Brigham and Women's Faulkner Hospital
Community Health Needs Assessment 2013

Introduction and Background

Brigham and Women's Faulkner Hospital (BWFH) is a 150 bed non-profit, community teaching hospital located in Jamaica Plain, just 3.4 miles from the Longwood medical area, and across the street from the Arnold Arboretum. Founded in 1900, Brigham and Women's Faulkner Hospital has a long history of meeting the health care needs of the residents of southwest Boston and surrounding suburbs. We offer comprehensive medical, surgical and psychiatric care as well as complete emergency, ambulatory and diagnostic services. Our largest inpatient services are internal medicine, cardiology, psychiatry, pulmonary, orthopedics, gastroenterology and general/GI surgery.

Brigham and Women's Faulkner Hospital provides its patients with the some of the most advanced medication safety technology by utilizing a combination of computerized order entry, administration records, infusion pumps and automated drug dispensing machines. In fact, Brigham and Women's Faulkner Hospital now uses a Bedside Medication Verification system, known as bar coding that automatically checks a patient's medical record to ensure that they're receiving the correct medicine and the correct dosage at the proper time.

Brigham and Women's Faulkner Hospital also has full accreditation from The Joint Commission. The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States and their accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Of the many benefits of going to Brigham and Women's Faulkner Hospital is their use of single bed patient rooms. Private rooms have been shown to increase patient satisfaction, reduce the risk of infections and offer more flexibility among practitioners to best treat patients. With more than 1,600 full and part time employees helping to meet the growing demand for medical services, Brigham and Women's Faulkner Hospital and Brigham and Women's Hospital surgical staff are now performing close to 11,000 surgical procedures a year.

Service Philosophy

At Brigham and Women's Faulkner Hospital, our world revolves around our patients and their families who depend on the excellent medical care, commitment to quality and personal attention they have come to expect from us. Our convenient setting, private rooms, patient friendly environment and compassionate and caring staff are just a few of the many aspects of care that patients tell us make a

difference. At Brigham and Women's Faulkner Hospital, we strive to treat each patient the way we would like to see a member of our own family treated, and it shows. We consistently receive excellent ratings in patient satisfaction surveys. The friendly and supportive environment that our patients appreciate also makes Brigham and Women's Faulkner Hospital a rewarding place to work.

Mission Statement

Brigham and Women's Faulkner Hospital strives to attain excellence in patient care services, provided in a learning environment with dignity, compassion and respect.

Teaching

Highly regarded as one of Boston's most important, community teaching hospitals, our post-graduate medical education is rooted in a long and innovative tradition. Brigham and Women's Faulkner Hospital serves as a training site for students from Tufts University School of Medicine and Harvard Medical School. Its medical, surgical and psychiatry residency programs are integrated with those of Brigham and Women's Hospital. The hospital also serves as a site for training several hundred health care professionals, annually, in the areas of nursing, nutrition, pharmacy, social work, psychiatry, rehabilitation therapies, addiction recovery and more. Our commitment to teaching extends to our employees who benefit from our extensive education and training programs.

Community Health and Benefits Mission Statement
(revised version adopted March 10, 2010)

The Board of Directors, Oversight Committee for Community Health and Wellness, hospital administration, and larger hospital community, are all committed to Faulkner's community health and wellness mission, which is:

- *To evaluate the health status of service area neighborhoods of West Roxbury, Roslindale, Hyde Park and Jamaica Plain and respond to identified needs*
- *To pay particular attention to health and wellness concerns affecting children in local schools, the elderly, women, and diverse populations who may experience health disparities, among others*
- *To provide a wide variety of free health screenings and immunizations, health education programs, and other services relating to important health issues affecting communities served*
- *To seek community participation in and feedback about our community benefits efforts, by involving community members in the hospital's planning and evaluation processes and by keeping the lines of communication open*
- *To engage in meaningful, active collaboration with a broad range of community residents, schools, service organizations, businesses, government agencies and others, to stay abreast of community needs, and to pool knowledge and resources in addressing those needs*

- *To periodically review and assess community benefits goals, services, and outcomes to insure that they remain relevant to issues affecting our communities, and to allocate or reallocate community benefits resources, as needed*

Oversight Committee for Community Health and Wellness
Purpose Statement

Brigham and Women's Faulkner Hospital Community Health and Wellness has a long standing commitment to the community to improve access to health care and promote wellness and prevention through education. Being current with data, compliant with guidelines and regulations and maintaining continuous working relationships with the community are all key factors in the success of this work. The Oversight Committee will work to uphold the Community Benefits Mission through support of the seven priority areas (listed below) of the Community Health and Benefits Department Plan:

Responsibilities:

- Review and evaluate the community mission, plan and programming with respect to the current needs assessment
- Provide input and recommendations to better serve the community health needs
- Facilitate active communication and sharing across all BWFH departments
- Oversee regulatory activity related to the Attorney General, the Massachusetts Department of Public Health, Federal Government, and State of Massachusetts
- Act as a champion for Brigham and Women's Faulkner Hospital's community health work and assist to make community connections and foster relationships in the community
- Represent and offer a unique perspective on what the community needs are and how best to meet them
- Oversee and review annual departmental plans for community health and benefit contribution

Membership:

- Marie Louise Kehoe, Chairperson
- Ethan d'Ablemont Burnes
- Susan Dempsey
- Jean Flanagan-Jay
- Michael Gustafson
- Betty Hanson
- Judy Hayes
- Marion Kelly
- Meg Kilmurray
- Susan Langill
- Linda Lauretti, MD
- Edward Liston-Kraft
- Sandra Lynch
- Vinnie McDermott
- Janet McGrail Spillane

- Katherine Rowley
- Tracy Sylven
- Lanny Thorndike
- John Woodard

Reporting Relationship:
The Oversight Committee for Community Health and Wellness reports to the Board of Directors.

Meeting Frequency:
The Oversight Committee for Community Health and Wellness meets twice a year for 1 hour.

Target Communities and Populations

- West Roxbury
- Hyde Park
- Roslindale
- Jamaica Plain

- Elderly
- Local School Children
- Underserved
- Barriers to healthcare

Organizational Commitment

Brigham and Women's Faulkner Hospital is dedicated to community benefits as a systematic program, rather than a series of isolated community health activities. Through the commitment of hospital leadership, there is a rich internal dialogue that helps to assure sustained financial and human resources commitment. There is a long history of engaging employees, nurturing collaborations with community partners and close involvement in building trust with neighbors.

Assessment of Community Health Needs, Goals and Assets

BWFH employs a dynamic and ongoing process to identify and prioritize the community health needs.

Program Design:

- Review of current data and assessments from local, state and national organizations
- Partnership with local community organizations

- In depth and thoughtful dialogue and input from individuals though stakeholder meetings and survey opportunities.

- Development of criteria used to select areas of priority and focus:
    - Estimated effectiveness
    - Are there adequate resources to implement the intervention strategy?
    - Are there existing efforts? If so, how can we best complement or enhance those efforts?
    - Collaborative opportunities with local stakeholders

Program Targeting:

- The targeting of specific program activities is based on the following criteria:
- Will the intervention fit the needs of the target population?
- How many people will we reach with the intervention?
- Is the intervention acceptable by the community?
- Is the intervention fiscally feasible?

Program Monitoring:

All program activities are tracked by the Community Health and Wellness Department with review from the BWFH Oversight Committee for Community Health and Wellness.

Assessment of Needs and Determination of Priorities

Assessment based on current information available from publicly available resources; existing programs; and views from people who represent the broad interest of the community served by the hospital:

Data from the following sources is collected and reviewed:

- data assessment
- surveys
- community stakeholder interviews
- neighborhood and community meetings

Consideration of statewide health priorities:

- chronic disease
- health disparities
- wellness
- supporting healthcare reform

Consideration of Partners Priorities:

- access
- economic opportunities
- workforce
- prevention

Brigham and Women's Faulkner Hospital
Community Health and Wellness

Goals Statements

- Improve and support healthy behaviors among neighborhood residents (Hyde Park, Jamaica Plain, Roslindale and West Roxbury).
- Educate neighborhood residents about risk factors associated with chronic disease.
- Help residents to improve self-management of chronic disease and associated risk factors.
- Maintain and strengthen existing community partnerships and relationships for continual feedback and input into the community benefits process.
- Forge new community partnerships to help address community needs and disparities.
- Work closely with Philanthropy to raise and secure funds to ensure the sustainability and growth of community benefits programs going forward.

2014-2016 PLAN

1.) Health and Safety of the Elderly
2.) Cardiovascular Disease (stroke & heart disease) Screening and Education
3.) Diabetes Management Education
4.) Breast & Colorectal Cancer Screening and Education (un- and under-insured)
5.) Domestic violence (BWF Passageways) Program
6.) Nutrition and Fitness Education
7.) Youth Workforce Development
8.) Reduce Barriers to Healthcare Access for Underserved and Vulnerable Populations

Plan Outline with Short-Term and Long-Term Goals

1.) Health and safety needs of the elderly

a. Medication safety
    a. Provide community education about medication safety at various locations.
    b. Offer pharmacy education sessions to elderly participants and or their caregiver to discuss medication management.
    c. Educate community members to the importance of medication reconciliation as it pertains to a hospitalization.
    d. Implement a medication safety hotline.
b. Increasing physical activity
    a. Initiate a weekly walking program for seniors.
    b. Provide information to seniors about the numerous activities in the area for them to be active.

    c. Educate seniors about the importance and benefits of a physically active lifestyle.
    d. Design and offer an exercise program option that can help seniors begin and explore various modalities to physical fitness.
    e. Establish a walking venue for seniors in the winter months.
    f. Partner with the local YMCA's to increase accessibility.
    g. Develop a homebound exercise program with senior housing facilities.
c. Influenza and Pneumococcal vaccines
    a. Provide free and accessible vaccines at a number of convenient locations where seniors frequent.
    b. Educate the community on the importance of getting a influenza or pneumococcal vaccine.
    c. Secure enough vaccine for the demand in the community.
    d. Establish protocol to identify appropriate pneumococcal vaccine candidates and reporting mechanism to primary care physicians to eliminate revaccination.
    e. Identify methods to vaccine independent living homebound seniors in the local community.
    f. Maintain a collaborative Core Measure Improvement Team to review Pneumonia readmissions.
d. Falls prevention
    a. Participate in the Master Trainer program for a Matter of Balance.
    b. Recruit and train Matter of Balance Lay Leader Coaches to help establish the program.
    c. Launch the Matter of Balance course in the community.
    d. Promote the program to physicians, stroke team and support group as a source of referral
    e. Create a home modification checklist and or tool kit for self administration.
    f. Establish a comprehensive home inspection and modification program to evaluate and correct a senior's risk of falling in the home.
    g. Organize a gait testing program for evaluation of a seniors risk to fall.
    h. Offer free vision and hearing screening programs for seniors.
    i. Educate seniors and caregivers about the many facets that contribute to the risk of falls.
e. Community Group Involvement
    a. Maintain a leadership role in various community groups.
    b. Participate in pertinent committee established initiatives.
    c. Collaborate with local agencies and groups to address the healthcare needs of seniors.
    d. Work in conjunction with community stakeholders to ensure minimal service overlap and reduce gaps in services.
f. Safe Transitions
    a. Provide guardianship process to needy elderly patients to ensure the safe transfer to appropriate care.
g. Arthritis
    a. Help to engage senior adults with arthritis in the recommended amount of physical activity through our walking and exercise programs
    b. Provide education about arthritis to the senior population

2.) Cardiovascular disease (stroke & heart disease) screening and education

a. Stroke
    a. Maintain an active hospital based Stroke Committee to ensure the highest level of care for stroke patients.
    b. Establish a stroke support group for stroke survivors and or their caregivers.
    c. Educate the community on stroke.
    d. Raise awareness of stroke signs and symptoms.

b. Cardiovascular Disease (BP, CHO, Glucose)
    a. Maintain a collaborative Core Measure Improvement Team for the prevention of CHF readmission.
    b. Educate the community about heart disease and diabetes.
    c. Provide screening programs to help residents identify and or monitor risk factors such as cholesterol levels, glucose and blood pressure

3.) Diabetes education

a. At staff level, obtain diabetes education certification from American Association of Diabetes Educators.
b. Develop a diabetes education program based on the AADE7 self care behaviors
    i. Healthy eating: making healthy food choices; understanding portion sizes; learning the best times to eat; learning the effect food has on blood glucose; reading labels; planning and preparing foods; understanding and coping with barriers and triggers, etc.
    ii. Being active: regular activity for overall fitness; weight management; blood glucose control; improve BMI; enhance weight loss; control lipids, blood pressure and reduce stress.
    iii. Monitoring: daily self-monitoring of blood glucose to help assess how food, physical activity and medication affect levels.
    iv. Taking medication: help patients to be knowledgeable about medications they are taking, including its action, side effects, efficacy, toxicity, prescribed dosage, appropriate timing and frequency of administration, effect of missed or delayed dose, instruction for storage, travel and safety.
    v. Problem solving: address barriers, such as physical, emotional, cognitive and financial obstacles and developing coping strategies.
    vi. Healthy coping: help to identify individual's motivation to change behavior then helping set achievable behavioral goals and guiding patient through obstacles.
    vii. Reducing risks: assist individuals in gaining knowledge about standards of care, and prevention to decrease risks, including; smoking cessation, foot inspections, blood pressure monitoring, self monitoring of blood glucose and personal care records.
c. Improving diabetes management for African Americans
d. Implement a comprehensive diabetes program for identified community members.

