CHNA 17 Assessment Report

2011

Prepared by the Regional Center for Healthy Communities (Metrowest)

Funded by Mount Auburn Hospital

MOUNT AUBURN HOSPITAL

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Executive Summary

Community Health Network Area (CHNA) 17 is a collaborative of organizations and residents from the cities and towns of Cambridge, Somerville, Arlington, Watertown, Belmont, and Waltham. Beginning in 2009 the CHNA carried out a comprehensive community health assessment that identified four priority areas that will guide the CHNA's work from 2011 to 2016. The assessment was carried out by a group of coalition members including residents, non-governmental organizations, schools, hospitals and health departments with technical assistance and evaluation support from outside consultants. Through a year and a half of meetings and community events, the group gathered and analyzed both quantitative and qualitative data to find topics that:

- people in our communities see as a problem
- affect all 6 CHNA communities
- can be changed measurably and sustainably in 5 years
- have resources related to them that we can build on
- affect vulnerable populations

Secondary data were collected from electronic sources and from CHNA member organizations. Primary data were collected through surveys and interviews of community members. After analyzing the data, the assessment guidance group identified the following four priority areas:

1.) Youth substance abuse, mental health and access to services
2.) Adult mental health
3.) Obesity and active living
4.) Crime and safety

The CHNA's efforts and expenditures over the coming years will be focused in these four areas.

Introduction

Who we are

A Community Health Network is a local coalition of public, non-profit, and private sector organizations working together to build healthier communities in Massachusetts through community-based prevention planning and health promotion. The Massachusetts Department of Public Health established the Community Health Network Area (CHNA) effort in 1992. Today this initiative involves all 351 towns and cities through 27 Community Health Networks. (www.mass.gov, 4/2011) Community Health Network Area (CHNA) 17 is a collaborative of organizations and residents from 6 cities and towns: Cambridge, Somerville, Arlington, Watertown, Belmont and Waltham.

Why we did a community health assessment

Between 2010 and 2016, CHNA 17 will receive a total of $1.5 million through Determination of Need funding from Mount Auburn Hospital. This is significantly more funding than the group has had in the past. In order to guide the group's use of the funds, the CHNA carried out a broad community health assessment to identify shared health priorities. The assessment will inform the group's health promotion and community-building efforts through the 5 years of funding.

The CHNA is founded on the concept that good health requires the broad and engaged participation of all members of a community. Throughout the assessment process, the CHNA made an effort to think about health not only as the physical health of the people who live in its member communities, but also as the spiritual, social, physical and emotional well-being of community members and of the community as a whole. Implicit in this approach is an understanding that health is not determined by healthcare, but by the social supports, environmental opportunities, policies and norms of the community and by the underlying economic factors and well-being of where people live.

Assessment Funding

The assessment was funded by Mount Auburn Hospital through a Determination of Need allocation. The funds paid for technical assistance from the Regional Center for Healthy Communities (Metrowest), a program of Mount Auburn Hospital, who helped to design the process and to facilitate the assessment group meetings. Mount Auburn Hospital's funding of the CHNA also supported the CHNA coordinator's time on the project and allowed the CHNA to hire the Institute for Community Health as an outside evaluator to help with data compilation and analysis, process design, and evaluation design. In addition, a small portion of a federal grant from Healthy People 2020 allowed the CHNA to incorporate social determinants of health

into the assessment process in a way that was deliberate and also allowed the group to offer stipends to unaffiliated community members to participate in the process.

Process and Players

The CHNA took a year and a half to carry out their assessment process. We began by building an assessment guidance group to lead the assessment process. We wrote an invitation to members to be part of the process. The CHNA articulated the roles of team members, wrote a timeline for meetings and described the work that members would have to do during and between meetings. Members passed out printed and electronic versions of the invitation and explained the process at general membership meetings. The first meeting of the assessment group had about 8 participants. The second had 16, and the third had even more. Although the attendance at meetings fluctuated, the number of people who had joined the group to participate and hear updates of the assessment process grew continually. The investment and participation from all six of the member communities increased over time. The roles and responsibilities of the planning group were as follows:

- Learn about assessment and help design the CHNA's assessment process
- Look at assessments that have already been done to see what other information should be gathered
- Help collect information about their community
- Look at the information from across the CHNA to find important ideas and decide how to present it to a wider group
- Plan community meetings to involve the public in the CHNA's assessment and planning
- Help involve a broad and diverse group of residents and other stakeholders in public meetings
- Develop a prioritization process for community needs
- Develop and finalize an expenditure plan based on the information that's collected

Stipends were available for 7 community members to be part of the planning team who would not be compensated through their job or who would otherwise not be able to participate. While this did allow a few unaffiliated individuals to participate in the team, their involvement was sporadic and much more active during the planning stages of the assessment. The majority of the assessment group members represented organizations or institutions with service areas within the CHNA borders. For a full list of assessment team members, see the Appendix.

The CHNA coordinator organized meetings of the assessment team, co-facilitated many of the discussions, captured decisions, shared the process with the larger membership, and connected the steering committee to the process. The Regional Center for Healthy Communities worked with the coordinator to develop a process and a timeline for the assessment, co-facilitated meetings, and participated in documentation and trouble-shooting. The Institute for Community Health was contracted as an evaluator for the project. They participated in

assessment meetings, helped to gather, analyze and compile data, and supported the group in planning a process to solicit further community input. After priorities had been chosen, they helped the CHNA begin to craft evaluation plans.

Methodology

Quantitative Data collection

After convening an assessment team, the second phase of the process was for the group to identify areas of interest to assess. We thought about more traditional health outcomes and also explored many of the social determinants of health. In order to help the group think about health more broadly than just health care and physical health, the assessment group answered the question "What does health mean to you?". The answers guided the development of an initial set of areas to explore. We brought their list to the CHNA's general membership to add areas that interested them but hadn't yet been mentioned. The fact that areas such as mental health, housing, hunger and violence were on the list allowed the full CHNA membership to move its thinking beyond chronic disease and acute illness.

Once we had created a long list of areas of interest, we began to collect existing information about each area from sources that included but were not limited to Mount Auburn Hospital's community needs assessment, MassCHIP (an online data repository created by the Massachusetts Department of Public Health), the Cambridge Homeless Census, the Cambridge Youth Health Survey and Parent Survey administered by the Cambridge Prevention Coalition, the state disabilities and disparities report, Youth Risk Behavior Surveys from Somerville, Arlington and Watertown, the Waltham Youth Survey, Walkscore.com and the Waltham Partnership for Youth. Members of the assessment guidance group helped to access information and reports from their communities and helped put the coordinator in touch with the right people in their towns. Our goal was to collect quantitative information about each subject for each of the 6 CHNA member communities.

As the data collection progressed, we became concerned that it would be difficult for the group to synthesize and use this information. We decided that we were collecting too much information and that it was not necessarily comparable between towns. In order to focus the data collection on only the information that would be most useful in making progress toward choosing priorities and developing a CHNA action plan, we decided that the assessment team should carry out a process to identify the criteria that we would later use to prioritize issues. We considered a broad range of criteria and decided to use the following five:

- People in our communities see this as a problem.
- This affects all 6 CHNA communities.
- We can make measurable and sustainable change on this in 5 years.
- There are resources related to this that we can build on.
- This affects vulnerable populations.

