

Codman Square Health Center
2013 Community Health Needs Assessment
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In partnership with



Health Resources in Action
Advancing Public Health and Medical Research

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EXECUTIVE SUMMARY

Introduction

Codman Square Health Center (CSHC) is a community-based, outpatient health care and multi-service center located in the Boston neighborhood of Dorchester, MA. In June 2013, CSHC contracted with Health Resources in Action (www.hria.org), a non-profit public health organization in Boston, to conduct its community health needs assessment (CHNA) to ensure that it is addressing the most pressing health concerns among its general patient population and among Dorchester residents who live in close proximity to the health center. In addition to meeting the Health Resources and Services Administration (HRSA) health center program requirements (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act), the overarching goals of the 2013 CSHC Community Health Needs Assessment (CHNA) were to:

- Identify the health-related needs and assets of CSHC's service area; and
- Determine where there are gaps and potential opportunities for CSHC to address these needs.

To this end, the CHNA report provides an overview of the key findings of the community health needs assessment, which explores a range of health behaviors and outcomes, social and economic issues, health care access, and gaps and strengths of existing resources and services.

Community Health Needs Assessment Methods

The community health needs assessment utilized a participatory, collaborative approach to look at health in its broadest context. The assessment process included synthesizing existing data on social, economic, and health indicators in Dorchester as well as among CSHC's patient population and conducting a staff survey completed by 133 clinical and non-clinical health center staff. Additionally the assessment process included conducting a community dialogue, four focus groups, and eleven interviews to identify the perceived health needs of the community, challenges to access services, current community strengths and assets, and opportunities for action. Participants represented different audiences, including CHSC board members, staff and patients, the faith community, the civic community, government officials, educational leaders, social service providers, health care providers, parents, and other community members, among others. Ultimately, the qualitative research engaged over 70 participants.

Key Findings

The following provides a brief overview of key findings that emerged from this assessment:

Community Social and Economic Context

- **Demographic Diversity:** Nearly every participant highlighted diversity as a key strength of Dorchester, including the range of age, cultural, ethnic, linguistic, and economic groups that characterize the neighborhood.
 - According to the Bureau of Primary Health Care Uniform Data System (UDS), CSHC served a total of 20,643 patients in 2012, over half of whom resided in Dorchester (53.6%).
 - Quantitative data illustrate that the majority of Boston's and CSHC's patient population was between the ages of 18 and 64 years (64.0% and 64.7%, respectively)
 - Blacks represent the largest racial/ethnic group in N. and S. Dorchester (41.7% and 47.3%), followed by Hispanic/Latinos in N. Dorchester (20.0%) and Whites in S. Dorchester (29.0%). Similarly, a majority of CSHC's patient population self-identified as Black (88.0%).
- **Income, Poverty, and Employment:** Several participants spoke of the economic challenges facing residents in the community, including underemployment. Economic data confirm that considerable

*"We are an amalgam of cultures and income diversity."
– Focus group participant*

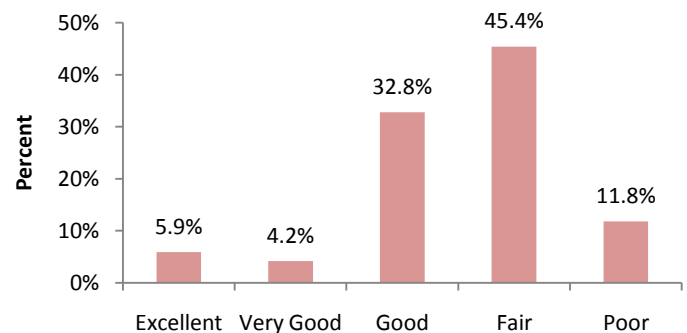
proportions of neighborhood residents are poor. N. Dorchester (26%) had a higher proportion of families living below the federal poverty line compared to the city overall (23%).