4.) Breast & colorectal cancer screening and education for un- and under-insured

a. Breast Health Care Access Program
    a. Provide free screening mammography to women without insurance
    b. Provide all follow up care to women in the breast health care access program
    c. Educate women about the importance of breast self exams and early detection
    d. Provide support groups and programs for survivors such as YMCA Pink Program and ACS Look Good Feel Better

b. Colorectal Health Care Access
    a. Provide free colonoscopy to those without insurance
    b. Provide all follow up care required to those in the program
    c. Increase the program to meet the demand of the number of participants
    d. Educate people about colorectal cancer and the importance of regular and timely screening

5.) Domestic violence (BWF Passageways) Program

a. Advocacy for patients
    a. Implement structure for MSW internship at Passageway at Faulkner for 2010-2011 academic year
    b. Increase capacity at Brigham and Women's Faulkner Hospital's campus to respond to the needs of victims of domestic abuse
b. Education and training programs at the hospital and in the community
    a. Create and implement strategic plan to provide outreach and training to hospital departments on an annual basis to promote provider awareness and access to Passageway program
    b. Sustain visibility for domestic violence issues at Faulkner Hospital
c. Community awareness and activities
    a. Explore opportunities for collaboration with ETHOS towards the goals of creating support groups for older women who have experienced intimate partner violence
    b. Establish linkages with community agencies and providers to strengthen the gaps in services for underserved populations.
d. Evaluation
    a. Maintain contact logs for direct services to victims
    b. Track referral sources by department to identify areas for continued training and education
    c. Monitor screening rates for DV in ED and on medical floors; identify opportunities for outreach and training for staff
    d. Document the specific needs for further expansion of domestic abuse programming on-site at Faulkner

6.) Nutrition and Fitness Education

a. Nutrition/Fitness Education
    a. Work with partner schools on Wellness Committee that would include school staff, parents and community stakeholders.
    b. Educate youth and residents about the importance of a physically active lifestyle.
    c. Educate youth and residents about the importance of healthy eating.
    d. Work with BPS and the school nutrition staff to help implement healthier food options for kids.
    e. Provide various fitness and nutrition programs to increase the opportunity for residents to get hands on experience in health and wellness
    f. Support residents in a fitness program for the purpose of lowering BMI
    g. Support residents in a nutrition health coach program model for the purpose of increasing consumption of healthy, fresh foods and bettering health
    h. Provide education to the school staff and parents of the school community about healthy nutrition and fitness.
    i. Implement a cardiovascular exercise program that would engage youth and families in physical fitness and promote a physically active lifestyle.
    j. Increase the number of school classroom visits by BWFH staff to help promote the goal of health and wellness at the schools.
    k. Develop a summer wellness promotion program to keep kids and their families connected and on-track with their healthy lifestyle.
    l. Increase awareness about consumption of sugar sweetened beverages to relationship to obesity and diabetes.

7.) Youth Workforce Development

a. Partner with BPIC for summer jobs program
    a. Provide a work opportunity to BPS students for the summer
    b. Allow students to explore various aspects of healthcare through the Summer Jobs Program
    c. Provide enrichment workshops during the summer to help the students hone and develop skills in areas such as interviewing, resume writing, etc.
b. Nursing & allied health job shadow
    a. Provide an opportunity for students interested in nursing to participate in a nursing specific job shadow day
    b. Increase the pipeline of nursing students for the Partners system
c. Career panels and general job shadow days
    a. Provide a look into healthcare for youth that allows them to learn numerous aspects of the field
d. Take an active and leadership role in planning for the future of Workforce Development in Boston/Massachusetts
    a. Member of Boston Partnership for Youth Career Awareness and Pipeline Programs
    b. Member of Youth Equity Campaign of Jamaica Plain

        c. Develop a path so that students can be tracked and guided from a young age through college or training program
        d. Increase the number of students that are exposed to the Workforce Development programs at BWFH
    e. TOPS-Training Opportunity Program for Students
        a. Continue to provide a work program for special needs students of the Mildred Avenue Middle School
        b. Increase the program to the Curley School

8.) Reduce barriers to healthcare access for underserved and vulnerable populations

a. Provide interpreters for non-English speaking patient and deaf and hard of hearing patients for all services at the BWFH campus
    a. Make better connections with providing interpreters upon discharge for at home care instructions
b. Provide Continuity of Care
c. Reduce barriers to health care for those who are underserved and or disadvantaged
    a. Provide free parking or transportation services to needy patients
    b. Provide patient financial counselors to help with enrollment in public assistance programs
d. Provide translation services for materials of non-hospital services at the BWFH campus
    a. Offer more languages for materials
    b. Continue to evaluate the needs and utilization
e. Leadership and active involvement in JP Tree of Life coalition
    a. Work to identify and address various health concerns for vulnerable populations
    b. Work closely with JP community members and leaders

The *Health of Boston 2012-2013:*
A Neighborhood Focus

Introduction

Since 1996, the Health of Boston reports have been commissioned annually to provide information about the health of city of Boston residents. As the title suggests, this year's report provides a closer look at the health of Boston's neighborhoods. In addition to demographic and socioeconomic data, the report presents approximately 30 health indicators by year and by racial/ethnic group for Boston overall and for each of the 15 Boston neighborhoods recognized in past HOB reports, plus the North End and Chinatown, as the data permits. These indicators were selected based on specific public health relevance and data availability. There are many other important health indicators not presented in this report that the Boston Public Health Commission will present in other reports and presentations. As always, we welcome requests for these data as well as more targeted requests for the indicator data presented in this report.

EXECUTIVE SUMMARY

Health of Boston 2012-2013:
A Neighborhood Focus provides extensive information about the health of city of Boston residents. In addition to demographic and socioeconomic data, the report presents health trends and racial/ethnic comparisons spanning approximately 30 health indicators for Boston overall and by Boston neighborhood. The report does not identify causality or make policy recommendations, but instead, provides descriptive information intended to encourage informed dialogue. What follows is a brief summary of some of the descriptive information presented within the report.

Health Equity

As you review the sections that follow, you will notice significant differences between the health of Boston's residents of color and the health of White residents. White residents, on average, enjoy better health than Black and Latino residents. These differences in health based on race are systemic, avoidable, unfair, and unjust; therefore, are referred to as health inequities. Health inequities are the result of multiple factors at the individual, community, and societal levels working together to create inequitable access, opportunities, and experiences based on race. Health inequities are found across multiple health conditions.

There are many factors at the individual and community levels that impact health – individual factors, such as biology and personal behaviors; relationships such as family and social networks; and social and physical environments of where one lives, works, and plays. While we often think first about biology, individual behavior, and health care access as the most important determinants of health, in actuality community-level factors, such as housing, education, environmental exposure, public safety, employment and income, are strong predictors of health. These features of one's social and physical environment are called the social determinants of health.

When examining how these factors contribute to health inequities, it is important to understand how experiences within the individual and community context differ by race. Health-promoting resources are distributed unevenly across the city and follow patterns of racial segregation and poverty concentration. This inequitable distribution of resources, coupled with residential

segregation, results in people of color often living in neighborhoods where there is less access to conditions and opportunities that promote health, such as fresh fruits and vegetables, open green space, quality housing, and employment. Understanding the pathways and mechanisms through which social conditions affect health and contribute to health inequities is fundamental to understanding the health of populations.

Boston: Demographic Profile

In 2010, Boston had 617,594 residents. The overall population of Boston increased 5% between 2000 and 2010. During that time, the number of Latino residents and Asian residents increased by 27% and 25%, respectively. While English was the language most frequently reported being spoken at home, 35% of Boston residents ages 5 and over reported speaking a language other than English at home. Among the languages other than English spoken at home, Spanish (including Spanish Creole) was the most widely spoken language (15% of all homes), followed by French (including Patois, Cajun, and French Creole) (5%), Chinese (4%), Portuguese (including Portuguese Creole) (2%), and Vietnamese (2%).

Boston: Socioeconomic Profile

Socioeconomic status (SES) is a measure of an individual's or family's economic and social position relative to others based on income, education, and occupation. Low socioeconomic status is associated with limited access to regular health care, adequate housing, quality education, nutritious food, recreational opportunities, and other resources associated with a healthy lifestyle. The socioeconomic status of Boston residents varies dramatically by race/ethnicity, gender, and age. Key points from the socioeconomic status section in this report include the following in 2010:

- Sixty percent of female-headed households with children under age 5 had income below the poverty level compared with 18% for all family households in Boston

- The median annual household income for Latino households was $23,243 compared with $61,636 for White households

- The percentage of Boston residents with less than a high school diploma or GED was significantly higher among Latino adults (32%), Asian adults (24%) and Black adults (20%) compared with White adults (7%)

- Black male residents had an unemployment rate of 32% – almost four times the rate of 9% for White male residents

- More than 7,600 homeless individuals were counted in Boston in 2011; 33% of these individuals were children

Boston Health Indicators: Trends

Analysis of select Boston health indicators over time revealed progress or sustained improvement in a number of key public health priority areas:

- The adolescent birth rate for Boston female residents ages 15-17 decreased 9% from 2005 to 2010 and the overall percentage of preterm births among all Boston resident births decreased from 11% in 2005 to a preliminary 9% in 2010.

- The 5-year rolling average infant death rate for Black infants declined 11% from the period 2001-2005 to 2006-2010, based on preliminary data, compared to a decline of 8% for Boston overall. Between the periods of 2001-2005 and 2006-2010, the 5-year rolling averages for infant death rates for most of Boston neighborhoods also declined.

- Boston's stroke-related death rate decreased 15% from 2005 to 2010 based on preliminary death data for 2010.

- Boston's heart disease hospitalization rate decreased 10% from 2005 to 2011 and the heart disease death rate decreased 16% from 2005 to 2010 based on preliminary death data for 2010.

- From 2001 to 2011, the percentage of Boston public high school students who reported smoking cigarettes decreased. Similarly, the percentage of Boston adult residents who reported smoking cigarettes decreased from 2001 to 2010.

- From 2001 to 2011, the percentage of Boston public high school students who reported persistent sadness (feeling sad, blue, or depressed every day for two weeks straight during the past year) decreased.

Analysis of other select Boston health indicators over time suggest continued need for improvement:

- Though similar to the US overall, based on preliminary data, Boston's 5-year rolling average for its infant death rate remains higher than the IMR for Massachusetts overall for the period of 2006-2010.

- From 2001 to 2011, the percentage of public high school students getting regular physical activity during the past week and the percentage reporting excessive alcohol consumption (binge drinking) during the past month remained statistically similar.

- From 2007 to 2011, the percentage of public high school students who reported drinking one or more sodas per day and the percentage considered obese remained statistically similar.

- From 2001 to 2010, the percentage of Boston adult residents considered obese (whose body mass index or BMI is 30 or more) increased.

- The percentage of Boston adults who reported getting regular physical activity, having asthma, having diabetes, and having persistent sadness (being sad, blue or depressed 15 or more days during the past month) remained statistically similar from 2001 to 2010.

Boston Health Indicators: Racial/Ethnic Group Comparisons

Comparisons of racial/ethnic heath indicator data show Boston's Black and Latino residents

continue to experience higher levels of chronic disease, mortality, and poorer health outcomes compared with White and Asian residents. Compared to Boston's White residents, Black and Latino residents had higher rates of:

- Births to adolescent females
- Low birth weight births
- Infant deaths
- Asthma emergency department visits among children less than 5 years old
- Heart disease hospitalizations
- Cerebrovascular disease (including stroke)-related hospitalizations
- Diabetes hospitalizations
- Nonfatal gunshot and stabbing injuries resulting in emergency department visits
- Homicide
- Adult obesity (based on self-reported height and weight)
- Adults who self-reported having persistent sadness (feeling sad, blue or depressed 15 or more of the past 30 days)

Neighborhood Profiles and Health Indicators

Where one lives contributes to shaping health behaviors and influencing one's health. In this year's Health of Boston, there is a much bigger emphasis on neighborhood-level data than in past years. Boston's neighborhoods vary in population characteristics and socioeconomic circumstances. As a result, for each neighborhood there are graphs, where data permits, that describe the population's gender and age distribution, household type, family poverty status, housing tenure (rental vs. owneroccupied), and educational attainment. Neighborhood-level racial/ethnic distribution data exist in the Boston Demographic Profile section to allow for comparisons with Boston overall, other neighborhoods, and over time. In addition, there is a map for each neighborhood that identifies locations of known community assets. Finally, each neighborhood presents health indicator tables in the same format as for Boston overall: indicators over time and by racial/ethnic group.

Neighborhood Health Indicators: Trends

Similar to Boston overall, an analysis of neighborhood select health indicators over time reveals progress for several key public health priority areas:

- According to preliminary death data for 2010, from 2005 to 2010, Mattapan and Roxbury experienced the greatest decrease in their adolescent birth rates for females ages 15-17 among Boston neighborhoods. The decrease for Mattapan was 55% and for Roxbury 40%. Roslindale and North Dorchester experienced the greatest decrease in preterm births, 40% and 27% respectively, from 2005 to 2010.