With help from the Regional Center for Healthy Communities and the Institute for Community Health, the assessment team decided what type of information we would need to collect in

order to be able to decide how well any particular health topic met the criteria. To answer the question of whether people in the community see it as a problem, we would need to ask community members what they saw as important issues. To know whether the issue affects all 6 communities we would need to look at quantitative data about magnitude and incidence of problems. To know whether we can make measureable change on a topic in 5 years we decided that members of the assessment team would be able to use their collective knowledge to decide. To know whether there are resources to build on, we decided that if the assessment team was diverse in terms of communities and agencies represented, the members could use their own knowledge to decide. This would avoid having to spend a significant amount of time and energy compiling a list of all of the resources available in every community. The question of whether the issue affects vulnerable populations was more difficult, but the group decided that the assessment team could also answer this question without referring to quantitative data.

With these requirements in mind, we continued to gather and compile secondary quantitative data in a more targeted way about the topic areas that the group had chosen to explore.

Qualitative Data Collection

The question of whether people in the communities see each particular issue as a problem required us to collect new local data about what issues are most relevant to them and their lives. We decided to ask a wide sample of community members in all 6 communities two questions:

1. What concerns you most about your community today?
2. What would make your community a better place to live?

These questions, and the way that they were presented and asked were crafted specifically to allow the answers to be broad and inclusive of the social determinants of health. We didn't want to bias people's thinking toward medical care or illness. We also tried to balance the questions between deficits and assets, and between challenges and vision for positive change.

We tried to ask the questions to groups that represented seniors, food pantries, faith communities and youth in each city and town as a way to reach a cross-section of ages and socio-economic strata within each community. In some cases assessment team members brought the questions to their own clients, in other cases youth interns took the questions to a public space such as town hall to record answers from whomever came by, and in some cases we asked CHNA members to bring the questions to meetings or events where they already planned to be.

In addition to bringing the questions out to communities and in order to build a larger base of support for the CHNA and for the idea of addressing social determinants in the coming years, we showed the video "Place Matters" at a CHNA meeting and encouraged each of the 6

member communities to hold at least one screening of an episode or a conversation about health and community building in their city. Three such screenings were held in Waltham and one was held at a CHNA general meeting. At each of the screenings, the organizer posed the CHNA's questions and documented the responses.

From the collected qualitative and quantitative information, we created Community Indicators Data Sheets for all 6 towns that could be presented to community members. While we had attempted to reach seniors, food pantries, faith communities and youth in every community, not every group had been reached in the initial survey phase of data collection. To address this, we contacted key informants from each town to share the data with them and to ask if there were issues that had not yet been identified. This was done through emails, phone calls and personal visits and meetings. A total of 64 organizations and community members were contacted to give their feedback to the initial data.

Findings

Community Data Sheets (begin on next page)

Community data sheets were compiled from both the quantitative data that had been collected and the results of surveys, key informant interviews and community meetings. The priorities presented for each community include indicators that show a more concerning rate than the state overall and themes or repeated concerns from qualitative data. For quantitative data sources, please see the relevant 'Data Sheet by Topic' in the following section.

We have been gathering data in your town by surveying community members, talking to community leaders and service providers, and looking at data collected by the schools and the state. These are the top issues affecting your town that we've learned about so far.

Community Data Indicators—Top Areas of Concern

	Arlington	Massachusetts
Invasive breast cancer incidence rate (# of new cases in one year per 100,000 people)	141	136
Marijuana--% of high school students who smoked marijuana in the past 30 days	24%	24%
Melanoma (skin cancer) incidence rate (# of new cases in one year per 100,000 people)	25	21
Prostate cancer age-adjusted death rate (# of deaths per 100,000 people)	27	26
Stroke age-adjusted death rate (# of deaths per 100,000 people)	43	42
Suicide rate (# of suicides per 100,000 people)	12	7

What Have Community Members Told Us Are Their Top Concerns?

(Feedback gathered from 11 people at community meetings)

- **Town budget concerns, leading to lack of funding for public services**
- **Lack of affordable housing for low and middle income populations**
- **Need for increased mental health and substance abuse services for youth**

What Have Community Leaders and Service Providers Told Us Are the Top Community Issues?

(Interviews with 2 community leaders from health department and older adult-serving agency)

- **Mental health**
  - **Lack of mental health services available to all populations**
  - **Recent increase in youth behavioral and family problems, domestic violence and suicides**

- **Older adults**
  - **Isolation, especially among immigrant elders**
  - **Lack of financial resources for housing and long-term care**

- **Working adults**
  - **Economic stress**
  - **Lack of access to health care**
  - **Lack of preventative health practices**

- **Youth**
  - **Substance abuse (alcohol, marijuana and prescription drugs)**

Does This Reflect Your Reality?

Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback gathered from staff person from the Board of Health, staff from a food assistance agency, and staff person from an older adult serving agency)

- **2 agencies definitely agree with above, 1 agency generally agrees**
- **Youth issues stand out as being of particular concern**

We have been gathering data in your town by surveying community members, talking to community leaders and service providers, and looking at data collected by the state. These are the top issues affecting your town that we've learned about so far.

Community Data Indicators—Top Areas of Concern

	Belmont	Massachusetts
Colorectal cancer incidence rate (# of new cases in one year per 100,000 people)	58	51
Invasive breast cancer incidence rate (# of new cases in one year per 100,000 people)	150	136
Melanoma (skin cancer) incidence rate (# of new cases in one year per 100,000 people)	33	21
Testicular cancer incidence rate (# of new cases in one year per 100,000 people)	13	6

What Have Community Members Told Us Are Their Top Concerns?

(Feedback gathered from 23 Seniors)

- **High taxes**
- **Lack of road maintenance**
- **Unfriendly people living in town**
- **Need for more services for older adults**

What Have Community Leaders and Service Providers Told Us Are the Top Community Issues?

(Interviews with 4 leaders from food assistance agency, health department, and 2 older adult-serving agencies)

- **Low income residents**
  - **Lack of services**

- **Older adults**
  - **Lack of affordable homecare**
  - **Lack of transportation to medical appointments**
  - **Need for increased heat, housing and nutrition assistance for frail older adults**

- **Youth**
  - **Lack of pediatricians**
  - **Youth substance abuse**

Does This Reflect Your Reality?

Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback from staff person from the Board of Health)

- **Areas of concern listed under data indicators are not really big issues for town**
- **Sample of community members surveyed wasn't big enough to accurately represent concerns. Also wishes there were more health issues listed here**
- **Context to add to leader and provider feedback—Primary source of public funding in Belmont is property tax, due to lack of commercial base. This puts big burden on residents, and currently there is shortage of public funds. Services are being cut, which leaves people unhappy, which in turn has an adverse effect on their health.**

We have been gathering data in your town by surveying community members, talking to community leaders and service providers, and looking at data collected by the schools and the state. These are the top issues affecting your town that we've learned about so far.

Community Data Indicators—Top Areas of Concern

	Cambridge	Massachusetts
Gonorrhea incidence rate (# of new cases in one year per 100,000 people)	43	38
Hepatitis B incidence rate (# of new cases in one year per 100,000 people)	18	7
HIV/AIDS prevalence rate (# of individuals with HIV/AIDS per 100,00 people)	363	264
Poverty		
--% of students eligible for reduced/free lunch	45%	29%
--% of adults that needed to see doctor but could not because of cost	17%	7%
Substance abuse-related emergency room visit age-adjusted rate (# of visits per 100,000 people)	1381	691

What Have Community Members Told Us Are Their Top Concerns?

