the night engaging in high-risk, self-destructive, and/or illegal activities. The program also offers case management to support accessing needed services and job opportunities. ○ Number of individuals served (Baseline(FY23):225; Year 1(FY24): 274) ○ Number of unhoused individuals who accessed permanent housing (Year 1(FY24): 48)
● Youth ● Older adults ● Low-resourced populations	Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	● Our Neighbors' Table: Weekly Wednesday Meal Program ● Nourishing the North Shore: VEGOUT Mobile Market ● TBD Grant opportunities	● AJH issued a community grant to Our Neighbors' Table (ONT) to support their Wednesday Meal program, which is open to anyone. The Wednesday Meal provides a hot meal to 300– 500+ unique people each month. ONT also provides home deliveries of the Wednesday Meal to those who are homebound and distributes extra prepared meals in the market on Thursday as an extra convenience for ONT guests ○ Guests served through the Wednesday Meal program (Baseline(FY23): 4,490) (Year 1(FY24): average of 263 per week) ● Nourishing the Northshore's VEGOUT Program brings healthy, local produce to members in the community that often do not have access to these food choices. Nourishing the North Shore combines excess produce from local farms with food that is grown at their garden and distributes produce directly through the community's food access agencies as well as NNS-run Farmers' Market

			style produce stands. All produce is free to those who are visiting the food access sites. o Unique households receiving food (Baseline(FY23): 1,000) o Servings of food distributed (Year 1(FY24): 190,000) ● Beth Israel Lahey Health (BILH) awarded the YMCA of the North Shore/Haverhill YMCA a grant to address social determinants of health needs and increase food access through the introduction of a freight container to operate a hydroponic farm. The YMCA partnered with the Haverhill Public Schools to house the farm at Gateway Academy, a public middle and high school. Students from the school and the YMCA afterschool program help to grow, tend, and harvest produce. The Freight Farm grows a variety of vegetables, including lettuce, bok choy, and spinach, that are distributed to Gateway students, YMCA participants and shared with local food pantries/homeless shelters. o Unique persons receiving food (Baseline(FY23): 1,040; Year 1(FY24): 3,200) o Student participants in STEM and nutritional activities (Baseline(FY23): 43; Year 1(FY24): 30) o People received via community events (Baseline(FY23): 154; Year 1(FY24): 350) ● In Year 1(FY24), AJH released a competitive Request for Proposal for community grants to support the FY23-FY25 Implementation Strategy. Four organizations were awarded funding for Year 1 and Year 2 to address food insecurity.

			● The Haverhill Public Schools' McKinney Vento Program provides support for students and their families who are unhoused. Anna Jaques Hospital's support for the program assists with maintaining ongoing food resources within Haverhill schools, such as Haverhill High School's Backpack 68 program and school food closets. In addition, this funding will support creating additional school food closets over two years. o Partnerships with local organizations (Year 1(FY24): 5) o Status: Program funded in Year 1(FY24). ● Anna Jaques Hospital supported Common Ground Ministries Café, which is open 365 days a year to provide for the foundational needs for the unhoused and/or lower income population in the Haverhill area. The program provides food, clothing, hygiene products, resources, and care for this specific population. Common Ground collaborates with local service providers and the Haverhill police regularly to understand and address the needs of the unhoused population. o Persons served per day (Year 1(FY24): 60-80+) o Status: Program funded in Year 1(FY24). ● Anna Jaques Hospital supported the First Parish Newbury Food Pantry, which provides free food to those in need, including residents of Newburyport, Salisbury, Amesbury, and other surrounding cities/towns. The organization serves approximately 600 guests each week, the majority of which live in Newburyport (45%). More than half the households served don't have transportation and depend on the organization's food delivery. The organization has pantries in all the schools in the Triton School District,

			which includes Salisbury Elementary School and Triton High School, serving Salisbury residents. o Households receiving food regularly (Baseline(FY23): 401) o Status: Program was funded for Baseline Year(FY23) only.
● Youth ● Older adults ● Low-resourced populations	Participate in multi-sector community coalitions to identify and advocate for policy, systems, and environmental changes that reduce and prevent food insecurity and/or housing challenges.	● Our Neighbors' Table: Food Task Force	● Anna Jaques Hospital is a member of several coalitions and committees that address social determinants of health, including the Our Neighbors' Table Food Task Force.