- Based on preliminary death data for 2010, between 2005 and 2010, heart disease hospitalization rates and heart disease death rates decreased for the majority of Boston neighborhoods. Decreases in rates for heart disease hospitalization ranged from 4% to 31%. The greatest decreases occurred for residents of Charlestown (30%) and South Boston (31%). Rates for both Mattapan and North Dorchester increased 30% and 9%, respectively.

- Heart disease death rates also decreased for most of Boston neighborhoods. According

to preliminary death data for 2010, between 2005 and 2010, decreases ranged, decreases for heart disease death rates ranged from less than 1% to 57%, with the North End and Jamaica Plain experiencing the greatest decreases of 57% and 36% respectively, followed by Mattapan and Back Bay with 34% each. North Dorchester was the only neighborhood whose heart disease death rate increased, although the increase was small (4%).

- Almost all of Boston neighborhoods experienced a decrease in asthma emergency department visits between 2005 and 2011 for children under the age of five. The greatest decreases occurred for South Boston (56%), Hyde Park (39%), and Roxbury (36%). Allston/Brighton, East Boston, and Fenway experienced increases of 23%, 27%, and 38% respectively.

The entire *Health of Boston 2012-2013:* www.bphc.org.

Selected Risk Factors and Disease Prevalence, Boston, 2010

Boston Statistics

Cigarette Smoking: 16% (14-17.3)
Regular Physical Activity: 57% (54.7-59.3)
Obesity: 21% (18.9-22.7)
Asthma: 11% (9.5-12.4)
Diabetes: 6% (5.4-7.0)

Hyde Park

Cigarette Smoking: 14% (8.4-19.9)
Regular Physical Activity: 50% (39.9-59.6)
Obesity: 31% (21.3-39.9)
Asthma: 12% (6-17.4)
Diabetes: 8% (4-12.2)

Jamaica Plain

Cigarette Smoking: 11% (6.2-15.3)
Regular Physical Activity: 58% (50-65.7)
Obesity: 16% (10.6-21.4)
Asthma: 15% (8.8-21.4)
Diabetes: 5% (2.6-7.2)

Roslindale

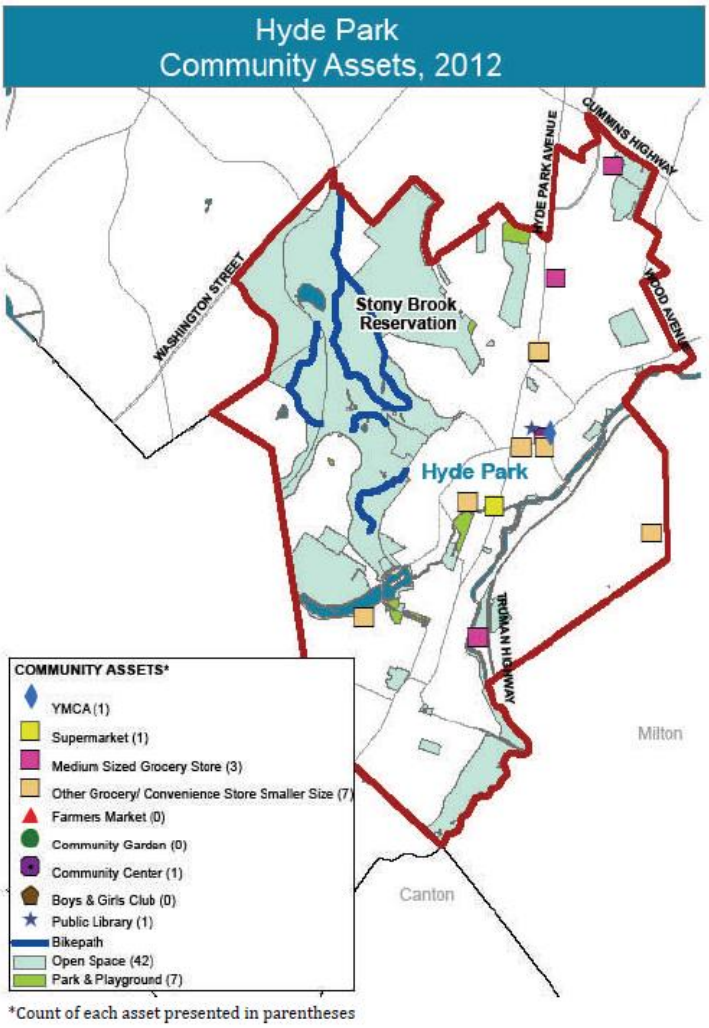
Cigarette Smoking: 10% (4.7-16.1)
Regular Physical Activity: 52% (41.3-61.8)

Obesity: 29% (19.7-38)
Asthma: 11% (5.3-15.8)
Diabetes: 6% (2.8-8.7)

West Roxbury

Cigarette Smoking: 15% (8.7-20.4)
Regular Physical Activity: 53% (44.6-61.5)
Obesity: 24% (15.7-32.4)
Asthma: 7% (3.4-11)
Diabetes: 6% (2.8-8.4)

Hyde Park



*Count of each asset presented in parentheses

Hyde Park was known as "Tist" by the area's Wampanoag Indians. It was incorporated as a town in 1868 and in 1912, became the last neighborhood to be annexed to Boston.

The neighborhood has a large amount of green space, including the George Wright Golf Course and the 450-acre Stony Brook reservation. In the 1800s, several prominent civil right activists, abolitionists and suffragists, including Sarah and Angelina Grimke and William Monroe Trotter, called this neighborhood home. The 54th Regiment, the renowned Black Civil War regiment trained at Camp Meigs in the Readville section of Hyde Park. The city's mayor, Thomas Menino, is a longtime resident of Readville as well.

Figure 10.1a Females by Age, Hyde Park, 2010

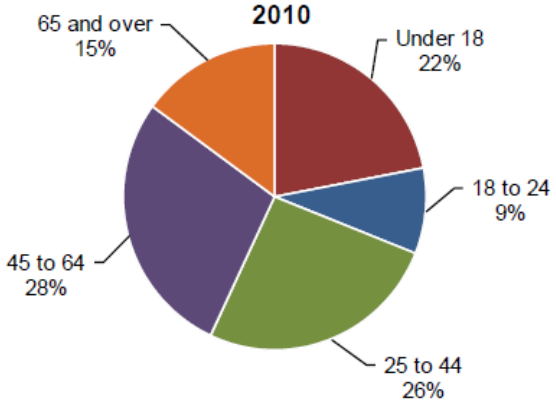
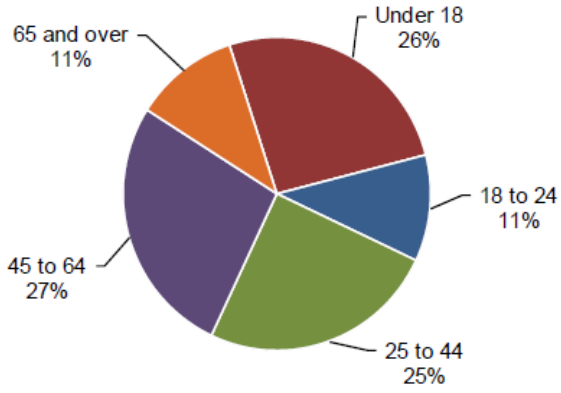


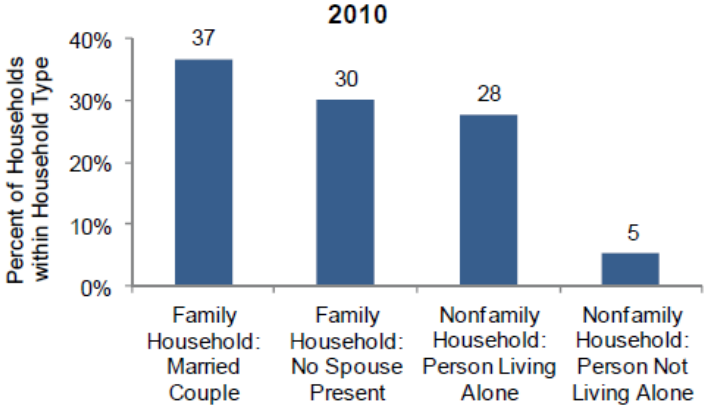
Figure 10.1b Males by Age, Hyde Park, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

Residents ages 45-64 accounted for the largest percentage of the Hyde Park population in 2010 (data not shown). Females 45-64 years of age were 28% of the female population in Hyde Park and males were 27% of the male population in the same age group.

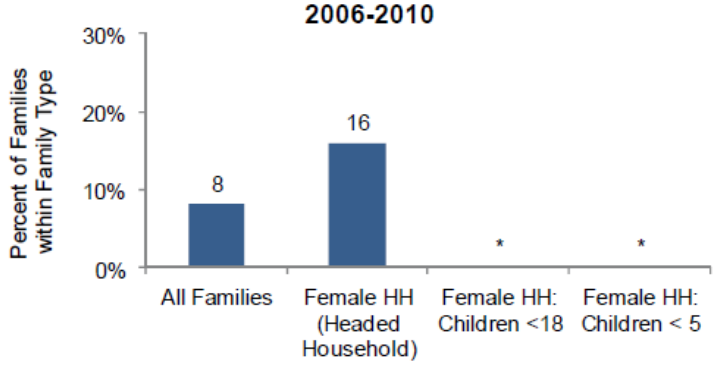
Figure 10.2 Type of Household, Hyde Park, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In Hyde Park, 67% of households were family households. The highest percentage of households was family households with a married couple present (37%). Thirty-three percent of households were nonfamily households.

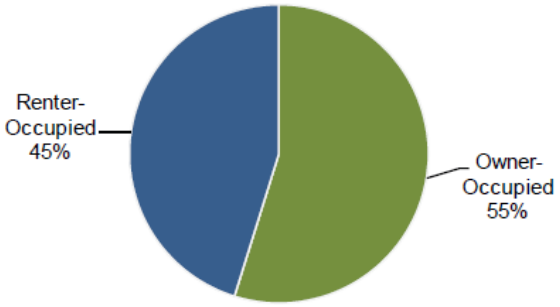
Figure 10.3 Families with Income Below Poverty Level by Family Type, Hyde Park, 2006-2010



* Insufficient sample size
DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

In Hyde Park, a higher percentage of female headed households (16%) had an income below the poverty level as compared with all families (8%).

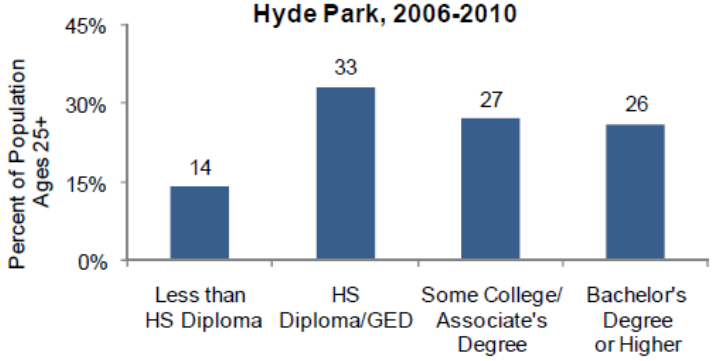
Figure 10.4 Housing Tenure, Hyde Park, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In Hyde Park, just over half (55%) of occupied units were owner-occupied.

Figure 10.5 Educational Attainment, Hyde Park, 2006-2010



DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

In Hyde Park, 14% of the population had less than a high school diploma. One-third of the population had a high school diploma/GED while only 26% had a Bachelor's degree or higher.

Figure 10.6a Selected Health Indicators, Hyde Park									
Selected Health Indicators	Annual Rates							Average Annual Rates[1]	
	2005	2006	2007	2008	2009	2010	2011	HP	BOSTON
Adolescent Birth Rate (per 1,000 females ages 15-17)	✧	17.4	17.4	14.7	n<5	14.7	NA	12.7	20.1
Low Birth Weight Births (percent of live births)	11.7%	9.4%	11.3%	10.0%	10.9%	8.2%	NA	10.3%	9.3%
Preterm Births (percent of live births)	12.7%	10.7%	13.7%	9.8%	12.0%	9.7%	NA	11.4%	9.9%
Asthma Emergency Department Visits (per 1,000 children under age 5)	31.6	35.1	36.1	35.1	28.5	21.4	19.3	29.6	31.5
Elevated Blood Lead Levels (percent of children testing positive)	2.2%	3.2%	1.4%	1.4%	1.6%	1.0%	1.2%	1.7%	1.4%
Chlamydia Incidence (per 100,000 residents)	NA	NA	NA	NA	691.5	740.7	933.7	788.6	720.9
Hepatitis C Incidence (per 100,000 residents ages 15-25)	NA	n<5	n<5	n<5	n<5	n<5	NA	26.7	45.7
Heart Disease Hospitalizations* (per 1,000 residents)	13.5	12.1	11.6	12.2	10.8	13.1	11.8	12.2	11.2
Diabetes Hospitalizations* (per 1,000 residents)	1.5	2.2	2.3	2.3	2.0	2.8	2.4	2.2	2.3
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2.8	2.3	3.0	2.9	3.0	2.9	2.7	2.8	2.5
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	1.1	1.3	0.9	1.0	0.9	1.5	1.0	1.1	0.9
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	51.5	36.4	28.4	25.9	32.1	23.1	NA	32.9	35.3
Homicide* (per 100,000 residents)	n<5	n<5	n<5	14.9	n<5	n<5	NA	10.0	7.9
Substance Abuse Deaths* (per 100,000 residents)	57.2	40.0	31.3	19.3	31.6	20.2	NA	33.2	33.9
Suicide* (per 100,000 residents)	n<5	n<5	n<5	n<5	n<5	n<5	NA	4.8	5.7

[1] Combines all years shown individually for the indicator for which data are available.