(Feedback gathered from 22 youth, adults and older adults)

- **Violence and lack of security**
- **Need for more activities and services for youth, older adults and the mentally ill**
- **Sidewalk and street safety, especially need for bike riders to ride safely**

What Have Community Leaders and Service Providers Told Us Are the Top Community Issues?

(Interviews with 4 leaders from health care organization, health department, immigrant-serving agency, and older-adult serving agency)

- **Immigrants**
  - **Fear of accessing care and services**
  - **Lack of time for preventative health care**
  - **Limited literacy and lack of English skills**
  - **Work in jobs with occupational hazards**
- **Low-income residents**
  - **High cost of health care**
  - **Large homeless population**
  - **No family shelter programs**
- **Mental health and substance abuse**
  - **Lack of mental health services available**
  - **Lack of substance abuse treatment support**
- **Older adults**
  - **High cost of prescription drugs**
  - **Lack of affordable housing**
  - **Shortage of social services due to budget cuts**
- **Youth**
- **Obesity**

Does This Reflect Your Reality?

Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback gathered from 2 city employees, staff people from 2 housing assistance agencies, and a staff person from an older adult serving agency)

- **All agree that in general, the data sheet accurately reflects Cambridge issues**
- **The growing homeless population, immigrant issues, lack of mental health and substance abuse services, and lack of time for preventative health care stand out as being of particular concern**
- **Additional issue not mentioned above—lack of escorted transportation for seniors following day surgeries or procedures**

We have been gathering data in your town by surveying community members, talking to community leaders and service providers, and looking at data collected by the schools and the state. These are the top issues affecting your town that we've learned about so far.

Community Data Indicators—Top Areas of Concern

	Somerville	Massachusetts
Diabetes mellitus-related hospitalization rate (# of hospitalizations per 100,000 people)	2258	1930
Heart attack death age-adjusted rate (# of deaths per 100,000 people)	60	45
Hepatitis C incidence rate (# of new cases in one year per 100,000 people)	109	62
HIV/AIDS prevalence rate (# of individuals with HIV/AIDS per 100,00 people)	402	264
Poverty --% of students eligible for reduced/free lunch --% of adults that needed to see doctor but could not because of cost	 63% 40%	 29% 7%
Substance abuse-related hospitalization rate (# of hospitalizations per 100,000 people)	588	350
Syphilis incidence rate (# of new cases in one year per 100,000 people)	17	6

What Have Community Members Told Us Are Their Top Concerns?

(Feedback gathered from 65 youth, adults, and older adults)

- **Violence and crime**
- **Need for increased safety for walking and biking**
- **Lack of healthy activities for youth**
- **Environmental issues—need more green space, better recycling, clean air**

What Have Community Leaders and Service Providers Told Us Are the Top Issues?

(Interviews with 3 leaders from health department, immigrant-serving agency and older adult-serving agency)

- **Immigrants**
  - **Lack of health care**
  - **Mental health issues, including stress**
  - **Obesity, poor nutrition and lack of access to physical activities**
  - **Occupational health and safety**

- **Older adults**
  - **Lack of access to medical care (lack of geriatric providers, lack of available appointments, lack of transportation, etc.)**
  - **Medication costs and medication management**
  - **Mental health issues**

- **Youth**
  - **Lack of mental health services**
  - **Obesity**
  - **Substance abuse**

Does This Reflect Your Reality?

Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback gathered from staff from 2 older-adult serving agencies, and 3 city employees)

- **Data sheet generally accurately reflects Somerville issues**
- **Access to medical care, medication costs and medication management, and mental health issues stand out as being of particular concern**
- **People with disabilities, immigrants, the LGBT population and youth are all populations of concern in Somerville**
- **Additional areas of concern:**
    - **Lack of access to exercise and wellness activities**
    - **More recreational opportunities, better city planning, and an emphasis on walkability are needed to help reduce obesity and stress**
    - **Need for fall prevention programs**
    - **Stress, both for long-time residents and immigrant**

We have been gathering data in your town by surveying community members, talking to community leaders and service providers, and looking at data collected by the schools and the state. These are the top issues affecting your town that we've learned about so far.

Community Data Indicators—Top Areas of Concern

	Waltham	Massachusetts
Heart-attack-related emergency department visit rate (# of visits per 100,000 people)	32	26
HIV/AIDS prevalence (# of individuals with HIV/AIDS per 100,00 people)	279	264
Invasive breast cancer incidence (# of new cases in one year per 100,000 people)	144	136
Poverty--% of students eligible for reduced/free lunch	33%	29%
% of high school students ever told they had a **sexually transmitted disease**	16%	5%
Stroke death age-adjusted rate (# of deaths per 100,000 people)	56	43
Substance abuse-related hospitalization rate (# of hospitalizations per 100,000 people)	384	350

What Have Community Members Told Us Are Their Top Concerns?

(Feedback gathered from 6 older adults)

- **Lack of clean air**
- **Obesity**

What Have Community Leaders and Service Providers Told Us Are the Top Issues?

(Interviews with 5 leaders from community coalition, health care organization, health department, older adult-serving agency and youth-serving agency)

- **Immigrants**
  - **Access to healthcare**
  - **High cost of healthy foods**
  - **Low or no literacy in any language**
  - **Mental health issues**

- **Older adults**
  - **Isolation of elderly immigrant population**
  - **Lack of transportation for homebound elders**

- **Youth**
  - **Alcohol and other substance abuse**
  - **Lack of healthy out of school time activities, including summer jobs**
  - **Mental health, especially depression**
  - **School safety/bullying**

Does This Reflect Your Reality?

Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback gathered from staff from food assistance program and staff person from social service agency)

- **Additional areas of concern**
  - **Increased demand on existing organizations with the cut backs across social service programs**
  - **Isolation of all elderly and all immigrants, not just elderly immigrants**
  - **Lack of access to good, quality outpatient therapy for all age groups, particularly youth and children**
  - **Lack of affordable childcare options**
  - **Lack of food access with the close of the Red Cross food pantry**
  - **Lack of jobs and affordable housing for people with developmental disabilities**
  - **Limited home care for elderly**
  - **Long wait list for English as second language courses**
  - **Need for safe and affordable housing**

We have been gathering data in your town by surveying community members, talking to community leaders and service providers, and looking at data collected by the schools and the state. These are the top issues affecting your town that we've learned about so far.

Community Data Indicators—Top Areas of Concern

	Watertown	Massachusetts
% of high school students who were **bullied** at school	37%	22%
% of high school students who **smoked marijuana** in the past 30 days	31%	25%
% of high school students who experienced **depression** symptoms in the past 12 months	26%	24%
% of high school students who **seriously considered suicide** in the past 12 months	15%	13%
% of high school students who were **hurt physically or sexually by their date**	15%	11%

What Have Community Members Told Us Are Their Top Concerns?

(Feedback gathered from 140 community meeting attendees (youth and adults) and 10 older adults)

- **High taxes**
- **Lack of activities for youth**
- **Lack of safety**
- **Lack of street maintenance**
- **Overcrowded areas**
- **Youth substance abuse**

What Have Community Leaders and Service Providers Told Us Are the Top Community Issues?