Priority: Mental Health and Substance Use

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
● Youth	Enhance relationships and partnerships with schools, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills.	● Girls Inc. Healthy Living Program ● Essex County Asset Builder Network	● Anna Jaques Hospital provided a community grant to Jeanne Geiger Crisis Center's Youth Empowerment Services (YES). YES consists of Girls, Inc., Bystander Education, and Healthy Relationships programming. These are violence prevention programs that teach elementary, middle and high school students how to lead conversations about healthy relationships, recognize signs of an abusive relationship, and become empowered to make positive and healthy decisions. o Program participants (Year 1(FY24): 27) o Status: Program funded in Year 1(FY24). ● Anna Jaques Hospital remains engaged with the Essex County Asset Builder Network. o Events hosted by program with hospital staff participation (Year 1(FY24): 2) ● AJH provided a community grant to Link House, Inc.'s CATCH (Children and Teen Center for Help) program to address these growing unmet needs around mental health and substance-use for

			school-aged children and teens in the community. The funds from this grant focused especially on child and teens aged 5 years old- 18 years old, and their immediate families who require receiving treatment and/or psychoeducation related to acute or chronic mental health concerns, in addition to treatment, education, and/or relapse prevention skills. o Patients receiving therapy (Baseline(FY23): 146; Year 1(FY24): 171)
● Older adults ● Low-resourced populations ● Youth	Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation and treatment.	● BILH Collaborative Care Model ● Outpatient Clinic, Outreach Services Haverhill ● Adult Day Treatment Services-Haverhill ● Emergency Department (ED) Recovery Coach ● Patient Care Navigator	• BILH provides a range of behavioral health, substance use, and addiction recovery services and counseling for adults, youth and families including inpatient and outpatient psychiatry services, outreach and community services. Collaborative Care Model (CoCM) has been adopted in BILH Primary Care practices to provide behavioral health services in the primary care setting. The primary care provider and the behavioral health clinician will develop a treatment plan that is specific to the patient's personal goals. A consulting psychiatrist may advise the primary care provider on medications that may be helpful. • Number of patients served (Baseline(FY23): 159; Year 1(FY24): 83) • AJH continued offering the Patient Care Navigator that supports women with Substance Use Disorder and/or Neonatal Abstinence Syndrome, a

			condition that impacts about 9.1 cases per 1,000 births in Massachusetts. The Patient Care Navigator serves women in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders. The Patient Care Navigator supports women throughout their pregnancy and into the first year of motherhood, working in collaboration with Women's Health Care and the Anna Jaques Birth Center & Neonatal Care Center. • Number of women served in recovery or seeking additional support (Baseline(FY23): 300; Year 1(FY24): 285) • AJH provides 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement. • Number of screens for behavioral health (Baseline: 974; Year 1: 1,377)

• Youth
• Older adults
• Low-resourced populations
	Support a model that spans the continuum of care from inpatient to outpatient and community initiatives that identify and address mental health needs and substance use disorders.	• The Pettengill House: Substance Addiction/ Mental Health Initiative
		• Essex County Outreach – Community Education Offerings
		• Family Services of the Merrimack Valley: Samaritans Program
		• Link House – Outpatient Services
			• AJH supported The Pettengill House's Behavioral Event and Substance Support Team (BESST), which is an initiative to unite a broad network of local providers dedicated to breaking down barriers and providing substance misuse/behavioral health support for individuals and families of all ages. The BESST model takes an "upstream" approach to addressing urgent mental health and substance misuse challenges along with additional social determinants of health, identifying core needs and implementing systemic solutions rooted in best practices and person-centered care.
			  • Number of unique individuals receiving direct services (Baseline(FY23): 481; Year 1(FY24): 192)
			  • Number of family members receiving support (Baseline(FY23): 94)
			  • Number of hospital patient care meetings (Year 1(FY24): 48)
			• AJH continued partnering with Essex County Outreach (ECO), a collaborative effort involving all 34 police departments within Essex County, as well as the sheriff's department, partnering with social service agencies, peer specialists, and other community support to increase resources for substance use and mental health.
			  • Unique persons assisted (Baseline(FY23): 104)