✧ Data suppressed to protect confidentiality.

*Age-adjusted rates

Gray text represents rates based on counts less than 20 and should be interpreted with caution.

Black text represents rates based on counts of at least 20.

Shaded in red are neighborhood rates or percentages that are higher than the corresponding Boston rate or percentage for the same year(s).

Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.

For data source information see end of section.

Figure 10.6b Selected Health Indicator, Hyde Park							
Selected Health Indicator	Rolling Averages						BOSTON
	2001-2005	2002-2006	2003-2007	2004-2008	2005-2009	2006-2010	2006-2010
Infant Deaths (per 1,000 live births)	7.8	8.4	8.0	6.8	8.6	6.8	5.9

Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Shaded in red are neighborhood rates that are higher than the corresponding Boston rate for the same year(s).
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 10.6c Selected Health Indicators, Hyde Park Leading Causes of Death, 2005-2010		
Cancer	Rate*	Count
2005	226.6	81
2006	198.6	73
2007	165.6	59
2008	256.2	92
2009	214.9	77
2010	224.0	81
HP 2005-2010	214.3	463
BOS 2005-2010	181.4	5,679
Diseases of the Heart	Rate*	Count
2005	160.2	57
2006	153.5	56
2007	157.7	56
2008	146.6	52
2009	118.4	44
2010	158.9	57
HP 2005-2010	149.2	322
BOS 2005-2010	152.0	4,831
COPD	Rate*	Count
2005	43.3	16
2006	56.2	20
2007	37.7	13
2008	40.5	14
2009	25.0	9
2010	27.5	10
HP 2005-2010	38.4	82
BOS 2005-2010	28.7	886

* Age-adjusted rates per 100,000 residents
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Shaded in red are neighborhood rates that are higher than the corresponding Boston rate for the same year(s).
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 10.7 Selected Adult Survey Health Indicators, Hyde Park							
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI)						
	2001	2003	2005	2006	2008	2010	BOSTON
Cigarette Smoking							
Percent	26%	20%	11%	18%	14%	14%	16%
CI	(14.1-38.1)	(10.7-30.3)	(5.6-16.7)	(11.0-25.0)	(6.4-22.2)	(8.4-19.9)	(14.0-17.3)
Regular Physical Activity							
Percent	48%	64%	59%	54%	49%	50%	57%
CI	(33.1-62.2)	(51.5-76.2)	(45.4-72.1)	(41.5-66.1)	(31.4-67.2)	(39.9-59.6)	(54.7-59.3)
Asthma							
Percent	*	12%	5%	17%	9%	12%	11%
CI		(3.1-21.7)	(0.8-9.6)	(7.6-25.5)	(3.3-14.4)	(6.0-17.4)	(9.5-12.4)
Diabetes							
Percent	12%	10%	7%	7%	5%	8%	6%
CI	(2.7-21.5)	(2.3-17.7)	(3.0-11.5)	(3.0-10.2)	(2.0-8.5)	(4.0-12.2)	(5.4-7.0)
Obesity							
Percent	25%	12%	17%	24%	28%	31%	21%
CI	(13.4-37.2)	(2.6-20.5)	(7.8-26.7)	(14.9-32.9)	(15.9-40.1)	(21.3-39.9)	(18.9-22.7)
Persistent Sadness							
Percent	5%	6%	3%	10%	9%	10%	9%
CI	(0.1-10.2)	(0.7-11.1)	(0.7-6.1)	(3.3-16.9)	(2.9-15.4)	(4.6-15.0)	(8.1-10.7)

*Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2001, 2003, 2005, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Figure 10.8a Selected Health Indicators by Race/Ethnicity, Hyde Park					
Selected Health Indicators	Years	Average Annual Rates			
		Asian	Black	Latino	White
Adolescent Birth Rate (per 1,000 females ages 15-17)	2006-2010	n<5	9.0	22.6	10.4
Low Birth Weight Births (percent of live births)	2010	n<5	10.0%	6.7%	7.1%
Preterm Births (percent of live births)	2010	n<5	10.4%	11.5%	7.9%
Infant Deaths (per 1,000 live births)	2009-2010	n<5	11.7	n<5	n<5
Asthma Emergency Department Visits (per 1,000 children under age 5)	2010-2011	n<7	19.6	26.8	10.8
Heart Disease Hospitalizations* (per 1,000 residents)	2011	n<7	12.7	9.3	11.5
Diabetes Hospitalizations* (per 1,000 residents)	2011	n<7	3.4	2.1	1.5
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2011	n<7	3.5	2.2	2.1
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	2010-2011	n<7	1.8	1.0	0.6
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	2007-2010	n<5	16.7	60.2	30.9
Homicide* (per 100,000 residents)	2008-2010	n<5	19.1	n<5	n<5
Substance Abuse Deaths* (per 100,000 residents)	2008-2010	n<5	11.0	24.8	39.6
Suicide* (per 100,000 residents)	2010	n<5	n<5	n<5	n<5

* Age-adjusted rates
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes
For data source information see end of section.

Figure 10.8b Selected Health Indicators by Race/Ethnicity, Hyde Park		
Leading Causes of Death, Average Annual Rates, 2008-2010		
Asian	**Rate***	**Count**
†	†	†
†	†	†
†	†	†
Black	**Rate***	**Count**
Cancer	198.8	85
Diseases of the Heart	71.5	30
Homicide	19.1	9
Latino	**Rate***	**Count**
Cancer	155.0	14
Cerebrovascular Disease (Incl. Stroke)	80.2	6
Other Injuries	25.6	5
White	**Rate***	**Count**
Cancer	286.7	148
Diseases of the Heart	209.2	117
COPD	54.7	30

* Age-adjusted rates per 100,000 residents
† Not calculated, n<5
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 10.9 Selected Adult Survey Health Indicators by Race/Ethnicity, Hyde Park				
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI), 2006, 2008, and 2010 Combined			
	Asian	Black	Latino	White
Cigarette Smoking Percent	*	9%	12%	22%
CI		(3.2-15.1)	(4.2-20.7)	(15.8-27.7)
Regular Physical Activity Percent	*	52%	39%	53%
CI		(36.1-67.1)	(22.0-56.7)	(44.6-60.6)
Asthma Percent	*	14%	10%	12%
CI		(5.7-21.8)	(0.9-19.3)	(7.2-16.5)
Diabetes Percent	*	7%	7%	6%
CI		(3.2-11.7)	(0.3-13.6)	(3.2-8.1)
Obesity Percent	*	31%	27%	27%
CI		(18.5-42.9)	(12.6-42.3)	(20.1-34.1)
Persistent Sadness Percent	*	10%	12%	9%
CI		(3.4-17.5)	(3.1-21.8)	(5.1-12.5)

* Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Hyde Park Notes, Data Sources and Data Analysis

Figure 10.1a, 10.1b Population by Age and Sex, Hyde Park, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.2 Type of Household, Hyde Park, 2010
NOTE: The census defines a family household as one in which at least one person living in the household is related by birth, marriage, or adoption to the householder (head of household).
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.3 Families with Income Below Poverty Level by Family Type, Hyde Park, 2006-2010
NOTE: Data are estimates based on the American Community Survey. The data on poverty status of households were derived from answers to income questions. Since poverty is defined at the family level and not the household level, the poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. (For nonfamily householders, their own income is compared with the appropriate threshold.) The income of people living in the household who are unrelated to the householder is not considered when determining the poverty status of a household, nor does their presence affect the family size in determining the appropriate threshold. The poverty thresholds vary depending on three criteria: size of family, number of related children and for 1- and 2-person families, age of householder.
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.4 Housing Tenure, Hyde Park, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.5 Educational Attainment, Hyde Park, 2006-2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.6a-10.6c Selected Health Indicators, Hyde Park
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston Resident Live Births, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Elevated Blood Lead Levels: Boston Public Health Commission Office of Environmental Health
Chlamydia Incidence: Massachusetts Department of Public Health, STD Division
Hepatitis C Incidence: Communicable Disease Database, Boston Public Health Commission, Communicable Disease Control Division
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis

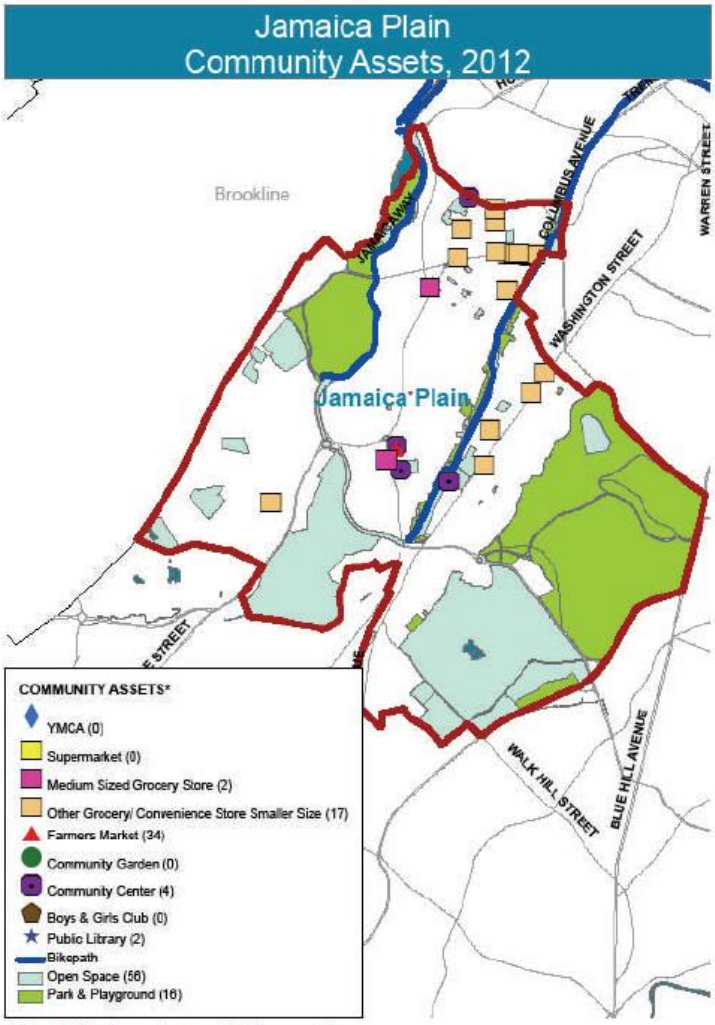
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, and Suicide: Boston Resident Deaths, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Leading Causes of Death: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.7 Selected Adult Survey Health Indicators, Hyde Park
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.8a, 10.8b Selected Health Indicators by Race/Ethnicity, Hyde Park
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston Resident Live Births, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, Suicide, and Leading Causes of Deaths: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 10.9 Selected Adult Survey Health Indicators by Race/Ethnicity, Hyde Park
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Jamaica Plain



*Count of each asset presented in parentheses

Jamaica Plain, originally part of the Town of Roxbury, was annexed to Boston in 1874. In the mid-19th century, 24 breweries were built along the Stony Brook that ran along the Jamaica Plain/Roxbury line. Drawn to the work at these breweries, German immigrants settled around Hyde Square. The availability of work in area factories also brought Irish immigrants to the neighborhood.

Jamaica Plain has much planned green space. In 1848, the beautiful Forest Hills Cemetery opened, with graves and monuments integrated into the natural landscape. Jamaica Pond and the Arnold Arboretum were incorporated into Boston's Emerald Necklace, Frederick Law Olmstead's renowned linked series of parklands. Today, the neighborhood is a diverse one, with large Latino, and gay and lesbian communities.

