2025 Community Health Needs Assessment and Implementation Strategy

Hebrew SeniorLife

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Acknowledgments

The 2025 Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) for Hebrew SeniorLife (HSL) were overseen and managed by staff that are part of HSL's Planning Team, and comprised the Steering Committee for this effort. The CHNA and Implementation Strategy were developed through a collaborative process that engaged HSL leadership, clinicians, and staff; regional health and social service providers; community advocates; and residents. HSL's Community Advisory Group (CAG) convened regularly throughout the assessment to help shape the approach and methodology, track progress, and offer critical input on preliminary findings and final recommendations.

Hebrew SeniorLife is deeply grateful to the health care and aging service organizations and community partners that generously contributed data to support this assessment. In particular, HSL thanks the Boston Community Health Collaborative, Beth Israel Lahey Health, and the City of Boston Age Strong Commission for sharing findings from their recent assessments and surveys. Their contributions significantly enriched the scope and depth of this effort.

Hebrew SeniorLife also extends sincere gratitude to all who contributed their time, expertise, and insights to support the development of a comprehensive and thoughtful CHNA and IS. Considerable care was taken to include a wide representation of perspectives. The dedication of those working to strengthen the region's health system—especially for populations experiencing health disparities—is deeply valued. This project was supported by JSI Research & Training Institute, Inc. (JSI), a public health research and consulting organization committed to improving the health of individuals and communities.

Hebrew SeniorLife Mission

In the spirit of the Fifth Commandment, as illuminated by the traditions of the Jewish people, HSL's mission is to honor elders, by respecting and promoting their independence, spiritual vigor, dignity and choice, and by recognizing that they are a resource to be cherished. As part of this mission, HSL accepts special responsibility for the frailest and neediest members of our community who are most dependent on the care that HSL provides. Everything HSL does flows from these tenets and is further inspired by the duty of *tikkun olam*—to heal the world. Today, HSL is focused on redefining every aspect of the aging experience for the better. They are committed to preserving independence, quality of life, and dignity, and do this by:

- Providing vibrant senior living communities
- Delivering a range of quality, personalized health care
- Conducting influential research on aging
- Teaching the next generation of geriatric care professionals

2025-2026 Hebrew SeniorLife Community Advisory Group

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Executive Summary

The 2025 Hebrew SeniorLife Community Health Needs Assessment provides a comprehensive assessment of the health and socioeconomic challenges facing residents across their Community Benefits Service Area (CBSA), which includes five Boston neighborhoods and six surrounding communities in the Greater Boston area. Through secondary data analysis, community surveys, informational interviews, and focus groups, this report identifies key health trends, risk factors, and disparities that impact the health outcomes of the region's diverse population.

Key Findings:

1. Economic Stability and Basic Needs
   Community members shared significant concerns about their ability to meet basic living needs, with housing affordability and stability standing out as the most urgent and consistent issue across discussions. Economic insecurity was a widespread theme, including challenges related to the high cost of living, low wages, and fixed incomes, particularly among older adults. Community members also cited difficulties accessing healthy and affordable food and reliable transportation for work, health care, and essential errands.
2. Chronic and Complex Conditions and Behavioral Health
   Community members and service providers highlighted the need for improved support for individuals managing long-term health conditions, functional limitations, and cognitive decline. Alzheimer's disease and dementia were frequently raised, particularly the need for resources to support both individuals and their caregivers. Additional concerns included barriers faced by people with disabilities, behavioral health needs such as mental health and substance use, and challenges related to managing chronic diseases over time.
3. Access to Health Care and System Navigation
   Community members and service providers identified significant barriers to accessing timely, affordable, and culturally appropriate health care. Long wait times, provider shortages, and high staff turnover were commonly cited challenges, along with the need for more culturally competent care, including improved language access and a more diverse provider workforce. Additional concerns included insurance and cost barriers, as well as the need for stronger coordination between health care and social service systems to better support individuals with complex needs.
4. Community Environment and Social Connectedness
   Both community members and service providers emphasized the importance of social connection and neighborhood environments in shaping health and well-being. Many

highlighted the impact of social isolation—particularly among older adults and caregivers—and described a need for more opportunities to engage with others through community programming and gathering spaces. Concerns were also raised about neighborhood safety, poor sidewalk conditions, and limited transportation infrastructure, with calls for more accessible and better-connected communities.

The findings of this CHNA will guide the development of Hebrew SeniorLife's Implementation Strategy, which will focus on addressing these key priority areas.

Assessment Background and Purpose

Since 1994, the Massachusetts Attorney General's Office has issued Community Benefit Guidelines, encouraging nonprofit hospitals and health maintenance organizations (HMOs) to address pressing community health issues. These guidelines were bolstered by the Affordable Care Act (ACA) in 2012, which mandated that these organizations engage in similar community health assessment, planning, and improvement activities. To better understand and address the social determinants of health, key health issues, and vulnerable populations, the Community Benefit Guidelines advocate for institutions to carry out thorough community health needs assessments (CHNAs) and develop strategic implementation plans. These plans are crafted with the expectation that institutions will actively engage the broader community and collaborate with various stakeholders, including health departments, service providers, and community-based organizations.

This CHNA represents the culmination of an in-depth process that began in December 2024 and concluded in September 2025. It offers a comprehensive review of community needs, including existing gaps, barriers, and strengths within Hebrew SeniorLife's Community Benefits Service Area (CBSA). The assessment draws upon quantitative data from federal, state, and local sources, as well as qualitative insights obtained through interviews, focus groups, partner surveys, a community listening session, and collaboration with a multi-sector Community Advisory Group(CAG). This report summarizes the key findings, highlighting the most significant health issues in Hebrew SeniorLife's CBSA, and identifies the population segments to prioritize in their community health improvement efforts.

The findings of this CHNA provide the foundation for the development of an Implementation Strategy (IS), which outlines how Hebrew SeniorLife will address the identified unmet needs. Additionally, this assessment serves as a valuable resource for guiding community health improvement efforts throughout the region.

The primary objectives of the CHNA and this report are to:

This CHNA is intended to be a valuable source of information and guidance to:

- Clarify issues related to community characteristics, barriers to care, existing service gaps, unmet community needs, and other health-related factors;
- Prioritize and promote community health investments;
- Facilitate a collaborative and comprehensive community health improvement planning process by leading discussions within and across sectors on community needs, health improvement, and health equity;
- Serve as a resource to others working to address health inequities.

The CHNA was conducted with the support and involvement of Hebrew SeniorLife's senior leadership. Representatives from senior leadership served on the Steering Committee and CAG, and were integral to the development of the IS.

The Steering Committee and CAG recognized the importance of aligning the CHNA with the broader state agenda of promoting health and well-being, addressing health disparities, and working toward health equity. Achieving health equity, defined as the attainment of the highest level of health for all people, requires sustained and focused efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Hebrew SeniorLife's commitment to conducting this assessment with a focus on health equity is detailed in the Approach & Methods section that follows.

Hebrew SeniorLife Community Benefits Service Area

Hebrew SeniorLife's CBSA includes five thriving Boston neighborhoods (Roslindale, Brighton, Hyde Park, Jamaica Plain, and West Roxbury) and six surrounding municipalities in the Greater Boston area (Dedham, Brookline, Needham, Westwood, Newton, and Chestnut Hill*).

Hebrew SeniorLife's licensed sites include:

- **Hebrew Rehabilitation Center in Boston,** located in Roslindale, a neighborhood of Boston
- Hebrew Rehabilitation Center at NewBridge, located in Dedham
- Hebrew SeniorLife also operates **Orchard Cove,** an award-winning senior living community in Canton, Massachusetts; **NewBridge on the Charles**, a modern living community offering a wide-range of options for older adults on an intergenerational campus; **Center Communities of Brookline**, offering independent living and supportive services for older adults in Brookline, Massachusetts; **Simon C. Fireman Community**, an independent living community for older adults in Randolph, Massachusetts; **Jack Satter House**, a community for older adults in Revere Beach, and **Leyland Community**, offering independent living for older adults in Upham's Corner, a neighborhood of Dorchester.

*Chestnut Hill is a village of Massachusetts, west of the City of Boston, and is located partially in the municipalities of Brookline, Boston, and Newton.

Approach and Methods

In recent years, leaders in health care, government, and social services have placed growing emphasis on the importance of coordinated, system-level planning to enhance health outcomes and address barriers to care. These efforts seek to break down silos and strengthen regional health systems through more integrated and responsive approaches. To be effective, community health improvement plans must be guided by a shared vision rooted in core principles:

- Comprehensive: Address the full continuum of care by involving health care providers, public health agencies, and community-based organizations.
- Data-informed: Rely on a combination of community voices, lived experiences, and robust data sources to guide priorities.
- Collaborative: Foster meaningful engagement across sectors, ensuring transparency and shared ownership throughout the process.
- Strategic and measurable: Present clear, actionable goals that can be tracked over time, with a focus on both immediate needs and long-term change.
- Rooted in evidence and experience: Build on research, clinical knowledge, and local expertise to develop strategies that resonate with and respond to community needs.

Public health practice has increasingly shifted from focusing solely on the treatment of physical illness to adopting a more holistic view of health. Greater attention is now being given to the social, economic, environmental, and behavioral factors that influence individuals' ability to achieve and maintain good health. State guidelines—such as those from the Massachusetts Attorney General's Office and Department of Public Health—reflect this evolution by emphasizing equity, prevention, and community engagement, and by prioritizing issues such as mental health, substance use, chronic disease, housing, and violence.

This CHNA was developed in alignment with these evolving priorities. It employs a mixed-methods approach that integrates quantitative data with community perspectives, with a strong focus on inclusive engagement through interviews, focus groups, a community listening session, and input from partner-led surveys and assessments. Hebrew SeniorLife also engaged senior leadership and clinical staff throughout the process to help identify key health issues and populations to be prioritized in the Implementation Strategy.

The assessment was completed in three phases. Table 1 below provides a summary of each phase and the associated activities. The community engagement index (Appendix A) includes additional information and materials related to the engagement activities/approach.

TABLE 1: SUMMARY OF APPROACH AND METHODS

Phase 1 Preliminary Assessment and Engagement	Phase 2 Targeted Engagement	Phase 3 Strategic Planning and Reporting
• Secondary Data Collection • Partner Interviews • Resource Inventory • CAG Meeting • Steering Committee Meetings	• Review of data from partner Community Health Surveys • Focus Groups • Community Listening Session • CAG Meeting • Steering Committee Meetings	• Integrated analysis • CAG Meeting • Steering Committee Meetings • Senior Leadership Meeting • Draft and Final Reporting

Quantitative Data and Data Limitations

The preliminary needs assessment and engagement effort relied on secondary data collected from local, state, and national sources, including the U.S. Census Bureau's American Community Survey 5-Year Estimates (2019-2023). This data provided a comprehensive characterization of the CBSA, covering demographics and population characteristics, social determinants of health, health status, health behaviors, and health outcomes. Data was gathered at the municipal, neighborhood, or zip code level whenever possible.

While the data was valuable in identifying health needs, the most significant limitation was the availability of timely data related to morbidity and mortality at the municipal level. Additionally, health-related data was not stratified by age, race/ethnicity, income, or other characteristics, which restricted the ability to objectively identify health disparities. Although qualitative activities such as the interviews, focus groups, and surveys provided some exploration of these issues, the lack of stratified quantitative data constrained the overall analysis. All collected data is compiled in the Hebrew SeniorLife Data Book (Appendix B). Whenever possible, data was benchmarked against state-level data for statistical significance.

To supplement the Data Book, JSI developed a visual repository of quantitative data using mySidewalk—a community data platform that offers access to a broad library of community-level data from national sources such as the U.S. Census Bureau, Centers for Disease Control and Prevention, and Bureau of Labor Statistics. It should be noted that, since mySidewalk primarily draws from publicly-available national datasets, some data points in the Data Book may be more current than those presented on the visual platform. The mySidewalk data repository for HSL can be found here.

Community Surveys

Hebrew SeniorLife is fortunate to have strong partnerships with other health care systems and community-based organizations. Several community partners demonstrated the strength of these relationships by willingly sharing data from their own community health surveys with HSL to inform this assessment. A description of the surveys used in this report is included below.

- **Beth Israel Lahey Health (BILH) FY25 Community Health Survey:** As part of their FY25 Community Health Needs Assessment process, BILH administered a community health survey to all community benefits service area municipalities in neighborhoods between July-November of 2024. Beth Israel Deaconess Hospital-Needham's community benefits service area includes three municipalities in HSL's CBSA (Dedham, Needham, Westwood). Results shared from this survey include responses from those municipalities.
- **Boston Community Health Collaborative (BCHC) 2025 Boston Community Health Needs Assessment Survey**: As part of a city-wide community health needs assessment, BCHC administered a community health survey in all Boston neighborhoods in the fall of 2024. Data included in this report represent responses from the neighborhoods of Allston/Brighton, Jamaica Plain, Roslindale, Hyde Park, and West Roxbury.
- **City of Boston AgeStrong Commission Needs Assessment:** From October 2024 to April 2025, AgeStrong Boston administered a survey to all adults in Boston over the age of 55. Data in this report includes responses from individuals in Allston/Brighton, Jamaica Plain, Hyde Park, Roslindale, and West Roxbury.

Qualitative Data & Community Engagement

Informational Interviews

Interviews were conducted with 20 individuals from the Hebrew SeniorLife's CBSA. Individual interviews were conducted via using a structured interview guide developed by JSI and the Steering Committee. JSI worked with the Steering Committee and CAG to identify a representative list of interviewees that could provide a broad perspective on the community health-related needs of the region. This list included administrative and clinical representatives from organizations that address the needs of older adults, as well as other sectors. Key themes and findings from these interviews are included in the narrative sections of this report.

TABLE 2: INFORMATIONAL INTERVIEWEES

Interviewee	Role & Affiliation
Marisol Amaya	Executive Director, La Alianza
Enrique Pepen	Boston City Councilor, District 5
Courtney Daly	Director, Dedham Council on Aging
Margery Gann	Chief Operating Officer, Ethos
Chelsea Lanson	Director of Planning and Community Development, HESSCO
Eileen O'Brien	Program Director, Living Well at Home (BMC)
Rachel Haddock	Social Worker, Westwood Council on Aging
Tracy Schneider	Senior Program Adviser, Temple Emanuel (Memory Cafe)
Eugene Barros and Andrea Dettorre	Director of Healthy Homes, Boston Public Health Commission Healthy Aging Director, Boston Public Health Commission
Debbi Cutler	Director of Health and Aging Programs, 2Life Communities
David Aronstein	Chairman of the Board, OutStandingLife
Beth Soltzberg	Director of the Alzheimer's and Dementia Family Support Programs, JF&CS
Cynthia Wilkerson	Executive Director, Little Brothers Friends of the Elderly
Cassie Cramer	Project Manager, Older Adult Behavioral Health Network
Peg Drisko	CEO, ESAC Boston
Madeline Wenzel	Associate VP of Caring and Social Justice, CJP
Brendan Fogarty	Board Member, Roslindale Village Main Streets
Nachet Mehciz	Nutrition Director, ETHOS
Galina Khatutsky	Senior Manager, RTI International; Hebrew SeniorLife Trustee

Focus Groups

Staff from JSI and Hebrew SeniorLife conducted a series of six focus groups. These sessions were instrumental in gathering valuable input from service providers and community residents, with a focus on understanding the health needs and experiences of older adults and their caregivers. The focus groups were organized in collaboration with the CAG, leveraging their community connections to ensure participation.

TABLE 3: FOCUS GROUPS

Focus Group Cohort	Date
Older adults in Roslindale (in collaboration with Boston AgeStrong Commission)	February 26, 2025
Hebrew Rehabilitation Center Roslindale patients and families	March 11, 2025
Family caregivers in Dedham	April 3, 2025
Older adults in Dedham	April 8, 2025
NewBridge on the Charles independent living residents	April 14, 2025
Older adults in Hyde Park	May 15, 2025

Community Listening Session

In May 2025, HSL held a virtual Community Listening Session to inform community residents and service providers of key findings from the community health needs assessment. Residents were presented with data findings from an integrated analysis of interviews, focus groups, surveys, and quantitative analyses, and were given the opportunity to provide additional insights and feedback. Ten individuals attended the Community Listening Session, representing a mix of residents and service providers.

Community Assets

Federal and Commonwealth Community Benefits requirements indicate that an inventory of community resources and assets should be created to inform the extent to which there are gaps in health-related services. A list of community assets has been compiled and can be found in Appendix C.

Evaluation of Prior Implementation Strategy

Hebrew SeniorLife did not receive any written comments on the 2022 CHNA since its posting. They also did not receive any feedback on the Massachusetts Attorney General's website, which publishes the hospital's annual Community Benefit Report and provides an opportunity for public comment. Hebrew SeniorLife encourages feedback on this report, and will take feedback into account when planning future assessments and implementation strategies.

Below is a summary of community benefits activities and accomplishments, organized by priority areas from HSL's FY23-FY25 Implementation Strategy. A more expansive table of activities and accomplishments is included in Appendix D.

Access to Geriatric Specialists

Goal: Increase availability and accessibility of our geriatric specialists and the ways seniors in the community can access them.

HSL implemented several initiatives to improve access to geriatric specialists. In outpatient therapy, a virtual reality system was piloted to deliver therapeutic services remotely; while the pilot was completed, there are currently no active users on the system. The STEP-HI Hip Fracture Recovery Clinical Trial has enrolled 36 participants and resulted in three publications to date. The CarFit Program reached 20 older adults with education aimed at improving road safety. The Therapy House Calls initiative offered 10 educational sessions in 2023 to support independence among older adults. Outpatient Nutrition Services engaged two employee clients and 47 community clients through educational programming and nutrition counseling.

Behavioral Health

Goal: Increase the availability and accessibility of outpatient Alzheimer's care, as well as mental health and depression services for seniors who live in the community and their families.

HSL undertook several initiatives to improve behavioral health services for older adults and individuals affected by cognitive and mental health challenges. At the Deanna and Sidney Wolk Center for Memory Health, approximately 70 caregivers were connected with resources and support programs designed to help individuals maintain independence and quality of life at any stage of brain health. Within the Psychiatry Division, one initiative aimed to improve coordination between psychiatry and the Wolk Center; however, referrals were ultimately deemed unnecessary due to integration of services. Another effort within the Psychiatry Division focused on expanding access to telehealth, with 6% of clinicians currently enabled to provide services remotely and an additional 33% working toward telehealth certification.

Social Determinants of Health

Goals:

- Prevent the exploitation of seniors for financial gain and increase awareness and access to financial assistance programs for community dwelling seniors.
- Increase the availability of linguistic services to community dwelling seniors.
- Increase the training of HSL staff in best practices to address cultural barriers.
- Improve health and reduce longstanding disparities in health and health care by reducing the impact of food insecurity, transportation challenges, language barriers, and domestic abuse.

In the area of hunger and nutrition, efforts to expand access to Meals on Wheels resulted in the delivery of 750 meals per day, five days a week. To address transportation barriers, 49 rides were

provided to community members traveling to or from Hebrew SeniorLife campuses, supported by multiple community partners. In the area of older adult protection, 126 referrals were made for shelter or support services, with 19 individuals sheltered and/or enrolled in outreach programs. Lastly, to promote language and cultural sensitivity, six Russian-language newsletters were published and distributed annually, and bilingual staff provided support to residents and patients. A translation option was added to HSL's website, which allows users to translate the page into Arabic, Chinese (simplified and traditional), French, Greek, Italian, Portuguese, Russian, Spanish, Hebrew, Vietnamese, or Haitian-Creole.

In Home Health

Goal: Expand availability to health and wellness interventions by offering more entry points to meet a senior care expert.

HSL launched several initiatives to expand access to in-home health services. A videoconferencing pilot was completed to evaluate technology options for early identification of health issues among high-risk home health patients. In community-based palliative care, the team submitted an application for Medicare Part B billing status and enhanced services by adding a social worker and integrating advance care planning tools. The Wellness Nurse Consultant Program expanded its reach to six new senior living sites, aiming to create a safety net for identifying early signs of illness and preventing unnecessary hospitalizations.

Key Findings: Population Characteristics and Social Determinants of Health

To accurately assess the community's needs and health status within our service area, it is essential to start with an overview of the population's geographic and demographic characteristics and the social, economic, and environmental factors that influence health outcomes and equity. This foundational information is critical for the following:

- Understanding disease burden, health disparities, and inequities.
- Identifying target populations and health-related priorities.
- Guiding strategic interventions.

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age, and they have a profound impact on individual and community well-being.[1] These factors—such as economic stability, education, social and community context, health care access, and the built environment—shape the opportunities and resources available to people, influencing health outcomes and disparities. Understanding the social determinants of health within a community is essential for identifying the root causes of health inequities and guiding the development of effective interventions.

Below is a summary of the main findings related to community characteristics and key SDOH indicators in the community, including income levels, employment status, educational attainment, housing conditions, access to nutritious food, transportation, and social support networks. These conditions influence and define the quality of life for many segments of the population in the CHNA service area. To augment the lack of quantitative data, the informational interviews, focus groups, listening sessions, and the community health surveys specifically solicited feedback on social determinants and barriers to care. Community engagement activities highlighted a dominant theme: social determinants—especially housing, transportation, and socioeconomic status—strongly affect Hebrew SeniorLife's CBSA. Hebrew SeniorLife recognizes how the social determinants affect health care access, outcomes, and disparities, and is committed to addressing them through collaborations with critical community partners.

More expansive data tables are included in Appendix B.

Geography and Total Population

Hebrew SeniorLife's Community Benefits Service Area covers the southwestern area of Greater Boston and includes a mix of urban neighborhoods and suburban towns spanning Suffolk and

[1] "Social Determinants of Health (SDOH) | About CDC." CDC, 17 January 2024, https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html.

Norfolk Counties. Like much of eastern Massachusetts, the area experiences a typical New England climate with warm, humid summers and cold, snowy winters. Newton and Brookline are the most populous individual municipalities.

TABLE 5: TOTAL POPULATION SIZE

Geography	Total Population
Brighton (02135)	43,683
Brookline	62,822
Dedham	25,109
Hyde Park (02136)	38,071
Jamaica Plain (02130)	41,109
Needham	32,059
Newton	88,504
Roslindale (02131)	31,564
West Roxbury (02132)	27,069
Westwood	16,213
Massachusetts	1,622,896

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023

Age

Age is a fundamental determinant of health, shaping the prevalence of health conditions, patterns of service utilization, and the effectiveness of preventive interventions. This section focuses on the community's age distribution, with particular attention to older adults.

Older adults generally have greater physical and mental health vulnerabilities and are more likely to depend on local community resources for support compared to younger populations.[2] Table 6 shows that the percentage of individuals over 65 living in Dedham, Newton, West Roxbury, and Westwood is significantly high compared to the Commonwealth overall.

In the U.S. and the Commonwealth, older adults are among the fastest-growing age groups. This demographic is disproportionately affected by chronic and complex health conditions, which are the leading causes of death among older adults. Conditions such as hypertension, diabetes, COPD, congestive heart failure, depression, anxiety, Alzheimer's disease, Parkinson's disease, and

[2] Lyons, "Age, Religiosity, and Rural America," Gallup Web Site, http://www.gallup.com/poll/7960/age-religiosity-rural-america.aspx., (March 11, 2013)

dementia are significantly more prevalent among this age group compared to younger adults. Projections from the CDC and the Healthy People 2020 Initiative estimate that by 2030, 37 million people nationwide—approximately 60% of those over 65—will live with multiple chronic conditions.[3]

One of the primary challenges facing older adults is navigating the health care system. This includes understanding their health insurance coverage, managing transportation to and from medical appointments, handling care transitions and discharge planning, and effectively managing medications.

TABLE 6: AGE CHARACTERISTICS OF OLDER ADULTS (%)

	Over 65 years	65-74 years	75-84 years	85 years and over
Brighton (02135)	13.5	6.9	3.2	3.3
Brookline	15.4	8.3	5.3	1.8
Dedham	20.3	10.6	5.4	4.3
Hyde Park (02136)	17.0	10.5	4.8	1.7
Jamaica Plain (02130)	13.2	7.9	3.2	2.1
Needham	17.5	9.3	4.5	3.7
Newton	19.1	11.1	5.5	2.5
Roslindale (02131)	14.5	8.8	3.5	2.2
West Roxbury (02132)	20.0	12.8	4.9	2.3
Westwood	18.3	7.5	6.5	4.4
Massachusetts	**17.5**	**10.3**	**4.9**	**2.2**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Race and Ethnicity

A substantial body of research highlights the disparities in health outcomes, access to health care, and utilization across different racial and ethnic groups. According to the Center for American Progress, "these disparities are not rooted in individual or group behavior, but are the result of decades of systemic inequality in America's economic, housing, and health care

[3]https://wayback.archive-it.org/5774/20220413203500/https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults

systems."[4] These inequities, often disproportionate and avoidable, underscore the importance of understanding demographic factors to identify populations at greater risk of adverse health outcomes.

Hebrew SeniorLife's service area is predominantly white, though there is diversity in all municipalities in neighborhoods. Compared to the Commonwealth overall, there is a significantly high percentage of Black/African American residents in Hyde Park and Roslindale, a significantly high percentage of Asian residents in Brighton, Brookline, Hyde Park, and Needham, and a significantly high percentage of Hispanic/Latino residents in Roslindale.

TABLE 7: RACE/ETHNICITY CHARACTERISTICS OF TOTAL POPULATION (%)

	White	Black/African American	Asian	Hispanic/Latino (any race)	Two or more races	Another race
Brighton (02135)	61.7	6.3	17.2	11.2	9.1	5.5
Brookline	67.7	3.1	17.7	6.0	9.7	1.8
Dedham	82.4	5.1	3.1	7.5	6.8	2.4
Hyde Park (02136)	24.0	48.7	2.7	26.7	11.9	12.2
Jamaica Plain (02130)	64.0	12.8	6.2	18.0	9.8	6.4
Needham	81.7	1.5	10.5	3.7	5.7	0.3
Newton	71.1	2.2	16.6	4.8	7.3	2.4
Roslindale (02131)	53.5	23.8	2.9	19.9	11.7	8.1
West Roxbury (02132)	74.4	3.9	8.1	10.9	8.3	5.1
Westwood	78.8	1.6	10.0	5.3	7.2	2.3
Massachusetts	**70.7**	**7.0**	**7.1**	**12.9**	**9.5**	**5.4**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

[4] Duke, Brendan. "Health Disparities by Race and Ethnicity." Center for American Progress, 7 May 2020, https://www.americanprogress.org/article/health-disparities-race-ethnicity/

Looking at race and ethnicity among older adult populations, there is a significantly high percentage of residents over 65 who identify as Black/African American in Hyde Park, a significantly high percentage who identify as Asian in Brighton, Brookline, and Newton, and a significantly high percentage of Hispanic/Latino residents in Jamaica Plain and Roslindale.