			• Status: Program was funded in Baseline Year (FY23) only. In Year 1(FY24), Anna Jaques Hospital had several meetings with ECO to discuss collaboration around patient discharge and recovery coaching. • AJH supported Family Services' Samaritans of the Merrimack Valley that aims to reduce the incidents of suicide in northeastern Massachusetts by providing a host of prevention and post-vention services including community outreach, trainings, survivor support and a 24-hour crisis hotline. • Individuals served through helplines (Baseline(FY23): 4,600) • Participants in training and supportive programs (Baseline(FY23): 495) • Suicide prevention training sessions (Baseline(FY23): 330) • Status: Program was funded in Baseline Year(FY23) only. • AJH provided grant funding to the Greater Newburyport Village for their membership assistance program. The Village's Good Neighbor Volunteers provide neighborly help at home and rides to appointments/events. In addition, the Village follows up with non-participating members, who may be suffering from isolation. • Percent of members enrolled in assistance program (Baseline(FY23): 20%) • Status: Program was funded in Baseline Year(FY23) only.

			• To support increased access and understanding of mental health resources throughout AJH's Community Benefits Service Area, Link House was awarded a three-year grant for Wellness Delivered, a comprehensive behavioral health education program. This program expands the reach of Link House, Inc.'s (LHI) outpatient services by taking comprehensive behavioral health education programming "on the road" to meet the community where it lives.
			  • Community education sessions delivered (Year 1(FY24): 2)
			  • Status: Program was implemented in Year 1(FY24).
			• To support increased access to mental health and substance use services and supports, Anna Jaques Hospital participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.
			  • Individuals trained in Mental Health First Aid (Year 1(FY24): 350)
			  • Status: Program was implemented in Year 1(FY24).

• Youth • Older adults • Low-resourced populations	Participate in multi-sector community coalitions to identify and advocate for policy, systems, and environmental changes to increase resiliency, promote mental health, reduce substance use, and prevent opioid overdoses and deaths.	• Amesbury Partnership of Amesbury Community & Teens (PACT) – AJH healthcare rep. for Drug Free Communities Grant • BEACON Coalition Task Force • Participate/collaborate with BESST Task Force (Mental Health / Substance Use DisorderTask Force)	• Status: In Year 1(FY24), the Community Benefits and Community Relations Manager at Anna Jaques Hospital participated in the Newburyport Public Schools Wellness Advisory Committee and joined the Partnership of Amesbury Community and Teens (PACT), a youth-focused substance prevention coalition. • Status: Anna Jaques Hospital social workers are regular participants in the BESST Task Force's monthly meetings. The BESST Coordinator also visits the hospital weekly to consult on patients prior to discharge.

Priority: Complex and Chronic Conditions

Goal: • **Address the prevalence and impact, risk/protective factors, and access issues associated with cancer.** • **Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.**			
Priority Cohort(s)	**Strategies**	**Initiatives to address the priority**	**Progress, Outcome, Impacts**
• Older adults • Low-resourced populations	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.	• Breast Care Navigator at the Gerrish Breast Care Center • Social Worker, AJH Cancer Center • Dietitian, AJH Cancer Center	• AJH Breast Care Navigator offers individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The Navigator provides cancer patients with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers, along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers. The Navigator works in collaboration with the clinical team to develop clinical pathways for appropriate care and acts as the contact clinical person for patient-related concerns. o Individuals provided support services and care coordination (Baseline(FY23): 266 women scheduled for image-guided breast biopsies and 100 GBCC patients and families undergoing breast surgery