- **Educational Attainment:** Quantitative data show high educational attainment among Boston’s adult residents aged 25 years and older, with 44% having earned a college degree or more; whereas less than 25% of Dorchester residents have a college degree or higher.
- **Housing and Transportation:** The lack of affordable housing was identified as an important issue in the community. In Boston, over 40% of renters contribute 35% or more of their income to housing costs, compared to 34.9% of homeowners. Furthermore, while some viewed the transportation in the area as an asset, others identified challenges with transportation. The Boston Indicator Project reports that more than one out of five workers residing in Dorchester – who lack access to MBTA subways or commuter lines – spend an hour or more getting to work each day.
- **Violence and Neighborhood Safety:** Concerns regarding neighborhood safety were a prominent theme across interviews and focus groups. N. and S. Dorchester reported an annual homicide rate of 17.9 and 19.4 homicides per 100,000 residents, respectively – more than double the city-wide rate (7.9 homicides per 100,000 residents).

Community Health Issues

- **Perceived Community Health Status:** Over half of all CSHC staff described the community’s health as fair/poor (57.2%). Among all staff, diabetes, mental health, and obesity were viewed as the top health issues of concern for both the community at large (nearly 60% of all staff) and CSHC’s patient population (nearly 40% of clinical staff).

Figure 1: Perceived Health Status of Community Served by All Staff, 2013



DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

- **Mortality and Morbidity:** Quantitative data indicate that cancer is the leading cause of death in Boston, followed by heart and cerebrovascular disease (including stroke). A similar pattern is seen in the neighborhoods of N. and S. Dorchester. Examining CSHC clinical data reported to the Uniform Data Reporting System show the percent of adult medical patients (18 years of age and older) with hypertension has nearly doubled over the past three years from 13.9% in 2010 to 26.0% in 2012.
- **Chronic Diseases and Related Risk Factors:** Similar to staff survey results, chronic conditions and their associated lifestyle behaviors were also top of mind concerns for focus group and interview participants, namely diabetes, obesity, and asthma.
 - In 2010, N. and S. Dorchester had a higher proportion of obese adults (31.0% and 24.0%, respectively) compared to Boston overall (21.0%). Participants also noted the barriers that residents face in addressing obesity, particularly access to healthy food and physical activity.
 - In 2010, N. and S. Dorchester also had a higher proportion of adult residents with diabetes (8.0% and 7.0%, respectively) compared to Boston (6.0%).
 - Participants also observed high rates of asthma in their community, which they described as exacerbated by poor air quality and housing conditions. In 2010, the prevalence of adult asthma was particularly high in N. Dorchester (18%) and well above that of Boston (11%). Additionally, children under age five in N. Dorchester (39.0 per 1,000) and S. Dorchester (32.8 per 1,000)

experienced higher rates of visits to the Emergency Department due to asthma, compared to children citywide (22.9 per 1,000).

- **Mental and Behavioral Health:** Mental health emerged as a pressing issue among participants as well who described mental health conditions ranging from stress and anxiety to depression and Post Traumatic Stress Disorder, which were often related to community violence and substance abuse.
 - Depressive symptoms affect both youth and adults in Boston. N. and S. Dorchester had the same proportion of adults reporting persistent sadness (feeling sad, blue, or depressed 15 or more of the past 30 days) as Boston (9%). In 2011, nearly 25% of Boston youth reported feeling sad or hopeless; however, this percentage has decreased since 2005.
 - The majority of participants primarily expressed concerns regarding the effects of residents witnessing violence in their neighborhoods and low perceptions of neighborhood safety. Rates of emergency department visits for nonfatal stabbing or gunshot wounds are higher in N. and S. Dorchester (1.6 and 2.1 visits per 1,000 residents, respectively) compared to Boston (0.9 visits per 1,000 residents).
 - Drug use was often noted in the context of mental health as a means of self-medication. According to the 2010 BBRFSS and 2011 YRBS, 23.0% of adults and 17.0% of youth indicated that they participated in excessive alcohol consumption. In 2010, the death rate due to substance abuse in N. and S. Dorchester (23.4 and 23.1 deaths per 100,000 population) was lower than that of Boston (33.9 deaths per 100,000 population).