TABLE 8: RACE/ETHNICITY CHARACTERISTICS OF POPULATION OVER 65 (%)

	White	Black/African American	Asian	Hispanic/Latino (any race)	Other races
Brighton (02135)	61.1	3.9	30.7	4.2	4.3
Brookline	83.5	2.2	9.5	3.1	4.8
Dedham	96.6	2.0	0.8	3.0	0.7
Hyde Park (02136)	40.3	45.5	2.8	13.8	11.4
Jamaica Plain (02130)	65.2	12.4	4.1	21.7	18.3
Needham	94.1	2.7	2.2	0.7	0.9
Newton	89.2	1.6	8.0	0.7	1.3
Roslindale (02131)	59.9	19.5	1.5	21.4	19.1
West Roxbury (02132)	87.4	3.9	4.9	4.8	3.7
Westwood	93.5	0.4	5.2	1.6	0.9
Massachusetts	**86.3**	**4.4**	**4.0**	**4.8**	**5.3**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Place of Birth and Language

Several interviewees identified immigrants, refugees, and individuals who speak a language other than English as groups that may face barriers to accessing health and social services. Key factors that hinder these individuals from accessing care include language barriers, lack of culturally competent care, and economic instability.

Table 9 represents the foreign-born population, which includes anyone not born a U.S. citizen or national. This category encompasses non-citizens as well as individuals born outside the U.S. who have since become naturalized citizens. Compared to the Commonwealth overall, the

percentage of foreign-born residents is significantly high in all service area locations, with the exceptions of Dedham, Needham, West Roxbury, and Westwood.

Language barriers create major obstacles to delivering effective and high-quality community services and health care. Individuals engaged in the assessment noted an increasing need for treatment and services offered in languages other than English, particularly Spanish, Haitian Creole, and Asian languages.

"We need quality care without language barriers. We need providers who speak the language or who have competent translation services."
- Interviewee

Although most residents in the service area speak English, there are several municipalities and neighborhoods where a notably high percentage of individuals speak a language other than English at home and have limited English proficiency (LEP)—defined as speaking English "less than very well." In Brighton, Hyde Park, and Roslindale, there are significantly more residents who speak a language other than English and have limited English proficiency compared to the Commonwealth overall.

TABLE 9: COUNTRY OF ORIGIN AND LANGUAGE OF TOTAL POPULATION (%)

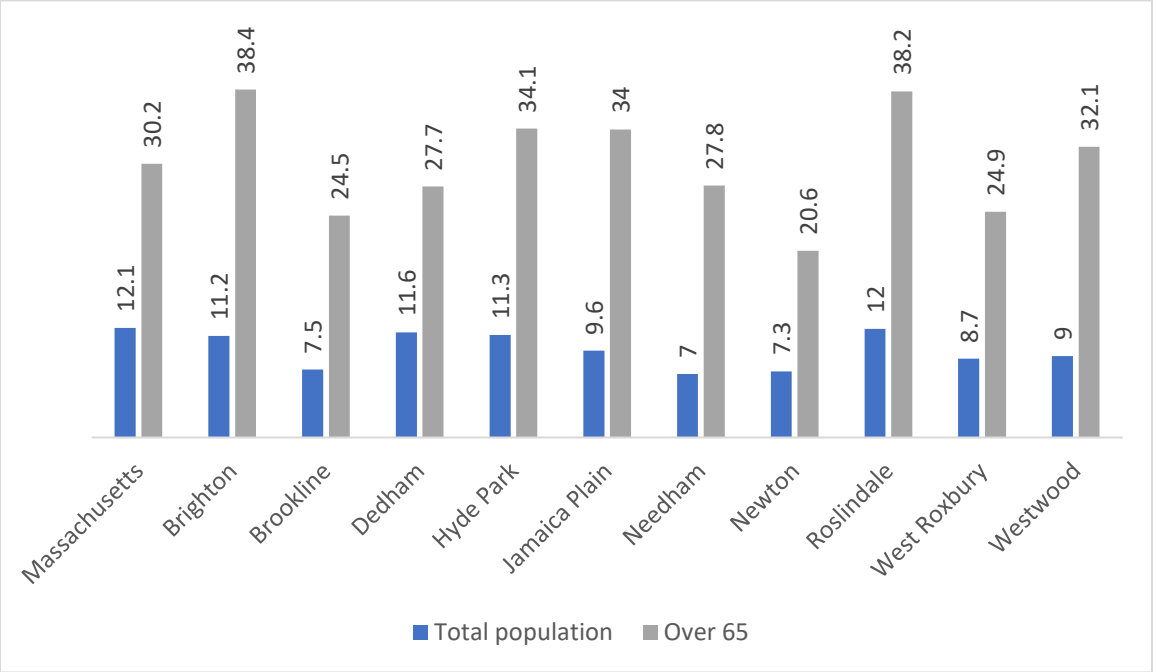
	Foreign-born	Speak a language other than English at home	Limited English Proficiency
Brighton (02135)	27.9	33.0	30.4
Brookline	27.5	30.4	7.3
Dedham	13.2	16.3	6.2
Hyde Park (02136)	29.9	41.6	18.0
Jamaica Plain (02130)	21.4	29.2	9.8
Needham	16.7	20.1	4.6
Newton	23.5	27.5	7.9
Roslindale (02131)	24.1	32.0	14.4
West Roxbury (02132)	19.4	25.0	8.4
Westwood	11.8	16.0	3.4
Massachusetts	**17.7**	**24.8**	**9.7**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Populations Living with a Disability

Across HSL's community benefits service area, the percentage of the civilian noninstitutionalized population who identify as disabled was lower or significantly lower compared to the Commonwealth overall. Looking specifically at the population over 65, the percentage of individuals with disabilities was significantly higher than the Commonwealth in Brighton and Roslindale.

FIGURE 1: INDIVIDUALS WITH A DISABILITY (%)



Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023

Table 10 reports the percentage of residents over 65 by disability types. None of the municipalities or neighborhoods in HSL's community benefits service area had percentages that were significantly higher than the Commonwealth overall.

TABLE 10: SELF-REPORTED DISABILITY CHARACTERISTICS OF POPULATION OVER 65 (%)

	Hearing difficulty	Vision difficulty	Cognition difficulty	Ambulatory difficulty	Self-care difficulty	Independent living difficulty
Brighton (02135)	14.3	7.6	15.4	26.1	16.2	24.7
Brookline	11.7	2.6	5.7	16.1	6.3	12.7
Dedham	11.7	4.6	3.5	15.4	10.0	13.9
Hyde Park (02136)	11.9	7.6	16.8	30.9	17.7	24.6
Jamaica Plain (02130)	12.9	11.1	8.7	22.3	7.1	14.9
Needham	9.6	1.8	7.2	20.5	12.5	14.6
Newton	10.3	3.0	4.0	12.4	6.2	9.7
Roslindale (02131)	11.8	7.5	15.2	22.4	11.7	19.6
West Roxbury (02132)	10.8	5.9	8.1	20.3	9.3	14.3
Westwood	16.0	2.0	4.1	20.4	6.8	15.0
Massachusetts	**12.3**	**4.8**	**7.5**	**18.6**	**7.3**	**13.2**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

LGBTQIA+

LGBTQIA+ individuals—those who identify as lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and others—are an integral part of communities across Massachusetts. According to the 2022 Behavioral Risk Factor Surveillance System (BRFSS), an estimated 6.5% of adults in Massachusetts identify as lesbian, gay, or bisexual.[5] National data from the U.S. Census Bureau's Household Pulse Survey also indicate a growing number of

[5] Centers for Disease Control and Prevention. (2023). Behavioral Risk Factor Surveillance System (BRFSS) 2022 Survey Data and Documentation. https://www.cdc.gov/brfss/index.html

individuals identifying as transgender or nonbinary, with younger generations reporting these identities at higher rates than older adults..[6]

LGBTQIA+ individuals may encounter challenges in accessing equitable and affirming health care. Barriers such as stigma, discrimination, limited provider knowledge, and a lack of culturally competent services continue to affect the quality of care received. These challenges are linked to disparities in both physical and behavioral health outcomes, including higher rates of depression, anxiety, substance use, suicidal ideation, and avoidance or delay of necessary medical care..[7]

LGBTQIA+ older adults may face unique health and social challenges, shaped by a lifetime of stigma, discrimination, and limited access to culturally competent services. They are more likely to experience social isolation, are less likely to have children or other family supports, and may be estranged from relatives, which can contribute to poorer mental and physical health outcomes.[8] LGBTQIA+ older adults may also delay or avoid seeking health care due to past negative experiences or fear, leading to unmet health needs. Additionally, as echoed by interviewees, lack of access to affirming senior housing and long-term care can further compromise their safety, autonomy, and overall well-being..[9]

The Massachusetts Healthy Aging Collaborative's Community Profiles provide an estimate of LGBT older adults in HSL's Community Benefits Service Area communities.

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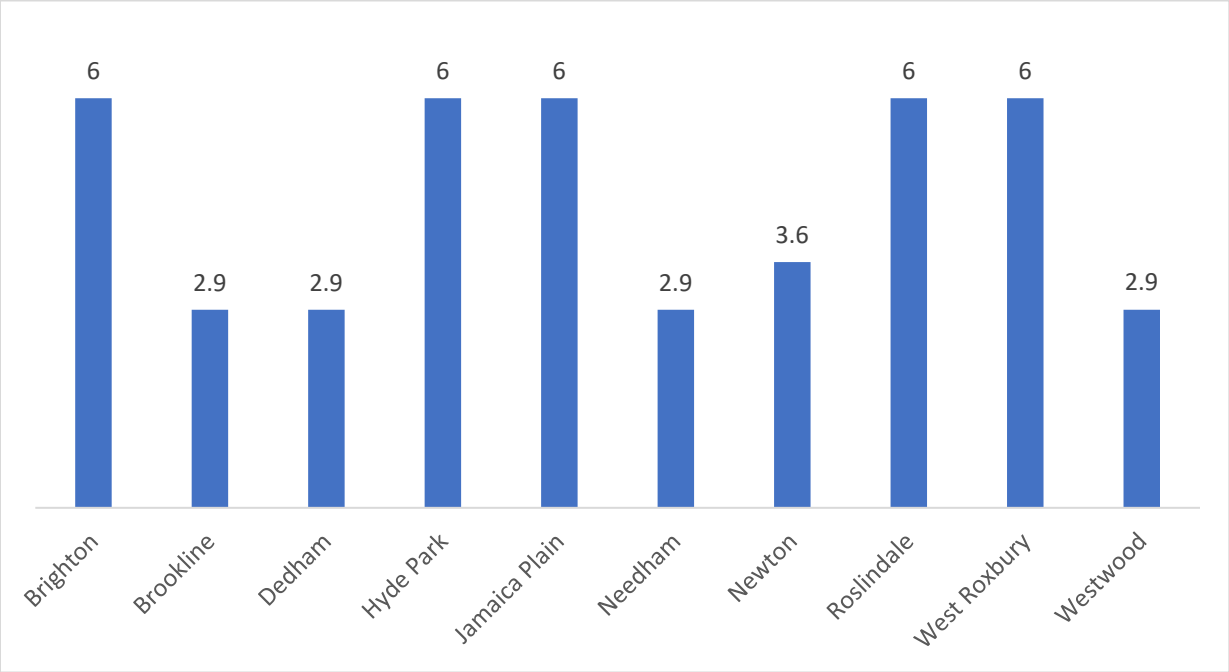
[6] U.S. Census Bureau. (2023). Household Pulse Survey: Phase 3.8 (2023). https://www.census.gov/data/experimental-data-products/household-pulse-survey.html

[7] National Academies of Sciences, Engineering, and Medicine. (2020). Understanding the well-being of LGBTQI+ populations. The National Academies Press. https://doi.org/10.17226/25877

[8] Fredriksen-Goldsen, K.I., Emlet, C.A., Kim, H.-J., Muraco, A., Erosheva, E. A., Hoy-Ellis, C.P., and Petry, H. (2021). The Aging and Health Report: Disparities among lesbian, gay, bisexual, and transgender older adults. Institute for Multigenerational Health.

[9] Institute of Medicine. (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. The National Academies Press.
https://doi.org/10.17226/13128

FIGURE 2: LGBT ADULTS OVER 60 (%)



Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles

Socioeconomic status

Socioeconomic status (SES), as measured by income, employment status, occupation, education, and the extent to which one lives in areas of economic disadvantage, is closely linked to morbidity, mortality, and overall well-being.[10] Higher SES is often associated with better health outcomes, greater access to health care, and more opportunities for education and employment. Conversely, lower SES can be linked to increased exposure to health risks, limited access to care, and greater vulnerability to chronic conditions. In this section, we will examine the socioeconomic characteristics of the community, including educational attainment, income, and poverty.

Individuals engaged through interviews, focus groups, and community health surveys identified economic instability as a significant concern, and a critical barrier to accessing the health care, social, and community services they need.

Educational Attainment

The communities in HSL's community benefits service area are highly educated, with the vast majority of municipalities and neighborhoods having significantly high percentages of residents

[10] Nancy E. Adler and Katherine Newman, "Socioeconomic Disparities in Health: Pathways and Policies," HealthAffairs, 2002; 21(2), doi: https://doi.org/10.1377/hlthaff.21.2.60

with either a high school or bachelor's degree or higher. One exception is Hyde Park, where the percentages were significantly lower than the Commonwealth overall.

TABLE 11: EDUCATIONAL ATTAINMENT OF TOTAL POPULATION (%)

	High school degree or higher	Bachelor's degree or higher
Brighton (02135)	93.1	71.1
Brookline	97.4	85.0
Dedham	94.1	55.1
Hyde Park (02136)	88.3	32.5
Jamaica Plain (02130)	93.9	72.6
Needham	97.3	80.8
Newton	97.3	80.7
Roslindale (02131)	89.3	51.9
West Roxbury (02132)	95.2	64.2
Westwood	95.5	71.0
Massachusetts	91.4	46.6

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Table 12 looks at educational attainment among residents over 65. Notably, Brookline, Needham, Newton, and Westwood have significantly higher percentages of older adults with graduate or professional degrees than the Commonwealth overall. In contrast, communities such as Hyde Park, Roslindale, and Jamaica Plain have significantly higher proportions of older adults with less than a high school education. Several communities, including Brookline and Newton, also have significantly lower percentages of older adults with only some high school or college education, suggesting higher overall educational attainment.

TABLE 12: EDUCATIONAL ATTAINMENT FOR POPULATION OVER 65 (%)

	Less than a high school education	Some high school or college	College degree	Graduate or professional degree
Brighton (02135)	16.1	36.0	20.3	27.6
Brookline	4.0	22.6	21.3	52.1
Dedham	8.8	48.9	21.4	20.9
Hyde Park (02136)	20.6	54.7	12.0	12.7
Jamaica Plain (02130)	22.4	31.1	16.1	30.4
Needham	2.7	28.6	26.8	41.8
Newton	4.0	22.8	23.5	49.8
Roslindale (02131)	25.3	42.5	14.3	18.0
West Roxbury (02132)	7.3	41.1	16.9	34.7
Westwood	3.9	33.7	27.1	35.2
Massachusetts	**12.7**	**50.3**	**18.1**	**18.9**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Employment, Income, and Poverty

Like education, income significantly influences nearly every aspect of an individual's life, including access to stable housing, nutritious food, transportation, health care, and child care. Financial resources also play a direct role in supporting both physical and mental health. A lack of steady employment is often associated with barriers such as inadequate health insurance, unaffordable medical care, and limited transportation options. Interview and focus group participants noted that many residents—particularly older adults—struggle to meet basic needs due to limited income.

Findings from the FY25 BILH Community Health Survey revealed that, sometime within the past year, respondents did not have enough money to afford:

- Mortgage or rent (22%)
- Food (22%)
- Transportation (20%)

- Medical needs (18%)
- Home repairs (7%)

Table 13 presents poverty levels and median household income across the community benefits service area communities. Brighton and Roslindale have significantly higher poverty rates among older adults than the Commonwealth. Brighton also stands out with a significantly higher overall poverty rate for all residents and older adults, and a significantly lower median household income ($88,208) compared to the Commonwealth. In contrast, communities such as Needham, Newton, and Westwood have significantly lower poverty rates, and significantly higher household incomes, with Needham reaching a median income of $212,241. These findings reflect stark economic disparities among communities.

TABLE 13: RESIDENTS LIVING IN POVERTY (%)

	Median household income ($)	Living below the federal poverty line (all residents)	Living below the federal poverty line (residents over 65)
Brighton (02135)	88,208	18.7	27.2
Brookline	140,361	9.8	11.6
Dedham	124,375	4.6	9.5
Hyde Park (02136)	96,862	9.9	15.5
Jamaica Plain (02130)	130,533	11.1	14.5
Needham	212,241	3.8	6.4
Newton	184,989	4.7	6.1
Roslindale (02131)	109,237	9.7	17.5
West Roxbury (02132)	139,545	4.1	4.9
Westwood	205,000	5.0	6.2
Massachusetts	**101,341**	**10.0**	**10.2**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Looking at income for older adults, Brighton stands out with higher percentages of older adult households earning below $20,000, well above the statewide average of 17.1%. In contrast, Needham, Newton, and Westwood have significantly lower shares of low-income older adult

households and significantly higher percentages earning over $100,000—each exceeding 54%, compared to the Commonwealth average of 31.0%.

TABLE 14: ANNUAL INCOME AMONG 65+ HOUSEHOLDS

	Below $20,000	Between $20,000-49,999	Between $50,000-99,999	Over $100,000
Brighton (02135)	34.7	26.5	17.4	21.3
Brookline	17.5	13.5	21.0	48.1
Dedham	17.9	20.6	26.8	34.7
Hyde Park (02136)	23.5	18.1	23.5	34.9
Jamaica Plain (02130)	20.0	19.5	18.8	41.7
Needham	8.4	13.7	21.7	56.2
Newton	10.2	14.3	20.0	55.5
Roslindale (02131)	22.6	20.7	24.7	32.0
West Roxbury (02132)	15.7	18.6	26.9	38.8
Westwood	7.1	23.7	14.4	54.8
Massachusetts	**17.1**	**25.3**	**26.7**	**31.0**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Food Insecurity

Food insecurity significantly impacts the well-being of individuals and communities. It occurs when people lack consistent access to enough nutritious food for an active, healthy life. Food insecurity can lead to a range of adverse health outcomes, including chronic diseases such as diabetes and hypertension, mental health issues like anxiety and depression, and developmental problems in children.[11]

[11] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0645

Food insecurity is a major public health issue in the nation, with significant implications for health across different age groups. Food-insecure older adults face higher rates of depression, asthma, diabetes, and congestive heart failure compared to those who have consistent access to nutritious food..[12]

Table 15 includes the percentage of residents in each community who received Supplemental Nutrition Assistance Program (SNAP) benefits within the past year. SNAP is a federal program that provides low-income individuals and families with financial support to purchase food; it plays a vital role in reducing food insecurity, improving nutrition, and supporting overall health—particularly among historically under-resourced populations such as older adults, people with disabilities, and families with children. By helping households afford nutritious food, SNAP contributes to better physical and mental health outcomes and can reduce long-term health care costs.

Compared to the Commonwealth, the percentage of residents receiving SNAP benefits was significantly higher in the neighborhoods of Hyde Park and Roslindale.

TABLE 15: SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM ENROLLMENT (%)

	Received SNAP benefits within the past 12 months
Brighton (02135)	12.5
Brookline	6.0
Dedham	7.4
Hyde Park (02136)	20.9
Jamaica Plain (02130)	11.0
Needham	3.0
Newton	4.4
Roslindale (02131)	18.2
West Roxbury (02132)	9.4
Westwood	1.7
Massachusetts	**13.8**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

[12] "Senior & Older Adults Research Archive." Feeding America, https://www.feedingamerica.org/research/state-senior-hunger.

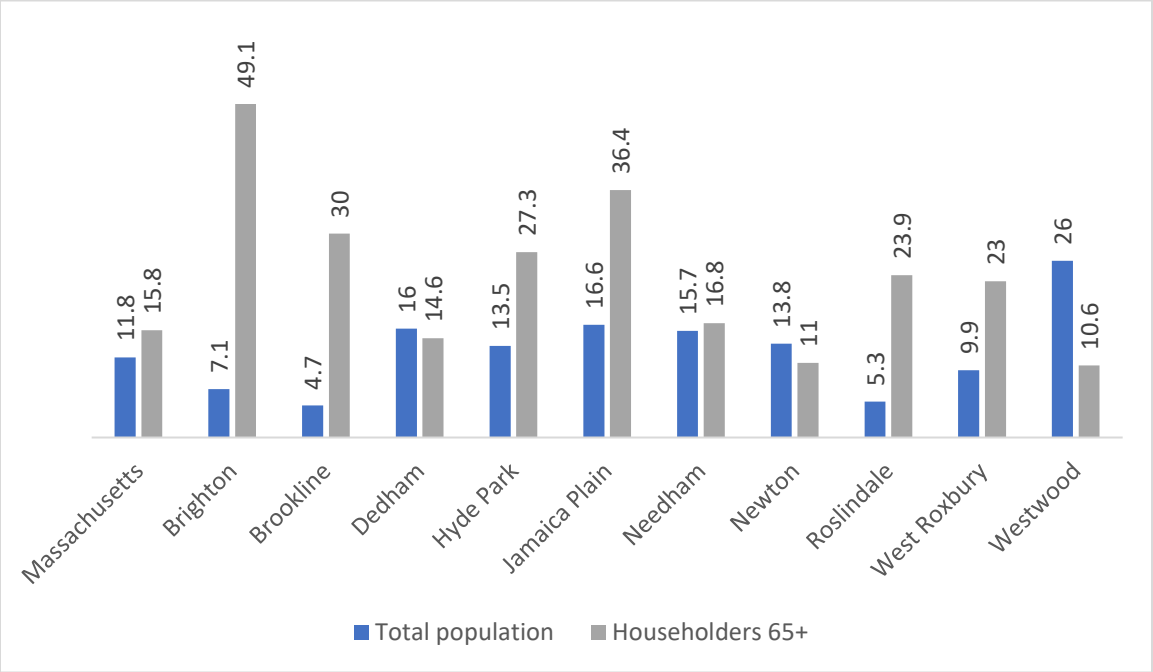
Individuals engaged in the assessment highlighted the growing impact of food insecurity on seniors, who may experience chronic food insecurity and difficulty managing underlying health conditions due to limited access to nutritious foods. Many individuals, especially those on fixed incomes, are forced to choose between food and other essential expenses.

Transportation

Transportation is a critical component of community health, particularly for older adults. Reliable and accessible transportation enables individuals to attend medical appointments, pick up prescriptions, access healthy food, participate in social activities, and remain connected to essential services. For older adults, limited mobility or lack of transportation can lead to missed health care, increased isolation, and declining physical and mental health. Ensuring safe, affordable, and convenient transportation options is key to supporting independence, preventing avoidable health complications, and promoting overall well-being as people age.

Figure 3 shows the percentage of householders, and householders over 65, without a personal vehicle. Understandably, the percentage of householders without a personal vehicle is higher in Boston neighborhoods, where there is better access to public transportation. However, individuals engaged in the assessment shared concerns about public transportation, citing unreliable schedules, long and indirect routes, and significant challenges for individuals with mobility limitations. These issues make it difficult for many—especially older adults and people with disabilities—to access essential services and maintain their independence.

FIGURE 3: HOUSEHOLDERS WITHOUT A VEHICLE (%)



Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023; Massachusetts Healthy Aging Collaborative, 2025 Community Profiles

Access to Technology

Access to technological resources such as computers and high-speed internet is increasingly vital to community health. These tools enable access to telehealth services, online health information, virtual social connections, and essential services like prescription refills or appointment scheduling. For older adults, in particular, digital access can reduce isolation, support chronic disease management, and enhance independence. Ensuring equitable access to technology helps bridge gaps in care and promotes overall well-being across aging populations.

Table 16 shows that Westwood, Brookline, Needham, and Newton have a significantly lower percentage of households lacking computers or internet and higher percentages of older adults reporting recent internet use. Hyde Park stands out for having a high percentage of households without internet (12.2%) and lower internet use among older adults (71.3%). These differences suggest that technological resources—and older adults' ability to use them—vary considerably by community, with implications for health care access, social connection, and service navigation.

TABLE 16: TECHNOLOGICAL RESOURCES FOR TOTAL POPULATION AND 60+ (%)

	Households without a computer	Households without access to internet	60+ who used internet in past month
Brighton (02135)	5.5	9.4	67.8
Brookline	2.5	4.6	83.8
Dedham	5.7	9.4	76.1
Hyde Park (02136)	6.0	12.2	71.3
Jamaica Plain (02130)	3.5	8.9	71.3
Needham	2.6	5.3	83.8
Newton	2.9	3.9	83.8
Roslindale (02131)	6.3	9.6	71.3
West Roxbury (02132)	6.6	8.2	71.3
Westwood	2.0	4.8	82.3
Massachusetts	**5.7**	**9.2**	**70.6**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Housing and Homelessness

Housing issues—particularly the lack of affordable housing, limited housing stock, and the high costs of housing upkeep—was identified as a critical community health concern. Housing concerns were the most frequently mentioned social determinant of health among individuals engaged in the assessment. Interviewees, focus group participants, and survey respondents emphasized the severe shortage of affordable housing for low- and moderate-income individuals and families, along with a general lack of available housing stock. While some subsidized housing exists, it is insufficient to meet the need for deeply affordable options. Individuals also expressed concern about the lack of affordable housing options, including community-style living arrangements for older adults.

When asked to identify top concerns in their community, "housing quality or affordability" was the top response among BILH Community Health Survey respondents (54%). The BCHC Community Health Needs Assessment Survey also revealed that housing was a top concern for individuals in Allston/Brighton (59%), Roslindale (40%), and Jamaica Plain (56%).

"There's a dichotomy between adults trying to stay at home and those that aren't able to afford to stay at home, but also can't afford alternatives like community-style living. There are few options for affordable low-income housing, but there's also a gap for people in the middle. "
- Interviewee

Housing is a community health issue for older adults, as safe, affordable, and accessible housing is essential to aging with dignity, maintaining independence, and supporting physical and mental well-being. Individuals engaged in the assessment reported that older adults living on fixed incomes may struggle with rising housing costs, leading to financial strain or housing instability. Inadequate housing—such as homes in disrepair or without accessibility features—can increase the risk of falls, isolation, and chronic health issues. In addition, limited housing options close to transportation, health care, and support services can make it difficult for older adults and individuals with disabilities to meet their daily needs and remain engaged in their communities.