Figure 11.1a Females by Age, Jamaica Plain, 2010

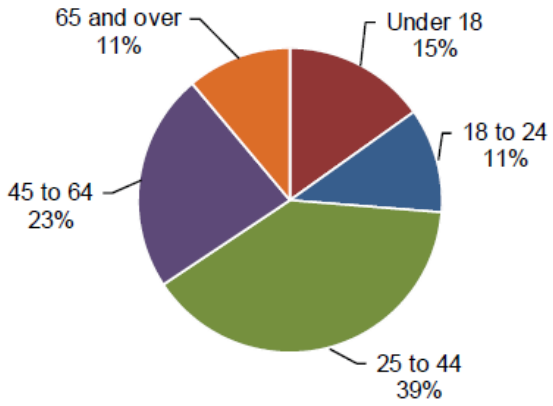
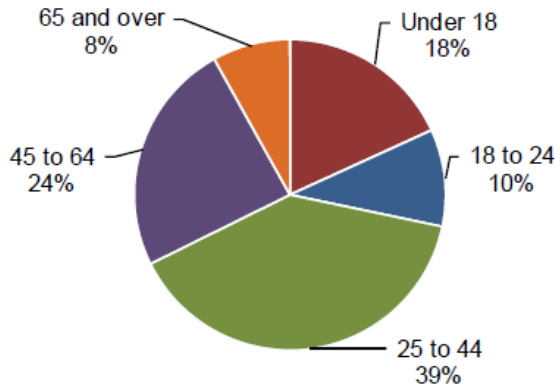


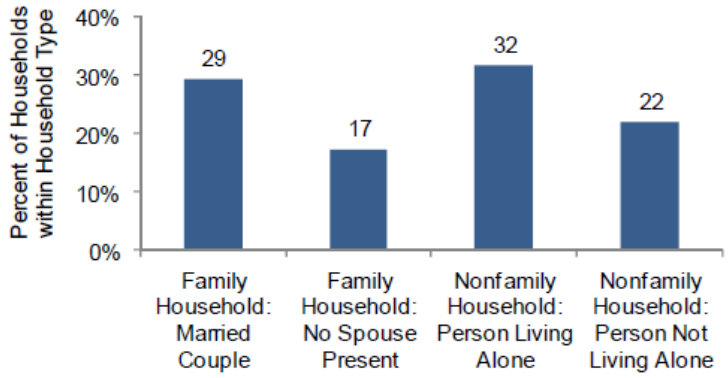
Figure 11.1b Males by Age, Jamaica Plain, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

Residents ages 25-44 accounted for the largest percentage of the Jamaica Plain population (data not shown). Females and males 25-44 years of age were 39% of their respective population in Jamaica Plain.

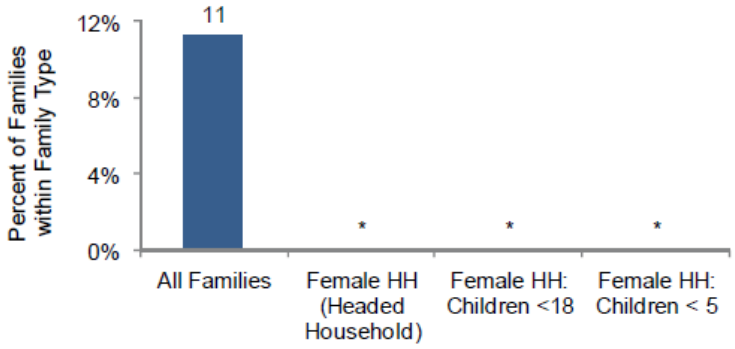
Figure 11.2 Type of Household, Jamaica Plain, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In Jamaica Plain, nonfamily households were a slight majority (54%). The highest percentage of households were people living alone (32%) while the lowest percentage of households were family households with no spouse present (17%).

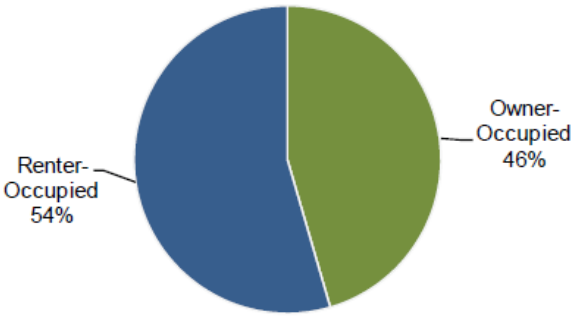
Figure 11.3 Families with Income Below Poverty Level by Family Type, Jamaica Plain, 2006-2010



* Insufficient sample size
DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

In Jamaica Plain, 11% of all families had an income below the poverty level.

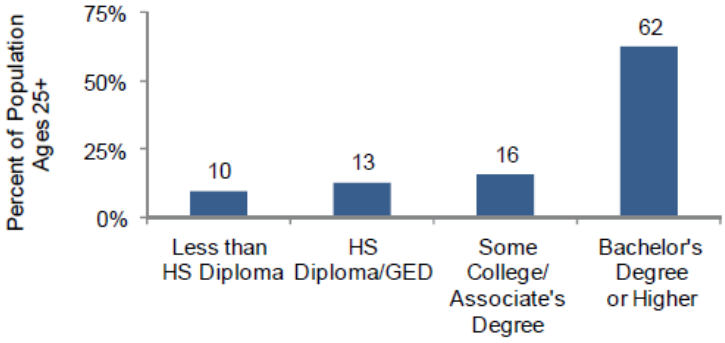
Figure 11.4 Housing Tenure, Jamaica Plain, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In Jamaica Plain, just over half (54%) of occupied units were renter-occupied.

Figure 11.5 Educational Attainment, Jamaica Plain, 2006-2010



DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

In Jamaica Plain, 62% of the population had a Bachelor's degree or higher. This was significantly higher than the other three lower levels of educational attainment.

Figure 11.6a Selected Health Indicators, Jamaica Plain									
Selected Health Indicators	Annual Rates							Average Annual Rates[1]	
	2005	2006	2007	2008	2009	2010	2011	JP	BOSTON
Adolescent Birth Rate (per 1,000 females ages 15-17)	21.9	27.4	32.9	16.4	21.9	19.2	NA	23.3	20.1
Low Birth Weight Births (percent of live births)	9.0%	8.3%	6.0%	7.1%	7.3%	7.2%	NA	7.5%	9.3%
Preterm Births (percent of live births)	10.0%	8.6%	8.5%	9.2%	9.3%	7.9%	NA	8.9%	9.9%
Asthma Emergency Department Visits (per 1,000 children under age 5)	21.9	27.3	30.3	34.8	21.9	20.9	17.9	25.0	31.5
Elevated Blood Lead Levels (percent of children testing positive)	1.8%	1.2%	0.7%	0.9%	0.8%	0.5%	0.6%	0.9%	1.4%
Chlamydia Incidence (per 100,000 residents)	NA	NA	NA	NA	559.3	485.9	567.8	537.7	720.9
Hepatitis C Incidence (per 100,000 residents ages 15-25)	NA	n<5	n<5	n<5	n<5	n<5	NA	32.3	45.7
Heart Disease Hospitalizations* (per 1,000 residents)	10.3	9.8	10.8	9.8	9.2	8.1	8.5	9.5	11.2
Diabetes Hospitalizations* (per 1,000 residents)	1.6	2.4	2.4	1.8	2.1	1.9	1.8	2.0	2.3
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2.5	2.1	1.9	2.4	1.8	2.0	2.1	2.1	2.5
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	0.9	0.9	1.0	0.6	0.7	0.8	0.5	0.8	0.9
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	39.6	n<5	19.0	n<5	n<5	27.9	NA	20.8	35.3
Homicide* (per 100,000 residents)	n<5	n<5	n<5	16.0	n<5	n<5	NA	7.8	7.9
Substance Abuse Deaths* (per 100,000 residents)	n<5	52.0	20.3	n<5	n<5	43.3	NA	25.3	33.9
Suicide* (per 100,000 residents)	n<5	n<5	n<5	n<5	n<5	n<5	NA	5.4	5.7

[1] Combines all years shown individually for the indicator for which data are available.

*Age-adjusted rates

Gray text represents rates based on counts less than 20 and should be interpreted with caution.

Black text represents rates based on counts of at least 20.

Shaded in red are neighborhood rates or percentages that are higher than the corresponding Boston rate or percentage for the same year(s).

Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.

For data source information see end of section.

Figure 11.6b Selected Health Indicator, Jamaica Plain							
Selected Health Indicator	Rolling Averages						BOSTON
	2001-2005	2002-2006	2003-2007	2004-2008	2005-2009	2006-2010	2006-2010
Infant Deaths (per 1,000 live births)	5.2	3.8	3.8	5.5	4.5	4.9	5.9

Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 11.6c Selected Health Indicators, Jamaica Plain		
Leading Causes of Death, 2005-2010		
Cancer	Rate*	Count
2005	172.8	48
2006	155.1	39
2007	153.9	41
2008	146.8	39
2009	134.3	35
2010	146.5	38
JP 2005-2010	151.6	240
BOS 2005-2010	181.4	5,679
Diseases of the Heart	Rate*	Count
2005	162.1	39
2006	141.5	37
2007	122.9	30
2008	121.6	29
2009	157.4	39
2010	104.4	25
JP 2005-2010	135.0	199
BOS 2005-2010	152.0	4,831
Other Injuries	Rate*	Count
2005	37.1	10
2006	47.1	13
2007	18.1	6
2008	n<5	n<5
2009	15.0	5
2010	41.9	12
JP 2005-2010	28.5	49
BOS 2005-2010	32.9	1,116

* Age-adjusted rates per 100,000 residents
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 11.7 Selected Adult Survey Health Indicators, Jamaica Plain							
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI)						
	2001	2003	2005	2006	2008	2010	BOSTON 2010
Cigarette Smoking							
Percent	*	14%	12%	15%	11%	11%	16%
CI		(4.8-22.7)	(6.7-17.2)	(7.5-21.7)	(0.9-21.5)	(6.2-15.3)	(14.0-17.3)
Regular Physical Activity							
Percent	*	58%	48%	68%	61%	58%	57%
CI		(44.7-71.5)	(39.5-56.8)	(60.4-75.0)	(50.6-72.0)	(50.0-65.7)	(54.7-59.3)
Asthma							
Percent	*	*	14%	6%	9%	15%	11%
CI			(8.5-18.8)	(3.3-9.2)	(4.8-12.9)	(8.8-21.4)	(9.5-12.4)
Diabetes							
Percent	*	*	4%	3%	5%	5%	6%
CI			(1.2-7.2)	(1.5-4.8)	(1.8-8.3)	(2.6-7.2)	(5.4-7.0)
Obesity							
Percent	*	13%	17%	10%	15%	16%	21%
CI		(4.9-21.9)	(10.3-23.0)	(6.4-13.5)	(9.1-21.7)	(10.6-21.4)	(18.9-22.7)
Persistent Sadness							
Percent	*	*	8%	7%	6%	7%	9%
CI			(3.8-13.0)	(3.2-11.4)	(2.2-10.0)	(3.4-9.8)	(8.1-10.7)

*Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2001, 2003, 2005, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Figure 11.8a Selected Health Indicators by Race/Ethnicity, Jamaica Plain					
Selected Health Indicators	Years	Average Annual Rates			
		Asian	Black	Latino	White
Adolescent Birth Rate (per 1,000 females ages 15-17)	2007-2010	n<5	37.3	22.3	17.9
Low Birth Weight Births (percent of live births)	2009-2010	13.5%	13.3%	8.6%	4.9%
Preterm Births (percent of live births)	2009-2010	10.8%	12.2%	9.1%	7.6%
Infant Deaths (per 1,000 live births)	2010	n<5	n<5	n<5	n<5
Asthma Emergency Department Visits (per 1,000 children under age 5)	2011	n<7	44.9	17.3	10.6
Heart Disease Hospitalizations* (per 1,000 residents)	2010-2011	3.4	13.1	8.6	6.9
Diabetes Hospitalizations* (per 1,000 residents)	2011	n<7	5.0	2.4	1.2
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2011	n<7	3.2	3.0	1.4
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	2010-2011	n<7	2.0	1.2	0.2
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	2009-2010	n<5	n<5	n<5	16.4
Homicide* (per 100,000 residents)	2007-2010	n<5	33.3	16.4	n<5
Substance Abuse Deaths* (per 100,000 residents)	2006-2010	n<5	40.2	28.4	28.5
Suicide* (per 100,000 residents)	2008-2010	n<5	n<5	n<5	10.2

* Age-adjusted rates
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 11.8b Selected Health Indicators by Race/Ethnicity, Jamaica Plain		
Leading Causes of Death, Average Annual Rates, 2008-2010		
Asian	**Rate***	**Count**
†	†	†
†	†	†
†	†	†
Black	**Rate***	**Count**
Diseases of the Heart	226.2	20
Cancer	157.5	18
Nephritis/Nephrosis	74.9	7
Latino	**Rate***	**Count**
Cancer	108.2	17
Diseases of the Heart	38.7	6
Homicide	21.8	6
White	**Rate***	**Count**
Cancer	151.2	73
Diseases of the Heart	131.8	65
Other Injuries	23.7	13

* Age-adjusted rates per 100,000 residents
† Not calculated, n<5
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 11.9 Selected Adult Survey Health Indicators by Race/Ethnicity, Jamaica Plain				
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI), 2006, 2008, and 2010 Combined			
	Asian	Black	Latino	White
Cigarette Smoking Percent	*	6%	12%	14%
CI		(0.9-11.2)	(4.5-20.4)	(8.4-20.3)
Regular Physical Activity Percent	*	65%	44%	65%
CI		(46.8-83.5)	(31.1-56.8)	(58.6-70.4)
Asthma Percent	*	10%	14%	9%
CI		(0.3-18.8)	(2.6-24.7)	(6.2-11.7)
Diabetes Percent	*	10%	10%	3%
CI		(0.3-19.3)	(4.9-14.3)	(1.5-3.7)
Obesity Percent	*	27%	21%	11%
CI		(10.6-42.5)	(12.1-30.0)	(7.6-13.5)
Persistent Sadness Percent	*	8%	16%	5%
CI		(0.0-17.7)	(6.3-25.4)	(2.9-6.8)

* Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Jamaica Plain Notes, Data Sources, and Data Analysis