(Interviews with 3 leaders from health department, older adult-serving agency, and youth-serving agency)

- **Immigrants**
  - **Health care access**
  - **Mental health issues**
  - **Parenting support**

- **Older adults**
  - **Isolation**
  - **Medication management**
  - **Mental health issues**

- **Youth**
  - **Lack of mental health services**
  - **Obesity**
  - **Substance abuse, especially alcohol use**

Does This Reflect Your Reality?

Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback gathered from 2 city employees)

- **Data sheet generally accurately reflects Watertown issues**
- **Additional areas of concern:**
  - **Asthma**
  - **Complications from obesity in children, especially diabetes**
  - **Lack of bicycle infrastructure, including dedicated bike paths/lanes. More bike-friendly city would lead to people being more active**
  - **Smoking**

Data Sheets by Topic

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of mental health services	Surveys Interviews		Interviews		Interviews	
Lack of access to healthcare	Interviews			Interviews		
Lack of services for low-income adults		Interviews				
General cuts in all public services	Surveys	Interviews	Survey		Interviews	
Lack of affordable childcare					Interviews	

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
% of renters paying >30% of household income for housing[1]	44%	46%	50%	49%	**52%**	44%	50%
% of property owners with mortgage paying >30% of household income for housing[1]	36%	39%	38%	**47%**	**51%**	**46%**	42%

Source: 1=Census American Community Survey 06-08 estimates
Highlighted boxes indicate percentages higher than the state overall

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of affordable housing for lower and middle income populations	Surveys	Interviews	Surveys		Surveys	
Lack of financial resources/assistance for housing for older adults	Interviews	Interviews	Surveys Interviews			
Lack of family shelter programs			Interviews			
Large homeless population			Interviews			

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
Invasive **breast cancer** incidence (female) - age adjusted rate per 100,000[1]	**143.4**	**136.9**	129.1	115.7	**151.8**	125.5	131.9
Invasive **colorectal cancer incidence** - age adjusted rate per 100,000[1]	51.8	49.8	49.8	50.6	52.7	46.3	54.2
Invasive **lung cancer incidence** - age adjusted rate per 100,000[1]	49.7	37.8	53.1	**72.8**	59.1	65	72.7
Invasive **melanoma/skin cancer incidence** - age adjusted rate per 100,000[3]	**24.4**	**35.6**	20.5	17.3	18.5	13.3	22.0
Invasive **prostate cancer incidence** - age adjusted rate per 100,000[4]	136.3	**166.7**	144.6	120.5	159	134.1	161.6
Diabetes mellitus-related death rate (age adjusted rate per 100,000)[5]	11.1	9.5	**18.6**	**23.1**	14.5	11.0	16.3
Acute myocardial infarction (heart attack)-related death rate (age adjusted rate per 100,000) [5]	32.4	30.7	**37.8**	**38.6**	**36.3**	**37.5**	34.9
Cerebrovascular disease (stroke)-related death rate (age adjusted rate per 100,000) [5]	33.5	**42.3**	34.8	30.9	**49.2**	**37.3**	36.4

Source: 1--MassCHIP, 3-year Average 2003-2005; 2--MassCHIP, 5-year average, 2001-2005; 3--MassCHIP, 4-year average, 2003-2006; 4--MassCHIP, 5-year Average, 2003-2007; 5-- MassCHIP, 3-year average 2004-2006

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of preventative health care	Interviews		Interviews	Interviews		
Health care access issues	Interviews	Interviews	Surveys Interviews	Interviews	Interviews	Interviews

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
Violent injuries that were treated in ED *(intentional gun-shot wound or stabbing)*[1]	7		10	23	7		
Crime index (*murders, rapes, robberies, assaults, burglaries, thefts, auto thefts, arson)*[2]	116	109	254	275	105	122	US avg=321
% of high school students who were bullied at school (time frame)[3]	14% (6 months)		6% (30 days)	**24%** (30 Days)	**23%** (Year)	**37%** (30 Days)	22% (Year)
% of high school students who were physically or sexually hurt by date (time frame) [3]	7% (Ever)		2% (12 mo)	6% (12 months)	10% (Ever)	**15%**	11% (Ever)
Hate crime incidents per bias motivation	5	2	5	1	1		

Source: 1= WRISS/MassCHIP, 2007 data; 2=City-data 2008; 3= Cambridge, Somerville, Watertown and Waltham High School YRBS, 2008; Arlington HS YRBS 2009; MA HS YRBS 2008; 4= FBI, 2008

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
High incidence of violence and crime			Surveys	Surveys		Surveys
School safety/bullying					Interviews	

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

Domestic Violence

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
% of high school students who were physically or sexually hurt by date (time frame)	7% (ever)		2% (12 months)	6% (12 months)	10% (ever)	15%	11% (ever)

Source: Cambridge, Somerville, Watertown and Waltham High School YRBS 2008; Arlington HS YRBS 2009; MA HS YRBS 2008

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Increase in Domestic Violence	Interviews					

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

Access to Services-- Immigrants

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Fear of accessing services			Interviews			
Limited literacy and lack of English skills			Interviews		Interviews	
Lack of health care access				Interviews	Interviews	Interviews

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
Mental disorders-related hospitalizations (age adjusted rate per 100,000)[1]	2300.4	1922.4	3281.4	**3649.3**	3064.7	2528.3	3490.8
Mental disorders-related emergency visits (age adjusted rate per 100,000)[2]	1895.4	1168.8	**3367.1**	3010.9	2236	1604	3103.2

Source: 1=MassCHIP, 3-year Average, 2004-2006; 2= MassCHIP, 3-year average, 2003-2005

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of availability of mental health services	Interviews		Surveys Interviews			Interviews
Mental health issues prevalent in immigrant communities				Interviews	Interviews	Interviews
Mental health issues prevalent in older adults				Interviews	Interviews	Interviews
Increase in mental health issues, especially stress, in community overall	Interviews			Interviews		

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
% of high school students who demonstrated depression symptoms in prior 12 mo			**25%**	**31%**	**26%**	**26%**	24%
% high school students who seriously considered suicide in prior 12 mo	10%		7%	12%	**14%**	**15%**	13%
% who have a trusted adult at school to talk to			**64%**	**52%**	**71%**	NA	84%
% who have a trusted adult out of school to talk to			72%	**67%**	87%	NA	69%

Source: Cambridge, Somerville, Watertown and Waltham High School YRBS 2008; Arlington HS YRBS 2009; MA HS YRBS 2007

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Need for increased mental health services for youth	Surveys Interviews		Interviews	Interviews	Interviews	Interviews
Need for healthy activities				Surveys	Surveys Interviews	Surveys