Additionally, some individuals lamented the lack of services for older adults who are experiencing homelessness or housing instability. Older adults experiencing homelessness face heightened health risks due to exposure, limited access to medical care, and the challenges of managing chronic conditions without stable shelter. As the aging population grows, so does the number of older adults experiencing or at risk for homelessness, underscoring the urgent need for age-appropriate housing and supportive services.

"Those who are at risk of homelessness or are currently homeless are not served by aging services—their needs are currently not being understood."
- Interviewee

Table 17 shows that in Brighton, a significantly high percentage of homeowners with a mortgage have housing costs above 35% of their total household income compared to the Commonwealth overall. Among homeowners with no mortgage, the percentage was significantly higher in Dedham, and among renters, the percentage was significantly higher than the Commonwealth in Needham.

TABLE 17: HOUSEHOLDS WITH HOUSING COSTS OVER 35% OF TOTAL HOUSEHOLD INCOME (%)

	Among owners with mortgage	Among owners with no mortgage	Among renters
Brighton (02135)	29.7	12.1	37.0
Brookline	25.8	14.5	35.9
Dedham	21.5	27.9	43.4
Hyde Park (02136)	24.5	9.1	44.2
Jamaica Plain (02130)	13.8	10.7	36.6
Needham	21.5	11.1	52.5
Newton	23.4	15.4	33.5
Roslindale (02131)	19.9	13.0	35.4
West Roxbury (02132)	16.6	6.8	35.7
Westwood	23.6	16.6	52.7
Massachusetts	**22.7**	**15.4**	**41.3**

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Table 18 displays housing characteristics specifically for older adults. Brighton stands out with a significantly higher percentage of older adults living alone and a significantly lower rate of homeownership compared to the Commonwealth. In contrast, Needham, Newton, and Westwood have notably higher homeownership rates and lower percentages of older adults living alone. Dedham, Hyde Park, and Roslindale show elevated rates of older renters spending more than 35% of their income on housing, with Dedham and Hyde Park exceeding the Commonwealth average. Westwood has the lowest rate of older adults with a mortgage and the highest ownership rate.

TABLE 18: HOUSING CHARACTERISTICS OF OLDER ADULTS (%)

	65+ who live alone	60+ who own their	60+ who have a mortgage	65+ homeowners who spend >35% of income on housing	65+ renters who spend >35% of income on housing	Grandparents who live with grandchildren
Brighton (02135)	46.0	42.0	48.6	25.5	35.2	0.7
Brookline	36.2	65.9	39.5	22.4	32.3	0.9
Dedham	30.0	75.3	46.7	33.2	55.0	1.0
Hyde Park (02136)	24.0	69.1	54.2	28.3	48.1	3.9
Jamaica Plain (02130)	29.6	64.0	53.9	17.9	43.0	1.2
Needham	21.9	81.7	40.9	21.7	41.4	1.3
Newton	21.9	79.8	41.7	26.0	39.2	1.4
Roslindale (02131)	26.0	60.8	51.6	21.3	39.3	1.6
West Roxbury (02132)	31.4	71.1	49.3	23.0	46.6	2.9
Westwood	24.7	82.7	29.5	24.0	51.3	2.3
Massachusetts	**28.1**	**72.9**	**46.8**	**27.3**	**43.6**	**2.8**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Health Insurance and Navigation

Whether an individual has health insurance—and the extent to which it covers necessary acute services, as well as access to a full spectrum of high-quality, timely, and preventive care—is critical to overall health and well-being.[13] Access to a regular source of primary care is especially critical, as it significantly affects an individual's ability to receive routine, preventive, and urgent

[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/

care, and to manage chronic conditions. While Massachusetts has one of the highest rates of health insurance coverage in the U.S., there are still gaps.

Table 19 shows that the percentage of residents without any form of health insurance is significantly higher in Brighton and Hyde Park compared to the Commonwealth overall. Most communities in HSL's community benefits service area have significantly higher percentages of residents with private health insurance compared to the Commonwealth.

TABLE 19: INSURANCE COVERAGE (%)

	With public insurance	With private insurance	No insurance
Brighton (02135)	27.2	77.6	3.7
Brookline	20.4	88.1	1.2
Dedham	29.5	84.7	1.7
Hyde Park (02136)	46.6	62.3	3.9
Jamaica Plain (02130)	28.7	78.2	1.7
Needham	19.5	91.1	1.2
Newton	22.3	88.6	1.4
Roslindale (02131)	32.7	74.8	1.7
West Roxbury (02132)	30.1	85.5	1.5
Westwood	21.1	93.0	0.7
Massachusetts	37.1	73.8	2.6

Source: U.S. Census Bureau, American Community Survey 5-year Estimates, 2019-2023
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

As seen in Table 20, there are significantly high percentages of older adults who are dually eligible for Medicare and Medicaid, and Medicare managed care enrollees, in Brighton, Hyde Park, and Jamaica Plain.

TABLE 20: INSURANCE COVERAGE FOR THOSE 65+ (%)

	Dually eligible for Medicare and Medicaid	Medicare managed care enrollees
Brighton (02135)	43.1	36.1
Brookline	11.4	20.5
Dedham	12.0	25.8
Hyde Park (02136)	29.8	36.3
Jamaica Plain (02130)	34.0	34.5
Needham	7.4	22.2
Newton	9.8	22.0
Roslindale (02131)	32.4	31.6
West Roxbury (02132)	17.4	25.2
Westwood	7.5	22.7
Massachusetts	**17.1**	**30.5**

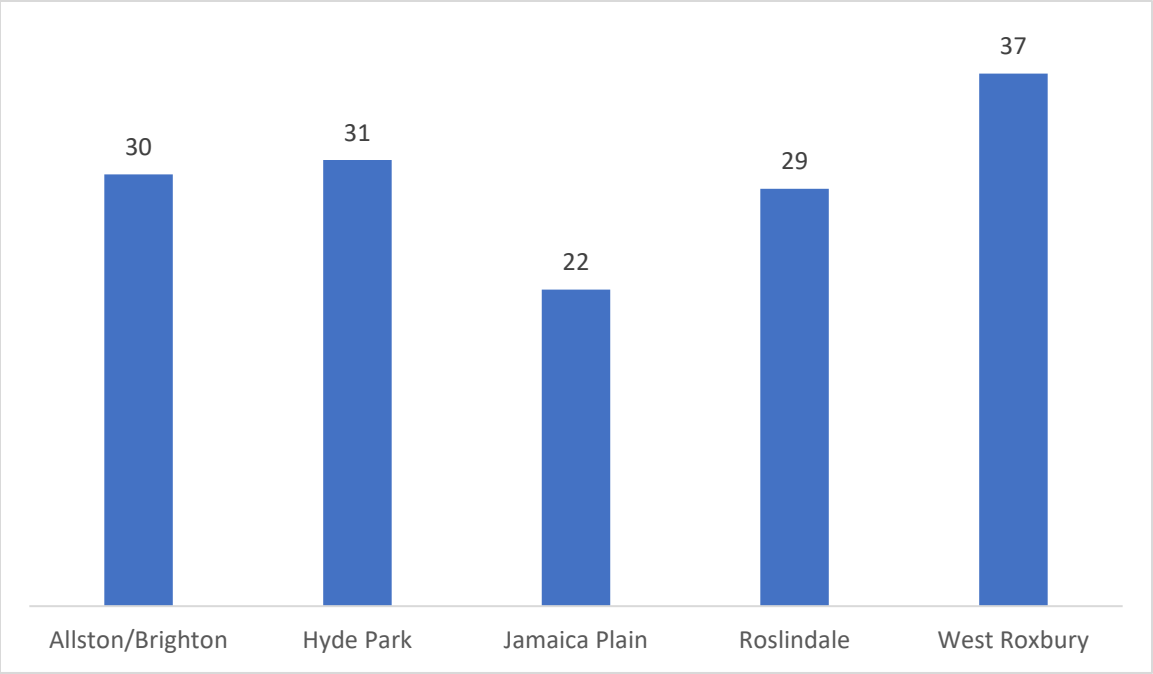
Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Interviewees and focus group participants shared concerns about navigating the health system and the complexities of the health insurance marketplace. These difficulties are especially pronounced for older adults who may be managing several chronic or complex conditions.

"Our health care system is still very siloed, especially as people get older and need different kinds of services like palliative care and hospital care. It should be a warm hand-off, and we need a lot more communication."
-Interviewee

In the 2025 BCHC Boston Community Health Needs Assessment Survey, respondents were asked about the factors that could assist in getting them the care they need. One of the most popular answers was "help with understanding and coordinating care."

FIGURE 4: RESPONDENTS WHO IDENTIFIED 'HELP WITH UNDERSTANDING AND COORDINATING CARE' AS A FACTOR THAT WOULD ASSIST IN ACCESSING CARE (%)



Source: 2025 Boston Community Health Needs Assessment, Boston Community Health Collaborative

Key Findings: Health Status, Behaviors, and Outcomes

Health status, behaviors, and outcomes vary across HSL's community benefits service area, and are shaped by a combination of individual, social, and environmental factors. Chronic conditions are prevalent, particularly among older adults. Health risk behaviors—including tobacco use, poor nutrition, physical inactivity, and substance use—contribute to these outcomes and place additional strain on health care systems. Community members also noted significant concerns around behavioral health, including social isolation, depression, anxiety, and stress. These findings highlight the need for prevention, early intervention, and coordinated care strategies to address both physical and behavioral health needs.

Overall Health Status

Table 21 presents self-reported health status among adults over age 60. Brighton, Hyde Park, Jamaica Plain, Roslindale, and West Roxbury report significantly higher percentages of older adults describing their health as fair or poor compared to the Commonwealth average of 18.5%. In contrast, Brookline, Needham, and Newton have significantly lower percentages. The percentage of older adults reporting more than 15 physically unhealthy days in the past month is fairly consistent across communities, with most areas similar to the Commonwealth average of 13.1%.

TABLE 21: SELF-REPORTED HEALTH STATUS FOR THOSE 60+ (%)

	With fair or poor self-reported health status	With over 15 physically unhealthy days in the past month
Brighton (02135)	29.4	15.6
Brookline	10.6	9.3
Dedham	15.1	16.3
Hyde Park (02136)	29.1	13.3
Jamaica Plain (02130)	29.1	13.3
Needham	10.6	9.3
Newton	10.6	9.3
Roslindale (02131)	29.1	13.3
West Roxbury (02132)	29.1	13.3
Westwood	14.7	11.2
Massachusetts	18.5	13.1

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Routine Health Visits

Statewide, approximately 90% of older adults reported having a physical exam or check-up in the past year, and 97% reported having a doctor that they see regularly. Most communities in the service area were close to these averages, though Dedham, Hyde Park, Jamaica Plain, Roslindale, and West Roxbury report slightly lower rates of recent check-ups (85.6%–85.7%). Despite this, nearly all communities report high levels of continuity of care, with more than 95% of older adults having a regular doctor. These findings suggest that while most older adults in the region maintain regular provider relationships, there may be opportunities to improve access to or uptake of annual preventive care in certain communities.

TABLE 22: ROUTINE HEALTH EXAMS (%)

	Had physical exam/check up in the past year	Has a regular doctor
Brighton (02135)	87.6	92.0
Brookline	88.7	98.7
Dedham	85.7	95.9
Hyde Park (02136)	85.6	97.4
Jamaica Plain (02130)	85.6	97.4
Needham	88.7	98.7
Newton	88.7	98.7
Roslindale (02131)	85.6	97.4
West Roxbury (02132)	85.6	97.4
Westwood	89.5	96.3
Massachusetts	**89.8**	**96.5**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles

Mental Health

Mental health concerns, including depression, anxiety, social isolation, and stress, emerged as a leading community health issue across HSL's service area. Nearly all interviewees emphasized behavioral health as a significant concern for older adults. Factors such as limited social networks, mobility challenges, and declining health increase the risk of isolation and emotional distress in this population. Despite the prevalence of conditions like depression, anxiety, and cognitive decline, these issues often go undiagnosed or untreated due to stigma, limited access to care, and the misconception that they are a normal part of aging. Older adults also face unique stressors, including the loss of loved ones and financial strain, which can further affect their mental health. Addressing these concerns requires improved access to behavioral health

services, strengthened social supports, and coordinated models of care that promote mental well-being and healthy aging.

"Traditional mental health supports are not accessible to older adults due to barriers like higher rates of stigma, co-occurring cognitive conditions, lack of transportation. We need to figure out ways to integrate behavioral health into aging services."
- Interviewee

Table 23, below, includes data related to behavioral health for older adults. Brighton stands out with a significantly higher percentage of adults over 60 experiencing 15 or more poor mental health days in the past month and the highest reported rate of depression, both well above Commonwealth averages. Several communities, including Brookline, Dedham, and Jamaica Plain, also report elevated depression rates, while Hyde Park reports a significantly lower rate. Brookline, Needham, and Newton have significantly fewer older adults experiencing extended poor mental health days. Anxiety rates among older adults are fairly consistent across communities, ranging from 30.0% to 34.7%, aligning closely with the Commonwealth average of 33.0%. These findings point to notable differences in mental health burden, with some communities showing greater needs for supportive behavioral health resources for older residents.

TABLE 23: MENTAL HEALTH AMONG OLDER ADULTS (%)

	60+ with 15 or more poor mental health days in the past month	65+ with depression	65+ with anxiety
Brighton (02135)	11.1	41.5	34.7
Brookline	4.5	37.8	32.6
Dedham	2.8	37.0	34.6
Hyde Park (02136)	5.9	30.4	24.7
Jamaica Plain (02130)	5.9	38.4	30.0
Needham	4.5	35.0	31.9
Newton	4.5	34.4	30.9
Roslindale (02131)	5.9	37.3	32.0
West Roxbury (02132)	5.9	34.6	32.3
Westwood	7.8	33.1	31.9
Massachusetts	8.4	34.6	33.0

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

In some neighborhoods, the absence of permanent senior centers further reduces access to consistent programming, resources, and social activities designed to support healthy aging. Without dedicated spaces and services, older adults may have fewer opportunities to build relationships, stay active, and access the support they need.

"Neighborhoods are changing very quickly. Businesses and third spaces are disappearing. This is a rapid change facing older adults who are aging in their communities." - Interviewee

Caregivers of older adults and individuals with chronic conditions often experience significant mental health challenges, including stress, anxiety, depression, and burnout. The emotional and physical demands of caregiving, such as managing medical needs, providing daily assistance, and navigating complex health systems, can have a serious impact on a caregiver's well-being. These challenges are often intensified by limited respite, financial strain, and a lack of social support. Many caregivers place the needs of others ahead of their own, which can lead to neglect of their physical and mental health.

"Caregiving is a risk factor for one's own care and well-being. Being a caregiver impacts one's economic prospects, and ability to take care of your own health since it makes you at risk for dementia and other health issues."
- Interviewee

Substance Use Disorder

While substance misuse among older adults was not identified as a major concern in our assessment findings, it remains an important issue to monitor. As people age, they may be more vulnerable to the effects of alcohol and medications, especially when managing multiple chronic conditions. Even relatively low levels of substance use can have serious health consequences in older populations and contribute to broader community health challenges, including increased health care utilization and caregiver stress.

Statewide, 9.4% of adults aged 65 and older have a substance use disorder, 10.9% of those aged 60 and older report excessive drinking, and 8.9% are current smokers. Rates of substance use disorder are generally close to the state average, though Brookline, Needham, and Newton report significantly lower prevalence. Smoking rates are also notably lower in several communities, including Brookline, Needham, and Newton, where just 2.5% of older adults currently smoke. Excessive drinking appears relatively consistent across communities, with most reporting rates between 9.4% and 10.8%, except in communities like Jamaica Plain and Roslindale, which report significantly lower rates.

TABLE 24: SUBSTANCE USE AMONG OLDER ADULTS (%)

	65+ with substance use disorder	60+ excessive drinking	60+ current smokers
Brighton (02135)	8.3	9.4	7.2
Brookline	5.6	10.8	2.5
Dedham	9.0	10.2	4.9
Hyde Park (02136)	10.3	6.5	6.5
Jamaica Plain (02130)	9.7	6.5	6.5
Needham	5.7	10.8	2.5
Newton	5.5	10.8	2.5
Roslindale (02131)	9.2	6.5	11.5
West Roxbury (02132)	9.2	6.5	6.5
Westwood	7.2	10.7	3.9
Massachusetts	**9.4**	**10.9**	**8.9**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Chronic and Complex Conditions

Diabetes, Cardiovascular, and Cerebrovascular Diseases

Chronic conditions are highly prevalent among older adults in the United States and are a leading driver of health care utilization and cost. The majority of adults aged 65 and older live with at least one chronic illness, such as heart disease, diabetes, arthritis, or chronic respiratory disease, and many manage multiple conditions simultaneously. These health issues can significantly impact quality of life, limit daily functioning, and increase the risk of hospitalization or long-term care needs. Managing chronic conditions often requires consistent access to health care, medications, and support services, making care coordination and community-based resources critical to promoting healthy aging and preventing complications.

Statewide, 72.9% of older adults have hypertension, 28.6% have diabetes, 4.6% have experienced a heart attack, and 11.2% have had a stroke. Hyde Park has the highest rates of both hypertension and diabetes, significantly exceeding state averages. Brighton, Dedham, and Roslindale also show elevated rates of chronic conditions, particularly hypertension and

diabetes. In contrast, Brookline, Needham, and Newton report significantly lower rates of diabetes, with Newton and Brookline also reporting lower rates of hypertension. Stroke prevalence is fairly consistent across most communities, although Westwood and Roslindale are slightly above average.

TABLE 25: CHRONIC DISEASES AMONG 65+ (%)

	With hypertension	With diabetes	Ever had a heart attack	Ever had a stroke
Brighton (02135)	74.6	37.5	4.3	11.1
Brookline	65.2	22.9	3.8	10.2
Dedham	75.6	28.7	5.2	12.0
Hyde Park (02136)	77.8	43.3	4.1	11.3
Jamaica Plain (02130)	67.6	30.9	3.9	10.2
Needham	68.2	21.8	3.4	11.6
Newton	64.2	21.3	3.9	9.8
Roslindale (02131)	74.2	35.8	4.5	12.6
West Roxbury (02132)	73.2	29.1	4.9	11.1
Westwood	73.2	23.1	4.6	12.3
Massachusetts	**72.9**	**28.6**	**4.6**	**11.2**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Cancer

Cancer is a leading cause of illness and death in the United States and has a significant impact on community health. It affects individuals and families physically, emotionally, and financially, and contributes to substantial health care costs and resource needs. Many cancers are influenced by behavioral, environmental, and social factors, making prevention, early detection, and access to timely treatment essential for reducing disparities and improving outcomes. Communities play a critical role in supporting cancer prevention efforts—such as promoting healthy lifestyles, increasing screening rates, and addressing environmental risks—while also ensuring that individuals affected by cancer have access to care, support services, and survivorship resources.

Older adults account for the majority of new cancer diagnoses and cancer-related deaths. As people age, their risk of developing cancer increases due to a combination of biological factors and accumulated exposure to risk factors. Older adults may also face unique challenges in cancer care, including multiple chronic conditions, functional limitations, and difficulties accessing treatment or support services.

As seen in Table 26, several communities report significantly higher rates of breast cancer, with Westwood reaching 16.5%. Prostate cancer rates are also elevated in Brookline, Westwood, Needham, Hyde Park, and Newton. Colon and lung cancer rates are relatively consistent across communities, with the exception of Newton, which shows a significantly lower rate of colon cancer.

TABLE 26: CANCER AMONG THOSE 65+ (%)

	With breast cancer (women)	With colon cancer	With lung cancer	With prostate cancer (men)
Brighton (02135)	12.7	2.8	2.3	13.1
Brookline	14.8	2.3	2.0	16.5
Dedham	12.0	2.8	2.3	14.2
Hyde Park (02136)	10.1	2.2	1.9	16.5
Jamaica Plain (02130)	11.5	2.4	2.1	15.5
Needham	14.7	2.2	1.9	17.5
Newton	13.2	1.9	1.9	16.0
Roslindale (02131)	12.1	1.8	2.8	12.9
West Roxbury (02132)	12.0	2.8	2.3	14.0
Westwood	16.5	2.5	2.4	16.8
Massachusetts	**11.6**	**2.4**	**2.1**	**13.6**

Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles
Shading represents statistical significance compared to the state. Data points highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

Neurodegenerative disorders

Neurodegenerative disorders, such as Alzheimer's disease and other forms of dementia, are increasingly common among older adults and represent a major public health concern. These conditions involve the progressive decline of cognitive function, memory, and the ability to perform daily activities, which can significantly impact quality of life and independence. As the

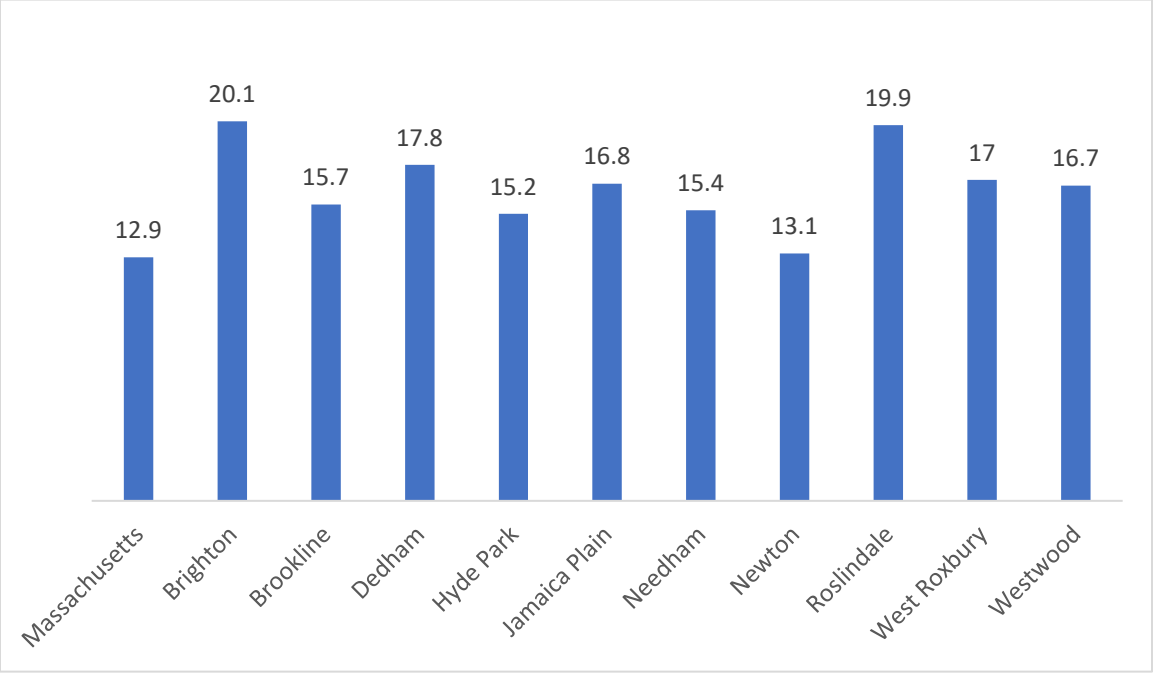
population ages, the prevalence of neurodegenerative disorders is expected to rise, placing greater demands on caregivers, health care providers, and long-term care systems. Early diagnosis, access to supportive services, and community-based resources are essential to help individuals and families manage the challenges associated with these conditions and to promote dignity and well-being in aging.

As reported by several individuals engaged in the assessment, these conditions also pose significant challenges for caregivers. As the diseases progress, caregiving responsibilities typically increase, involving round-the-clock supervision, assistance with personal care, and management of complex medical needs. Many caregivers also face disruptions to their employment and finances, particularly when formal support services are limited or unaffordable. Individuals reported a need for better access to supportive services like respite care and support groups.

"When it comes to dementia and long-course diseases, it's rare that people have the economic base to access everything they need. Often the adult caregiver is depleting their savings to take care of their parents which puts them at a greater risk and worse off position." - Interviewee

Compared to the Commonwealth overall, the percentage of individuals over 65 with Alzheimer's or related dementia is significantly high in all communities, with the exception of Newton, which was closer to the Commonwealth average of 13%.

FIGURE 5: ADULTS 65+ WITH ALZHEIMER'S OR RELATED DEMENTIAS (%)



Source: Massachusetts Healthy Aging Collaborative, 2025 Community Profiles

Priority Areas and Populations

Community Health Priority Areas

The 2025 Hebrew SeniorLife Community Health Needs Assessment provided a valuable opportunity to evaluate the health status, challenges, and opportunities across the region. Through extensive data collection, including secondary data analysis, a community health survey, interviews, and focus groups, this report offers a comprehensive overview of the health status within Hebrew SeniorLife's service area.

Following a thorough review of the CHNA findings with the Community Advisory Group, Hebrew SeniorLife conducted a prioritization and strategic planning process to identify the key health areas to be addressed in the Implementation Strategy. These priority areas include:

- **Economic Stability and Basic Needs:** The assessment findings highlighted challenges related to financial strain and access to essential resources. Sub-priorities included economic insecurity, particularly among older adults and low-income households; housing affordability, with rising costs placing pressure on renters and homeowners alike; food insecurity, which continues to impact individuals and families across age groups; and transportation barriers, which limit access to health care, employment, and daily necessities
- **Chronic/Complex Conditions and Behavioral Health:** This priority area reflects a range of needs affecting both individuals and caregivers. Sub-priorities include the growing demand for support services for people living with Alzheimer's disease and other forms of dementia, as well as for their caregivers. Community members also emphasized the barriers faced by people with disabilities, including challenges accessing transportation, communication supports, and specialized care. Behavioral health concerns were frequently mentioned. Additionally, there is a need for improved support around chronic disease management to help individuals maintain their health and independence.
- **Access to Care and Health System Navigation:** Residents and providers highlighted several barriers that make it difficult for individuals to receive the care they need. Sub-priorities include challenges accessing timely appointments, particularly for specialty care and behavioral health services. There is also a need for stronger care coordination between health care providers and social service organizations to ensure individuals receive comprehensive and continuous support. Additionally, insurance and payment-related barriers were cited as significant obstacles to accessing care.
- **Community Environment and Social Connectedness:** Individuals engaged in the assessment expressed a strong desire for more opportunities to build relationships and engage with others. Social isolation, particularly among older adults and individuals with limited mobility or resources, was a common concern. Community members emphasized

the importance of creating more inclusive and welcoming spaces for connection, as well as increasing access to programs and activities that promote engagement. Additionally, there is a need for stronger community infrastructure—including safe sidewalks, crosswalks, and accessible public transit—to support mobility, independence, and participation in community life.