Figure 11.1a, 11.1b Population by Age and Sex, Jamaica Plain, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.2 Type of Household, Jamaica Plain, 2010
NOTE: The census defines a family household as one in which at least one person living in the household is related by birth, marriage, or adoption to the householder (head of household).
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.3 Families with Income Below Poverty Level by Family Type, Jamaica Plain, 2006-2010
NOTE: Data are estimates based on the American Community Survey. The data on poverty status of households were derived from answers to income questions. Since poverty is defined at the family level and not the household level, the poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. (For nonfamily householders, their own income is compared with the appropriate threshold.) The income of people living in the household who are unrelated to the householder is not considered when determining the poverty status of a household, nor does their presence affect the family size in determining the appropriate threshold. The poverty thresholds vary depending on three criteria: size of family, number of related children and for 1- and 2-person families, age of householder.
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.4 Housing Tenure, Jamaica Plain, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.5 Educational Attainment, Jamaica Plain, 2006-2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.6a–11.6c Selected Health Indicators, Jamaica Plain
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston Resident Live Births, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Elevated Blood Lead Levels: Boston Public Health Commission Office of Environmental Health
Chlamydia Incidence: Massachusetts Department of Public Health, STD Division
Hepatitis C Incidence: Communicable Disease Database, Boston Public Health Commission, Communicable Disease Control Division
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, and Suicide: Boston Resident Deaths, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health

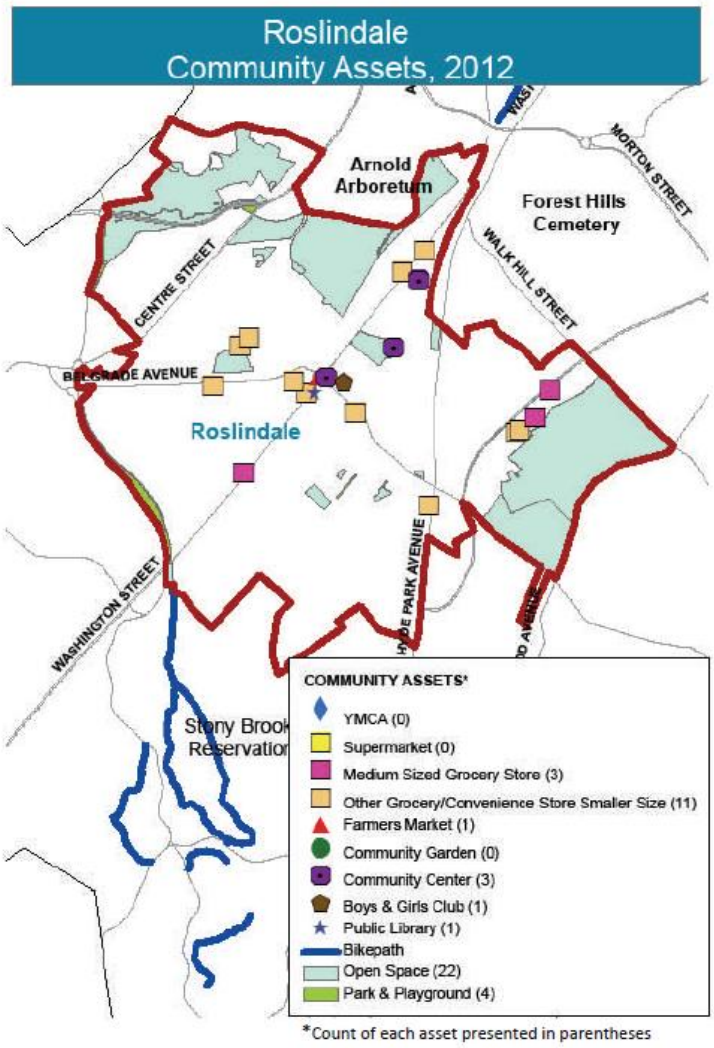
Leading Causes of Death: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.7 Selected Adult Survey Health Indicators, Jamaica Plain
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.8a, 11.8b Selected Health Indicators by Race/Ethnicity, Jamaica Plain
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston Resident Live Births, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, Suicide, and Leading Causes of Deaths: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 11.9 Selected Adult Survey Health Indicators by Race/Ethnicity, Jamaica Plain
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Roslindale



*Count of each asset presented in parentheses

Roslindale was originally part of the City of Roxbury and was called South Street Crossing. The establishment of a post office branch in 1870 precipitated the name change when the Postal Service rejected the name South Street Crossing. Officials decided to name the area after Roslyn, a town in Scotland; "dale" was added as the area was surrounded by hills. The neighborhood was annexed to the City of Boston with West Roxbury in 1873.

For most of the 20th century, Roslindale Square was a thriving business district. The 1970s brought competition from suburban malls, which forced businesses to close, stores to remain vacant, and the Square to be devoid of shoppers. An active local revitalization effort that began in the 1980s earned Roslindale Square a "Main Street" award from the National Trust for Historic Preservation. It is known nationally as a model of neighborhood economic revitalization.

Figure 14.1a Females by Age, Roslindale, 2010

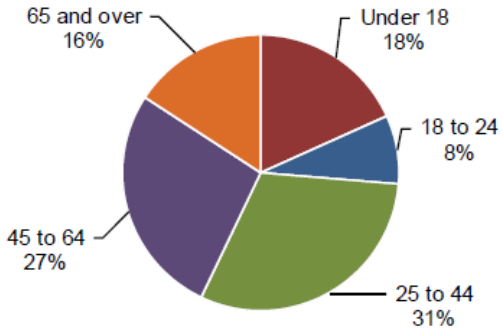
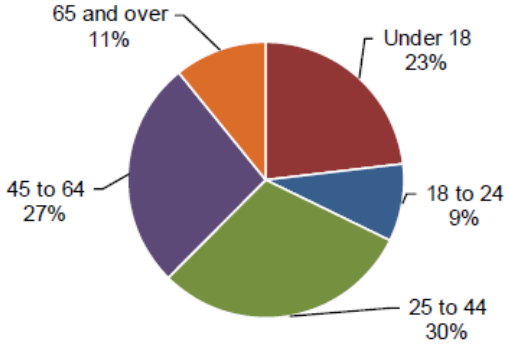


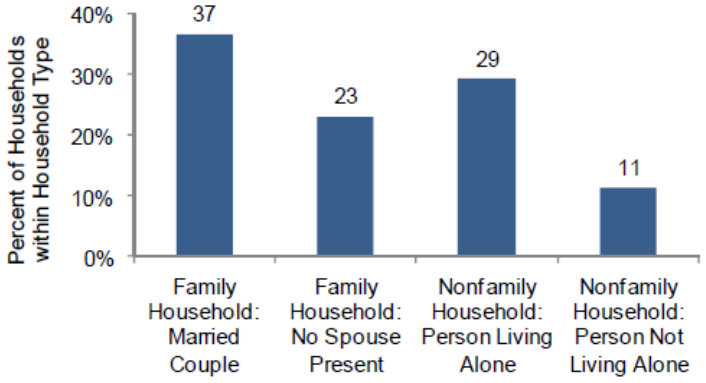
Figure 14.1b Males by Age, Roslindale, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

Residents ages 25-44 accounted for about one-third (31%) of the Roslindale population in 2010 (data not shown). Females and males 25-44 years of age were 31% and 30% of their respective population in Roslindale.

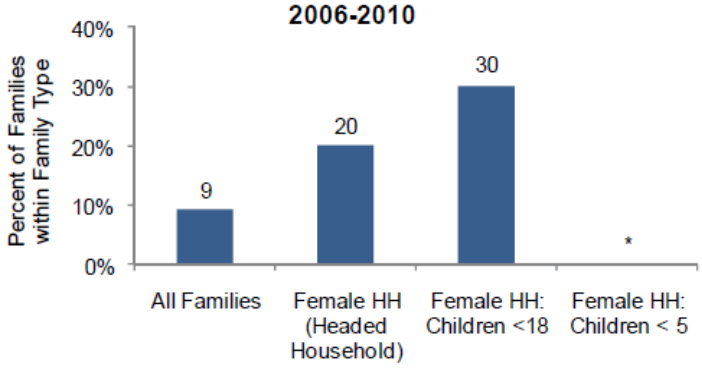
Figure 14.2 Type of Household, Roslindale, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In Roslindale, 60% of households were family households. The highest percentage of households were family households with a married couple present (37%); 29% of households consisted of persons living alone.

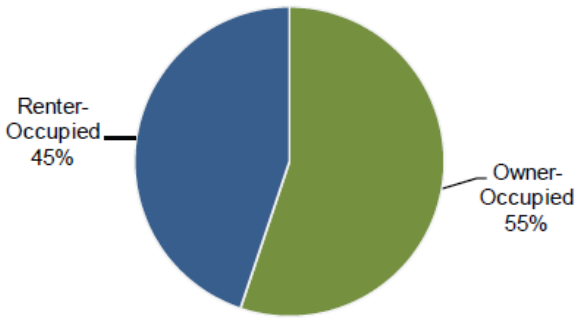
Figure 14.3 Families with Income Below Poverty Level by Family Type, Roslindale, 2006-2010



*Insufficient sample size
DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

Nine percent of all families in Roslindale had an income below the poverty level.

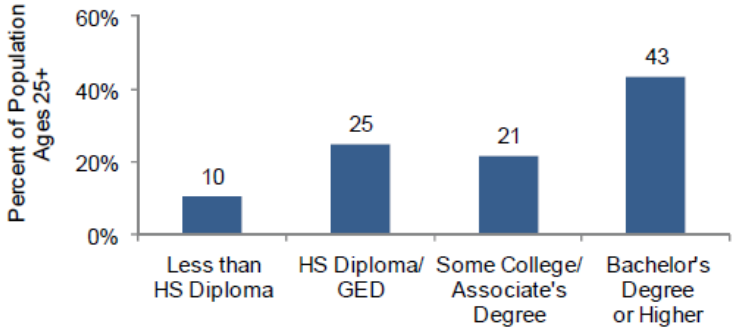
Figure 14.4 Housing Tenure, Roslindale, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In Roslindale, just over half (55%) of occupied units were owner-occupied.

Figure 14.5 Educational Attainment, Roslindale, 2006-2010



DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

In Roslindale, 43% of the population had a Bachelor's degree or higher. Twenty-five percent of the population had a high school diploma/GED, which was significantly lower than the percent with a Bachelor's degree or higher.

Figure 14.6a Selected Health Indicators, Roslindale									
Selected Health Indicators	Annual Rates							Average Annual Rates[1]	
	2005	2006	2007	2008	2009	2010	2011	RS	BOSTON
Adolescent Birth Rate (per 1,000 females ages 15-17)	✧	14.4	21.5	14.4	n<5	18.0	NA	14.4	20.1
Low Birth Weight Births (percent of live births)	7.6%	8.0%	10.1%	8.4%	6.1%	6.2%	NA	7.8%	9.3%
Preterm Births (percent of live births)	9.0%	8.4%	11.7%	7.0%	8.7%	5.4%	NA	8.4%	9.9%
Asthma Emergency Department Visits (per 1,000 children under age 5)	20.3	33.0	32.5	31.5	23.9	31.5	17.8	27.2	31.5
Elevated Blood Lead Levels (percent of children testing positive)	2.7%	2.1%	1.8%	1.3%	1.6%	1.2%	0.6%	1.6%	1.4%
Chlamydia Incidence (per 100,000 residents)	NA	NA	NA	NA	606.9	576.7	559.9	581.1	720.9
Hepatitis C Incidence (per 100,000 residents ages 15-25)	NA	n<5	n<5	n<5	n<5	n<5	NA	43.0	45.7
Heart Disease Hospitalizations* (per 1,000 residents)	14.1	13.0	12.7	11.4	11.4	10.0	10.1	11.8	11.2
Diabetes Hospitalizations* (per 1,000 residents)	1.1	2.0	2.2	1.7	1.5	2.1	1.6	1.8	2.3
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2.5	2.3	2.6	2.8	1.9	2.3	1.7	2.3	2.5
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	0.9	1.1	1.1	1.0	1.1	1.0	0.7	1.0	0.9
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	35.8	52.8	58.3	34.9	28.0	39.8	NA	41.6	35.3
Homicide* (per 100,000 residents)	n<5	n<5	n<5	n<5	n<5	n<5	NA	5.3	7.9
Substance Abuse Deaths* (per 100,000 residents)	25.2	47.9	24.7	29.0	32.9	26.7	NA	31.1	33.9
Suicide* (per 100,000 residents)	n<5	n<5	n<5	n<5	n<5	n<5	NA	4.4	5.7

[1] Combines all years shown individually for the indicator for which data are available.

✧ Data suppressed to protect confidentiality.

*Age-adjusted rates

Gray text represents rates based on counts less than 20 and should be interpreted with caution.

Black text represents rates based on counts of at least 20.

Shaded in red are neighborhood rates or percentages that are higher than the corresponding Boston rate or percentage for the same year(s).

Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.

For data source information see end of section.