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
% adults who are overweight or obese[1]			43.4%	47.6%			58%
Obesity-related hospitalizations (age adjusted rate per 100,000)[2]	25.3	18.5	16.3	29.4	34.7	33.2	44.3
Diabetes mellitus-related death rate (age adjusted rate per 100,000)[3]	11.1	9.5	**18.6**	**23.1**	14.5	11.0	16.3
Diabetes mellitus-related emergency visits (age adjusted rate per 100,000)[4]	416.6	308.9	768.6	862.3	658.7	518.5	952.9
Acute myocardial infarction (heart attack)-related hospitalizations (age adjusted rate per 100,000) [2]	127.9	103.8	160.9	187.1	190.7	141.2	217
Acute myocardial infarction (heart attack) related emergency visits (age adjusted rate per 100,000) [4]		6.7	9.4	15.8	**28.5**		26.5
Acute myocardial infarction (heart attack)-related death rate (age adjusted rate per 100,000[3]	32.4	30.7	**37.8**	**38.6**	**36.3**	**37.5**	34.9
Cerebrovascular disease (stroke)-related emergency visits (age adjusted rate per 100,000)[4]	21.4	15.5	33.7	31.2	30.8	22.7	47.5
Cerebrovascular disease (stroke)-related death rate (age adjusted rate per 100,000) [3]	33.5	**42.3**	34.8	30.9	**49.2**	**37.3**	36.4
% of high school students that met vigorous physical activity guidelines[6]			62%	59%		**63%**	63%
% of adults that vigorous physical activity guidelines			36%	35%			30%
% of high school students that met moderate physical activity guidelines	**60%**		**62%**	**59%**		63%	63%
% of adults that met moderate physical activity guidelines			42%	48%			

Source: 1--5-city and MA BRFSS, 2008; 2--MassCHIP, 3-year average 2004-2006; 3--MassCHIP, 3-year average 2005-2007; 4--MassCHIP, 3-year average 2003-2005; 5—City and town websites; 6--Youth: Cambridge, Somerville, Watertown and Waltham High School YRBS 2008; MA HS YRBS 2007; 7--Adults: 5-city and MA BRFSS, 2008

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Need for more infrastructure for physical activity (safe streets, bike lanes, green space, etc.)			Surveys	Surveys Interviews	Surveys	Interviews
Youth obesity is top community issue				Interviews		Interviews

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of affordable services/financial assistance for services	Interviews	Interviews	Interviews			
General lack of services for older adults		Surveys	Surveys Interviews			
Lack of transportation access (especially to medical care)		Interviews	Interviews	Interviews	Interviews	
Lack of access to medical care			Interviews	Interviews		
Lack of access to homecare		Interviews			Interviews	

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

Poverty

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
WIC % of estimated need met[1]	39%	57%	61%	94%		93%	
% of children under 3 with food stamp participation[2]	3%	3%	13%	15%	12%	5%	19%
Median household income[3]	$80,511	$86,823	**$43,533**	**$60,674**	**$62,620**	$70,127	$64,684
% of population below federal poverty level[3]	5%	4%	**15%**	**16%**	**12%**	7%	10%
% of families with children under 18 below poverty line[3]	4%	6%	**15%**	**19%**	**13%**	7%	11%
% of students eligible for free/reduced school lunch[4]	11%	8%	**46%**	**68%**	32%	27%	33%
Count of families receiving transitional assistance (welfare)[5]	31	16	285	276	168	39	
% with no access to a vehicle[6]	5.2%	3.8%	**21.2%**	**14.6%**	5.4%	**7.2%**	5.2%
% uninsured adults[7]			0.4%	**5%**			4.1%
% adults needed to see a doctor but could not because of cost in last 12 months[8]			**17.4%**	**39.7%**			6.9%

Source: 1= July 2009 WIC needs assessment; 2= Kids Count data Center, 2007; 3= US Census American Community Survey 06-08 estimates; 4=2009-10 MA DESE school district profiles; 5= Department of Transitional Assistance via MassCHIP, 2007; 6=US Census, ACS 2008; 7=5-city BRFSS 2008 (Cambridge and Somerville) and US Census, ACS 2008 (MA); 8=5-city and MA BRFSS, 2008

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
High cost of health care			Interviews	Interviews		
High cost of healthy foods		Interviews			Interviews	
Lack of affordable childcare					Interviews	
Lack of employment opportunities					Surveys	

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
% of high school students ever been told they had a sexually transmitted disease[1]			1%	2%	**16%**		5%
HIV/AIDS prevalence crude rate per 100,000[2]	116.3	98.1	**362.5**	**402**	**278.7**	198.4	263.5
HIV incidence crude rate per 100,000[2]	NA	0	**20.7**	**17.3**	11.8		12
Hepatitis C incidence crude rate per 100,000[3]	29.1		53.2	**108.8**	52	34.1	61.5
Hepatitis B incidence crude rate per 100,000[3]			**17.7**	**14.6**			6.9
Syphilis incidence rate per 100,000[2]	0	0	**7.9**	**17.3**			6.1
Gonorrhea incidence rate per 100,000[2]		25.6	**43.3**	**39.8**	8.4	18.6	37.7
Chlamydia incidence rate per 100,000[2]	92.1	98.1	211.8	226.9	159.5	102.3	236.6
Age-specific birth rate per 1000, among 15-19 year-olds[4]	4.7	2.8	5.6	15.2	15.0	5.1	20.1 (2008)
% of high school students who ever had sexual intercourse[1]	25%		43%	**46%**	**46%**	34%	44%
% of high school students who had sexual intercourse in the last 3 months[1]			32%	**39%**		17%	33%
% of high school students who used a condom last time had sex[1]			74%	69%	65%	68%	61%

Source: 1-- Cambridge, Somerville, Watertown and Waltham High School YRBS 2008; MA HS YRBS 2007; 2--MassCHIP, 2006; 3--MassCHIP, 2007; 4-- MassCHIP 3-year average (2005-2007) or MA DPH Birth Report, 2008

Feedback from community surveys and key informant interviews: No sexual health issues were identified in the surveys or interviews

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
Alcohol/substance abuse related hospitalizations (age adjusted rate per 100,000)[1]	256.8	165.2	**431.1**	**572.7**	**355.5**	245.1	346.1
Alcohol/substance abuse related emergency visits (age adjusted rate per 100,000)[2]	398.4	265.3	**1295.1**	**790**	576.3	319	636.1
Admissions to state funded SA treatment, all substances/alcohol (rate per 100,000)[3]	599.7	362.4	708.2	1210	695.1	675.9	1636.5
% adults who are current smokers[4]			7.5%	14.1%			16.0%
% adults who had at least one alcoholic beverage in past 30 days[4]			**74.1%**	**67.9%**			63.6%

Source: 1-MassCHIP, 3-year average, 2004-2006; 2-MassCHIP, 3-year average, 2003-2005; 3-MassCHIP (BSAS), 2007; 4-5-city and MA BRFSS, 2008

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of substance abuse treatment services			Surveys Interviews			

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Statewide
% of high school students who smoked tobacco in the last 30 days	16%		10%	16%	10%	**18%**	18%
% high school students who consumed alcohol in the last 30 days	36%		42%	37%	43%	45%	46%
% high school students who smoked marijuana in the last 30 days	24%		**28%**	21%	19%	**31%**	25%
% of high school students who used oxycontin w/o a prescription in last 30 days	5%		1%	3%	7% (Lifetime)	8%	

Source: Cambridge, Somerville, Watertown and Waltham High School YRBS 2008; Arlington HS YRBS 2009; MA HS YRBS 2007

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of youth substance abuse services	Surveys					
Youth substance abuse is a top community issue	Interviews	Interviews		Interviews	Interviews	Surveys Interviews

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Lack of mental health services	Surveys			Interviews	Surveys Interviews	Interviews
Lack of substance abuse services	Surveys				Surveys	
Lack of pediatricians		Interviews				
General lack of healthy activities for youth			Surveys	Surveys	Surveys Interviews	Surveys

1=Based on survey data collected at community events in spring/summer 2010, key informant interviews collected by Mt. Auburn for their community assessment report in Spring 2009, and individual feedback gathered from key informants in summer 2010.