Priority Populations

Beyond identifying a series of community health priority areas, the assessment aimed to identify specific segments of the population that should be the focus of Hebrew SeniorLife's 2026-2028 Implementation Strategy. These segments were identified because they face current and historical barriers to accessing health care and community services.

- Older adults with chronic conditions
- Older adults facing economic insecurity
- Older adults living with disabilities
- LGBTQIA+ older adults
- Older adults at risk for or experiencing abuse and neglect
- Caregivers

FY26-FY28 Implementation Strategy

Hebrew SeniorLife's current Implementation Strategy was developed in 2022 and addressed priority areas and populations identified in the 2022 Community Health Needs Assessment. This updated assessment provides new insights on the characteristics of HSL's community benefits service area and the priorities identified through an integrated analysis of quantitative and qualitative data.

Below are goals and objectives associated with each of the priority areas from this 2025 assessment effort. Please refer to Appendix E for the full FY26-FY28 Implementation Strategy for more details.

Priority Area 1: Economic Stability and Basic Needs

Goal: Ensure that individuals, particularly older adults and low-income populations, have equitable access to essential resources and supports that promote financial security, safe living environments, healthy food, stable housing, and opportunities for education and personal well-being.

Objectives:

- Combat hunger and isolation, and encourage health and independence of older adults living at home
- Increase road safety for all
- Provide access to good, sufficient, healthy, and culturally appropriate food
- Provide employees and their families with tangible and meaningful support through some of life's most challenging and emotional transitions
- Provide tuition cost assistance to employees and their family members to pursue their educational goals
- Provide emergency shelter program exclusively for abused, neglected, or exploited older adults
- Provide deed-restricted affordable housing to very low and low-income older adults

Priority Area 2: Chronic/Complex Conditions and Behavioral Health

Goal: Promote healthy aging and improved quality of life by expanding access to comprehensive care for chronic and behavioral health conditions, advancing brain health and dementia support, strengthening the healthcare workforce, and fostering environments that support wellness, safety, and independence for older adults.

Objectives:

- Prevent loss of bone with aging
- Emphasize clinical nutrition and food service management to help raise the standards in senior health care
- Raise awareness and provide nutrition education
- Address workforce shortage by providing financial assistance for employees to achieve degrees and licensure
- Address workforce shortage by providing training and opportunities for entry-level healthcare careers
- Increase the number of professionals in geriatric medicine through instructional hours
- Improve workplace safety and enhance emergency preparedness
- Increase interest in healthcare environment, especially for careers involving Alzheimer's and other dementias
- Provide exposure and entry-level training for high schoolers interested in pursuing careers in the health professions and related fields
- Provide comprehensive outpatient care related to brain health, cognitive and behavioral problems, and memory loss, whether due to Alzheimer's disease, other dementias, or other neurological or psychiatric conditions
- Help individuals maintain the highest possible level of brain function as they age and provide the family and caregiver support that is critical to achieving the best long-term outcomes
- Conduct a longitudinal research study to introduce life-changing resources and services to promote brain health
- Creating a health-promoting housing environment for older adults.

Priority Area 3: Access to Care and Health System Navigation

Goal: Improve access to comprehensive, culturally responsive, and person-centered care by expanding education, support services, and system navigation resources that empower older adults to make informed decisions, maintain independence, and achieve better health outcomes.

Objectives:

- Build multi-generational relationships and break generational stereotypes through programs that encourage multi-generational conversation and interaction
- Help older adults access healthcare to improve health outcomes
- Raise awareness of care options by providing education about HRC services
- Ensure steady communication to internal and external stakeholders

- Provide free health insurance information and assistance for Medicare-eligible adults and their caregivers
- Provide professional, accurate, and culturally sensitive translation and interpreter services to ensure health equity and patient-centered care
- Drive positive social change by influencing decision-makers and shaping public policies
- Offer a range of preventative care services that are easy and safe to access
- Support older adults living in affordable housing in achieving improved health outcomes, quality of life, and independence
- Optimize seniors' independence through programming

Priority Area 4: Community Environment and Social Connectedness

Goal: Foster a supportive and connected community by promoting emotional, spiritual, and social well-being, encouraging lifelong engagement, and advancing collective responsibility to improve health and quality-of-life for all.

Objectives:

- Provide geriatric-focused spiritual care training for seminary students, future clergy, and aspiring or current health care chaplains
- Restore employees' emotional and spiritual well-being to optimize resiliency and healing of the mind, body, and spirit
- Build a culture of wellness that engages all employees, promotes healthy lifestyles, supports mental health and emotional well-being, and reduces overall health risks in the workforce
- Offer lifelong learning and social connection opportunities to maintain mental, physical, and cognitive health
- Benefit the community or a specific cause by promoting social responsibility
- Collect blood donations to replenish the community's blood supply and ensure a readily available resource for patients in need

Appendix A: Community Engagement Summary

Informational Interviews (20)	
Purpose: Interviews were conducted to collect qualitative information from key health and social service providers, city/town officials, representatives from community organizations or advocacy groups, and other community leaders to: • Confirm and refine findings from secondary data • Provide community context • Clarify needs and priorities of the community. **Methods:** JSI worked with the Steering Committee to identify a representative group of interviewees. Interviews were approximately 30-60 minutes long and were conducted via Zoom using a structured interview guide created by the JSI. Detailed notes were taken for each interview.	See list of interviewees (page 10)
Focus Groups (6)	
Purpose: Focus groups were conducted with key segments of the population, and/or key types of service providers or community stakeholders. This activity allows for the collection of more targeted and nuanced information than what is gathered in interviews or community health surveys. Focus groups: • Augment findings from secondary data and informational interviews • Allow for exploration of strategic and programmatic options to address identified health issues, service gaps, and/or barriers to care. **Methods:** Focus groups were conducted using a structured guide developed by the JSI Project Team. Each group lasted approximately 60 minutes and were conducted in-person or via Zoom. Participants were	Roslindale Older Adults (AgeStrong), February 26th, 2025 Hebrew Rehabilitation Center Roslindale Patients and Families, March 11th, 2025 Family Caregivers, April 3rd, 2025 Dedham Older Adults, April 8th, 2025 NewBridge on the Charles Residents, April 14th, 2025 Hyde Park Older Adults, May 15th, 2025

recruited by Hebrew SeniorLife and community partners. Detailed notes were taken at each session and were compiled and analyzed to identify key themes.	

Community Surveys

Beth Israel Lahey Health (BILH) FY25 Community Health Survey: As part of their FY25 Community Health Needs Assessment process, BILH administered a community health survey to all community benefits service area municipalities in neighborhoods between July-November of 2024. Beth Israel Deaconess Hospital-Needham's community benefits service area includes three municipalities in HSL's CBSA (Dedham, Needham, Westwood). Results shared from this survey include responses from those municipalities.

Boston Community Health Collaborative (BCHC) 2025 Boston Community Health Needs Assessment Survey: As part of a city-wide community health needs assessment, BCHC administered a community health survey in all Boston neighborhoods in the fall of 2024. Data included in this report represent responses from the neighborhoods of Allston/Brighton, Jamaica Plain, Roslindale, Hyde Park, and West Roxbury.

City of Boston AgeStrong Commission Needs Assessment: From October 2024 to April 2025, AgeStrong Boston administered a survey to all adults in Boston over the age of 55. Data in this report includes responses from individuals in Allston/Brighton, Jamaica Plain, Hyde Park, Roslindale, and West Roxbury.

Appendix B: Data Book

Key

Significantly low compared to Massachusetts based on margin of error

Significantly high compared to Massachusetts overall based on margin of error

					Areas of Interest												
	Massachusetts	Middlesex County	Norfolk County	Suffolk County	Boston	Brighton (02135)	Brookline	Dedham	Hyde Park (02136)	Jamaica Plain (02130)	Needham	Newton	Norwood	Roslindale (02131)	West Roxbury (02132)	Westwood	
Demographics																	**Source**
Population																	US Census Bureau, American Community Survey 2019-2023
Total population	6992395	1622896	724540	782172	663972	43,683	62822	25109	38,071	41,109	32059	88504	31380	31,564	27,069	16213	
Male	48.9%	49.4%	48.5%	48.3%	48.1%	47.9%	46.0%	48.1%	47.0%	45.3%	48.0%	48.6%	48.8%	48.9%	48.5%	47.6%	
Female	51.1%	50.6%	51.5%	51.7%	51.9%	52.1%	54.0%	51.9%	53.0%	54.7%	52.0%	51.4%	51.2%	51.1%	51.5%	52.4%	
Age Distribution																	US Census Bureau, American Community Survey 2019-2023
Under 5 years (%)	5.0%	5.1%	5.2%	4.9%	4.6%	2.8%	5.3%	5.1%	5.2%	6.4%	4.7%	4.1%	6.1%	6.9%	6.0%	5.1%	
5 to 9 years	5.2%	5.4%	5.5%	4.1%	3.8%	1.7%	4.9%	5.0%	6.9%	3.7%	8.9%	5.6%	4.9%	4.9%	4.4%	8.4%	
10 to 14 years	5.7%	5.6%	6.1%	4.6%	4.4%	2.2%	6.0%	5.3%	8.3%	3.9%	9.2%	6.6%	5.3%	4.8%	6.1%	7.8%	
15 to 19 years	6.5%	6.3%	6.4%	6.9%	7.1%	3.1%	4.6%	4.6%	4.8%	2.9%	7.6%	9.6%	5.0%	4.7%	5.2%	7.4%	
20 to 24 years	6.8%	6.8%	6.1%	9.1%	9.9%	14.3%	10.9%	6.6%	4.6%	5.7%	4.0%	6.8%	5.2%	3.9%	3.0%	5.4%	
25 to 34 years	14.1%	15.1%	12.9%	22.5%	23.5%	38.4%	18.2%	11.9%	15.2%	27.7%	4.8%	9.9%	16.8%	16.6%	14.6%	8.5%	
35 to 44 years	12.9%	13.8%	13.2%	13.6%	13.3%	10.0%	13.2%	13.4%	14.6%	16.1%	14.3%	11.6%	13.3%	17.9%	12.9%	10.0%	
45 to 54 years	12.6%	12.8%	13.3%	10.7%	10.2%	6.2%	11.2%	13.6%	12.5%	10.0%	15.5%	14.0%	12.4%	12.4%	13.2%	15.0%	
55 to 59 years	7.0%	6.8%	7.3%	5.5%	5.5%	4.1%	5.3%	6.8%	5.2%	5.3%	7.5%	6.2%	6.2%	7.0%	7.4%	8.4%	
60 to 64 years	6.8%	6.2%	6.7%	5.2%	5.0%	3.7%	4.9%	7.5%	5.6%	5.1%	6.0%	6.5%	6.3%	6.3%	7.1%	5.6%	
65 to 74 years	10.3%	9.3%	10.0%	7.7%	7.6%	6.9%	8.3%	10.6%	10.5%	7.9%	9.3%	11.1%	9.5%	8.8%	12.8%	7.5%	
75 to 84 years	4.9%	4.6%	4.9%	3.5%	3.4%	3.3%	5.3%	5.4%	4.8%	3.2%	4.5%	5.5%	5.7%	3.5%	4.9%	6.5%	
85 years and over	2.2%	2.1%	2.4%	1.8%	1.7%	3.3%	1.8%	4.3%	1.7%	2.1%	3.7%	2.5%	3.6%	2.2%	2.3%	4.4%	
Under 18 years of age	19.6%	19.6%	20.7%	16.2%	15.2%	7.8%	19.3%	18.7%	23.2%	16.0%	28.1%	20.8%	19.3%	19.9%	19.7%	26.5%	
Over 65 years of age	17.5%	16.0%	17.4%	13.0%	12.7%	13.5%	15.4%	20.3%	17.0%	13.2%	17.5%	19.1%	18.7%	14.5%	20.0%	18.3%	
Race/Ethnicity																	Community Survey 2019-2023
White alone (%)	70.7%	69.0%	71.4%	48.1%	47.8%	61.7%	67.7%	82.4%	24.0%	64.0%	81.7%	71.1%	73.0%	53.5%	74.4%	78.8%	
Black or African American alone (%)	7.0%	5.0%	7.2%	19.1%	21.5%	6.3%	3.1%	5.1%	48.7%	12.8%	1.5%	2.2%	7.0%	23.8%	3.9%	1.6%	
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.4%	0.3%	0.2%	0.2%	0.0%	0.2%	0.6%	0.1%	0.4%	0.0%	0.1%	0.2%	0.0%	
Asian alone (%)	7.1%	13.2%	12.1%	9.0%	10.0%	17.2%	17.7%	3.1%	2.7%	6.2%	10.5%	16.6%	6.8%	2.9%	8.1%	10.0%	
Native Hawaiian and Other Pacific Islander (S	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.4%	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	
Some Other Race alone (%)	5.4%	4.2%	2.3%	7.8%	7.1%	5.5%	1.8%	2.4%	12.2%	6.4%	0.3%	2.4%	5.6%	8.1%	5.1%	2.3%	
Two or More Races (%)	9.5%	8.4%	6.8%	15.5%	13.2%	9.1%	9.7%	6.8%	11.9%	9.8%	5.7%	7.3%	7.5%	11.7%	8.3%	7.2%	
Hispanic or Latino of Any Race (%)	12.9%	9.0%	5.5%	22.8%	18.9%	11.2%	6.0%	7.5%	26.7%	18.0%	3.7%	4.8%	9.1%	19.9%	10.9%	5.3%	
Foreign-born																	Community Survey 2019-2023
Foreign-born population	1,236,518	366,954	138,392	230,245	182,633	12,190	17,300	3,315	11,399	8,809	5,349	20,831	6,768	7,849	5,244	1,907	
Naturalized U.S. citizen	54.5%	51.0%	60.1%	50.3%	53.2%	50.7%	43.4%	61.5%	66.8%	60.0%	71.8%	65.8%	46.0%	64.4%	79.7%	74.0%	
Not a U.S. citizen	45.5%	49.0%	39.9%	49.7%	46.8%	49.3%	56.6%	38.5%	33.2%	40.0%	28.2%	34.2%	54.0%	35.6%	20.3%	26.0%	
Region of birth: Europe	18.1%	16.9%	20.0%	10.9%	11.0%	18.2%	26.5%	40.9%	6.3%	16.8%	38.2%	31.4%	21.3%	13.7%	33.2%	27.8%	
Region of birth: Asia	30.5%	42.9%	47.6%	23.9%	28.2%	52.2%	55.8%	21.3%	5.6%	21.4%	42.3%	50.3%	30.7%	8.0%	34.2%	56.2%	
Region of birth: Africa	9.5%	7.6%	7.3%	10.4%	11.1%	6.9%	3.8%	5.2%	10.6%	12.6%	6.1%	4.3%	6.7%	8.8%	5.4%	2.6%	
Region of birth: Oceania	0.3%	0.5%	0.3%	0.2%	0.3%	0.1%	0.2%	0.3%	0.0%	0.1%	0.6%	0.6%	0.2%	0.3%	1.9%	0.3%	
Region of birth: Latin America	39.4%	29.7%	22.8%	53.1%	47.8%	21.0%	10.0%	29.4%	77.0%	47.2%	11.3%	10.0%	40.4%	68.1%	24.3%	12.0%	
Region of birth: Northern America	2.2%	2.4%	2.0%	1.4%	1.6%	1.6%	3.7%	3.0%	0.5%	1.9%	1.6%	3.5%	0.8%	1.1%	1.0%	1.2%	
Language																	Community Survey 2019-2023
English only	75.2%	71.7%	77.0%	61.6%	64.8%	67.0%	69.6%	83.7%	58.4%	70.8%	79.9%	72.5%	73.3%	68.0%	75.0%	84.0%	
Language other than English	24.8%	28.3%	23.0%	38.4%	35.2%	33.0%	30.4%	16.3%	41.6%	29.2%	20.1%	27.5%	26.7%	32.0%	25.0%	16.0%	
Speak English less than "very well"	9.7%	9.9%	8.4%	17.9%	15.5%	14.3%	7.3%	6.2%	18.0%	9.8%	4.6%	7.9%	12.3%	14.4%	8.4%	3.4%	
Spanish	9.6%	6.4%	3.5%	19.2%	15.5%	8.4%	4.1%	5.4%	20.3%	14.3%	2.8%	3.2%	7.3%	16.9%	9.1%	2.8%	
Speak English less than "very well"	4.1%	2.4%	0.9%	9.8%	7.3%	2.3%	0.7%	2.1%	8.7%	5.8%	0.4%	0.7%	3.1%	8.1%	2.3%	1.0%	
Other Indo-European languages	9.2%	12.2%	9.0%	10.1%	10.1%	9.9%	11.6%	7.3%	17.0%	8.9%	9.4%	11.2%	13.9%	11.3%	8.6%	6.6%	
Speak English less than "very well"	3.2%	4.1%	2.8%	3.9%	3.8%	4.4%	2.3%	3.1%	8.0%	2.2%	1.9%	3.1%	7.5%	5.0%	3.2%	0.9%	
Asian and Pacific Islander languages	4.4%	7.8%	8.6%	6.5%	7.3%	12.6%	10.8%	2.0%	1.9%	2.9%	5.1%	10.2%	3.7%	1.5%	6.3%	5.5%	
Speak English less than "very well"	1.9%	2.9%	4.3%	3.5%	3.9%	7.0%	3.8%	0.7%	0.6%	1.0%	1.7%	3.5%	1.4%	0.5%	2.7%	1.5%	
Other languages	1.6%	2.0%	1.9%	2.6%	2.3%	2.0%	3.8%	1.6%	2.4%	3.1%	2.9%	2.8%	1.7%	2.4%	1.0%	1.1%	
Speak English less than "very well"	0.4%	0.5%	0.4%	0.8%	0.6%	0.7%	0.6%	0.4%	0.7%	0.8%	0.6%	0.5%	0.3%	0.9%	0.3%	0.1%	

Employment																	Community Survey 2019-2023
Unemployment rate	5.1%	4.2%	4.9%	6.2%	6.0%	3.3%	3.5%	3.6%	6.4%	3.2%	4.5%	3.3%	3.5%	5.3%	3.8%	1.8%	
Unemployment rate by race/ethnicity																	
White alone	4.5%	4.0%	4.6%	4.4%	4.1%	3.1%	3.4%	3.8%	3.0%	2.0%	4.4%	3.5%	4.3%	4.1%	3.8%	2.1%	
Black or African American alone	7.9%	6.4%	8.0%	8.6%	8.6%	4.2%	10.2%	0.9%	6.1%	5.8%	13.4%	3.6%	4.2%	8.4%	13.3%	0.0%	
American Indian and Alaska Native alone	6.9%	5.5%	16.0%	7.6%	10.4%	0.0%	0.0%	-	0.0%	45.5%	0.0%	0.0%	0.0%	0.0%	0.0%	-	
Asian alone	4.0%	3.5%	4.1%	4.7%	4.7%	2.9%	3.6%	4.9%	4.9%	1.8%	3.6%	3.1%	0.5%	2.9%	2.5%	0.8%	
Native Hawaiian/OPI alone	4.8%	10.9%	0.0%	0.0%	0.0%	-	-	-	-	0.0%	-	0.0%	-	-	-	-	
Some other race alone	8.0%	6.4%	6.1%	10.4%	11.1%	7.2%	4.8%	5.6%	17.6%	2.9%	0.0%	1.5%	1.2%	7.2%	0.0%	0.0%	
Two or more races	7.9%	5.4%	6.2%	8.9%	8.3%	2.8%	2.5%	1.1%	3.3%	9.5%	6.2%	2.1%	0.4%	4.4%	2.6%	0.0%	
Hispanic or Latino origin (of any race)	8.1%	6.2%	5.5%	9.6%	9.4%	4.2%	3.9%	0.0%	10.1%	8.9%	5.7%	2.0%	1.6%	6.5%	2.3%	0.0%	
Unemployment rate by educational attainment																	
Less than high school graduate	9.1%	8.1%	7.5%	10.6%	9.7%	5.8%	5.4%	1.1%	1.0%	13.4%	0.0%	1.1%	4.3%	4.4%	0.0%	0.0%	
High school graduate (includes equivalency)	6.4%	5.9%	7.1%	8.7%	9.2%	4.9%	18.5%	1.9%	5.8%	5.6%	0.5%	2.7%	3.8%	13.1%	5.8%	4.2%	
Some college or associate's degree	5.2%	4.9%	5.1%	7.6%	8.1%	3.4%	3.8%	1.7%	5.4%	8.8%	5.6%	8.2%	4.3%	6.8%	4.4%	1.0%	
Bachelor's degree or higher	2.7%	2.7%	2.6%	2.9%	2.9%	2.7%	2.6%	2.4%	7.3%	1.5%	3.8%	2.5%	1.9%	2.0%	3.6%	0.7%	
Income and Poverty																	Community Survey 2019-2023
Median household income (dollars)	101,341	126,779	126,497	92,859	94,755	88,208	140,631	124,375	96,862	130,533	212,241	184,989	97,110	109,237	139,545	205,000	
Population living below the federal poverty line in the last 12 months																	
Individuals	10.0%	7.5%	6.6%	16.5%	16.9%	18.7%	9.8%	4.6%	9.9%	11.1%	3.8%	4.7%	8.2%	9.7%	4.1%	5.0%	
Families	6.6%	6.7%	4.7%	4.6%	3.3%	11.8%	4.7%	3.7%	8.4%	5.6%	1.8%	3.0%	3.0%	7.1%	2.6%	3.9%	
Individuals under 18 years of age	11.8%	7.4%	5.8%	21.2%	21.8%	25.7%	4.9%	3.2%	13.1%	13.1%	2.5%	2.4%	11.5%	10.7%	2.7%	2.1%	
Individuals over 65 years of age	10.2%	8.6%	8.7%	20.3%	21.0%	27.2%	11.6%	9.5%	15.5%	14.5%	6.4%	6.1%	8.8%	17.5%	4.9%	6.2%	
Female head of household, no spouse	19.1%	15.4%	14.9%	23.3%	23.2%	16.1%	11.6%	9.0%	15.3%	23.5%	11.1%	14.7%	23.0%	16.8%	7.9%	6.4%	
White alone	7.6%	6.0%	5.6%	11.6%	11.7%	15.4%	9.0%	4.3%	4.9%	7.3%	3.1%	3.9%	5.8%	5.3%	3.8%	5.5%	
Black or African American alone	17.1%	15.4%	11.7%	19.7%	19.8%	27.2%	8.8%	9.6%	10.1%	21.4%	1.8%	14.6%	11.9%	12.8%	15.8%	7.9%	
American Indian and Alaska Native alone	19.1%	12.7%	11.1%	13.1%	15.4%	0.0%	0.0%	-	0.0%	13.1%	0.0%	14.0%	0.0%	0.0%	0.0%	-	
Asian alone	11.0%	8.6%	8.1%	23.5%	24.3%	22.9%	13.4%	7.3%	19.0%	10.2%	4.8%	6.9%	6.3%	7.2%	1.4%	4.1%	
Native Hawaiian/OPI alone	21.7%	4.7%	40.9%	35.2%	35.2%	0.0%	-	0.0%	100.0%	0.0%	57.7%	-	-	-	-	-	
Some other race alone	20.1%	14.2%	12.3%	20.9%	23.5%	27.9%	18.7%	1.9%	9.6%	15.7%	0.0%	5.0%	8.7%	26.9%	6.5%	0.0%	
Two or more races	15.7%	10.5%	7.4%	20.9%	21.2%	23.0%	7.3%	3.7%	14.6%	20.7%	10.1%	4.6%	29.2%	12.1%	3.0%	1.4%	
Hispanic or Latino origin (of any race)	20.6%	15.1%	9.4%	22.6%	25.3%	27.8%	6.4%	3.7%	13.9%	22.0%	7.0%	8.6%	15.8%	20.4%	5.9%	7.9%	
Less than high school graduate	24.4%	20.4%	19.5%	30.3%	33.1%	39.6%	34.4%	15.6%	22.7%	29.2%	8.2%	22.0%	15.6%	28.9%	6.3%	11.8%	
High school graduate (includes equivalency)	12.7%	12.1%	10.4%	19.0%	20.5%	21.0%	34.5%	8.4%	7.2%	32.4%	6.9%	13.2%	11.9%	11.9%	8.3%	13.1%	
Some college, associate's degree	9.2%	8.2%	8.2%	14.8%	15.9%	19.6%	20.8%	6.0%	8.7%	9.7%	5.3%	6.0%	7.9%	12.6%	6.6%	4.4%	
Bachelor's degree or higher	4.0%	3.4%	3.2%	6.7%	6.8%	10.3%	4.2%	2.7%	5.3%	4.8%	3.0%	3.4%	3.2%	3.5%	3.1%	1.7%	
With Social Security	29.8%	25.8%	28.6%	20.9%	19.8%	18.8%	21.8%	33.6%	30.9%	0.198	26.6%	27.3%	29.9%	21.2%	29.3%	32.6%	
With retirement income	22.9%	20.9%	22.7%	13.7%	13.2%	11.9%	17.4%	24.9%	21.1%	0.144	22.1%	22.4%	23.7%	18.6%	26.5%	24.0%	
With Supplemental Security Income	5.6%	3.9%	3.8%	6.5%	6.6%	5.7%	2.4%	2.7%	7.7%	0.026	3.1%	2.5%	4.5%	6.2%	3.2%	4.8%	
With cash public assistance income	3.5%	2.8%	2.5%	3.8%	3.7%	3.2%	2.0%	3.6%	1.0%	0.025	2.2%	2.1%	2.0%	3.7%	2.7%	1.5%	
With Food Stamp/SNAP benefits in the past 12 months	13.8%	8.6%	8.7%	18.7%	18.6%	12.5%	6.0%	7.4%	20.9%	0.108	3.0%	4.4%	9.1%	18.2%	9.4%	1.7%	
Housing																	US Census Bureau, American Community Survey 2019-2023
Occupied housing units	91.6%	95.5%	95.9%	91.0%	90.7%	93.6%	94.8%	96.7%	96.7%	95.4%	97.0%	94.6%	95.3%	93.9%	92.8%	96.0%	
Owner-occupied	62.6%	61.6%	68.5%	36.6%	35.4%	21.7%	46.1%	72.7%	53.4%	45.6%	84.3%	71.0%	51.8%	57.0%	0.71	87.2%	
Renter-occupied	37.4%	38.4%	31.5%	63.4%	64.6%	78.3%	53.9%	27.3%	46.6%	54.4%	15.7%	29.0%	48.2%	43.0%	0.29	12.8%	
Lacking complete plumbing facilities	0.3%	0.3%	0.3%	0.4%	0.4%	0.1%	0.1%	0.1%	0.8%	0.2%	0.8%	0.2%	0.5%	0.2%	0.0%	0.0%	
Lacking complete kitchen facilities	0.8%	0.9%	0.7%	1.0%	1.0%	1.8%	0.6%	1.1%	0.4%	1.4%	1.0%	0.5%	0.9%	0.7%	1.3%	0.6%	
No telephone service available	0.8%	0.6%	0.5%	1.2%	1.2%	0.5%	0.2%	0.2%	1.8%	1.2%	1.1%	0.2%	1.7%	0.9%	0.3%	0.1%	
Monthly housing costs <35% of total household income																	
Among owner-occupied units with a mortgage	22.7%	20.7%	21.6%	25.6%	24.1%	29.7%	25.8%	21.5%	24.5%	13.8%	21.5%	23.4%	22.5%	19.9%	16.6%	23.6%	
Among owner-occupied units without a mortgage	15.4%	15.2%	16.9%	15.0%	14.0%	12.1%	14.5%	27.9%	9.1%	10.7%	11.1%	15.4%	12.8%	13.0%	6.8%	16.6%	
Among occupied units paying rent	41.3%	37.4%	40.7%	41.7%	41.0%	37.0%	35.9%	43.4%	44.2%	36.6%	52.5%	33.5%	42.6%	35.4%	35.7%	52.7%	