Figure 14.6b Selected Health Indicator, Roslindale							
Selected Health Indicator	Rolling Averages						BOSTON
	2001-2005	2002-2006	2003-2007	2004-2008	2005-2009	2006-2010	2006-2010
Infant Deaths (per 1,000 live births)	5.5	3.6	3.6	6.0	6.2	5.4	5.9

Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 14.6c Selected Health Indicators, Roslindale		
Leading Causes of Death, 2005-2010		
Diseases of the Heart	Rate*	Count
2005	178.3	83
2006	166.0	79
2007	166.0	79
2008	189.3	89
2009	152.6	70
2010	130.8	66
RS 2005-2010	163.8	466
BOS 2005-2010	152.0	4,831
Cancer	Rate*	Count
2005	235.7	93
2006	218.0	84
2007	177.5	66
2008	176.5	71
2009	229.5	89
2010	160.8	64
RS 2005-2010	199.6	467
BOS 2005-2010	181.4	5,679
COPD	Rate*	Count
2005	30.6	14
2006	34.7	13
2007	21.8	10
2008	35.5	14
2009	19.0	9
2010	53.3	22
RS 2005-2010	32.5	82
BOS 2005-2010	28.7	886

* Age-adjusted rates per 100,000 residents
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Shaded in red are neighborhood rates that are higher than the corresponding Boston rate for the same year(s).
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 14.7 Selected Adult Survey Health Indicators, Roslindale							
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI)						
	2001	2003	2005	2006	2008	2010	BOSTON 2010
Cigarette Smoking							
Percent	16%	16%	19%	13%	10%	10%	16%
CI	(6.7-25.7)	(6.3-25.2)	(9.4-29.2)	(5.8-19.7)	(4.0-15.2)	(4.7-16.1)	(14.0-17.3)
Regular Physical Activity							
Percent	42%	53%	50%	58%	52%	52%	57%
CI	(28.3-56.5)	(39.9-66.7)	(40.1-60.6)	(48.2-67.0)	(40.0-63.9)	(41.3-61.8)	(54.7-59.3)
Asthma							
Percent	11%	7%	12%	11%	16%	11%	11%
CI	(3.5-19.2)	(0.7-13.8)	(3.6-19.8)	(5.0-17.9)	(5.0-27.1)	(5.3-15.8)	(9.5-12.4)
Diabetes							
Percent	*	9%	8%	6%	4%	6%	6%
CI		(3.0-11.6)	(3.6-11.6)	(2.7-8.5)	(1.3-5.9)	(2.8-8.7)	(5.4-7.0)
Obesity							
Percent	27%	27%	25%	16%	21%	29%	21%
CI	(14.9-38.8)	(15.3-39.3)	(15.9-33.3)	(10.7-21.1)	(13.0-29.7)	(19.7-38.0)	(18.9-22.7)
Persistent Sadness							
Percent	*	*	7%	5%	6%	8%	9%
CI			(2.7-11.2)	(2.1-7.7)	(2.5-8.5)	(3.3-12.1)	(8.1-10.7)

* Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2001, 2003, 2005, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Figure 14.8a Selected Health Indicators by Race/Ethnicity, Roslindale					
Selected Health Indicators	Years	Average Annual Rates			
		Asian	Black	Latino	White
Adolescent Birth Rate (per 1,000 females ages 15-17)	2007-2010	n<5	14.8	19.2	9.7
Low Birth Weight Births (percent of live births)	2006-2010	7.2%	11.1%	8.0%	6.6%
Preterm Births (percent of live births)	2006-2010	5.2%	11.8%	9.1%	7.0%
Infant Deaths (per 1,000 live births)	2008-2010	n<5	19.8	n<5	n<5
Asthma Emergency Department Visits (per 1,000 children under age 5)	2011	n<7	41.1	17.2	9.1
Heart Disease Hospitalizations* (per 1,000 residents)	2011	9.4	9.7	6.7	10.7
Diabetes Hospitalizations* (per 1,000 residents)	2011	n<7	2.1	4.0	1.0
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2010-2011	n<7	3.8	1.5	1.6
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	2009-2011	n<7	1.6	1.2	0.3
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	2008-2010	n<5	64.7	n<5	32.0
Homicide* (per 100,000 residents)	2006-2010	n<5	19.8	n<5	n<5
Substance Abuse Deaths* (per 100,000 residents)	2009-2010	n<5	n<5	43.9	30.7
Suicide* (per 100,000 residents)	2008-2010	n<5	n<5	n<5	8.3

* Age-adjusted rates

Gray text represents rates based on counts less than 20 and should be interpreted with caution.

Black text represents rates based on counts of at least 20.

Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.

For data source information see end of section.

Figure 14.8b Selected Health Indicators by Race/Ethnicity, Roslindale		
Leading Causes of Death, Average Annual Rates, 2008-2010		
Asian	**Rate***	**Count**
Cancer	193.9	5
†	†	†
†	†	†
Black	**Rate***	**Count**
Cancer	178.7	24
Diseases of the Heart	122.4	15
Cerebrovascular Disease (Incl. Stroke)	64.7	7
Latino	**Rate***	**Count**
Cancer	96.2	15
Other Injuries	36.7	6
Diseases of the Heart	26.8	5
White	**Rate***	**Count**
Diseases of the Heart	180.4	205
Cancer	208.4	180
COPD	43.9	42

* Age-adjusted rates per 100,000 residents
† Not calculated, n<5
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 14.9 Selected Adult Survey Health Indicators by Race/Ethnicity, Roslindale				
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI), 2006, 2008, and 2010 Combined			
	Asian	Black	Latino	White
Cigarette Smoking Percent	*	11%	8%	13%
CI		(3.9-17.9)	(0.0-15.9)	(7.6-17.4)
Regular Physical Activity Percent	*	51%	53%	56%
CI		(32.0-69.3)	(35.3-70.3)	(49.2-61.9)
Asthma Percent	*	22%	10%	12%
CI		(2.4-41.1)	(2.4-17.0)	(7.9-15.4)
Diabetes Percent	*	3%	*	6%
CI		(0.6-6.1)		(4.0-8.6)
Obesity Percent	*	21%	23%	22%
CI		(8.0-33.9)	(11.3-33.9)	(16.7-27.6)
Persistent Sadness Percent	*	6%	9%	5%
CI		(0.9-11.6)	(2.9-15.7)	(2.9-7.4)

* Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Roslindale Notes, Data Sources, and Data Analysis

Figure 14.1a, 14.1b Population by Age and Sex, Roslindale, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.2 Type of Household, Roslindale, 2010
NOTE: The census defines a family household as one in which at least one person living in the household is related by birth, marriage, or adoption to the householder (head of household).
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.3 Families with Income Below Poverty Level by Family Type, Roslindale, 2006-2010
NOTE: Data are estimates based on the American Community Survey. The data on poverty status of households were derived from answers to income questions. Since poverty is defined at the family level and not the household level, the poverty status of the household is determined by the poverty status of the householder. Households are classified as poor when the total income of the householder's family is below the appropriate poverty threshold. (For nonfamily householders, their own income is compared with the appropriate threshold.) The income of people living in the household who are unrelated to the householder is not considered when determining the poverty status of a household, nor does their presence affect the family size in determining the appropriate threshold. The poverty thresholds vary depending on three criteria: size of family, number of related children and for 1- and 2-person families, age of householder.
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.4 Housing Tenure, Roslindale, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.5 Educational Attainment, Roslindale, 2006-2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.6a-14.6c Selected Health Indicators, Roslindale
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston Resident Live Births, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Elevated Blood Lead Levels: Boston Public Health Commission Office of Environmental Health
Chlamydia Incidence: Massachusetts Department of Public Health, STD Division
Hepatitis C Incidence: Communicable Disease Database, Boston Public Health Commission, Communicable Disease Control Division
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis

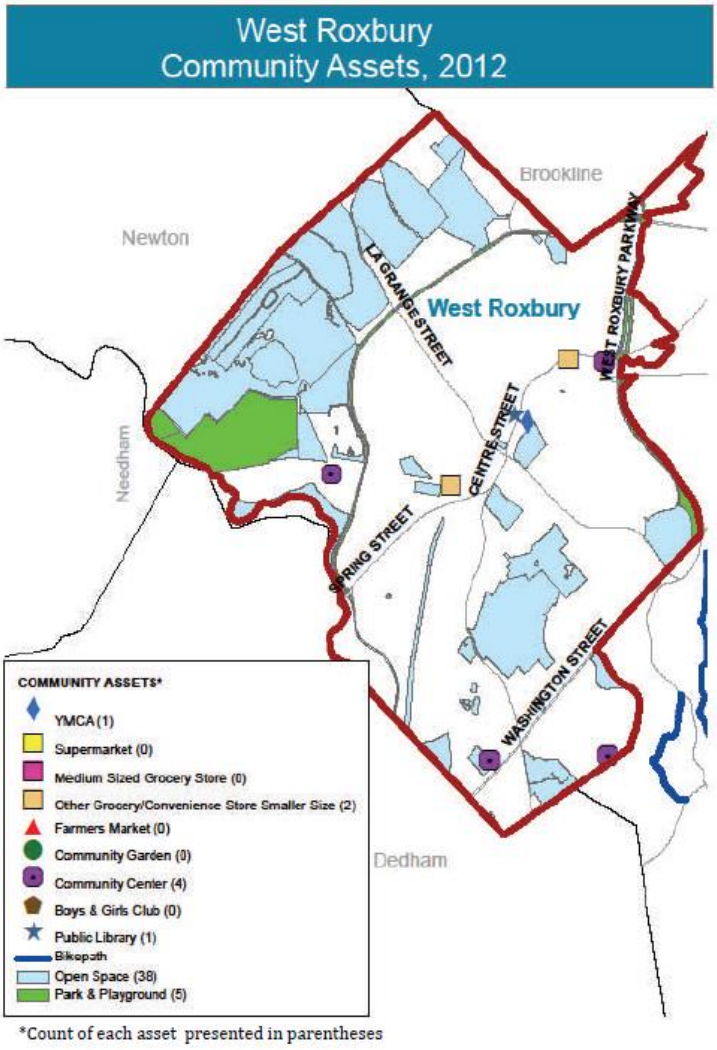
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, and Suicide: Boston Resident Deaths, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Leading Causes of Death: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.7 Selected Adult Survey Health Indicators, Roslindale
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.8a, 14.8b Selected Health Indicators by Race/Ethnicity, Roslindale
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston Resident Live Births, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, Suicide, and Leading Causes of Deaths: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 14.9 Selected Adult Survey Health Indicators by Race/Ethnicity, Roslindale
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

West Roxbury



*Count of each asset presented in parentheses

Before 1630, West Roxbury was home to the Wampanoag Indian Tribe. When first inhabited by the Puritans, West Roxbury was part of the town of Roxbury and included the neighborhoods of Roslindale and Jamaica Plain. In 1851, West Roxbury broke away from Roxbury and formed its own government. The neighborhood was annexed by Boston in 1874.

In 1841, Brook Farm was established by Transcendentalists in West Roxbury as an experimental cooperative farm. Its members and regular visitors included many 19th century progressive writers and philosophers including Nathaniel Hawthorne, Ralph Waldo Emerson, Margaret Fuller, and Horace Greeley.

Figure 20.1a Females by Age, West Roxbury, 2010

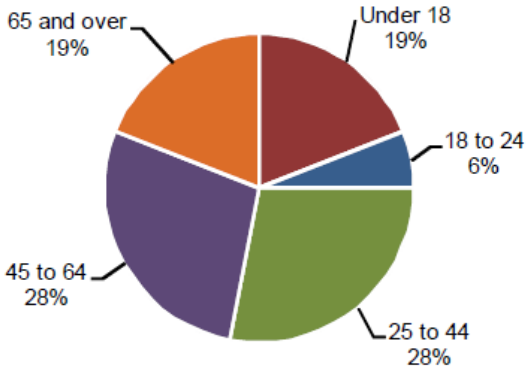
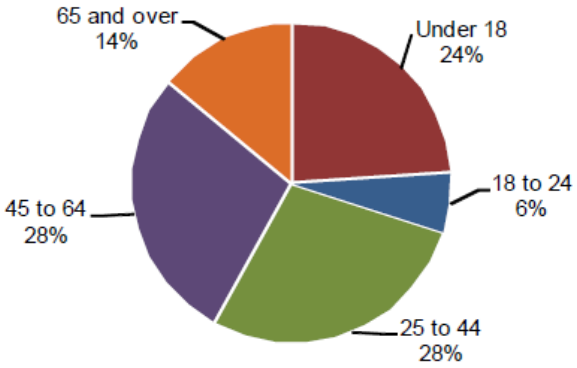


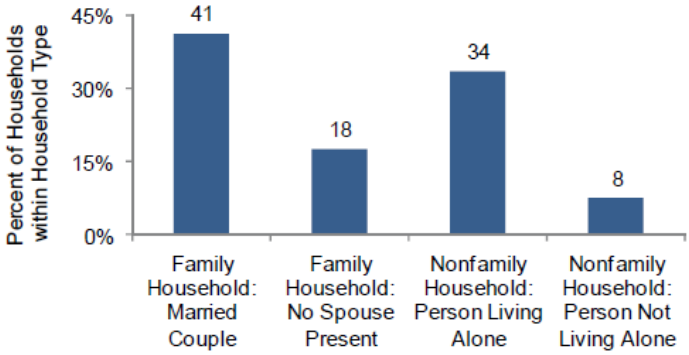
Figure 20.1b Males by Age, West Roxbury, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

Residents ages 25 to 64 accounted for over half (56%) of the West Roxbury population in 2010 (data not shown). Females 25 to 44 years of age as well as those 45 to 64 years of age were 28% of the female population. Males in those same age groups accounted for the same percentages as females.