			for both benign and malignant conditions). o Status: Program ended in FY23. ● Status: The AJH Cancer Center does not have a Social Worker on staff. ● EnhanceFitness is a proven community-based senior fitness and arthritis management program. It helps older adults become more active, energized, and empowered for independent living. The program is especially beneficial for older adults living with arthritis. AJH supported this program at the YMCA of Greater Haverhill. o Percent of participants that maintained/increased their feeling of overall health during the 16-week program (Baseline(FY23): 90%) o Percent of participants who improved their physical abilities over the 16-week program (Baseline(FY23): 75%) o Status: Program was funded in Baseline Year(FY23) only. ● AJH hosts free weekly "Baby and Me" classes in Newburyport and Haverhill for any parent in the community. These groups are facilitated by a Birth Center Lactation Consultant/Registered Nurse to support every person's parenting experience. A person does not need to be breastfeeding/chest feeding to

			enjoy this group. All aspects of parenting are discussed. o Parents participating weekly in classes (Baseline(FY23): 15; Year 1(FY24): 15) ● Anna Jaques Hospital provided a community grant to Sarah's Place, which provides medical oversight and assistance with activities of daily living while promoting a sense of purpose and a community of caring for participants. With increased awareness, access to adult day health programs keeps aging adults healthy and independent in the community. Anna Jaques Hospital's grant funding supports bilingual outreach to provide education about the resources and benefits of adult day health programs. o Number of elder/senior housing sites receiving onsite education (Year 1(FY24): 4) o Status: Program implemented in Year 1(FY24).
● Youth ● Older adults ● Low-resourced populations	Support community-based programs/initiatives that increase access to healthy foods and/or physical activity to support cancer survivorship.	● YMCA Haverhill: Corner Stone Program ● YWCA Newburyport: Encore Program ● North of Boston Cancer Resource: Speaker Series	● AJH supported the Cornerstone Program at the Greater Haverhill YMCA. Cornerstone is a collaborative health and wellness program providing support to cancer patients, cancer survivors, and their immediate families. A free one-year YMCA membership is provided to the family and two weeks of summer camp programming at no cost.

			○ Number of survivorship support program memberships (Baseline(FY23): 41) ○ Number of families provided summer camp (Baseline(FY23): 8) ○ Status: Program was funded in Baseline Year(FY23) only. ● AJH supported the YWCA of Newburyport's Encore and After Encore Program, which is a unique survivorship program for those who have experienced cancer at any point in their lives. The program provides free access to a tailored exercise program, incorporating land and water exercises appropriate for all fitness levels at any point in their treatment journey and beyond. ○ Encore/After Encore participants (Baseline(FY23): 36; Year 1(FY24): 48) ● AJH supported the North of Boston Cancer Resource (NBCR), which offers support and education to people affected by cancer from diagnosis, through treatment and beyond. Through the Gift Certificate/Voucher Program they fund supportive services from their resource guide to recipients. Services include oncology massage, manual lymph drainage, acupuncture, reiki, personal training, yoga therapy, guided imagery, health coaching and nutrition counseling. Through their monthly Speaker Series, NBCR provides information that

			promotes empowerment through knowledge and self-care. o Individuals reached through Speaker Series (Baseline(FY23): 271; Year 1(FY24): 240) o Complementary care sessions provided (Baseline(FY23): 160; Year 1(FY24): 226) ● AJH sponsors the Haverhill Farmers' Market, which is dedicated to promoting healthy eating and supporting local business, sustainability, and community spirit by providing fresh local produce, baked and prepared foods, and handcrafted goods. Several vendors accept payment from the Supplemental Nutrition Assistant Program (SNAP) and Women, Infants, and Children (WIC) helping lower income families access locally grown fresh produce. The market is accessible by free, public transportation. o Number of weekly markets hosted per year (Baseline(FY23):19; Year 1(FY24): 19)
● Older adults	Participate in multi-sector community coalitions to identify and advocate for policy, systems, and environmental changes that reduce and prevent, or provide needed supports related to cancer.	● North of Boston Cancer Resource Board of Directors	● North of Boston Cancer Resource Board of Directors o # of AJH staff in Board positions (Baseline(FY23): 2; Year 1(FY24): 2)