Access to Technology																US Census Bureau, American Community Survey 2019-2023
Among households																
Has smartphone	89.2%	91.5%	90.7%	90.5%	90.9%	89.5%	94.3%	85.3%	89.7%	93.1%	91.6%	93.9%	88.6%	91.9%	89.4%	89.6%
Has desktop or laptop	83.2%	88.4%	87.7%	81.9%	83.2%	87.6%	92.6%	85.4%	76.6%	89.0%	90.4%	94.0%	86.6%	84.7%	87.5%	93.7%
With a computer	95.1%	96.5%	96.5%	94.6%	94.8%	1.5%	97.4%	94.7%	1.5%	2.0%	97.3%	97.8%	96.1%	1.9%	2.0%	98.4%
With a broadband Internet subscription	91.8%	94.2%	94.2%	90.3%	90.6%	86.3%	96.0%	91.0%	82.3%	86.4%	94.8%	96.9%	94.3%	85.2%	84.8%	94.9%
Transportation																US Census Bureau, American Community Survey 2019-2023
Car, truck, or van -- drove alone	62.7%	56.0%	59.0%	36.6%	34.1%	37.3%	28.1%	65.2%	61.2%	30.9%	57.5%	49.6%	63.3%	49.8%	55.2%	60.6%
Car, truck, or van -- carpooled	6.9%	6.4%	5.6%	6.2%	5.4%	7.1%	3.3%	6.9%	9.4%	3.2%	3.8%	5.6%	9.2%	5.5%	7.4%	9.8%
Public transportation (excluding taxicab)	7.0%	8.0%	9.5%	23.6%	24.0%	28.4%	20.1%	5.4%	15.4%	27.1%	7.6%	8.7%	9.6%	17.7%	13.0%	5.8%
Walked	4.2%	4.2%	3.2%	12.3%	13.8%	5.8%	15.2%	2.6%	2.4%	8.2%	1.9%	5.4%	1.6%	3.3%	1.1%	0.1%
Other means	2.5%	3.2%	2.1%	3.8%	4.0%	2.8%	6.2%	1.2%	1.2%	6.2%	0.3%	1.9%	1.8%	4.0%	1.2%	0.3%
Worked from home	16.7%	22.2%	20.6%	17.5%	18.8%	18.6%	27.0%	18.6%	10.4%	24.4%	28.8%	28.7%	14.6%	19.8%	22.0%	23.4%
Mean travel time to work (minutes)	29.3	30.0	32.9	30.9	30.2	32.6	28.1	30.2	33.9	30.4	28.6	26.7	31.2	33.4	32.9	30.2
Vehicles available among occupied housing units																
No vehicles available	11.8%	10.4%	8.9%	31.8%	33.5%	31.7%	27.4%	7.9%	15.4%	11.8%	6.7%	5.7%	6.6%	23.5%	13.1%	4.1%
1 vehicle available	35.8%	36.5%	35.4%	43.5%	43.2%	44.7%	47.7%	36.0%	43.6%	35.8%	23.1%	35.2%	42.9%	51.3%	49.0%	23.5%
2 vehicles available	35.8%	37.8%	39.1%	18.9%	17.8%	16.5%	20.3%	40.2%	27.5%	35.8%	54.5%	45.3%	36.1%	19.9%	28.0%	46.4%
3 or more vehicles available	16.6%	15.3%	16.6%	5.9%	5.5%	7.1%	4.7%	16.0%	13.5%	16.6%	15.7%	13.8%	14.4%	5.3%	9.9%	26.0%
Education																US Census Bureau, American Community Survey 2019-2023
Educational attainment of adults 25 years and older																
Less than 9th grade	4.2%	3.3%	3.0%	7.4%	6.5%	3.7%	1.7%	1.5%	5.5%	3.8%	1.1%	1.4%	4.0%	6.7%	1.9%	2.4%
9th to 12th grade, no diploma	4.4%	3.2%	2.7%	5.0%	4.6%	3.2%	0.9%	4.4%	6.2%	2.4%	1.5%	1.3%	2.8%	4.1%	2.9%	2.0%
High school graduate (includes equivalency)	22.8%	17.5%	17.4%	20.5%	18.3%	11.1%	5.0%	20.4%	27.4%	10.8%	7.0%	6.6%	19.7%	19.9%	13.3%	9.4%
Some college, no degree	14.4%	11.2%	12.4%	12.1%	11.6%	8.1%	5.2%	12.3%	17.7%	7.7%	6.5%	5.9%	13.5%	11.1%	10.4%	9.2%
Associate's degree	7.5%	5.7%	7.0%	5.1%	4.9%	2.8%	2.2%	6.3%	10.8%	2.8%	3.0%	4.2%	6.9%	6.4%	7.2%	5.9%
Bachelor's degree	25.3%	28.8%	30.0%	26.8%	28.5%	40.4%	27.3%	29.2%	20.5%	28.0%	29.7%	28.2%	30.8%	25.5%	30.4%	35.5%
Graduate or professional degree	21.4%	30.2%	27.7%	23.1%	25.6%	30.7%	57.8%	25.9%	12.0%	44.6%	51.2%	52.4%	22.3%	26.4%	33.7%	35.5%
High school graduate or higher	91.4%	93.4%	94.4%	87.6%	88.9%	93.1%	97.4%	94.1%	88.3%	93.9%	97.3%	97.3%	93.2%	89.3%	95.2%	95.5%
Bachelor's degree or higher	46.6%	59.0%	57.6%	49.9%	54.1%	71.1%	85.0%	55.1%	32.5%	72.6%	80.8%	80.7%	53.1%	51.9%	64.2%	71.0%
Educational attainment by race/ethnicity																
White alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	7,592	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	94.6%	96.0%	97.0%	95.5%	96.4%	97.8%	98.9%	95.6%	7,157	97.3%	98.2%	98.4%	95.3%	95.5%	96.6%	96.8%
Bachelor's degree or higher	49.4%	60.9%	59.3%	66.0%	72.5%	79.4%	86.8%	56.3%	3,117	80.1%	81.2%	81.9%	52.2%	65.1%	66.5%	69.5%
Black alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	12,566	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	87.1%	89.6%	90.0%	86.4%	86.4%	94.2%	78.4%	86.2%	10,893	84.8%	78.5%	94.2%	91.1%	81.3%	86.7%	100.0%
Bachelor's degree or higher	30.7%	40.0%	39.4%	27.4%	26.7%	44.5%	41.6%	39.9%	3,467	43.4%	43.3%	60.4%	41.1%	29.0%	41.4%	33.5%
American Indian or Alaska Native alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	61	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	75.2%	69.1%	78.6%	73.3%	77.5%	68.1%	78.1%	-	61	100.0%	100.0%	72.8%	78.6%	96.8%	100.0%	-
Bachelor's degree or higher	24.4%	31.3%	41.8%	30.2%	44.0%	68.1%	17.1%	-	6	32.5%	0.0%	66.1%	78.6%	96.8%	0.0%	-
Asian alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	744	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	90.3%	84.2%	80.8%	80.9%	85.7%	96.9%	92.6%	674	96.7%	93.8%	95.2%	96.5%	93.4%	97.6%	94.9%
Bachelor's degree or higher	64.0%	71.3%	61.0%	57.0%	57.4%	59.6%	88.5%	71.3%	317	88.5%	84.0%	79.9%	88.8%	58.2%	78.1%	85.1%
NH/OPI alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	32	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	86.6%	98.5%	65.9%	100.0%	100.0%	100.0%	-	-	32	100.0%	100.0%	-	-	-	-	-
Bachelor's degree or higher	40.0%	20.9%	44.5%	63.0%	63.0%	100.0%	-	-	0	65.0%	100.0%	-	-	-	-	-
Some other race alone	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	3,210	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	71.6%	73.6%	81.9%	71.5%	71.6%	59.2%	81.9%	91.4%	2,661	81.4%	100.0%	89.9%	72.7%	69.8%	68.9%	74.1%
Bachelor's degree or higher	20.0%	27.1%	40.3%	22.2%	24.8%	35.7%	63.1%	58.1%	745	50.2%	100.0%	55.2%	46.6%	19.4%	24.4%	74.1%
Two or more races	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	2,503	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	80.6%	85.6%	92.3%	72.7%	77.3%	89.1%	97.3%	80.6%	2,116	84.9%	97.3%	95.1%	80.2%	83.5%	95.0%	83.2%
Bachelor's degree or higher	33.6%	46.1%	57.3%	30.3%	36.6%	68.5%	85.8%	39.3%	1,023	56.0%	82.2%	83.5%	42.7%	48.5%	56.7%	83.2%
Hispanic or Latino Origin	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	6,044	(X)	(X)	(X)	(X)	(X)	(X)	(X)
High school graduate or higher	73.4%	77.6%	90.0%	70.6%	72.8%	78.0%	92.1%	84.4%	5,071	77.0%	96.8%	91.0%	77.7%	75.1%	82.8%	65.7%
Bachelor's degree or higher	23.3%	34.9%	53.2%	22.5%	26.6%	57.4%	79.9%	46.9%	1,463	41.4%	88.0%	73.5%	34.1%	26.5%	36.1%	62.1%

Health insurance coverage																Community Survey 2019-2023
With health insurance coverage	97.4%	97.6%	98.1%	96.7%	97.0%	96.3%	98.8%	98.3%	96.1%	98.3%	98.8%	98.6%	97.9%	98.3%	98.5%	99.3%
With private health insurance	73.8%	80.0%	82.0%	67.5%	69.9%	77.6%	88.1%	84.7%	62.3%	78.2%	91.1%	88.6%	75.4%	74.8%	85.5%	93.0%
With public coverage	37.1%	29.9%	29.1%	38.1%	35.8%	27.2%	20.4%	29.5%	46.6%	28.7%	19.5%	22.3%	36.5%	32.7%	30.1%	21.1%
No health insurance coverage	2.6%	2.4%	1.9%	3.3%	3.0%	3.7%	1.2%	1.7%	3.9%	1.7%	1.2%	1.4%	2.1%	1.7%	1.5%	0.7%
Disability																Community Survey 2019-2023
Percent of population With a disability	12.1%	9.8%	9.7%	12.3%	12.1%	11.2%	7.5%	11.6%	11.3%	9.6%	7.0%	7.3%	10.7%	0.122	8.7%	9.0%
Under 18 with a disability	4.9%	4.1%	3.6%	6.0%	5.8%	2.1%	3.7%	5.8%	1.6%	3.7%	1.8%	3.4%	3.7%	3.8%	4.5%	0.9%
18-64	9.4%	7.1%	6.9%	9.2%	9.1%	7.5%	4.7%	8.3%	8.7%	6.6%	3.2%	4.5%	8.5%	9.2%	5.0%	5.5%
65+	30.2%	27.9%	27.3%	38.1%	37.2%	38.4%	24.5%	27.7%	34.1%	34.0%	27.8%	20.6%	26.3%	38.2%	24.9%	32.1%

					Areas of Interest							
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Dedham	Needham	Newton	Norwood	Westwood	Source
Access to Care												
Ratio of population to primary care physicians	103.5	128.3	125.7	150.0	150.0	125.7	125.7	125.7	128.3	125.7	125.7	County Health Rankings, 2021
Ratio of population to mental health providers	135.7	145.3	145.1	94.3	94.2	145.3	144.9	145.2	145.4	145.0	145.2	County Health Rankings, 2023
Addiction and substance abuse providers (rate per 100,000 population)	31.3	18.0	16.4	47.3	50.0	7.9	7.9	12.5	3.4	66.4	0.0	CMS- National Plan and Provider Enumeration System (NPPES), 2024
Overall Health												
Adults age 18+ with poor or fair general health (crude %)	13.8	Data unavailable	Data unavailable	Data unavailable	16.4	8.9	11.8	11.2	8.6	13.8	11.2	Behavioral Risk Factor Surveillance System, 2022
Mortality rate (crude rate per 100,000)	900.2	764.9	871.1	645.8								CDC-National Vital Statistics System, 2018-2021
Premature mortality rate (per 100,000)	308.1	188.0	233.2	180.6								Massachusetts Death Report, 2021
Risk Factors												
Farmers Markets Accepting SNAP, Rate per 100,00 low income	1.8	4.8	2.2	1.3	1.6	10.9	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	7.6	8.1	11.1	10.6	5.1	7.1	4.2	3.2	12.7	4.6	USDA - SNAP Retailer Locator, 2024
Population with low food access (%)	27.8	24.6	35.7	1.0	0.6	3.8	30.3	21.8	9.9	2.9	63.1	USDA - Food Access Research Atlas, 2019
Obesity (adults) (%), age-adjusted prevalence	27.2	Data unavailable	Data unavailable	Data unavailable	27.3	24.4	28.5	24.2	20.4	28.5	no data	BRFSS, 2022
High blood pressure (adults) (%) age-adjusted prevalence	No data	Data unavailable	Data unavailable	Data unavailable	28.2	22.6	23.9	21.6	22.2	24.9	no data	BRFSS, 2021
High cholesterol among adults who have been screened (%)	No data	Data unavailable	Data unavailable	Data unavailable	29.5	31.1	30.8	30.5	29.5	31.2	no data	BRFSS, 2021
Adults with no leisure time physical activity (%), age-adjusted	21.3	Data unavailable	Data unavailable	Data unavailable	23.3	14.3	17.6	13.1	12.9	18	no data	BRFSS, 2022
Chronic Conditions												
Current asthma (adults) (%) age-adjusted prevalence	11.3	Data unavailable	Data unavailable	Data unavailable	11.7	10.3	11.3	10.3	10.3	11.5	no data	BRFSS, 2022
Diagnosed diabetes among adults (%), age-adjusted	10.5	Data unavailable	Data unavailable	Data unavailable	10.1	7.1	7.6	6.2	6.3	7.9	no data	BRFSS, 2022
Chronic obstructive pulmonary disease among adults (%), age-adjusted	5.7	Data unavailable	Data unavailable	Data unavailable	5.5	3.4	5	3.4	3.3	5	no data	BRFSS, 2022
Coronary heart disease among adults (%), age-adjusted	6.2	Data unavailable	Data unavailable	Data unavailable	5.5	4.4	5.3	4.4	4.2	5.3	no data	BRFSS, 2022
Stroke among adults (%), age-adjusted	3.6	Data unavailable	Data unavailable	Data unavailable	3.2	2	2.4	1.9	1.9	2.5	no data	BRFSS, 2022
Cancer												
Mammography screening among women 50-74 (%), age-adjusted	84.9	Data unavailable	Data unavailable	Data unavailable	83.4	86.1	85.2	86.7	85	85.4	no data	BRFSS, 2022
Colorectal cancer screening among adults 45-75 (%), age-adjusted	71.5	Data unavailable	Data unavailable	Data unavailable	60.8	66	64.8	68.1	68.8	64.6	no data	BRFSS, 2022
Cancer incidence (age-adjusted per 100,000)												
All sites	449.4	426.6	462.7	408.9	408.9	463.3	463.0	463.6	426.3	463.0	464.9	State Cancer Profiles, 2016-2020
Lung and Bronchus Cancer	59.2	52.1	56.3	54.9	54.8	56.1	57.8	55.3	52.2	56.1	56.9	State Cancer Profiles, 2016-2020
Prostate Cancer	113.2	108.6	117.7	111.7	111.8	116.6	115.7	117.2	108.5	115.2	120.3	State Cancer Profiles, 2016-2020
Prevention and Screening												
Adults age 18+ with routine checkup in Past 1 year (%) (age-adjusted)	81.0	Data unavailable	Data unavailable	Data unavailable	77.4	79.7	85.2	78.8	77	78.6	no data	Behavioral Risk Factor Surveillance System, 2022
Adults over 18 with no leisure-time physical activity (age-	18.2	15.5	15.9	20.4	20.6	0.0	64.8	90.2	15.2	88.6	no data	Behavioral Risk Factor Surveillance System, 2021
Cholesterol screening within past 5 years (%) (adults)	No data	Data unavailable	Data unavailable	Data unavailable	86.1	90.3	89.3		89			Behavioral Risk Factor Surveillance System, 2021
Communicable and Infectious Disease												
STI infection cases (per 100,000)												
Chlamydia	385.8	264.0	358.2	264.0	807.8	264.0	264.0	264.0	293.2	264.0	264.0	Prevention. 2021
Syphilis	10.6	9.8	6.9	25.8	25.8	6.9	6.9	6.9	9.9	6.9	6.9	Prevention. 2021
Gonorrhea	214.0	84.2	64.0	298.0	298.0	64.0	64.0	64.0	84.2	64.0	64.0	Prevention. 2021

HIV prevalence	385.8	288.2	234.1	832.2	832.2	234.1	234.1	234.1	288.2	234.1	234.1	Prevention. 2021
Tuberculosis (per 100,000)	2.2	2.7	1.7	4.6	4.6	1.7	1.7	1.7	2.7	1.7	1.7	Prevention. 2022
COVID-19												
Percent of Adults Fully Vaccinated	78.1	87.7	87.8	81.3	83.3	85.8	85.8	85.8	87.0	85.8	85.8	CDC - GRASP, 2018 - 2022
Estimated Percent of Adults Hesitant About Receiving COVID-	4.5	4.0	3.8	4.4	4.4	3.8	3.8	3.8	4.0	3.8	3.8	
Vaccine Coverage Index	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	
Substance Use												
Current cigarette smoking (%), age-adjusted	10.4	Data unavailable	Data unavailable	Data unavailable	11.8	6.9	10.6	7	6.7	10.6	no data	BRFSS, 2021
Binge drinking % (adults) , age-adjusted	17.2	Data unavailable	Data unavailable	Data unavailable	19	19.9	22.1	22.4	18.9	21	no data	BRFSS, 2022
Drug overdose (age-adjusted per 100,000 population)	32.7	Data unavailable	Data unavailable	Data unavailable				26.0		26.0	26.0	CDC- National Vital Statistics System, 2016-2020
Adults Age 18+ Binge Drinking in the Past 30 Days (Age-	17.9	18.2	18.8	17.7								Behavioral Risk Factor Surveillance System, 2021
Male Drug Overdose Mortality Rate (per 100,000)	48.3	32.6	38.5	51.0								
Female Drug Overdose Mortality Rate (per 100,000)	17.6	12.0	14.2	15.2								
Substance-related deaths (Age-adjusted rate per 100k)												Dashboard, 2024
Any substance	61.9	41.1	40.3	74.2	74.3	16.1	54.9	23.4	15.4	50.6	0.0	
Opioid-related deaths	33.7	20.1	21.8	45.0	45.4	10.9	38.3	*	*	18.5	0.0	
Alcohol-related deaths	29.1	20.4	18.6	30.2	29.6	*	30.1	*	7.5	25.9	0.0	
Stimulant-related deaths	23.0	13.6	13.6	35.3	37.6	*	24.4	0.0	*	*	0.0	
Substance-related ER visits (age-adjusted rate per 100K)												Dashboard, 2024
Any substance-related ER visits	1605.7	1246.4	1182.2	2674.7	2862.5	700.0	1231.6	754.1	665.7	1266.8	544.8	
Opioid-related ER visits	169.3	102.9	89.8	253.0	278.4	18.6	82.9	32.0	24.9	122.8	*	
Opioid-related EMS Incidents	248.8	176.3	138.6	379.2	395.9	87.0	161.6	37.4	59.6	120.2	55.3	
Alcohol-related ER visits	1235.6	962.1	929.9	2156.4	2312.2	529.2	982.1	628.6	459.5	1004.0	390.1	
Stimulant-related ER visits	15.7	13.6	9.9	29.2	34.5	*	*	*	*	18.4	0.0	
Substance Addiction Services												Dashboard, 2024
Individuals admitted to BSAS services (crude rate per 100k)	588.4	340.3	352.4	932.9	966.6	80.7	362.7	93.5	115.8	417.6	92.2	
Number of BSAS providers		201.0	88.0	231.0	217.0	5.0	1.0	3.0	3.0	9.0	0.0	
Number of clients of BSAS services (residents)		3702.0	1540.0	4681.0	4225.0	38.0	53.0	16.0	59.0	63.0	*	
Avg. distance to BSAS provider (miles)	17.0	17.0	19.0	11.0	11.0	17.0	20.0	30.0	23.0	17.0	18.0	
Buprenorphine RX's filled	9982.0	6002.1	7796.8	7972.3	7412.3	1487.6	8196.7	1339.9	2170.4	10423.6	2748.1	
Individuals who received buprenorphine RX's		508.3	668.1	764.1	744.2	150.3	666.3	121.5	275.5	860.5	252.1	
Naloxone kits received		35323.0	16008.0	34809.0	33510.0	551.0	124.0	135.0	335.0	480.0	40.0	
Naloxone kids: Opioid deaths Ratio		78.0	55.0	97.0	113.0	56.0	12.0	*	*	97.0	-	
Fentanyl test strips received		50130.0	21900.0	69000.0	66100.0	1600.0	3800.0	300.0	1430.0	1600.0	0.0	
Environmental Health												
Environmental Justice (%) (Centers for Disease Control and	56.6	72.4	55.9	97.8	98.3	100.0	100.0	44.5	91.4	33.1	34.2	Justice Health Criteria , Centers for Disease Control and
Lead screening %	68.0				67.0	54.0	78.0	76.0	62.0	79.0	84.0	Program (CLPPP), 2021Percentage of children age 9-47
Prevalence of Blood Lead Levels (per 1,000)	13.6				14.8	5.3	3.8	2.6	5.4	9.6	0.0	estimates, 2021 5-year annual average rate (2017-2021)
% of houses built before 1978	67.0				75.0	83.0	75.0	67.0	81.0	72.0	65.0	ACS 5-year estimates for housing, 2017 - 2021
Asthma Emergency Department Visits (Age-adjusted rate)	28.6				42.2	8.1	18.6	8.4	9.8	24.6	12.8	Analysis (CHIA), 2020
Pediatric Asthma Prevalence in K-8 Students (%) (per 100 K-8	9.9				14.4	6.9	9.8	6.2	7.2	9.3	11.1	MDPH BCEH, 2022-2023 school year
Age Adjusted Rates of Emergency Department Visit for Heat	7.6	5.5	7.0	5.2	5.0	0.0	NS	NS	NS	NS	0.0	Center for Health Information and Analysis, 2020
Air Quality Respiratory Hazard Index (EPA - National Air Toxics	0.3	0.3	0.3	0.4								EPA - National Air Toxics Assessment, 2018
Mental Health												
A. Suicide mortality rate (age-adjusted death rate per 100,000)	50.7	36.9	41.2	47.8	47.8	41.2	41.2	41.2	36.9	41.2	41.2	CDC-National Vital Statistics System, 2016-2021
Depression among adults (%), age-adjusted	21.6	Data unavailable	Data unavailable	Data unavailable	22.9	20	22.3	20.8	22.6	22.3	no data	Behavioral Risk Factor Surveillance System, 2022
Adults feeling socially isolated (%), age-adjusted	No data	Data unavailable	Data unavailable	Data unavailable	35.1	28.9	30.4	29	32.3	31.2	no data	Behavioral Risk Factor Surveillance System, 2022
Adults reporting a lack of social and emotional support (%), age-adjusted	No data	Data unavailable	Data unavailable	Data unavailable	25.6	18.9	20.2	18.3	21.1	21.7	no data	Behavioral Risk Factor Surveillance System, 2023
Adults experiencing frequent mental distress (%), age-adjusted	13.6	Data unavailable	Data unavailable	Data unavailable	17	13	15.6	12.9	13.2	15.7	no data	Behavioral Risk Factor Surveillance System, 2022

Adults Age 18+ with depression (crude %)	20.9	19.3	19.2	21.1	22.0	20.1	20.0	18.6	19.2	20.6	18.7	Behavioral Risk Factor Surveillance System, 2021
Adults age 18 and older who reported 14 or more days of poor	14.7	12.9	13.1	16.0	17.3	13.3	13.1	0.2	11.9	0.1	0.0	Behavioral Risk Factor Surveillance System, 2021
Youth experiences of harassment or bullying (allegations, rate	0.1	0.1	0.1	0.0	0.0	0.0	0.0		0.0			Collection, 2020-2021
Maternal and Child Health/Reproductive Health												
Infant Mortality Rate (per 1,000 live births)	4.0	3.0	3.0	5.0	5.0	3.0	3.0	3.0	3.0	3.0	3.0	County Health Rankings, 2015-2021
Low birth weight (%)	7.6	7.0	7.0	8.0	8.4	6.9	6.9	6.9	7.1	6.9	6.9	County Health Rankings, 2016-2022
Safety/Crime												
Property Crimes Offenses (#)												Massachusetts Crime Statistics, 2023
Burglary	10028.0				1265.0	45.0	4.0	21.0	62.0	18.0	11.0	
Larceny-theft	60647.0				9359.0	500.0	156.0	142.0	502.0	247.0	131.0	
Motor vehicle theft	7224.0				1200.0	35.0	8.0	7.0	11.0	23.0	7.0	
Arson	377.0				32.0	0.0	0.0	0.0	2.0	1.0	1.0	
Crimes Against Persons Offenses (#)												
Murder/non-negligent manslaughter	162.0				51.0	0.0	0.0	0.0	1.0	0.0	0.0	
Sex offenses	4365.0				372.0	9.0	5.0	17.0	16.0	7.0	3.0	
Assaults	72086.0				15157.0	173.0	112.0	80.0	214.0	172.0	60.0	
Human trafficking	0.0				9.0	0.0	0.0	0.0	0.0	0.0	0.0	
Hate Crimes Offenses (#)												
Race/Ethnicity/Ancestry Bias	222.0				82.0	1.0	1.0		9.0	0.0		
Religious Bias	88.0				23.0	1.0	0.0		6.0	1.0		
Sexual Oreintation Bias	80.0				36.0	1.0	0.0		1.0	0.0		
Gender Identity Bias	22.0				9.0	1.0	0.0		1.0	0.0		
Gender Bias	2.0				0.0	0.0	0.0		0.0	0.0		
Disability Bias	0.0				0.0	0.0	0.0		0.0	0.0		