Analysis

The following comments and observations were made by members of the assessment team as they analyzed the data. The analysis was done collectively during the meeting where we scored and prioritized their list of health topics. While the points mentioned here are reflections of the conversation, every member of the assessment team did not necessarily hold each opinion.

In terms of sexual health, we noted that while the data suggest that it is a problem, no one mentioned it during community conversations and interviews. This indicates that the community does not see it as a problem. There are number of local resources to build on related to sexual health. These include the Regional Center for Healthy Communities library, the Boston Area Rape Crisis Center, REACH, hospitals and the school system.

In discussing chronic disease, we noted that many issues came up that were indirectly related to chronic disease, including access, transportation, prevention messages, and difficulty in connecting with existing resources.

Crime and safety were discussed extensively. We decided that the issue affects all 6 CHNA communities, in part because any incidence of crime is enough to merit concern for the community and Waltham, Arlington and Somerville are currently working to address safety in some form. This indicates that there are existing resources to build on if the CHNA works on crime and safety.

We discussed the fact that the data collected focused on bullying, sexual violence and hate crimes, so any interventions that the CHNA considers should also focus on these areas. We noticed that access to services was seen as a problem by some communities and not by others. For example, it was identified as a problem in Somerville, and not at all in Watertown. The group agreed that it makes sense that it would not have come up in Watertown because public transportation is more widely available.

In considering whether access to services particularly affects vulnerable populations, members of the group considered that vulnerable populations are fairly invisible. We noted that elders and individuals with disabilities are often the ones most affected by transportation access. The group agreed that it might be possible to increase access by providing transportation, but some issues raised by community also relate to affordability of services. The team discussed access to services for immigrants. We mentioned that while there are existing resources, they're only useful to many immigrants if we are able to pay for translators. We noted that there are a lot of resources related to obesity and active living to build on.

In reflecting on the data related to domestic violence, we noted that it was difficult to get information on the subject, particularly from Belmont. We also noted that in many places people don't really see this issue as a problem. People don't talk about it and it's hidden. In

terms of whether the CHNA could make a difference on the issue they discussed the possibility of building on existing programs in the schools in some communities such as Arlington and Watertown. We also noted that the domestic violence tends to increase with economic instability. These could be opportunities for intervention if the CHNA decides to address domestic violence.

We felt that the qualitative responses collected for housing and homelessness were not representative of the full CHNA. We thought it might be possible that more people might have mentioned it in interviews and surveys if there had been more done in Watertown and Somerville.

The data related to youth substance abuse was incomplete, with much of Belmont's information missing and binge drinking rates not provided for Cambridge. Despite this, we were able to analyze the data that were available and discuss the topic. We noted that there is a lack of substance abuse treatment services, and that the issue is often hidden. We noted that there's a significant difference between what the data say about whether this is an issue for all communities and whether people in the community see it as a problem. This difference could be an opportunity to use the CHNA voice to bring the issue into the public view and help people recognize it as a problem, particularly by publicizing the data in a way that indicates the problem without talking to adults in the community about challenging issues like modeling substance-free living. We noted that there's a similar discrepancy between the data and public opinion, and thus a similar opportunity for the CHNA to help highlight the issue for domestic violence. In exploring whether there are existing resources to build on, the team noted that while there are some, including CASPAR, many are at capacity and there have been significant cuts in services.

We noted that some of the data related to mental health and youth are positive. We felt that we can make a difference with this population and the CHNA's role could be to bring back resources that no longer exist. Two of the ways that the CHNA could affect the issue would be by increasing local collaboration and by addressing insurance issues related to mental health.

In terms of adult mental health, we feel that here are many waiting lists and don't feel confident that the CHNA can make a difference on the issue. Despite this, we noted the importance of talking about mental health issues in public. We noted the many difficulties and complexities of addressing mental health and also discussed the significant mental health disparities that exist for certain vulnerable populations.

We noted that many of these issues are interconnected and not isolated from one another.

Prioritization

Through this conversation the assessment group rated each of the 15 health issues that rose to the top of the list of concerns (either through the preliminary data, community voiced concerns or both) according to how well they met the criteria that we had chosen for priority issues. For each topic we looked at the data and talked as a group to decide how to rate the topic on a scale of 1 to 5 for each of the criteria. The criteria were: whether community members see it as a problem, whether it affect s all 6 member communities, whether we can make measurable and sustainable change on this in 5 years, whether there are resources related to this that we can build on and whether it affects vulnerable populations. (For a chart of the detailed rankings, see Appendix).

The issues that ranked highest were:

1. Youth substance abuse
2. Youth access to services
3. Youth mental health
4. Adult mental health
5. Obesity and active living
6. Crime and safety

These six issues with the top scores were presented to the CHNA Steering Committee.

Next Steps

The Steering Committee made a recommendation that youth issues (mental health, substance abuse and access to services) be combined. They developed a formula based on the scores to divide the yearly funds that the CHNA has allocated for interventions ($195,000) between the issues.

- Youth Issues = $123,000
- Mental Health (Adults) $37,000
- Obesity and Active Living $17,500
- Crime and Safety $17,500

The CHNA general membership was asked to select one of the four top priority areas and join a temporary task force focused on that one priority. Each task force was given the task of working through a visioning and planning process that would be incorporated into the development of a logic model for each priority area and would guide the CHNA when thinking about how specifically funding in each category would be allocated and what the desired health outcomes for each area would be.

The CHNA decided to continue to provide minigrants with a broader focus as a way to fund work that is important but may not have been identified as a priority in the assessment process.

Discussion: Limitations and Unexpected Successes

The process of carrying out the community health assessment and prioritizing health areas for the CHNA's future work was not easy. There were many stumbling blocks along the way and there were challenges at every turn. A few of the more interesting challenges related to planning a broad yet timely process and engaging community members in a meaningful way in a process that can sometimes be technical and cumbersome.

It was difficult to strike a balance between the group's interest in exploring a wide variety of social determinants of health and the time constraints that made collecting and analyzing all of that data impossible. We were able to address this somewhat by refining and reducing the list of indicators, and identifying the criteria that the group would use to prioritize issues earlier in the process than initially expected. This allowed us to collect only the information about each indicator that would actually be used to make a decision and not spend time on interesting but less useful data.

Although the CHNA entered the assessment process with the intention of including the voice of unaffiliated community members and had some funding available to stipend assessment team members who would otherwise not be paid to participate, the vast majority of the assessment team members were there representing an organization or an institution. While the assessment team was diverse and large, it did not necessarily represent the complete demographics or diversity of opinions of the full CHNA population. In some ways the team's efforts at surveying and interviewing a broad base of residents in each community was a response to the lack of the perspective of unaffiliated community members at the planning table.

It was challenging to engage people from all sectors of all member communities. We were only able to screen the film Unnatural Causes four times, and we were not able to collect information from some sectors of each community. For example, in at least one town schools and elected officials were not contacted, but other sectors in the same community were included. At times this reflected a lack of response when we reached out to busy people, but in other cases it was because we didn't have the time and the resources to disseminate information about the assessment as widely and deeply as we would have liked. Despite the challenges, we tried to be representative of all communities and to include as many varied voices as possible.