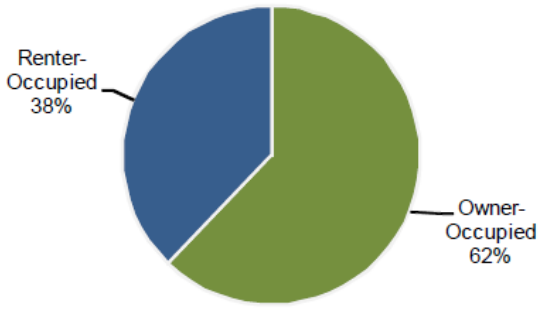
Figure 20.2 Type of Household, West Roxbury, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, AmericanFactFinder

In West Roxbury, 59% of households were family households. The highest percentage of households were family households with a married couple present (41%). Thirty-four percent of households consisted of persons living alone.

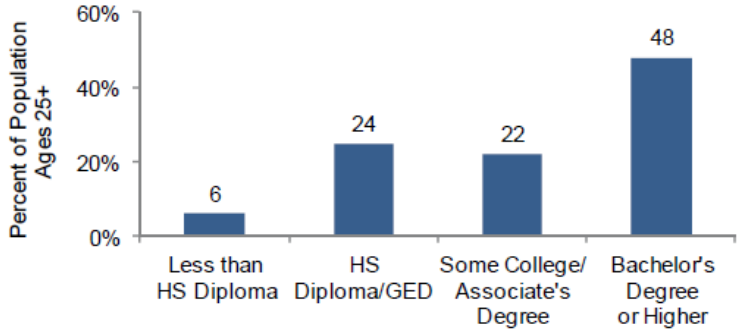
Figure 20.3 Housing Tenure, West Roxbury, 2010



DATA SOURCE: Census 2010, US Department of Commerce, Bureau of the Census, American FactFinder

In West Roxbury, almost two-thirds (62%) of occupied units were owner-occupied.

Figure 20.4 Educational Attainment, West Roxbury, 2006-2010



DATA SOURCE: US Census Bureau, 2006-2010 American Community Survey

In West Roxbury, 48% of the population had a Bachelor's degree or higher, and 24% of the population had a high school degree/GED. Lower percentages of the population had either less than a high school diploma (6%) or some college/Associate's degree (22%).

Figure 20.5a Selected Health Indicators, West Roxbury									
Selected Health Indicators	Annual Rates							Average Annual Rates[1]	
	2005	2006	2007	2008	2009	2010	2011	WR	BOSTON
Adolescent Birth Rate (per 1,000 females ages 15-17)	n<5	n<5	n<5	n<5	n<5	n<5	NA	2.7	20.1
Low Birth Weight Births (percent of live births)	6.1%	8.1%	7.0%	5.9%	6.2%	8.8%	NA	7.0%	9.3%
Preterm Births (percent of live births)	7.4%	8.8%	8.5%	8.0%	6.4%	9.9%	NA	8.2%	9.9%
Asthma Emergency Department Visits (per 1,000 children under age 5)	✧	15.7	13.2	6.9	13.8	10.0	n<7	10.3	31.5
Elevated Blood Lead Levels (percent of children testing positive)	1.0%	1.4%	1.0%	0.5%	1.1%	0.5%	0.7%	0.9%	1.4%
Chlamydia Incidence (per 100,000 residents)	NA	NA	NA	NA	96.7	154.7	189.5	146.9	720.9
Hepatitis C Incidence (per 100,000 residents ages 15-25)	NA	n<5	n<5	n<5	n<5	n<5	NA	78.3	45.7
Heart Disease Hospitalizations* (per 1,000 residents)	9.9	10.1	8.2	9.2	8.7	8.2	8.6	9.0	11.2
Diabetes Hospitalizations* (per 1,000 residents)	1.1	0.9	1.1	1.2	1.3	0.8	1.4	1.1	2.3
Cerebrovascular Disease Hospitalizations (Incl. Stroke)* (per 1,000 residents)	2.0	1.7	2.1	1.6	1.9	2.1	2.1	1.9	2.5
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	n<7	n<7	0.4	n<7	n<7	n<7	n<7	0.3	0.9
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	36.7	49.9	46.9	25.3	25.3	34.5	NA	36.4	35.3
Homicide* (per 100,000 residents)	n<5	n<5	n<5	n<5	n<5	n<5	NA	n<5	7.9
Substance Abuse Deaths* (per 100,000 residents)	n<5	47.9	51.1	18.2	27.6	16.9	NA	28.7	33.9
Suicide* (per 100,000 residents)	n<5	n<5	n<5	n<5	n<5	n<5	NA	7.5	5.7

[1]Combines all years shown individually for the indicator for which data are available.

*Age-adjusted rates

✧Data suppressed to protect confidentiality.

Gray text represents rates based on counts less than 20 and should be interpreted with caution.

Black text represents rates based on counts of at least 20.

Shaded in red are neighborhood rates or percentages that are higher than the corresponding Boston rate or percentage for the same year(s).

Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.

For data source information see end of section.

Figure 20.5b Selected Health Indicator, West Roxbury					
Selected Health Indicator	Rolling Averages				BOSTON
	2002-2007	2003-2008	2004-2009	2005-2010	2005-2010
Infant Deaths (per 1,000 live births)	2.5	2.1	2.1	2.6	5.8

Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes In data values may occur during data quality processes.
For data source information see end of section.

Figure 20.5c Selected Health Indicators, West Roxbury		
Leading Causes of Death, 2005-2010		
Cancer	Rate*	Count
2005	178.6	68
2006	200.3	70
2007	173.2	66
2008	165.2	59
2009	184.4	70
2010	199.1	74
WR 2005-2010	183.5	407
BOS 2005-2010	181.4	5,678
Diseases of the Heart	Rate*	Count
2005	178.3	70
2006	151.0	63
2007	176.1	70
2008	154.6	66
2009	151.5	61
2010	127.8	56
WR 2005-2010	156.6	386
BOS 2005-2010	152.0	4,831
Cerebrovascular Disease (Incl. Stroke)	Rate*	Count
2005	36.7	16
2006	49.9	21
2007	46.9	22
2008	25.3	11
2009	25.3	11
2010	34.5	14
WR 2005-2010	36.4	95
BOS 2005-2010	35.3	1,116

*Age-adjusted rates per 100,000 residents
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Shaded in red are neighborhood rates that are higher than the corresponding Boston rate for the same year(s).
Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 20.6 Selected Adult Survey Health Indicators, West Roxbury							
Selected Adult Survey Health Indicators	Percentage of Adult Residents and Confidence Intervals (CI)						
	2001	2003	2005	2006	2008	2010	BOSTON 2010
Cigarette Smoking Percent	15%	20%	15%	10%	16%	15%	16%
CI	(6.0-24.3)	(6.8-32.9)	(6.8-23.7)	(5.6-14.2)	(8.4-23.7)	(8.7-20.4)	(14.0-17.3)
Regular Physical Activity Percent	49%	59%	56%	54%	55%	53%	57%
CI	(35.4-62.0)	(43.1-74.2)	(45.6-65.6)	(45.6-62.4)	(46.6-63.9)	(44.6-61.5)	(54.7-59.3)
Asthma Percent	10%	*	12%	11%	14%	7%	11%
CI	(1.6-18.8)		(5.9-17.9)	(6.5-16.1)	(7.3-20.4)	(3.4-11.0)	(9.5-12.4)
Diabetes Percent	*	4%	10%	4%	7%	6%	6%
CI		(0.5-8.5)	(4.2-14.8)	(1.5-5.7)	(3.5-10.6)	(2.8-8.4)	(5.4-7.0)
Obesity Percent	15%	13%	13%	13%	23%	24%	21%
CI	(6.7-23.6)	(1.3-23.8)	(7.5-19.4)	(7.7-18.8)	(15.2-31.1)	(15.7-32.4)	(18.9-22.7)
Persistent Sadness Percent	*	*	4%	8%	7%	9%	9%
CI			(0.8-6.3)	(3.6-13.4)	(3.6-10.8)	(3.3-15.4)	(8.1-10.7)

*Insufficient sample size

DATA SOURCE: Boston Behavioral Risk Factor Survey, 2001, 2003, 2005, 2006, 2008, and 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission

Figure 20.7a Selected Health Indicators by Race/Ethnicity, West Roxbury					
Selected Health Indicators	Years	Average Annual Rates			
		Asian	Black	Latino	White
Adolescent Birth Rate (per 1,000 females ages 15-17)	2010	n<5	n<5	n<5	n<5
Low Birth Weight Births (percent of live births)	2008-2010	7.7%	5.8%	13.9%	6.3%
Preterm Births (percent of live births)	2008-2010	7.7%	8.5%	13.0%	7.4%
Infant Deaths (per 1,000 live births)	2010	n<5	n<5	n<5	n<5
Asthma Emergency Department Visits (per 1,000 children under age 5)	2008-2011	n<7	25.6	30.4	4.5
Heart Disease Hospitalizations* (per 1,000 residents)	2010-2011	5.7	15.4	7.8	8.0
Diabetes Hospitalizations* (per 1,000 residents)	2009-2011	n<7	2.5	2.7	1.0
Cerebrovascular Disease Hospitalizations (Incl.Stroke)* (per 1,000 residents)	2009-2011	1.7	2.5	1.8	2.0
Nonfatal Gunshot/Stabbing Emergency Department Visits* (per 1,000 residents)	2009-2011	n<7	n<7	n<7	0.2
Cerebrovascular Disease Deaths (Incl. Stroke)* (per 100,000 residents)	2010	n<5	n<5	n<5	36.3
Homicide* (per 100,000 residents)	2010	n<5	n<5	n<5	n<5
Substance Abuse Deaths* (per 100,000 residents)	2009-2010	n<5	n<5	n<5	22.7
Suicide* (per 100,000 residents)	2009-2010	n<5	n<5	n<5	10.4

* Age-adjusted rates
Gray text represents rates based on counts less than 20 and should be interpreted with caution.
Black text represents rates based on counts of at least 20.
Birth and death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.
For data source information see end of section.

Figure 20.7b Selected Health Indicators by Race/Ethnicity, West Roxbury		
Leading Causes of Death, Average Annual Rates, 2006-2010		
Asian	**Rate***	**Count**
†	†	†
†	†	†
†	†	†
Black	**Rate***	**Count**
Diseases of the Heart	183.1	17
Cancer	161.8	16
†	†	†
Latino	**Rate***	**Count**
Cancer	63.6	5
†	†	†
†	†	†
White	**Rate***	**Count**
Cancer	197.9	313
Diseases of the Heart	157.9	294
Cerebrovascular Disease (Incl. Stroke)	37.8	74

*Age-adjusted rates per 100,000 residents

†Not calculated, n<5

Gray text represents rates based on counts less than 20 and should be interpreted with caution.

Black text represents rates based on counts of at least 20.

Death data for 2010 are preliminary and should be interpreted with caution. Until data are final, some changes in data values may occur during data quality processes.

For data source information see end of section.

West Roxbury Notes, Data Sources, and Data Analysis

Figure 20.1a, 20.1b Population by Age and Sex, West Roxbury, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 20.2 Type of Household, West Roxbury, 2010
NOTE: The census defines a family household as one in which at least one person living in the household is related by birth, marriage, or adoption to the householder (head of household).
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 20.3 Housing Tenure, West Roxbury, 2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 20.4 Educational Attainment, West Roxbury, 2006-2010
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 20.5a-20.5c Selected Health Indicators, West Roxbury
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston resident live births, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Elevated Blood Lead Levels: Boston Public Health Commission Office of Environmental Health
Chlamydia Incidence: Massachusetts Department of Public Health, STD Division
Hepatitis C Incidence: Communicable Disease Database, Boston Public Health Commission, Communicable Disease Control Division
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, and Suicide: Boston Resident Deaths, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Leading Causes of Death: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 20.6 Selected Adult Survey Health Indicators, West Roxbury
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Figure 20.7a, 20.7b Selected Health Indicators by Race/Ethnicity, West Roxbury
DATA SOURCES:
Adolescent Birth Rate, Low Birth Weight Births, and Preterm Births: Boston resident live births, Massachusetts Department of Public Health
Infant Deaths: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health
Asthma Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Heart Disease Hospitalizations, Diabetes Hospitalizations, and Cerebrovascular Disease Hospitalizations (Incl. Stroke): Inpatient Hospital Discharge Database, Massachusetts Center for Health Information and Analysis
Nonfatal Gunshot/Stabbing Emergency Department Visits: Hospital Emergency Department Visits identified among three databases: Inpatient Hospital Discharge Database, Outpatient Hospital Emergency Department Database, and Outpatient Hospital Observation Database, Massachusetts Center for Health Information and Analysis
Cerebrovascular Disease Deaths (Incl. Stroke), Homicide, Substance Abuse Deaths, Suicide, and Leading Causes of Deaths: Boston Resident Deaths, Massachusetts Department of Public Health
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office