2025 Massachusetts Community Health Equity Survey (Youth) - Data not available for all municipalities/neighborhoods in service area

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

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

			MASSACHUSETTS		Middlesex		Norfolk		Suffolk		Boston		Brookline		Needham	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Housing	Current living situation	No steady place	1908	1.30%	528	1.10%	*	*	*	*	*	*	*	*	*	*
		Worried about losing	1908	2.60%	528	2.70%	163	3.70%	186	4.80%	*	*	*	*	*	*
		Steady place	1908	95.10%	528	95.80%	163	95.70%	186	92.50%	70	98.60%	40	95.00%	109	96.30%
Housing	Issues in current housing	Yes, at least one	1830	24.50%	510	22.00%	155	15.50%	180	48.30%	68	36.80%	37	24.30%	106	11.30%
Basic Needs	Food insecurity, past month	Never	1963	87.80%	546	90.80%	164	93.90%	192	70.30%	72	83.30%	40	90.00%	110	94.50%
		Sometimes	1963	9.90%	546	7.00%	164	4.30%	192	25.00%	72	11.10%	*	*	*	*
		A lot	1963	2.30%	546	2.20%	*	*	192	4.70%	*	*	*	*	*	*
Basic Needs	Current internet access	No internet	1938	1.30%	538	0.90%	*	*	189	3.20%	*	*	*	*	*	*
		Does not work well	1938	6.60%	538	5.20%	*	*	189	14.80%	71	8.50%	*	*	*	*
		Works well	1938	92.20%	538	93.90%	164	98.20%	189	82.00%	71	90.10%	40	95.00%	110	99.10%
Neighborhood	Able to get where you need to go	Somewhat or strongly disagree	1864	2.50%	516	1.60%	*	*	184	3.80%	*	*	*	*	*	*
		Somewhat agree	1864	14.60%	516	10.30%	160	6.30%	184	29.30%	69	21.70%	39	12.80%	*	*
		Strongly agree	1864	82.80%	516	88.20%	160	93.10%	184	66.80%	69	76.80%	39	87.20%	108	97.20%
Neighborhood	Experienced neighborhood violence, lifetime	Never	1833	65.00%	504	73.80%	159	79.20%	182	30.20%	68	35.30%	39	74.40%	107	81.30%
		Rarely	1833	22.80%	504	19.20%	159	16.40%	182	31.90%	68	36.80%	39	20.50%	107	15.00%
		Somewhat often	1833	8.50%	504	4.60%	159	3.80%	182	30.80%	68	19.10%	*	*	*	*
		Very often	1833	3.70%	504	2.40%	*	*	182	7.10%	68	8.80%	*	*	*	*
Safety & Support	Have someone to talk to if needed help	No	1739	3.90%	469	3.20%	*	*	177	4.00%	*	*	*	*	*	*
		Yes, adult in home	1739	80.50%	469	83.80%	152	86.80%	177	70.10%	66	71.20%	38	84.20%	101	91.10%
		Yes, adult outside home	1739	37.30%	469	36.20%	152	35.50%	177	39.00%	66	33.30%	38	50.00%	101	28.70%
		Yes, friend or non-adult family	1739	43.00%	469	44.80%	152	39.50%	177	39.00%	66	39.40%	38	44.70%	101	34.70%
Safety & Support	Feel safe with my family/caregivers	Not at all	1768	1.00%	473	1.70%	*	*	*	*	*	*	*	*	*	*
		Somewhat	1768	7.70%	473	6.80%	155	4.50%	178	11.20%	66	7.60%	*	*	*	*
		Very much	1768	91.30%	473	91.50%	155	94.80%	178	87.60%	66	90.90%	38	92.10%	104	99.00%

			MASSACHUSETTS		Middlesex		Norfolk		Suffolk		Boston		Brookline		Needham	
Safety & Support	Feel I belong at school	Not at all	1760	5.90%	472	5.50%	*	*	179	4.50%	66	10.60%	*	*	*	*
		Somewhat	1760	29.10%	472	28.60%	155	21.90%	179	35.80%	66	34.80%	38	28.90%	104	16.30%
		Very much	1760	65.00%	472	65.90%	155	76.80%	179	59.80%	66	54.50%	38	65.80%	104	83.70%
Safety & Support	Feel my family/caregivers support my interests	Not at all	1745	2.40%	467	3.20%	*	*	178	2.80%	*	*	*	*	*	*
		Somewhat	1745	17.10%	467	15.40%	153	12.40%	178	27.00%	66	27.30%	37	24.30%	103	6.80%
		Very much	1745	80.50%	467	81.40%	153	86.90%	178	70.20%	66	71.20%	37	73.00%	103	93.20%
Safety & Support	Did errands/chores for family, past month	Yes	1761	68.20%	471	66.50%	155	63.20%	179	70.40%	66	57.60%	38	71.10%	104	58.70%
Safety & Support	Helped family financially, past month	Yes	1761	7.20%	471	5.30%	155	3.90%	179	22.30%	66	18.20%	*	*	*	*
Safety & Support	Provided emotional support to caregiver, past month	Yes	1761	21.20%	471	18.30%	155	20.00%	179	24.60%	66	24.20%	38	39.50%	104	12.50%
Safety & Support	Dealt with fights in the family, past month	Yes	1761	11.90%	471	13.40%	155	10.30%	179	11.20%	66	9.10%	38	13.20%	104	8.70%
Safety & Support	Took care of a sick/disabled family member, past month	Yes	1761	7.50%	471	6.40%	155	5.80%	179	7.80%	*	*	*	*	104	4.80%
Safety & Support	Took care of children in family, past month	Yes	1761	14.20%	471	13.00%	155	9.70%	179	24.00%	66	18.20%	*	*	104	9.60%
Safety & Support	Helped family in ANY way, past month	Yes	1761	75.10%	471	72.20%	155	68.40%	179	79.90%	66	66.70%	38	84.20%	104	60.60%
Safety & Support	Experienced intimate partner violence	Ever	1589	13.10%	442	8.60%	122	9.00%	157	15.30%	59	8.50%	35	17.10%	*	*
		In past year	1567	7.80%	440	5.20%	122	4.10%	154	9.10%	*	*	*	*	*	*
Safety & Support	Experienced household violence	Ever	1536	14.20%	420	11.00%	118	7.60%	152	12.50%	58	10.30%	*	*	72	8.30%
		In past year	1519	5.50%	417	5.30%	118	4.20%	148	4.10%	*	*	*	*	*	*
Safety & Support	Experienced sexual violence	Ever	1558	9.20%	430	7.70%	121	6.60%	150	10.00%	*	*	*	*	*	*
		In past year	1551	3.10%	428	2.10%	*	*	*	*	*	*	*	*	*	*
Safety & Support	Experienced discrimination	Ever	1674	45.20%	446	44.80%	152	35.50%	171	55.00%	61	47.50%	37	56.80%	102	25.50%
		In past year	1674	19.60%	446	19.50%	152	15.80%	171	15.80%	61	21.30%	37	27.00%	102	7.80%
Employment	Worked for pay, past year	No	1652	51.50%	433	56.10%	149	62.40%	170	51.20%	62	66.10%	37	40.50%	99	68.70%
		Yes, <10 hours per week	1652	18.10%	433	21.70%	149	22.80%	170	12.90%	62	11.30%	37	24.30%	99	23.20%
		Yes, 11-19 hours per week	1652	13.30%	433	12.20%	149	7.40%	170	14.10%	62	8.10%	37	16.20%	*	*

			MASSACHUSETTS		Middlesex		Norfolk		Suffolk		Boston		Brookline		Needham	
Employment	Worked for pay in the past year	Yes, 20-34 hours per week	1652	10.30%	433	6.50%	*	*	170	16.50%	62	12.90%	*	*	*	*
		Yes, >35 hours per week	1652	6.80%	433	3.50%	149	4.70%	170	5.30%	*	*	*	*	*	*
Education	Educational challenges, past year	None of these	1484	66.80%	386	67.60%	142	77.50%	159	67.90%	56	73.20%	36	66.70%	94	84.00%
		Frequent absences	1484	7.60%	386	8.30%	*	*	159	8.20%	*	*	*	*	*	*
		Needed more support in school	1484	7.00%	386	6.50%	142	3.50%	159	8.20%	*	*	*	*	*	*
		Needed more support outside school	1484	6.30%	386	8.00%	*	*	159	8.20%	*	*	*	*	*	*
		Safety concerns	1484	5.10%	386	5.20%	*	*	*	*	*	*	*	*	*	*
		Temperature in classroom	1484	18.50%	386	16.60%	142	18.30%	159	17.60%	56	16.10%	36	25.00%	94	13.80%
Education	Hurt or harrassed by school staff, past year	Never	1503	87.70%	391	90.50%	143	93.00%	160	88.10%	56	89.30%	37	86.50%	94	94.70%
		Once or twice	1503	9.10%	391	6.90%	143	6.30%	160	8.10%	*	*	*	*	94	5.30%
		Monthly	1503	1.60%	391	1.30%	*	*	*	*	*	*	*	*	*	*
		Daily	1503	1.60%	391	1.30%	*	*	*	*	*	*	*	*	*	*
Education	Helpful school resources provided	College-preparation	1459	57.90%	382	61.30%	142	64.10%	156	55.80%	54	50.00%	37	73.00%	93	64.50%
		Extracurricular activities	1459	74.40%	382	82.20%	142	83.10%	156	60.30%	54	63.00%	37	89.20%	93	79.60%
		Guidance conselour	1459	58.80%	382	59.40%	142	66.90%	156	62.80%	54	59.30%	37	70.30%	93	63.40%
		Programs to reduce bullying, violence, racism	1459	19.10%	382	24.30%	142	19.00%	156	13.50%	54	24.10%	*	*	93	21.50%
Healthcare Access	Unmet need for short-term illness care (among those needing care)	Yes	473	3.50%	139	5.00%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those needing care)	Yes	320	3.70%	106	5.70%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those needing care)	Yes	125	10.70%	*	*	*	*	*	*	*	*	*	*	*	*

			MASSACHUSETTS		Middlesex		Norfolk		Suffolk		Boston		Brookline		Needham	
Healthcare Access	Unmet need for home and community-based services (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those needing care)	Yes	278	16.50%	72	20.80%	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those needing care)	Yes	102	10.10%	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those needing care)	Yes	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those needing care)	Yes	62	7.90%	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	ANY unmet heath care need, past year (among those needing any care)	Yes	857	10.30%	234	10.70%	67	7.50%	70	14.30%	*	*	*	*	*	*
Mental Health	Psychological distress, past month	Low	1376	22.10%	362	22.10%	101	22.80%	131	22.90%	48	29.20%	34	20.60%	57	21.10%
		Medium	1376	33.00%	362	34.00%	101	38.60%	131	38.20%	48	39.60%	34	41.20%	57	40.40%
		High	1376	18.40%	362	20.20%	101	21.80%	131	15.30%	48	12.50%	34	23.50%	57	22.80%
		Very high	1376	26.60%	362	23.80%	101	16.80%	131	23.70%	48	18.80%	34	14.70%	57	15.80%
Mental Health	Feel isolated from others	Usually or always	1517	14.80%	394	14.70%	136	6.60%	161	18.00%	56	16.10%	*	*	*	*
Mental Health	Suicide ideation, past yeard	Yes	1338	14.60%	352	12.80%	104	13.50%	138	7.20%	*	*	*	*	61	11.50%
Substance Use	Tobacco use, past month	Yes	1499	8.00%	390	6.70%	136	3.70%	163	11.70%	58	8.60%	*	*	*	*
Substance Use	Alcohol use, past month	Yes, past month	1484	8.00%	382	8.40%	134	8.20%	160	5.60%	*	*	*	*	89	6.70%
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%	*	*	*	*	160	3.10%	*	*	*	*	*	*
Substance Use	Non-medical cannabis use, past month	Yes, past month	1484	7.10%	382	7.30%	134	5.20%	159	9.40%	55	9.10%	*	*	*	*

			MASSACHUSETTS		Middlesex		Norfolk		Suffolk		Boston		Brookline		Needham	
Substance Use	Non-medical cannabis use, past year	Yes, past year	1487	10.80%	383	9.40%	134	7.50%	160	15.00%	56	14.30%	*	*	89	5.60%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Cocaine/crack use, past year	Yes	1487	0.40%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/ Ketamine use, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	1487	0.30%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	1487	0.70%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	1487	0.60%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	1487	1.00%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	OCT drug use, non-medical, past year	Yes	1487	0.50%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	1487	2.20%	*	*	*	*	*	*	*	*	*	*	*	*
Emerging Issues	Someone close died from COVID-19	Yes	1445	7.30%	376	8.00%	*	*	160	9.40%	*	*	*	*	*	*
		Not sure	1445	5.70%	376	6.40%	128	5.50%	160	10.00%	*	*	*	*	82	8.50%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years1	Yes	767	25.40%	190	22.10%	70	21.40%	94	27.70%	36	19.40%	*	*	50	24.00%
Emerging Issues	Flooding in home or on street, past 5 years1	Yes	767	5.50%	190	7.40%	70	7.10%	*	*	*	*	*	*	50	10.00%
Emerging Issues	More ticks or mosquitoes, past 5 years1	Yes	767	20.20%	190	20.50%	70	22.90%	94	12.80%	*	*	*	*	50	22.00%
Emerging Issues	Power outages, past 5 years1	Yes	767	25.40%	190	26.80%	70	20.00%	94	23.40%	36	33.30%	*	*	50	20.00%
Emerging Issues	School cancellation due to weather, past 5 years1	Yes	767	39.40%	190	38.90%	70	21.40%	94	24.50%	36	36.10%	*	*	50	22.00%

			MASSACHUSETTS		Middlesex		Norfolk		Suffolk		Boston		Brookline		Needham	
Emerging Issues	Unable to work due to weather, past 5 years1	Yes	767	7.60%	190	6.80%	*	*	94	6.40%	*	*	*	*	*	*
Emerging Issues	Extreme temperatures at home, work, school, past 5 years1	Yes	767	33.30%	190	28.90%	70	31.40%	94	36.20%	36	27.80%	*	*	50	26.00%
Emerging Issues	Other climate impact, past 5 years1	Yes	767	0.90%	*	*	*	*	*	*	*	*	*	*	*	*
Emerging Issues	ANY climate impact, past 5 years1	Yes	767	59.70%	190	56.30%	70	48.60%	94	56.40%	36	52.80%	*	*	50	48.00%

2025 Massachusetts Community Health Equity Survey (Adults) Data not available in all municipalities/neighborhoods in service area

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			MASSACHUSETTS		MIDDLESEX		NORFOLK		SUFFOLK		Boston		Brookline		Dedham		Needham		Newton	
Topic	**Question**	**Response**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Housing	Current living situation	No steady place	14888	2.50%	3353	1.70%	1313	1.10%	1279	5.70%	1124	5.50%	468	1.10%	*	*	*	*	*	*
		Worried about losing	14888	8.00%	3353	6.50%	1313	6.60%	1279	9.30%	1124	9.10%	468	8.10%	*	*	*	*	310	3.90%
		Steady place	14888	89.30%	3353	91.60%	1313	92.10%	1279	84.50%	1124	84.90%	468	90.60%	34	94.10%	75	98.70%	310	95.50%
Housing	Issues in current housing	Yes, at least one	11103	37.00%	2437	39.10%	1006	31.70%	965	45.10%	845	43.70%	361	38.00%	*	*	55	30.90%	229	34.10%
Basic Needs	Trouble paying for childcare/school	Yes	7486	4.60%	1689	4.70%	630	4.00%	665	5.00%	583	5.00%	216	3.70%	*	*	*	*	156	3.80%
Basic Needs	Trouble paying for food or groceries (including formula or baby food)	Yes	7486	18.80%	1689	12.20%	630	11.70%	665	21.20%	583	19.90%	216	10.60%	*	*	*	*	156	5.10%
Basic Needs	Trouble paying for health care	Yes	7486	15.00%	1689	13.30%	630	10.30%	665	16.10%	583	16.00%	216	7.40%	*	*	*	*	156	6.40%
Basic Needs	Trouble paying for housing	Yes	7486	19.40%	1689	15.60%	630	11.10%	665	22.70%	583	22.00%	216	8.80%	*	*	*	*	156	8.30%
Basic Needs	Trouble paying for technology	Yes	7486	8.40%	1689	6.00%	630	4.90%	665	9.30%	583	8.90%	216	4.20%	*	*	*	*	156	3.80%
Basic Needs	Trouble paying for transportation	Yes	7486	12.60%	1689	9.40%	630	7.60%	665	14.60%	583	14.10%	216	5.10%	*	*	*	*	156	3.80%
Basic Needs	Trouble paying for utilities	Yes	7486	17.20%	1689	11.90%	630	9.40%	665	16.10%	583	14.80%	216	5.10%	*	*	*	*	156	5.10%
Basic Needs	Trouble paying for ANY basic needs	Yes	7486	35.20%	1689	27.10%	630	24.90%	665	40.50%	583	37.90%	216	19.00%	*	*	*	*	156	12.20%
Basic Needs	Applied for/received economic assisstance	Yes	14928	20.30%	3366	12.40%	1317	13.40%	1278	34.30%	1122	34.40%	461	10.20%	*	*	75	6.70%	313	5.80%
Basic Needs	End of month finances	Not enough money	13814	16.50%	3141	11.00%	1201	11.00%	1191	19.80%	1054	18.90%	429	9.10%	33	15.20%	*	*	282	7.40%
		Just enough money	13814	31.10%	3141	24.90%	1201	28.10%	1191	40.00%	1054	40.30%	429	21.40%	33	18.20%	64	14.10%	282	17.40%
		Money left over	13814	52.40%	3141	64.10%	1201	60.90%	1191	40.20%	1054	40.80%	429	69.50%	33	66.70%	64	81.30%	282	75.20%
Basic Needs	Current internet access	No internet	11425	3.00%	2514	1.60%	1030	0.90%	981	5.50%	861	4.90%	*	*	*	*	*	*	*	*
		Does not work well	11425	9.30%	2514	7.00%	1030	6.10%	981	9.00%	861	8.10%	368	6.00%	*	*	*	*	239	2.10%
		Works well	11425	87.70%	2514	91.50%	1030	93.00%	981	85.50%	861	87.00%	368	92.90%	*	*	57	100.00%	239	97.50%
Neighborhood	Able to get where you need to go	Somewhat or strongly disagree	11064	7.00%	2521	5.50%	968	4.90%	965	6.30%	840	6.30%	326	3.10%	*	*	*	*	226	5.80%
		Somewhat agree	11064	22.00%	2521	21.70%	968	17.30%	965	19.50%	840	18.10%	326	10.70%	*	*	51	19.60%	226	17.30%
		Strongly agree	11064	71.00%	2521	72.80%	968	77.90%	965	74.20%	840	75.60%	326	86.20%	*	*	51	72.50%	226	77.00%
Neighborhood	Experienced neighborhood violence, lifetime	Never	11008	58.60%	2509	63.50%	967	64.60%	960	43.90%	835	46.90%	327	67.90%	*	*	51	70.60%	225	69.80%
		Rarely	11008	28.90%	2509	28.60%	967	28.70%	960	31.90%	835	31.70%	327	29.10%	*	*	51	27.50%	225	27.10%
		Somewhat often	11008	9.10%	2509	5.80%	967	5.50%	960	15.00%	835	12.80%	327	2.80%	*	*	*	*	225	2.20%

			MASSACHUSETTS		MIDDLESEX		NORFOLK		SUFFOLK		Boston		Brookline		Dedham		Needham		Newton	
		Very often	11008	3.40%	2509	2.10%	967	1.10%	960	9.30%	835	8.50%	*	*	*	*	*	*	*	*
Safety & Support	Can count on someone for favors	Yes	14393	80.60%	3236	83.50%	1285	84.10%	1256	75.20%	1103	75.60%	461	84.60%	33	87.90%	72	83.30%	294	90.80%
		Not sure	14393	6.50%	3236	6.60%	1285	5.60%	1256	5.80%	1103	5.40%	461	5.00%	*	*	72	8.30%	294	5.40%
Safety & Support	Can count on someone to care for you if sick	Yes	14366	73.20%	3233	75.50%	1281	75.40%	1252	68.20%	1098	68.50%	459	73.20%	32	75.00%	71	76.10%	293	80.50%
		Not sure	14366	10.20%	3233	10.80%	1281	9.90%	1252	10.10%	1098	9.70%	459	11.10%	*	*	71	12.70%	293	9.90%
Safety & Support	Can count on someone to lend money	Yes	14325	64.60%	3226	72.50%	1281	73.00%	1242	60.00%	1091	61.70%	460	76.30%	33	66.70%	71	80.30%	293	84.30%
		Not sure	14325	12.90%	3226	11.60%	1281	10.80%	1242	12.50%	1091	12.20%	460	8.30%	33	15.20%	71	7.00%	293	7.20%
Safety & Support	Can count on someone for support with family trouble	Yes	14336	79.20%	3222	82.70%	1277	83.60%	1250	77.20%	1099	77.40%	458	84.70%	33	78.80%	71	84.50%	292	90.80%
		Not sure	14336	7.00%	3222	6.80%	1277	6.10%	1250	6.10%	1099	5.90%	458	6.10%	*	*	71	8.50%	292	4.10%
Safety & Support	Can count on someone to help find housing	Yes	14247	62.30%	3212	66.10%	1266	66.70%	1247	60.40%	1093	62.10%	451	66.70%	33	69.70%	69	59.40%	291	69.40%
		Not sure	14247	16.30%	3212	17.40%	1266	16.40%	1247	13.30%	1093	13.10%	451	16.90%	33	15.20%	69	24.60%	291	20.60%
Safety & Support	Experienced intimate partner violence	Ever	13621	29.70%	3068	26.50%	1207	23.80%	1174	26.90%	1036	25.80%	431	21.60%	33	30.30%	70	18.60%	284	22.50%
		In past year	13359	4.50%	3029	3.20%	1195	3.20%	1152	5.20%	1018	4.70%	430	2.10%	*	*	*	*	283	2.10%
Safety & Support	Experienced sexual violence	Ever	13628	21.00%	3073	22.60%	1211	18.10%	1194	21.30%	1049	22.00%	432	16.40%	33	24.20%	66	12.10%	283	23.30%
		In past year	13593	1.40%	3070	1.20%	1210	0.40%	1190	2.20%	1046	2.20%	*	*	*	*	*	*	283	1.80%
Safety & Support	Experienced discrimination	Ever	14130	55.20%	3160	59.10%	1256	57.60%	1235	59.20%	1084	57.80%	452	61.90%	34	64.70%	71	50.70%	287	60.60%
		In past year	14130	18.00%	3160	17.20%	1256	16.80%	1235	22.00%	1084	21.30%	452	12.60%	34	23.50%	71	16.90%	287	14.30%
Employment	Have multiple jobs (among all workers)	Yes	6896	20.90%	1542	19.30%	563	21.00%	600	20.50%	536	20.00%	182	20.90%	*	*	*	*	144	19.40%
Employment	Location of work (among all workers)	At home only	9173	7.50%	2091	10.40%	771	10.00%	762	6.60%	678	6.60%	238	14.70%	*	*	39	12.80%	180	16.10%
		Outside home only	9173	54.60%	2091	42.40%	771	43.70%	762	50.10%	678	49.70%	238	29.00%	*	*	39	35.90%	180	32.80%
		Both at home/outside home	9173	37.40%	2091	46.60%	771	46.00%	762	42.90%	678	43.20%	238	55.50%	*	*	39	51.30%	180	51.10%
Employment	Paid sick leave at work (among all workers)	Yes	6903	75.30%	1543	76.80%	564	74.30%	599	75.60%	534	75.80%	182	64.80%	*	*	*	*	142	76.10%
		Not sure	6903	4.20%	1543	3.60%	564	4.40%	599	4.00%	534	3.60%	182	5.50%	*	*	*	*	*	*
Healthcare Access	Reported chronic condition	Yes	6821	65.20%	1509	63.00%	635	65.00%	578	64.50%	510	64.50%	229	63.80%	*	*	37	62.20%	131	55.70%
Healthcare Access	Unmet need for short-term illness care (among those who needed this care)	Yes	3455	7.60%	849	5.90%	331	6.00%	281	11.00%	253	11.10%	135	5.20%	*	*	*	*	*	*
Healthcare Access	Unmet need for injury care (among those who needed this care)	Yes	1674	9.00%	443	7.70%	152	4.60%	116	7.80%	103	7.80%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for ongoing health condition (among those who needed this care)2	Yes	3052	9.00%	713	6.60%	275	8.70%	290	6.90%	270	6.70%	94	6.40%	*	*	*	*	55	9.10%