The size of the assessment team grew as the assessment progressed. Often we think about assessment as a grueling or boring process, but this assessment involved stakeholders in genuine way and allowed the future users of the assessment results to guide and shape the process. In many ways this was wonderful and in others it was challenging. One of the challenges was that people entered the process and joined the team with varying levels of experience and expertise in assessment and data analysis. This forced the members, facilitators

and even the consultant evaluators to make language and processes as accessible, practical and simple as possible. This, in turn, made the results more comprehensible and allowed all members of the process to be heard and to own the decisions that followed from the assessment.

In terms of data collection, the Institute for Community Health relied heavily on MassCHIP and YRBS data. MassCHIP is wonderfully consistent data, but sometimes it's old and many types of data are not included. There was also inconsistency in terms of what data each community collects and makes available to the public.

Some of the topics that the CHNA was interested in exploring can be difficult to talk about. These include domestic violence, homelessness and other topics. It's possible that the lack of data and people's discomfort in discussing the issues made them less visible in the CHNA's assessment than they should have been. It's also possible that even service providers are not fully aware of the existence and extent of these issues. It was suggested that the CHNA set up funding for these and other stigmatized topics.

Conclusion

The process design evolved as the project progressed, taking into consideration new findings, the interests of new members and ideas about how to better engage the community in the assessment process. The process as a whole evolved and so did the assessment team's skills.

As a result of the assessment process, the CHNA has a shared and articulated direction, with specific priorities for the coming years. After looking at the data that were collected and compiled as part of the assessment process, CHNA members are more aware of their communities' similarities and differences. The steering committee of the CHNA has grown to include representatives from communities that had traditionally been less involved in the CHNA. Now, as the results of the assessment are being used to establish grant opportunities, to guide policy change efforts and to inform meeting agendas, CHNA leadership has invited the general membership to be part of this activity design both at general meetings and outside. The whole CHNA is actively engaged in the process of deciding how the funds that will be coming to the CHNA should be spent. Regardless of the intricacies of the data that drove the assessment, these are significant accomplishments for the group to have made in a year and a half.

Acknowledgements

A special thanks to Mount Auburn Hospital for ongoing funding and support of the CHNA. Thank you to Sadie for her courageous leadership of the CHNA as we embarked upon a new and daunting assessment process. Thank you to the members of the Assessment Guidance group who devoted a tremendous amount of time and energy to making this process as useful, rational and equitable as possible. Thanks also to the teams at the Regional Center for Healthy Communities and the Institute for Community Health for invaluable technical assistance.

Thank you to the steering committee members who give their time and their expertise for the benefit of the community at large. Thanks to all of the members of CHNA 17. This work, and the organization itself, would not exist without you and your passion.

A heartfelt thanks to Mount Auburn Hospital for your confidence in the community's collective ability to steward the hospital's community investment dollars, and to the Healthy People 2020 team who provided us with catalyzing funds to grow our assessment from a standard collection of physical health indicators to a richer and deeper exploration of the social determinants of health.

And to the members of the assessment team, thank you for guiding the process so knowledgeably and ably. Thank you for trusting the process when appropriate and for challenging and expanding the process when appropriate.

Thank you to Cathy O'Connor and the Office of Healthy Communities at the Massachusetts department of Public Health for ongoing guidance and insight, and for providing us a structure within which to foster true collaborations and capacity.

Appendices

Assessment team members

Elizabeth Aguilo (Paine Senior Services)
Emily Bhargava (Regional Center for Healthy Communities (Metrowest))
Phyllis Brown (Arlington)
Lisa Brukilacchio (Somerville Community Health Agenda)
Stacy Carruth (Regional Center for Healthy Communities (Metrowest))
Emily Chiasson (Institute for Community Health)
Frank Connelly (Cambridge Prevention Coalition)
Liz Daube (CAH)
Mary DeCourcey (Mount Auburn Hospital)
Judy Fallows (Healthy Waltham)
Eileen Feldman (Community Access Project, Somerville)
John Gatto (Cambridge Cares About AIDS)
Rebecca Harmer (RCHC Intern)
Lynn Horgan (Arlington)
Mary Johnson (Mount Auburn Hospital)
Susan Kilroy-Ames (Cambridge Public Health Department)
Alice Knowles (Institute for Community Health)
Laura Kurman (Wayside Multiservice Center/ Watertown Youth Coalition)
Marsha Lazar (Cambridge Public Health Department)
Coleen Leger (Arlington)
Deborah Levine Goodman (Cambridge Learning Center)

Lea Susan Ojamaa (Mass Department of Public Health)
Ife Rollins (Prospect Hill Academy)
Sadie Simone (CHNA 17)
Felipe Vaquerano (CLC)

Survey Instruments

General format:

CHNA 17 : Community Health Survey

Question 1: What town/city do you live in?
Question 2: What concerns you most about your community today?
Question 3: What should you make your community a better place for you to live?

Watertown-specific format:

The Watertown Youth Coalition is surveying young people and adults about concerns, solutions and strengths of Watertown.

Q1: What concerns you most about Watertown today?
Q2: What would make Watertown a better place for you to live?
Q3: In your opinion, what strengths or positives does the Watertown community have?
Q4: What would make Watertown and WHS more welcoming and respectful to new or diverse people?
Q5: If you or your friends had money to support young people living in Watertown, what would you or your friends use it for?