Appendix E:
2026-2028 Implementation Strategy

Beth Israel Lahey Health
Anna Jaques Hospital

FY26-FY28 Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Anna Jaques Hospital (AJH) is a community hospital located in the coastal town of Newburyport that serves Massachusetts' North Shore and Southern New Hampshire's seacoast region. Anna Jaques takes pride in its strategic partnership with Beth Israel Deaconess Medical Center in delivering a comprehensive suite of cancer services, including chemotherapy, surgical oncology, and access to clinical trials. The hospital recently added two new operating rooms and robotic surgery capabilities.

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 AJH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. AJH'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 AJH'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.

AJH collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). AJH 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, AJH 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 1,300 residents, and organized a community listening session. In total, the assessment process collected information from more than 1,400 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, AJH'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 AJH's IS. This prioritization process helps to ensure that AJH 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 AJH'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.

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

The following goals and strategies are developed so that they:

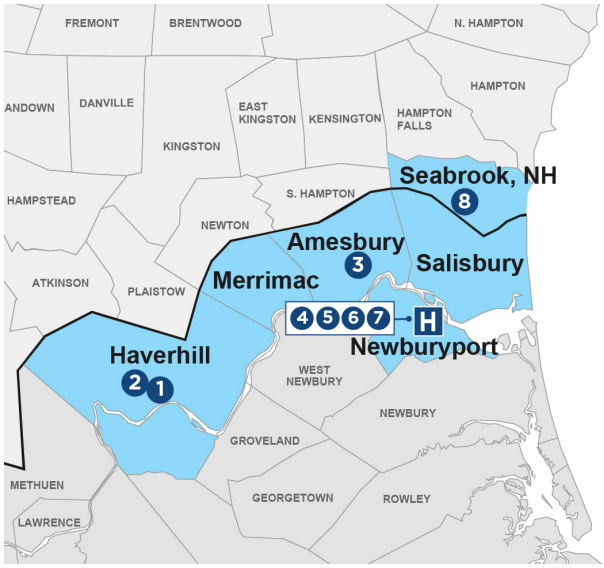
- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the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

Recognizing that community benefits planning is ongoing and will change with continued community input, AJH'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. AJH is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

AJH's CBSA includes the six municipalities of Amesbury, Haverhill, Merrimac, Newburyport, and Salisbury in Massachusetts and Seabrook in New Hampshire. Collectively, these cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment) and geography (e.g., urban, suburban, and semi-rural). There is also diversity with respect to community needs. There are segments of AJH'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. AJH 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. AJH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

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



Beth Israel Lahey Health
Anna Jaques Hospital

Community Benefits Service Area

H Anna Jaques Hospital

1. Diagnostic Imaging Services
2. Ultrasound at Women's Health Care, Haverhill
3. Amesbury Health Center
4. Satellite Offices at the Medical Office Building
5. Diagnostic Ultrasound at Women's Health Care
6. Outpatient Rehabilitation Services
7. Aquatic Rehabilitation
8. Anna Jaques Hospital Laboratory

Prioritized Community Health Needs and Cohorts

AJH 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.