			MASSACHUSETTS		MIDDLESEX		NORFOLK		SUFFOLK		Boston		Brookline		Dedham		Needham		Newton	
Healthcare Access	Unmet need for home and community-based services (among those who needed this care)2	Yes	334	25.40%	69	34.80%	40	27.50%	48	16.70%	44	18.20%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for mental health care (among those who needed this care)2	Yes	2441	21.10%	596	17.40%	222	21.60%	220	21.80%	198	21.20%	85	16.50%	*	*	*	*	*	*
Healthcare Access	Unmet need for sexual and reproductive health care (among those who needed this care)	Yes	998	7.00%	243	6.60%	77	10.40%	116	6.90%	104	5.80%	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for substance use or addiction treatment (among those who needed this care)	Yes	109	13.90%	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Healthcare Access	Unmet need for other type of care (among those who needed this care)2	Yes	760	12.80%	174	11.50%	72	11.10%	53	24.50%	41	17.10%	*	*	*	*	*	*	*	*
Healthcare Access	ANY unmet health care need, past year (among those who needed any care)	Yes	6941	15.20%	1655	12.60%	635	13.70%	634	15.80%	567	15.20%	237	11.40%	*	*	*	*	145	7.60%
Healthcare Access	Telehealth visit, past year	One or more visit	6747	51.20%	1504	58.80%	636	56.10%	579	51.60%	511	52.10%	233	62.20%	*	*	39	61.50%	129	62.00%
		Offered, didn't have	6747	7.00%	1504	7.60%	636	6.90%	579	7.80%	511	8.00%	233	6.90%	*	*	*	*	129	8.50%
		Not offered	6747	22.10%	1504	19.00%	636	20.80%	579	20.60%	511	20.70%	233	16.70%	*	*	39	20.50%	129	17.80%
		No healthcare visits	6747	20.30%	1504	14.80%	636	16.70%	579	20.60%	511	19.80%	233	14.60%	*	*	39	12.80%	129	11.60%
Healthcare Access	Child had unmet mental health care need (among parents)	Yes	4184	20.20%	1016	19.20%	394	18.80%	259	18.10%	219	18.30%	138	17.40%	*	*	*	*	115	22.60%
		Not sure	4184	3.80%	1016	3.60%	394	4.60%	259	5.00%	219	5.00%	138	5.10%	*	*	*	*	115	4.30%
Mental Health	Psychological distress, past month	Low	13267	36.80%	3024	38.70%	1183	40.20%	1146	34.80%	1014	36.50%	428	40.40%	32	34.40%	67	43.30%	271	42.80%
		Medium	13267	32.00%	3024	34.30%	1183	35.20%	1146	29.50%	1014	28.60%	428	41.10%	32	40.60%	67	44.80%	271	35.80%
		High	13267	13.90%	3024	13.70%	1183	11.70%	1146	15.80%	1014	15.50%	428	10.00%	*	*	*	*	271	10.70%
		Very high	13267	17.30%	3024	13.40%	1183	12.80%	1146	19.90%	1014	19.40%	428	8.40%	32	18.80%	*	*	271	10.70%
Mental Health	Feel isolated from others	Usually or always	10237	13.00%	2311	10.90%	906	9.70%	905	11.60%	789	11.00%	312	7.70%	*	*	*	*	208	7.20%
Mental Health	Suicide ideation, past year	Yes	13036	7.40%	2981	7.00%	1168	4.70%	1119	6.80%	985	7.00%	423	2.80%	*	*	*	*	266	6.80%
Substance Use	Tobacco use, past month	Yes	10305	14.10%	2294	8.40%	908	6.30%	915	15.00%	808	14.20%	339	2.90%	*	*	*	*	219	5.00%
Substance Use	Alcohol use, past month	Yes, past month	13463	49.60%	3027	56.30%	1209	52.10%	1187	40.20%	1042	41.00%	438	55.00%	32	50.00%	70	62.90%	276	62.00%
Substance Use	Medical cannabis use, past month	Yes, past month	13607	6.40%	3057	4.40%	1221	4.40%	1192	3.90%	1047	3.20%	441	3.40%	*	*	*	*	277	5.10%
Substance Use	Medical cannabis use, past year	Yes, past year	13626	7.40%	3061	5.40%	1224	5.00%	1195	4.80%	1049	4.00%	442	4.10%	*	*	*	*	277	6.10%
Substance Use	Non-medical cannabis use, past month	Yes, past month	13612	13.80%	3058	11.20%	1223	10.80%	1195	14.90%	1049	15.40%	442	9.70%	33	21.20%	70	10.00%	277	8.70%
Substance Use	Non-medical cannabis use, past year	Yes, past year	13626	18.00%	3061	16.60%	1224	13.20%	1195	20.60%	1049	21.50%	442	13.60%	33	21.20%	70	14.30%	277	13.00%
Substance Use	Amphetamine/methamphetamine use, past year	Yes	13626	0.50%	3061	0.40%	*	*	1195	0.70%	1049	0.70%	*	*	*	*	*	*	*	*

			MASSACHUSETTS		MIDDLESEX		NORFOLK		SUFFOLK		Boston		Brookline		Dedham		Needham		Newton	
Substance Use	Cocaine/crack use, past year	Yes	13626	1.20%	3061	0.70%	*	*	1195	1.10%	1049	0.90%	*	*	*	*	*	*	*	*
Substance Use	Ecstasy/MDMA/LSD/Ketamine use, past year	Yes	13626	0.80%	3061	0.80%	1224	0.40%	1195	1.50%	1049	1.30%	*	*	*	*	*	*	*	*
Substance Use	Fentanyl use, pasy year	Yes	13626	0.60%	*	*	*	*	1195	0.50%	1049	0.50%	*	*	*	*	*	*	*	*
Substance Use	Heroin use, past year	Yes	13626	0.60%	3061	0.30%	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Opioid use, not prescribed, past year	Yes	13626	0.80%	3061	0.30%	*	*	1195	0.70%	1049	0.80%	*	*	*	*	*	*	*	*
Substance Use	Opiod use, not used as prescribed, past year	Yes	13626	0.60%	3061	0.50%	*	*	1195	0.80%	1049	0.90%	*	*	*	*	*	*	*	*
Substance Use	Prescription drugs use, non-medical, past year	Yes	13626	1.70%	3061	1.20%	1224	1.30%	1195	1.30%	1049	1.10%	442	1.40%	*	*	*	*	277	2.20%
Substance Use	OCT drug use, non-medical, past year	Yes	13626	0.80%	3061	0.60%	1224	0.70%	*	*	*	*	*	*	*	*	*	*	*	*
Substance Use	Psilocybin use, past year	Yes	13626	2.30%	3061	1.80%	1224	1.10%	1195	2.40%	1049	2.40%	442	1.60%	*	*	*	*	277	1.80%
Emerging Issues	COVID-19 vaccinatination, past year	Yes	6729	67.80%	1506	76.40%	636	78.50%	568	68.10%	501	69.90%	239	90.40%	*	*	38	84.20%	126	85.70%
		Not sure	6729	3.60%	1506	3.30%	636	2.50%	568	3.70%	501	3.00%	239	2.50%	*	*	*	*	*	*
Emerging Issues	Ever had long COVID (among those who had COVID-19)	Yes	6196	22.00%	1445	17.90%	554	15.50%	475	21.70%	413	20.80%	186	12.40%	*	*	*	*	141	11.30%
Emerging Issues	Felt unwell due to poor air quality/heat/allergies, past 5 years	Yes	10422	37.40%	2312	40.00%	902	38.50%	938	38.90%	827	39.90%	337	40.90%	*	*	52	34.60%	218	41.30%
Emerging Issues	Flooding in home or on street, past 5 years	Yes	10422	11.00%	2312	11.90%	902	10.90%	938	9.80%	827	9.80%	337	11.60%	*	*	*	*	218	17.00%
Emerging Issues	More ticks or mosquitoes, past 5 years	Yes	10422	32.20%	2312	35.20%	902	23.90%	938	16.70%	827	17.30%	337	22.30%	*	*	52	28.80%	218	26.60%
Emerging Issues	Power outages, past 5 years	Yes	10422	24.50%	2312	25.60%	902	20.40%	938	14.10%	827	14.30%	337	18.40%	*	*	52	15.40%	218	22.00%
Emerging Issues	School cancellation due to weather, past 5 years	Yes	10422	17.60%	2312	19.20%	902	15.20%	938	12.00%	827	12.20%	337	16.30%	*	*	52	19.20%	218	24.80%
Emerging Issues	Unable to work due to weather, past 5 years	Yes	10422	14.80%	2312	14.60%	902	10.90%	938	13.10%	827	13.50%	337	9.80%	*	*	*	*	218	11.90%
Emerging Issues	Extreme temperatures at home, work, school, past 5 years	Yes	10422	28.30%	2312	32.40%	902	24.50%	938	29.20%	827	29.70%	337	29.10%	*	*	52	21.20%	218	33.00%
Emerging Issues	Other climate impact, past 5 years	Yes	10422	1.70%	2312	1.70%	902	1.90%	938	1.50%	827	1.50%	337	1.50%	*	*	*	*	218	2.30%
Emerging Issues	ANY climate impact, past 5 years	Yes	10422	67.20%	2312	72.30%	902	63.30%	938	59.30%	827	59.30%	337	64.10%	*	*	52	63.50%	218	71.10%

Appendix C: Community Assets and Resources

City/Community	Organization Type	Organization Name	Website	Phone Number
Roslindale	Fitness/Wellness Centers	BCYF Roslindale	https://roslindalecc.weebly.com/hours-and-directions.html	(617) 635-5185
	Health Care and Behavioral Health Providers	Greater Roslindale Medical & Dental Center (GRMDC)	https://www.roslindale.org/	(617) 323-4440
	Aging Service Providers	ETHOS	https://www.ethocare.org/	(617) 522-6700
	Aging Service Providers	City of Boston - Age Strong Commission	https://www.boston.gov/departments/age-strong-commission	(617) 635-4335
	Food Assistance	Roslindale Food Collective	https://www.roslindalefoodcollective.org/	(857) 829-0111
Dedham	Housing	Dedham Housing Authority	http://dedhamhousing.org/	(781) 326-3543
	Transportation	CareCab	https://www.dedham-ma.gov/town-departments/health/carecab	(781) 805-5712
	Food Assistance	Dedham Food Pantry	https://dedhamfoodpantry.org/	(781) 269-1541
	Aging Service Providers	Dedham Council on Aging	https://www.dedham-ma.gov/town-departments/council-on-aging	(781) 751-9495
Brookline	Health Care and Behavioral Health Providers	Bournewood Health Systems	https://www.bournewood.com/	(888) 553-5812
	Health Care and Behavioral Health Providers	The Brookline Center *for* Community Mental Health	https://www.brooklinecenter.org/find-help/help-adults-elders/	(617) 277-8107
	Housing	Brookline Housing Authority	https://www.brooklinehousing.org/	(617) 277-2022
	Transportation	BSC Medical Transportation	https://www.brooklineseniorcenter.org/services/transportation/	617) 879-4878
	Food Assistance	Brookline Food Pantry	https://brooklinefoodpantry.org/	(617) 800-5339
	Fitness/Wellness Centers	Brookline Senior Center Fitness Center	https://www.brooklinema.gov/1064/Fitness-Center	(617) 730-2106
	Aging Service Providers	Brookline Council on Aging	https://www.brooklinema.gov/245/Council-on-Aging	(617) 730-2777
Needham	Health Care and Behavioral Health Providers	LifeStance Health	https://lifestance.com/location/needham-ma-175-highland-ave/	(781) 474-5280
	Housing	Needham Housing Authority	https://needhamhousing.org/	(781) 444-3011
	Transportation	Ride Match	https://massridematch.org/provider-details/?id=2901	
	Food Assistance	Needham Community Council Food Pantry	https://needhamcouncil.org/food-pantry/	(781) 444-2415
	Aging Service Providers	Needham Council on Aging	https://www.needhamma.gov/519/Council-on-Aging	(781) 455-7555
Westwood	Health Care and Behavioral Health Providers	Mass General Brigham Healthcare Center (Westwood)	https://www.brighamandwomens.org/westwood-health-care-center/brigham-and-womens-health-care-center-westwood	(877) 937-8128
	Housing	Westwood Housing Authority/Westwood Affordable Housing Associates Inc.	https://www.townhall.westwood.ma.us/government/boards-committees/westwood-housing-authority	(781) 329-5380
	Food Assistance	Westwood Food Pantry	http://www.westwoodfoodpantry.org/	(781) 269-2008
	Aging Service Providers	Westwood Council on Aging	https://www.townhall.westwood.ma.us/government/boards-committees/council-on-aging	(781) 329-8799
Newton	Health Care and Behavioral Health Providers	Serenity Care PACE	https://serenitypace.org/	(617) 699-5815
	Housing	Newton Housing Authority	http://www.newtonhousing.org/	(617) 552-5501
	Transportation	GoGo Newton Transportation System	https://www.newtonma.gov/government/planning/gogo	(617) 796-1000
	Food Assistance	Newton Food Pantry	https://newtonfoodpantry.org/	(617) 796-1233
	Food Assistance	Centre Street Food Pantry	https://www.centrestfoodpantry.org/	(617) 340-9554
	Aging Service Providers	Newton Council on Aging	https://www.newtonma.gov/government/seniors	(617) 796-1660

Chestnut Hill	Health Care and Behavioral Health Providers	Mass General Brigham Healthcare Center (Chestnut Hill)	https://www.brighamandwomens.org/chestnut-hill-health-care-center/clinical-services-directory-chestnut-hill-care-center	1-800-294-9999
	Health Care and Behavioral Health Providers	Temple Health - Chestnut Hill Hospital	https://www.templehealth.org/locations/chestnut-hill-hospital/services/senior-behavioral-health	(215) 248-8200
	Food Assistance	Chestnut Hill Meals on Wheels	https://chestnuthillmow.org/	(215) 233-5555
Brighton	Health Care and Behavioral Health Providers	Charles River Community Health	https://www.charlesriverhealth.org/	(617) 783-0500
	Health Care and Behavioral Health Providers	Beth Israel Lahey Health (Charles River Community Health)	https://www.bidmc.org/locations/charles-river-community-health	(617) 783-0500
	Housing	Allston Brighton Community Development Corporation	https://allstonbrightoncdc.org/rental-relief/	(617) 787-3874
	Food Assistance	Allston Brighton Food Pantry	https://abfoodpantry.com/	(617) 254-4046
	Aging Service Providers	Veronica B. Smith Senior Center	https://www.boston.gov/departments/age-strong-commission/veronica-b-smith-senior-center	(617) 635-6120
Hyde Park	Health Care and Behavioral Health Providers	Mattapan Community Health Center	https://www.mattapanchc.org/	(617) 296-0061
	Health Care and Behavioral Health Providers	Hyde Park Behavioral Health	https://www.hydeparkbehavioralhealth.com/	(617) 413-6618
	Food Assistance	Hyde Park Food Pantry	http://www.hydeparkfoodpantry.org/	N/A
	Aging Service Providers	ETHOS	https://www.ethocare.org/	(617) 522-6700
Jamaica Plain	Health Care and Behavioral Health Providers	Southern Jamaica Plain Community Health Center	https://www.brighamandwomens.org/medicine/general-internal-medicine-and-primary-care/southern-jamaica-plain-health-center/overview	(617) 983-4100
	Health Care and Behavioral Health Providers	Arbour Hospital	https://arbourhospital.com/	(833) 227-2687
	Transportation	U.S. Department of Veteran Affairs	https://www.va.gov/boston-health-care/dav-vans-transportation-for-veterans/	(617) 295-7001
	Food Assistance	The Centre Food Hub	https://www.thecentrejp.org/food-justice	(617) 971-8840
	Aging Service Providers	ETHOS	https://www.ethocare.org/jphome/	(617) 522-6700
	Other	BCYF Curtis Hall	https://www.boston.gov/departments/boston-centers-youth-families/bcyf-curtis-hall	(617) 635-5193
	Other	BCYF Grove Hall Senior Center	https://www.boston.gov/departments/boston-centers-youth-families/bcyf-grove-hall-senior-center	(617) 635-1484
	Aging Service Providers	City of Boston - Age Strong Commission	https://www.boston.gov/departments/age-strong-commission	(617) 635- 4418
West Roxbury	Health Care and Behavioral Health Providers	Brigham and Women's Faulkner Community Physicians at West Roxbury	https://www.brighamandwomens.org/medicine/general-internal-medicine-and-primary-care/faulkner-community-physicians/west-roxbury-doctors-and-locations	(617) 469-4000
	Health Care and Behavioral Health Providers	The Dimock Center	https://dimock.org/	(617) 442-8800
	Transportation	MBTA	https://www.boston.gov/departments/transportation/free-route-23-28-and-29-bus-program	(617) 635-4680
	Food Assistance	Rose's Bounty Food Pantry	https://www.stratfordstreetunitedchurch.org/food-pantry-overview.html	(857) 203-0404
	Aging Service Providers	ETHOS	https://www.ethocare.org/agewell-west-roxbury/	(617) 522-6700

	Private Care	Privatus	https://www.privatuscare.com/location/boston/	(617) 275-4050
	Private Care	Peace of Mind	https://peaceofmindinc.com/	(617) 522-5774
	Private Care	Adaptive Homecare	https://adaptivehc.com/	(617) 937-9378
	Private Care	Commonwealth Caregivers	https://www.commonwealthcaregivers.com/	(781) 483-4460
	Private Care	Traditions Home Health Services	https://www.traditionshhs.com/	(508) 634-3993
	Private Care	FCP Live in Caregiver	https://www.liveinhomecare.com/	(866) 559-9492
	Private Care	CarePatrol	https://carepatrol.com/about-carepatrol/	(781) 879-3038
	Private Care	A Place for Mom	https://www.aplaceformom.com/	(866) 518-0936
	Private Care	Always Best Care	https://alwaysbestcare.com/greater-boston/about-us/	(617) 489-9000
	Private Care	Home Instead	https://www.homeinstead.com/home-care/usa/ma/norwood-milton/704/	(781) 352-4660
	Private Care	ComForCare	https://www.comforcare.com/massachusetts/canton/	(781) 821-2800
	Private Care	Cornerstone Caregiving	https://cornerstonecaregiving.com/locations/norwood-ma/	(617) 762-5505
	Private Care	Visiting Angels	https://www.visitingangels.com/newton/home	(617) 795-2727
	Private Care	VNA Care	https://vnacare.org/True/by-service/private-care	(508) 366-1766
	Health Care and Behavioral Health Providers	Massachusetts Behavioral Health Helpline	https://www.masshelpline.com/	(833) 773-2445
All	Health Care and Behavioral Health Providers	Community Behavioral Health Centers	https://www.mass.gov/community-behavioral-health-centers	(800) 528-4890
	Health Care and Behavioral Health Providers	Boston Medical Center's Community Behavioral Health Center (The Best Team Crisis Line)	https://www.bmc.org/cbhc	(800) 981-4357
	Health Care and Behavioral Health Providers	(National) 988 Suicide & Crisis Lifeline	https://988lifeline.org/	988
	Transportation	MBTA	https://www.mbta.com/fares/reduced/senior-charliecard	(617) 222-3200
	Transportation	City of Boston - Age Strong Shuttle	https://www.boston.gov/departments/age-strong-commission/age-strong-shuttle	(617) 635-4366
	Other	Home Energy Assistance - HEAP	https://www.mass.gov/info-details/learn-about-home-energy-assistance-heap	211
	Housing	MetroHousing Boston	https://www.metrohousingboston.org/	(617) 859-0400
	Housing	Boston Housing Authority	https://www.bostonhousing.org/en/Home.aspx	(617) 988-4000
	Housing	Executive Office of Housing and Livable Communities (EOHLC)	https://www.mass.gov/orgs/executive-office-of-housing-and-livable-communities	(617) 573-1100
	Health Care and Behavioral Health Providers	Mystic Valley Elder Services	https://mves.org/	(781) 324-7705
	Support and Education	Alzheimer's Association	https://www.alz.org/help-support/i-have-alz/programs-support	(800) 272-3900

Appendix D: Evaluation of FY23-FY25 Implementation Strategy

Geriatric Specialists						
Overall goal: Increase availability and accessibility of our geriatric specialists and the ways seniors in the community can access them.						
Area	**Target Population**	**Programmatic Objectives**	**Community Activities / Strategies**	**Metrics**	**Status**	**Community Partners**
Outpatient Therapy	Seniors at home who need rehab services	Offer HRC Rehab virtual visits for patients who are better served to receive therapy at home	• Pilot virtual reality system to deliver therapeutic interventions • Offer remote therapeutic monitoring applicability and usability • Incorporate therapy assessments for fall risks as part of assisted living application • Determine best practices for falls prevention in assisted living settings and apply to other facilities • Collaborate with Marcus Institute on Pilot and Feasibility Study for Multi-Component Prehabilitation Program for High-Risk Older Adults Undergoing Major Elective Surgery	Metrics: • VR pilot complete • # users on remote therapeutic monitoring • Assisted Living application therapy assessments in place • Production of best practices document and # other facilities utilizing practices • Feasibility pilot complete	Status: • VR pilot complete • 0 active users but pilot phase at beginning stages • Assisted Living application therapy assessment in place with 4/year staff training and according to best practices • Feasibility pilot complete for Pre-Hab study	XR Health PhyxUp Health , NewBridge Assisted Living team, Marcus Institute and Dr. Dae Kim
STEP-HI Hip Fracture Recovery Clinical Trial	Women age 65 and older	Through collaboration between Marcus Institute and rehab, test strategies that may improve recovery after a hip fracture, specifically whether combining testosterone with exercise can lead to even greater improvements in physical abilities	• Continue to recruit participants • Conduct ongoing study of intervention • Continued outreach to professional hospital networks throughout Greater Boston • Publish and promote results	Metrics: • # participants recruited to the study to date • # of publications that promote results (Berry/Kiel)	Status: • 36 participants • 3 publications	Beth Israel, Brigham and Women, Faulkner
CarFit Program	Seniors in surrounding communities	Increase road safety for all	Offer educational program for older adults to check how well their personal vehicles “fit” them	Metrics: • # adults participating	• 20 older adults	
Therapy House Calls	Seniors living at home	Optimize seniors' independence through Service Area and Programming	• Extend educational sessions led by clinicians called Optimizing Independence to other senior housing communities • Gait Speed Testing to assess impact of pandemic on function • Increase # of seniors impacted by our service delivery	Metrics: • # of educational sessions offered • # participants of Gait Speed Testing • % increase of seniors impacted by service delivery	Status: • 10 educational sessions offered in FY24 • 3 Gait Speed Fairs offered (# of participants not measured) • FY21 visits = 6068, FY24 visits = 7007, 15.5% increase	Brookline Housing Authority Properties, MLK in Brockton, and Hamilton Wade Douglas in Roxbury

Outpatient Nutrition Services	Seniors in surrounding communities and HSL employees	Raise awareness and provide nutrition education for older people in the community	• Increase awareness of nutritional services at HSL by working with R3 and marketing teams to provide presentation on topics such as diabetes management, hypertension, healthful eating, and how to eat nutritionally when financially insecure at Needham, Brookline, and Jamaica Plain Senior Centers • Offer 1:1 counseling w/Medical Nutrition Therapy (MNT) for seniors in the community, HSL seniors from all sites, and HSL employees • Initiate group education for seniors or employees as alternative way to conduct nutritional counseling on topics such as: diabetes, cardiac, and weight management • Offer nutritional counseling sessions for Harvard-Pilgrim insured employees via Preventative Health MNT and coordinate with Livewell to earn participation points	Metrics: • # employee clients • # of community clients • # of nutritional groups • # presentations in the community • # hours spent on research • Listing of MNT client referral sources	Status: • 2 employee clients • 47 community clients • 2 nutritional groups; 3 cooking demonstrations for 32 older adults • 3 community presentations • Thousands of hours research conducted by dedicated nutrition research team within Marcus Institute for Research • 2 client referral sources: outpatient rehab team, wellness benefits fair	Centre Communities of Brookline, NewBridge on the Charles IL/AL, Simon C. Fireman Community, Umass extension services
Dietetic Internship	Seniors in surrounding communities and HSL employees	Raise awareness and provide nutrition education for elders in the community	• Conduct clinical dietary intern rotations to provide geriatric clinical nutrition, dietary counseling, and support	Metrics: • # older adults served	Status: • 1000+ older adults served	Brigham & Women's Faulkner Hospital, Emerson Hospital, South Shore Medical Center, Community Servings, Cultivate Nutrition Counseling, UMass Extension, Crystal Savoy RD Nutrition Counseling
Community Education/ Awareness	Local Boston seniors, caregivers, and community partners	Raise awareness of care options by providing education about HRC services	• Sponsor public caregiver support groups • Sponsor memory cafe to the public • Sponsor community events and forums	Metrics: • # public caregiver support groups • # memory cafes to the public • # community events and forums	Status: • 12 support groups sponsored annually • 12 memory cafes sponsored annually • 20 community events and forums sponsored annually	Alzheimer's Association, Local COAs, local faith orgs
Get up And Go	Seniors in surrounding communities	Provide individualized and supervised fitness and strengthening programs for seniors in the area at a reduced cost	Expand program to more seniors through more outreach	Metrics: • Increased load change with resistance exercise • % increase participant volume	Status: • 13%-34.5% increase in load change • 33% increase in participant volume	JP @ Home, Ethos, OP Therapy Services Referrals, Wolk Center

Outpatient Therapy	Geratric specialists at HRC	Increase number of specialty certifications to meet diverse needs in the aging senior population	• Increase awareness of opportunities for community access to specialty certifications in collaboration with the marketing department	Metrics: • # new certifications for the following specialties: Lymphedema, Hand Therapy, Certified Geriatric Specialist, Certification in Modified Barium Swallow assessments, Orthopedic Certified, LSVT Big, LSVT Loud, Functional Medicine Certified, Driver Safety, CarFit, Vestibular Therapy, Wound care, Pilates, Tai Ji, Pelvic Floor, Vital Stim • Patient satisfaction measures • # specialty treatment plans	Status: • Zero new certifications although existing certifications remained current • Received 95 or higher rating on all Patient Satisfaction measures • Increased volume of specialty referrals including Drivers Safety assessments, Pelvic Floor rehab, Hand therapy and Lymphedema, Functional Wellness Coaching 1:1, and Tai Ji for Better balance program	ASHT (THerapist listed as Certified Hand Therapist-referrals come directly from website), APTA, AOTA,ASHA, AAA, AARP, CMMSC, Neurology Center of New England
Progressive Community-Based Ambulatory Care Center	Seniors in surrounding communities	Offer increased accessibility to HRC's ambulatory care cluster, where community dwelling seniors can easily and safely access a range of preventative care services	• Offer increased accessibility to ambulatory wellness services through increased marketing and use of HRC Transportation program	Metrics: • Patient satisfaction measures • % increase patient volume for following services: Wolk Center for Memory Health, Outpatient Therapy (Physical Therapy, Occupational Therapy, Speech Language Pathology), Audiology, OP Nutrition Services, Bone Density Scan, OP Modified Barium Swallows	Status: • Received 95 or higher rating on all measures for PT/OT/Speech; Wolk Center will begin measuring July 2025 • Wolk: 214% increase; Outpatient Therapy: 75% increase; Audiology, OP Nutrition Services, Bone Density Scan, OP Modified Barium Swallows no significant change in volume	
Memory Health	People living with cognitive symptoms or disorders at any stage - and their families and caregivers	Provide comprehensive outpatient care related to brain health, cognitive and behavioral problems, and memory loss, whether due to Alzheimer's disease, other dementias, or other neurological or psychiatric conditions	• Program expansion to HSL housing sites clinics and other senior living sites • Reach more seniors through mobile van concept • Assessment & Diagnosis including neurology, psychiatry, neuropsychology, and geriatric specialists • Clinical Treatment including the opportunity to participate in leading edge research • Initiate brain health programming and to reach seniors in their residence as part of their wellness plan	Metrics: • # new HSL housing sites clinics and other senior living sites reached • # seniors reached through mobile van concept • # seniors reached at-home for brain health programming • # diagnostic procedures performed • % increase of new patient volume and clinic visit targets • # functional assessments conducted	Status: • Serving as consultant to one new senior living site for brain health community • Mobile van concept paused • 8 at-home patients reached through Lifestyle Coaching • 89 diagnostic procedures (lumbar puncture) • 214% increase in clinical visits; YOY average increase of 160 new patients • 70 functional assessments	Orchard Cove, Councils on Aging (Needham, Milton, JP@Home)