Constituencies surveyed by town

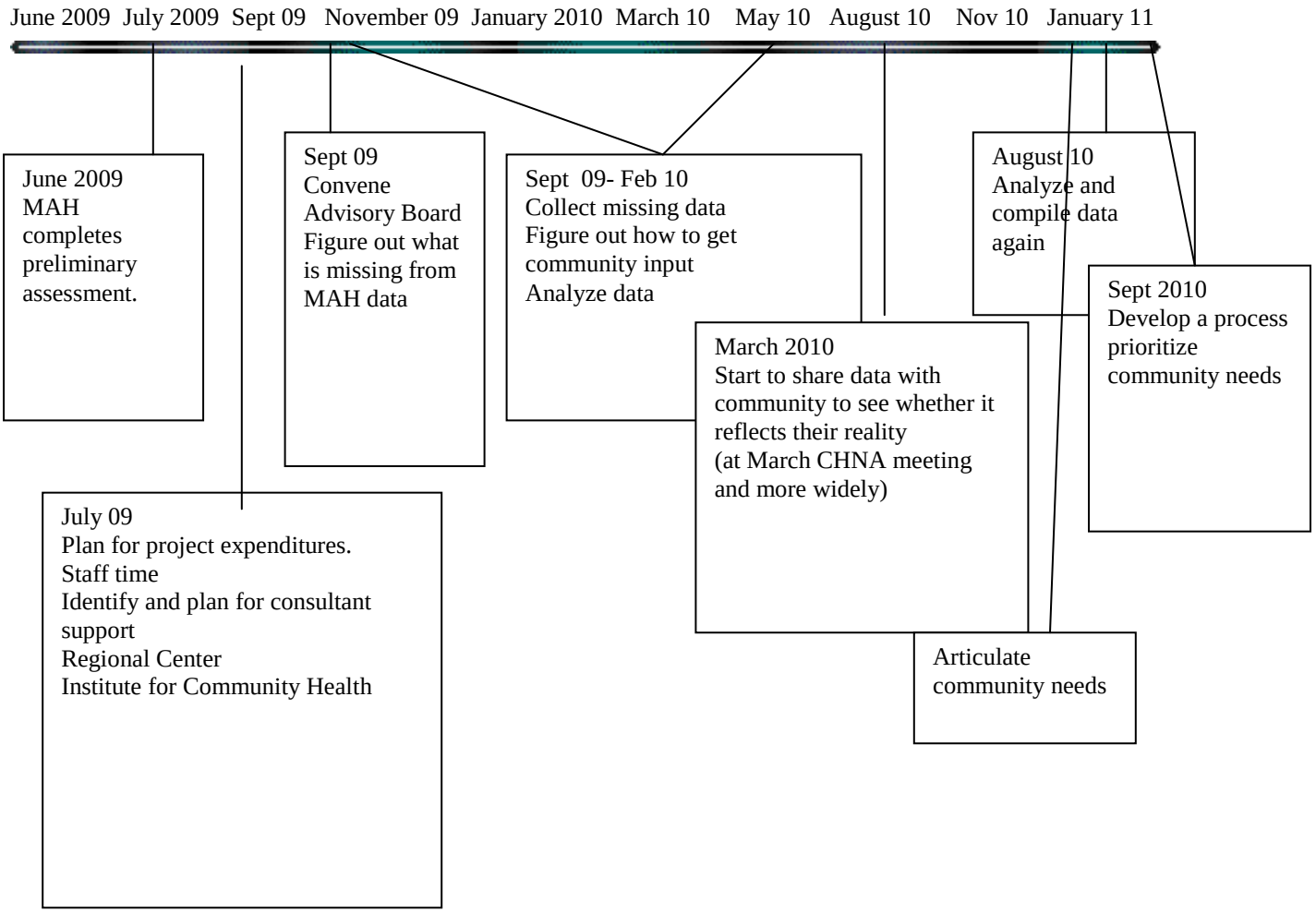
	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Seniors	X	X	X	X	X	X
Youth	X	X	X	X		X
Food Pantry	X		X		X	
Church/Groups						
Community Meeting	X		X	X	X	X
Town Hall		X	X	X		X

Additional Organizations Contacted for Key Informant Interviews

	Town
ARLINGTON	
Board of Health	Arlington
Arlington Council on Aging -contact	Arlington
Arlington Equal Opportunity Committee - event	Arlington
Arlington Housing Authority - event	Arlington
Arlington Redevelopment Meeting - event	Arlington
Pleasant St Congregational Church - contact	Arlington
Town of Arlington Food Pantry - contact	Arlington
First Parish Unitarian Universalist Church - contact	Arlington
BELMONT	
Beth El Temple Center - contact	Belmont
Board of Health Belmont - event	Belmont
Outreach Belmont - contact	Belmont
The First Church in Belmont - contact	Belmont
Belmont Housing Trust - event	Belmont
Belmont Superintendent - contact	Belmont
CAMBRIDGE	
Cambridge Family and Children Service - contact	Cambridge
Cambridge Youth Programs - contact	Cambridge
First Parish Unitarian Universalist Church Cambridge - contact	Cambridge
Regular City Council Meeting Cambridge - event	Cambridge
St James Episcopal Church Cambridge - contact	Cambridge
Economic Dev, Training & Employment Committee - event	Cambridge
The Department of Cambridge Community Development	Cambridge
Grand Opening LGBT - event	Cambridge
Public Works Cambridge - event	Cambridge
Public Health Cambridge - event	Cambridge
City of Cambridge director of financial systems and operations - contact	Cambridge
Ethipoian Community MAA - contact	Cambridge
Cambridge Housing Authority - contact	Cambridge
Cambridge Senior Center - Cambridge Council of Aging - contact	Cambridge
Cambridge Cares About Aids - contact	Cambridge

Food Pantry - contact	Cambridge
Cambridge Community Foundation - contact	Cambridge
Heading Home - contact	Cambridge
Boston Area of Rape Crisis Center - contact	Cambridge
SOMERVILLE	
Board of Health Somerville	Somerville
2010 Commission for Disabled Persons - event	Somerville
2010 Comission for Women - event	Somerville
Board of Alderman Regular Meeting Somerville - event	Somerville
Clarendon Hill Presbytarian Church	Somerville
Congregate Meals for Seniors Somerville - Aging Center	Somerville
Project SOUP food Pantry	Somerville
ResiStat Meetings Ward Somerville - event	Somerville
Somerville Council on Aging	Somerville
Teen Empowerment Somerville	Somerville
Unity Church of God	Somerville
Wayside Youth and Family Support Network	Somerville
Youth Build USA	Somerville
WALTHAM	
Director of Public Health Waltham	Waltham
Conservation Commission Meeting - event	Waltham
Immanuel United Methodist Church	Waltham
Epoch Senior Living	Waltham
Grandmas Pantry Waltham	Waltham
Hope International Church	Waltham
Jewish Family and Children Service Family Table Pantry	Waltham
Maristhill Nursing and Rehab Center	Waltham
MHSA Food Pantry	Waltham
WATERTOWN	
Board of Health	Watertown
Watertown Commission on Disability	Watertown
Church of the Good Shepherd	Watertown
Watertown Council on Aging	Watertown
Watertown Food Pantry	Watertown
Watertown Food Pantry	Watertown
Watertown Housing Partnership	Watertown
Watertown Town Council Meeting: Health Department	Watertown
Greater Boston Church of Spiritualism - contact	Watertown

Assessment Timeline



Issue Rating Chart

Scores were given to each of the health topic areas based on the data collected and on the assessment team members' knowledge of local resources, potential for change and health disparities. The criteria against which the topics were scored were:

- People in our communities see as a problem
- Affects all 6 CHNA communities
- Can be changed measurably and sustainably in 5 years
- Have resources related to them that we can build on
- Affect vulnerable populations

Scale for rating the issues:
1=Definitely does not meet this criterion
2=Probably does not meet this criterion
3=Partially meets the criterion
4=Probably meets this criterion
5=Definitely meets this criterion

	Affects all cities	People see this as a problem	We can make a difference	Existing Resources	Vulnerable Populations*	**Total**
Substance abuse youth	5	4.5	5	4	5	**23.5**
Youth access to services	5	4	4	4	5	**22**
Mental Health Youth	5	5	4	3	5	**22**
Mental Health Adults	5	5	5	3.5	3.5	**22**
Obesity and active living	5	4	3.5	4	5	**21.5**
Crime	5	3	4	4	5	**21**
Senior access to services	4	4	3.5	4	5	**20.5**
Chronic Health Conditions	5	5	3.5	3.5	3	**20**
Immigrant access to services	3	4	4	3.5	5	**19.5**
homelessness affordable housing	5	4	2.5	3	5	**19.5**
Domestic Violence	5	2	3	4	5	**19**
Substance abuse adults	5	2	3	3.5	4	**17.5**
Poverty/ hunger access to food	3	4	2	3	5	**17**
Sexual Health	4	1	4	3	5	**17**
General Population access to services	4	3.5	2	2	4	**15.5**