AJH Priority Cohorts

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

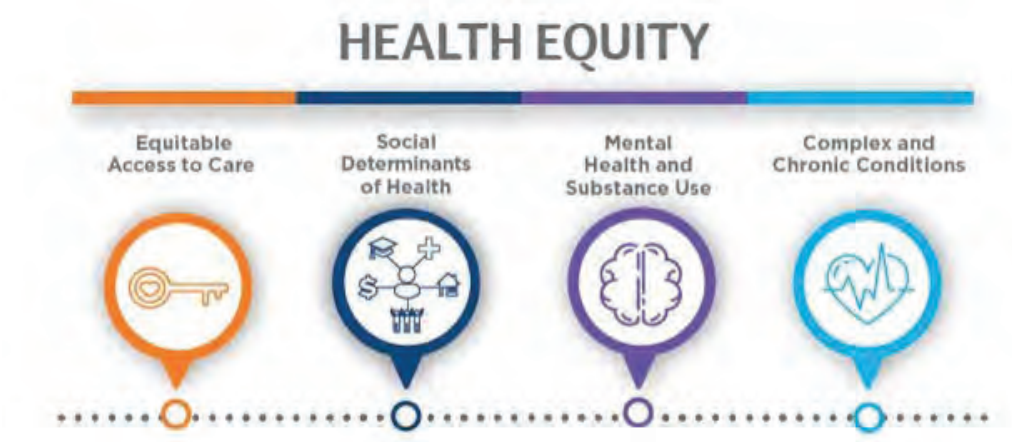
Community Health Needs Not Prioritized by AJH

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

The issues that were identified in the AJH CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, economic insecurity, access to fresh/healthy foods, language and cultural barriers to services, long wait times, health insurance and cost barriers, depression/anxiety/stress, youth mental health, older adult loneliness and isolation, alcohol use, opioid use, navigating the behavioral health system, issues relating to aging, cardiovascular disease, chronic disease education/prevention/screening, healthy eating, caregiver resources and support, maternal health, and care navigation.

AJH 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 providers not accepting new patients, long wait lists, and an inherently complicated health care system that is 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: AJH 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 AJH and/or its partners to improve the health of those living in its CBSA. Additionally, AJH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, AJH 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, AJH 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 and financial counseling.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Health insurance eligibility and enrollment assistance activities • Financial counseling activities • Programs and activities to support culturally/ linguistically competent care and interpreter services • Expanded primary care and medical specialty care services for Medicaid-covered, insured, and underinsured populations	• # of people served • # of people enrolled • # of encounters • # of practices supported	• Hospital-based activities
Advocate for and support policies and systems that improve access to care	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Social Determinants of Health

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

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

Resources/Financial Investment: AJH 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 AJH and/or its partners to improve the health of those living in its CBSA. Additionally, AJH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, AJH 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, AJH 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 by expanding access to affordable, nutritious food.	• Low-resourced populations • Older adults • Youth	• Food access, nutrition support, and educational programs and activities	• # of people served • # of pantries/ farmers market • # of community partners	• 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	• # of people/ families served • # of people who secured housing	• Housing support and community development agencies

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

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Provide and promote career support services and career mobility programs to hospital employees and community residents.	• All priority populations	• Career advancement and mobility programs	• # of employees served • # of people hired • # of persons served	• Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

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

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

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

Resources/Financial Investment: AJH 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 AJH and/or its partners to improve the health of those living in its CBSA. Additionally, AJH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, AJH 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, AJH 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 youth • Health education, awareness, and wellness activities for all age groups • Mental Health First Aid trainings	• # of people served • # of classes organized	• Private, non-profit, health-related agencies • Hospital-based activities
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• All priority populations	• Primary care and behavioral health integration and collaborative care programs • Provide access to behavioral health services • Outreach, support, and navigation programs and activities • Substance use and mental health screening, monitoring, counseling, and referral programs	• # of people served • # of consultations	• 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: AJH 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 AJH and/or its partners to improve the health of those living in its CBSA. Additionally, AJH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, AJH 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, AJH will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

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

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

General Regulatory Information

Contact Person:	Janel D'Agata-Lynch Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 4, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 4, 2025
Date written plan was required to be adopted:	February 15, 2026
Authorized governing body that adopted the written plan:	Anna Jaques Hospital Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 1, 2022
Name and EIN of hospital organization operating hospital facility:	Anna Jaques Hospital 04-2104338
Address of hospital organization:	25 Highland Avenue Newburyport, MA 01950

Beth Israel Lahey Health
Anna Jaques Hospital