Behavioral and Mental Health						
Overall goal: Increase the availability and accessibility of outpatient Alzheimer's and dementia care for seniors who live in the community and their families.						
Area	**Target Population**	**Programmatic Objectives**	**Community Activities / Strategies**	**Metrics**	**Status**	**Community Partners**
Wolk Center for Memory Health	Families and patients at any stage of brain health/memory loss	Help individuals maintain the highest possible level of brain function as they age—and provide the family and caregiver support that is critical to achieving the best long-term outcomes	• Resources and Support for Living with Dementia including support groups, personalized resource planning, and individual and family counseling • Expand family caregiver program services • Expand customized support group offerings (examples: spouses, newly diagnosed individuals/families) • Expand use of TMS treatment programming beyond singular diagnosis of depression • Use of telehealth interface with patients/caregivers	Metrics: • # caregivers connected with resources/support • # of new services/resources offered to family caregivers and # of caregivers served • # new, customized support group offerings • Use of TMS treatment programming beyond singular diagnosis of depression • % increase of of telehealth use with patients/caregivers • # seniors reached at-home for brain health programming • # of cross team referrals and external referrals • # Blog posts	Status: • ~70 caregivers connected with resources/support • 3 types of support groups and 1 respite program offered; ~50 caregivers served • 3 customized support group offerings • 20 patients benefitted from off-label TDCs treatment for cognitive reserve • ~33% current patients appointments via telehealth • 8 at-home patients reached through Lifestyle Coaching • 105 referrals • 21 blog posts	
Psychiatry Division	Patients and families affected by dementia	Improve identification of / coordination of services for patients and families affected by dementia	• Initiate scheduled monthly meetings between Wolk and Psychiatry to review identified clients and coordinate services	Metrics: • # clients referred to Wolk by Psychiatry • # clients referred to Psychiatry by Wolk	Status: • Referrals not needed because psychiatrist added to Wolk Center staff; Wolk psychiatrist saw 233 patients • 2 Transcranial magnetic stimulation patients referred	SpringWell, Jewish Family & Children's Services
Psychiatry Division	Patients whose mobility challenges limit access to behavioral health care	Increased access to behavioral health services through use of telehealth for clients whose mobility challenges would otherwise limit access	• Enable all behavioral health clinicians to implement telehealth • Provide clients technical support necessary to enable them to use telehealth services	Metrics: • % clinicians telehealth enabled • # of patients receiving behavioral health services via telehealth	Status: • 6% clinicians telehealth enabled • 8 patients served via telehealth	MassAbility (formerly Mass Rehab)

In-Home Health						
Overall goal: Expand availability to health and wellness interventions by offering more entry points to meet a senior care expert.						
Area	**Target Population**	**Programmatic Objectives**	**Community Activities / Strategies**	**Metrics**	**Status**	**Community Partners**
In-Home Telehealth Videoconferencing	Home Health patients at high risk for rehospitalization	Enable early indication of disease exacerbation and improved disease management	• Explore technology use options, including fall detection, for seniors residing in community • Institute methodology to capture SDOH data as part of senior care planning	Metrics: • Technology use option exploration complete and, based on findings, viable options being pursued/implemented • Methodology established and implemented/ SDOH data capture in progress	Status: • The videoconferencing pilot was completed, but face-to-face proved to be more effective for our patient population (older adults >90 years of age); it was not pursued further. • No methodology instituted due to cessation of videoconferencing.	
Community Based Palliative Care	Frail elders with advancing illness who live in their homes in the community	Ensure patient has a holistic support network and comprehensive expertise through team approach	• Apply for Medicare Part B billing status which will allow for reach to seniors beyond those currently being served by HSL home health • Reinvigorate community based educational programming in post pandemic era	Metrics: • Application submission for Medicare Part B billing status • Assuming approval received, reach extended beyond HSL home health clients to 7 patients in year 1, 12 patients in year 2 • # community-based education efforts (presentations, webinars, blogs, social media) • # presentations to Case Management Society of New England Frail Elders Conference, Aging Life Care Association NE	• Application submission for Medicare Part B billing status completed and approval received • HSL home health clients extended to 19 patients • 12-15 community-based education efforts • No presentations to Case Management Society of New England Frail Elders Conference, Aging Life Care Association NE	
New Wellness Nurse Consultant Program	Residents in HSL senior living communities and seniors using HSL private pay services	Create a safety net for detecting early disease exacerbation and functional decline	• Expand reach to HSL senior living and HSL private pay services	Metrics: • # new senior living sites served • # new people served HSL private pay services	Status: • 6 new senior living sites served • 28 new people served HSL private pay services • 1,242 new non-HSL older adults served	2Life Communities, R3, Brookline Housing Authority, Winn Companies

Social Determinants of Health						
Overall goal: Improve health and reduce longstanding disparities in health and health care by reducing the impact of the following social determinants: food insecurity, transportation challenges, language barriers, and domestic abuse.						
Area	**Target Population**	**Programmatic Objectives**	**Community Activities / Strategies**	**Metrics**	**Status**	**Community Partners**
Hunger/ Nutrition	Seniors in the greater Boston area		Increase number of seniors who receive Meals on Wheels	Metrics: • # meals per day, five days a week	Status: • 750 meals per day, five days a week	Ethos, Springwell, Mystic Valley
Transportation	Seniors in Greater Boston	Offer free transportation service to limited-income, community-dwelling seniors, including those who are frail or critically-ill	• Offer free transportation to seniors who are living in other HSL communities or receiving care in their homes that enables them access to Wolk Center for Memory Health and other outpatient services at HRC • Increase community outreach as part of the transportation program to ensure we are reaching seniors who would most benefit from this service • Seek funding to enable expansion of vehicle utilization as "mobile clinics"	Metrics: • # rides • # community partners utilizing our service • additional funding secured	Status: • 49 rides for community members transported to Wolk Center; 187 rides for community members to HRC outpatient therapy; 276 rides for HRC long term care patients transported to medical patients • 2 community partners • No additional funding secured	Centre Communities of Brookline, NewBridge on the Charles
Protecting Seniors	Seniors who are at risk for abuse, neglect or financial exploitation	Combat the incidence of elder abuse in Massachusetts	• Offer shelter and victim support services to seniors who are suffering from abuse, neglect or financial exploitation • Collaborate with community partners to provide education and build awareness • Establish and facilitate multi-agency elder abuse prevention coalitions (known as multidisciplinary teams)	Metrics: • # of referrals for shelter or supportive services • # of seniors sheltered (incl relocation to permanent housing at HSL sites) • # of educational offerings • # of agencies participating in HSL-led multidisciplinary teams	Status: • 126 referrals • 19 sheltered and/or placed in HSL housing • 18 educational sessions • over 25 agencies routinely participate in the two CPEAN-led MDTs	Somerville-Cambridge Elder Services; Old Colony Elder Services; HESSCO; Central Boston Elder Services; Boston Senior Home Care; Pension Action Center (at UMass Boston); AgeStrong; Executive Office of Aging and Independence; City of Boston Inspectional Services; Brookline Health Department; Brookline Police Department; Boston Police Department; Brookline Senior Center; Little Brothers/Friends of the Elderly; Hearth, Inc; Center for Violence Prevention and Trauma Recovery at BIDMC; Eastern Bank; Metro Credit Union; Brookline Bank; Brewster Ambulance; Brookline Center for Community Mental Health; Brookline Housing Authority; Boston Housing Authority; Norfolk County Domestic Violence Roundtable; Administration for Community Living (federal agency within HHS); Boston College (research consulting); Boston University (social work interns and hoarding coaching); Metro Mediation; Brigham & Women's Hospital/Faulkner Hospital; Action for Boston Community Development (ABCD); Metro Housing Boston; Office of the Suffolk County District Attorney; Boston Medical Center; Ethos
Language and cultural sensitivity	Russian speaking seniors in the greater Boston area	Actively provide professional, accurate, and culturally sensitive translation and interpreter services to ensure health equity and patient-centered care	• Publication of biannual newsletter for Russian Speaking community at large • Support HRC outpatient service lines with translation of written materials and interpreter services	Metrics: • # of newsletters published • # of interpreters available to outpatient services • # languages offered for interpreter services • # of translated written materials for various HRC outpatient services	Status: • 6 newsletters published (two per year) • 10 Interpreters (staff and per diem) • 4 Languages: Russian, Spanish, Greek, Cantonese/Mandarin plus additional languages provided via 24/7 Telephonic interpreters • 3 types of translated documents: Surveys for Marcus Institute, 4Ms Framework Quality reports, Flyers for employee website (Spanish and Russian)	

Appendix E: FY26-FY28 Implementation Strategy

Economic Stability and Basic Needs

Goal: Ensure that individuals, particularly older adults and low-income populations, have equitable access to essential resources and supports that promote financial security, safe living environments, healthy food, stable housing, and opportunities for education and personal well-being.

Priority populations	Strategy	Objective	Activity/Activities to accomplish strategy	Sample metric/s for strategy objective	Potential community partners
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults	Hunger/ Nutrition	Combat hunger and isolation and encourage health and independence of older adults living at home	• Delivery of nutritious meals and offering social interaction and safety checks to homebound older adults	• # meals served/week • # participants	Ethos and Springwell, Aging Services Access Points (ASAPs)
• Older adults with chronic conditions	CarFit Program	Increase road safety for all	• Offer educational program for older adults to check how well their personal vehicles “fit” them	• # assessments	AOTA, AARP, Canton Council on Aging
• Older adults with chronic conditions • Older adults facing economic insecurity	LiveWell Food Insecurity Program	Provide access to good, sufficient, health, and culturally appropriate food	• Holiday Support Program • Resources and support	• $ raised for food insecurity • # informational resources offered	
• Older adults facing economic insecurity	Jamie and Harold Kotler HELP (HSL’s Employee Lifeline Program)	Provide employees and their families tangible and meaningful support through some of life’s most challenging and emotional transitions	Financial assistance to employees who meet the program’s guidelines	• # applicants • # recipients	N/A

• Older adults with chronic conditions • Older adults facing economic insecurity	Hebrew SeniorLife Scholarship Program	Provide tuition cost assistance to employees and their family members to pursue their educational goals	• Award educational scholarships	• # scholarships awarded • $ distributed	N/A
• Older adults at-risk for or experiencing abuse and neglect	Center for Prevention of Elder Abuse and Neglect	Provide emergency shelter program exclusively for abused, neglected, or exploited seniors	• Offer shelter and victim support services to seniors who are suffering from abuse, neglect or financial exploitation • Collaborate with community partners to provide education and build awareness • Establish and facilitate multi-agency elder abuse prevention coalitions (known as multidisciplinary teams)	• # of referrals for shelter or supportive services • # of older adults sheltered • # of educational/awareness symposiums/offerings • # of agencies participating in HSL-led multidisciplinary teams	Somerville-Cambridge Elder Services; Old Colony Elder Services; HESSCO; Central Boston Elder Services; Boston Senior Home Care; Pension Action Center (at UMass Boston); AgeStrong; Executive Office of Aging and Independence; City of Boston Inspectional Services; Brookline Health Department; Brookline Police Department; Boston Police Department; Brookline Senior Center; Little Brothers/Friends of the Elderly; Hearth, Inc; Center for Violence Prevention and Trauma Recovery at BIDMC; Eastern Bank; Metro Credit Union; Brookline Bank; Brewster Ambulance; Brookline Center for Community Mental Health; Brookline Housing Authority; Boston Housing Authority; Norfolk County Domestic Violence Roundtable; Administration for Community Living (federal agency within HHS); Boston College (research consulting); Boston University (social work interns and hoarding coaching); Metro Mediation; Brigham & Women's Hospital/Faulkner Hospital; Action for Boston Community Development (ABCD); Metro Housing Boston; Office of the Suffolk County District Attorney; Boston Medical Center; Ethos; Councils on Aging; Older Adult Behavioral Health Network, Massachusetts Housing and Shelter Alliance; SPRiNG Alliance; Greater Boston Legal Services; Jewish Family & Children's Services, and Central Boston Elder Services

• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect • Caregivers	Proposed Roslindale Housing Community	Provide deed-restricted affordable housing to very-low and low-income seniors	• 78-unit energy-efficient affordable housing community that will provide housing to seniors at or below 50% of AMI	• # of deed-restricted affordable housing units	City of Boston, WalkUp Roslindale, Longfellow Area Neighborhood Association and the Arnold Arboretum

Chronic/Complex Conditions and Behavioral Health

Goal: Promote healthy aging and improved quality of life by expanding access to comprehensive care for chronic and behavioral health conditions, advancing brain health and dementia support, strengthening the healthcare workforce, and fostering environments that support wellness, safety, and independence for older adults.

Priority populations	Strategy	Objectives	Activity/Activities to accomplish strategy	Sample metric/s for strategy objective	Potential community partners
• Older adults with chronic conditions	Research study	Prevent loss of bone with aging	Test new way to prevent bone loss with a "synbiotic" that combines a probiotic and prebiotic	• Improvement in bone density and strength as well • Improvements in biomarkers of bone loss	Hinda and Arthur Marcus Institute for Aging Research
• Older adults with chronic conditions • Older adults facing economic insecurity	Dietetic Internship	Emphasize clinical nutrition and food service management to help raise the standards in senior health care	• Conduct clinical dietary intern rotations to provide geriatric clinical nutrition, dietary counseling, and support • Leverage social media to educate employees on nutrition topics	• # interns trained • # interns hired • # average views per year	Brigham & Women's Faulkner Hospital, Emerson Hospital, South Shore Medical Center, Community Servings, Cultivate Nutrition Counseling, UMass Extension, Crystal Savoy RD Nutrition Counseling, Simmons University Partnership, Lori Lieberman & Associates (Outpatient), Boston Medical Center- South (Medical Complex)m Boston College (Plan Your Own), Dedham Public Schools (Community)

• Older adults with chronic conditions • Older adults facing economic insecurity	Outpatient Nutrition Services	Raise awareness and provide nutrition education	• Presentations on nutrition-related topics • 1:1 counseling w/Medical Nutrition Therapy (MNT)	• # presentations in the community • # 1-1 counseling sessions	Centre Communities of Brookline, NewBridge on the Charles IL/AL, Simon C. Fireman Community, Umass extension services, Local Senior Centers, Commission on Malnutrition Prevention Among Older Adults
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	Nursing Scholarship Program	Address workforce shortage by providing financial assistance for employees to achieve degrees and licensure	• Scholarship awards • Learn while you earn program • Career counseling	• # scholarships awarded • $ distributed • # degrees/certifications achieved	
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	CNA and Nursing clinical hours	Address workforce shortage by providing training and opportunities for entry level healthcare careers	• Serve as training and clinical site • Clinical hours • Learn while you earn program • Job placement	• # students completed clinical training • # students trained in program • $ provided for learn while you earn program • # students who passed CNA exam • # job placements	Edward M. Kennedy High School, Boston area nursing homes and hospitals

• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	Academic Programs (Teaching time)	Increase number of professionals in geriatric medicine through instructional hours	• Department of Medicine staff, researchers, and allied clinical and specialty support educators provide geriatric medicine teaching instruction	• # instructional hours • # students trained • # active affiliations	Affiliate academic institutions
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	Basic Life Support/CPR	Improve workplace safety and enhance emergency preparedness	• Re/certification in Basic Life Support/CPR training for staff whom the training is not a requirement of their position	• # participants	American Heart Association
• Older adults with chronic conditions • Caregivers	Professionalism classes	Increase interest in healthcare environment, especially for careers involving Alzheimer's and other dementias	• Introductory class person-centered and age friendly care and professionalism	• # participants	Edward M. Kennedy High School
• Older adults with chronic conditions • Caregivers	High School Summer Internship	Provide exposure and entry-level training for high schoolers interested in pursuing careers in the health professions and related fields	• College preparatory and vocational high school program to achieve certified nursing assistant status • Summer Internship for a college student to gain leadership experience	• # participants • # certifications achieved • $ provided for learn while you earn program	Edward M. Kennedy High School

• Older adults with chronic conditions • Older adults facing economic insecurity • Caregivers	Wolk Center for Memory Health	Provide comprehensive outpatient care related to brain health, cognitive and behavioral problems, and memory loss, whether due to Alzheimer's disease, other dementias, or other neurological or psychiatric conditions	• Assessment & Diagnosis including neurology, psychiatry, neuropsychology, and geriatric specialists • Clinical Treatment including the opportunity to participate in leading edge research • Initiate brain health programming and to reach seniors in their residence as part of their wellness plan	• # seniors reached at-home for brain health programming • # diagnostic procedures performed • % increase of new patient volume and clinic visit targets	Councils on Aging (Needham, Milton, JP@Home)
• Older adults with chronic conditions • Older adults facing economic insecurity • Caregivers	Wolk Center for Memory Health	Help individuals maintain the highest possible level of brain function as they age and provide the family and caregiver support that is critical to achieving the best long-term outcomes	• Resources and Support for Living with Dementia including support groups, personalized resource planning, and individual and family counseling • Family caregiver program services • Customized support group offerings (examples: spouses, newly diagnosed individuals/families) • TMS treatment programming beyond singular diagnosis of depression • Telehealth interface with patients/caregivers	• # support groups • # customized support group offerings • # of of telehealth use with patients/caregivers • # of cross team referrals and external referrals • # Blog posts • # of patients receiving behavioral health services via telehealth	SpringWell, Jewish Family & Children's Services. MassAbility (formerly Mass Rehab)

• Older adults with chronic conditions	Healthy Aging Initiative	Conduct longitudinal research study to introduce life-changing resources and services to promote brain health	• Longitudinal study that leverages the expertise of all scientists and research centers at the Hinda and Arthur Marcus Institute for Aging Research	• # residents and community members participants • # reports provided • # lectures provided • # social events provided • # Health Fair events provided • # newsletters published • # publications (abstracts, papers) submitted and/or presented/published • # funding requests submitted and/or awarded	Hinda and Arthur Marcus Institute for Aging Research
• Older adults with chronic conditions	Healthy Environments for Aging Lab	Creating a health-promoting housing environments for older adults.	• Observation study involving long-term monitoring of home environments and outcomes related to health and well-being in older adults. • Developing and testing technology to optimize home enviornments for sleep, and cognitive and physical function in older adults	• # of residents and community member participants. • # of publications (abstracts, papers) and presentations. • # of reseach Grant Applications	Hinda and Arthur Marcus Institute for Aging Research

Access to Care and Health System Navigation

Goal: Improve access to comprehensive, culturally responsive, and person-centered care by expanding education, support services, and system navigation resources that empower older adults to make informed decisions, maintain independence, and achieve better health outcomes.

Priority populations	Strategy	Objectives	Activity/Activities to accomplish strategy	Sample metric/s for strategy objective	Potential community partners
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	Volunteer, Youth, and Community Engagement	Build multigenerational relationships and break generational stereotypes through programs that encourage multigenerational conversation and interaction	• Weekly multigenerational discussion groups • Weekly multigenerational games and art hours • Weekly volunteer-led programs (tech support, balance clinic, coffee hour, Bible study, meditations & fitness classes) • Volunteer musicians • One-on-one matching	• # volunteers per fiscal year • # partnerships per fiscal year • # of volunteer hours per fiscal year	Beaver Summer Camp, Nobles Day Camp, School of Rock- Brookline
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities	Transportation	Help older adults access healthcare to improve health outcomes	• Offer free transportation to seniors who are living in other HSL communities or receiving care in their homes that enables them access to Wolk Center for Memory Health and other outpatient services at HRC	• # rides	Centre Communities of Brookline, NewBridge on the Charles
• Older adults with chronic conditions • Caregivers	Community Education/ Awareness	Raise awareness of care options by providing education about HRC services	• Public caregiver support groups • Memory cafes • Community events and forums	• # support groups • # memory cafes • # events and forums	Alzheimer's Association,Brookline COA, Newton COA, Needham COA, Canton COA, Temple Emaneul Newton, Wellesley COA, Sharon Men's Club

• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect • Caregivers	Marketing & Communications	Ensure steady communication to internal and external stakeholders	Monthly family newsletters, monthly marketing newsletter, quarterly professional newsletter, bi-weekly employee newsletters, social media posts, blog	• # social media posts• #	N/A
• Older adults facing economic i	Shine Counselors (Serving the Health Insurance Needs of Everyone (SHINE) Program)	Providing free health insurance information and assistance for Medicare eligible adults and their caregivers	• 1-1 counseling sessions	• # counselings sessions	Mass.gov Shine Program, Brookline Senior Center
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect • Caregivers	Language and cultural sensitivity	Provide professional, accurate, and culturally sensitive translation and interpreter services to ensure health equity and patient-centered care	• Publication of biannual newsletter for Russian Speaking community at large • Support HRC outpatient service lines with translation of written materials and interpreter services	• # of newsletters published • # of interpreters available to outpatient services • # languages offered for interpreter/translation services, face to face and written	Language Solutions (paid contract -keep?)

• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect • Caregivers	Policy Advocacy	Drive positive social change by influencing decision-makers and shaping public policies	Public affairs strategy with accompanying legislative advocacy agenda	• # testimonies submitted • # of committees and commissions served on	State and Federal Agencies, MA Legislature and US Congress
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities	Progressive Community-Based Ambulatory Care Center	Offer a range of preventative care services that are easy and safe to access	• Wolk Center for Memory Health • Physical Therapy • Occupational Therapy • Speech Language Pathology • Audiology • Outpatient Nutrition Services • Bone Density Scan • Outpatient Modified Barium Swallow Studies • Get up and Go (Outpatient Fitness)	• # of older adults/patients • # participants	JP @ Home, Ethos, OP Therapy Services Referrals, Wolk Center
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	R3 program (Right Care, Right Place, Right Time)	Support older adults living in affordable housing in achieving improved health outcomes, quality of life and independence	• Comprehensive assessments • Care coordination • Supports and services • Health education • Wellness programming	• # residents with health care proxies • # resident with primary care visit in past 12 months • # older adults served • # programs	Brookline Housing Authority, Brookline Senior Center, Kroc Center, Serenity Care PACE, Uphams Corner Pace

• Older adults with chronic conditions	Therapy House Calls	Optimize seniors' independence through programming	• Educational sessions led by clinicians called Optimizing Independence to other senior housing communities • Gait Speed Testing to assess impact of pandemic on function • Patients impacted by service delivery	• # of educational sessions offered • # participants of Gait Speed Testing • % patients	Brookline Housing Authority Properties, MLK in Brockton, and Hamilton Wade Douglas in Roxbury

Community Environment and Social Connectedness

Goal: Foster a supportive and connected community by promoting emotional, spiritual, and social well-being, encouraging lifelong engagement, and advancing collective responsibility to improve health and quality of life for all.

Priority populations	Strategy	Objectives	Activity/Activities to accomplish strategy	Sample metric/s for strategy objective	Potential community partners
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect	Spiritual Care	Geriatric-focused spiritual care training for seminary students of many faiths, future clergy seeking spiritual care skills, and aspiring or current health care chaplains	• Clinical Pastoral Education • Clinical Pastoral Education Alumni Supervisory Group • Rabbinical Assembly	• # students trained • # alumni participants • # rabbinical assemblies	
• Older adults with chronic conditions • Older adults facing economic insecurity	Code Lavender	Restore employee(s) emotional and spiritual well-being and to optimize resiliency and healing of the mind, body, and spirit	• Evidence-based relaxation and restoration interventions to provide support for staff during times of high emotional stress	• # Urgent vs. Non-Urgent • # of Codes per Site: Roslindale, Dedham • Total # of Codes • Total #of staff that benefited/attended from the Code (all sites) • Total #of staff that benefited/attended (Roslindale campus)	

• Older adults with chronic conditions • Older adults facing economic insecurity	LiveWell Programs	Build a culture of wellness that engages all employees, promotes healthy lifestyles, supports mental health and emotional well-being, and ultimately reduces the overall health risks within our workforce	• Mental health and life support • Onsite virtual fitness classes • Stress reduction and emotional well-being programs • Meditation and mindfulness programs • Nutrition counseling and seminars	• # enrolled • # of services used • # of counseling sessions; text therapy; coaching • # legal assist; financial assist and other life support services	
• Older adults facing economic insecurity	Community Life Programs	Offer lifelong learning and social connections to maintain mental, physical and cognitive health	• Stimulating programs such as lectures, discussion groups, musical performances • Membership at local health and wellness center • Gardening group and activities • Transportation to local entertainment, museums, grocery shopping • Discounted dining program and affordable food options for low income residents • 108 Community Center space utilization to host programs for Brookline older adults	• # programs • # health memberships • # gardening participants • % low income residents who participate in discounted dining program	Gleaners, Kroc Center, PACE, local food pantries, Meal on Wheels, Brookline Housing Authority, Brookline Senior Center, R3

• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect • Caregivers	Event Sponsorships	Benefit the community or a specific cause, promoting social responsibility	• Event Sponsorship	• # sponsorships	Alzheimer's Association, Mass ALA, BJFF, FOBH, Jog Your Memory, Temple Emanuel Newton, Sharon Recreation Department, New England Baptist Hospital, ALCA, Charles River Regional Chamber, Canton Chapter of Keep Massachusetts Beautiful, Paul Revere Heritage Site, BIDMC, Canton Farmers Market
• Older adults with chronic conditions • Older adults facing economic insecurity • Older adults living with disabilities • LGBTQIA+ older adults • Older adults at-risk for or experiencing abuse and neglect • Caregivers	Blood drive sponsor	Collect blood donations to replenish the community's blood supply and ensure a readily available resource for patients in need	• Blood drive space and support	• # drives • # units collected	American Red Cross