“Lack of access to care; without a job there’s no health insurance. Without health insurance there’s no health care, there’s poor health.”
– Interview participant

- **Health Care Access and Utilization:** Challenges regarding access to care were raised in almost every focus group and interview. Barriers included: health insurance coverage and cost, navigating the complex healthcare system, and culturally sensitive care.
 - In 2012, a majority of CSHC’s patient population used its medical services (94.5%), followed by enabling services, and vision services (30.4% and 20.4%, respectively).
 - Staff were most satisfied with public transportation to health services and overall health/medical services and least satisfied with substance abuse treatment services and interpreter services.
 - According to clinical staff survey respondents, insurance coverage, long wait times for appointments, and language barriers were the primary challenges for patients to access care, followed by lack of transportation and cost of care.
 - The challenges to accessing care faced by the under- and uninsured was a common theme raised by assessment participants. Challenges ranged from the inability to afford prescription medications to insufficient coverage for substance abuse treatment.
 - In addition to health insurance coverage, several participants described the difficulties of navigating an increasingly complex and fragmented healthcare system. Challenges included scheduling appointments in a timely manner (e.g., waiting six weeks for an appointment) and finding a primary care physician who is accepting new patients.
 - Assessment participants frequently noted the barriers posed by cultural and linguistic differences between patients and providers. Immigrants were identified as a particularly vulnerable population.

Community Assets and Programs

Assessment participants were asked to identify their communities’ strengths and assets. The following key themes emerged from that discussion:

- **Community Cohesion and Activism:** Dorchester was described as a neighborhood with a “*strong sense of community.*” Participants characterized residents as passionate and invested in the

community. They shared how community activists have been able to successfully mobilize residents to advocate for and achieve change.

- **Local Organizations and Businesses:** Assessment participants also indicated that there are numerous resources available to residents in the community. They described the recreational facilities and green spaces, seasonal farmers markets, area hospitals and neighborhood health centers, and the multitude of faith based organizations as community assets.

Community Suggestions for Future Programs, Services, and Initiatives

Assessment participants shared their suggestions around future programming and services:

- Participants emphasized the importance of improving the built environment in order to address health concerns. Specific areas of note included food access, green space, physical infrastructure, and housing.
- Limited employment opportunities in the community were viewed as a root cause for health issues, ranging from violence and drug abuse to teen pregnancy and obesity. Therefore creating job opportunities and supporting workforce development was encouraged to align skills with employment, particularly among youth.
- While participants noted that numerous organizations serve the community, they also indicated that better integration and coordination of services was needed. Community members would like to see increased collaboration across sectors and among key stakeholders in Dorchester.
- Strengthening community outreach and engagement was recommended by participants in order to improve access to existing resources and overcome cultural and linguistic barriers. Participants strongly encouraged employing community health workers and patient navigators to “hit the pavement” and connect residents to services.
- Many participants mentioned providing health education to the community that focuses on prevention and promoting a healthy lifestyle. Specific topics of interest included healthy eating, explaining the affordable care act, and preventing chronic diseases.

“We have a slew of resources available, but it’s about communicating the availability of those resources. And the way you get that out is through outreach, to bring people into the inner folds.”
– Community Dialogue Participant

Key Themes and Conclusions

Several overarching themes emerged from this synthesis of data, including:

- The social, economic, and physical context of the community underscores all aspects of daily life for residents, although the community also possesses several strengths.
- Chronic diseases and related lifestyle behaviors were viewed as important community health issues which disproportionately affect minority and low-income residents.
- Mental and behavioral health emerged as a pressing issue for the community, for which there is a lack of services.
- Despite the expansion of healthcare coverage, insurance status, a complex healthcare system, and cultural and linguistic differences prevent residents from receiving care.

Future opportunities were identified for expansion of CSHC’s work in the community and its partnerships with organizations. As CSHC moves forward, it can leverage the assets of the community to improve the health of residents in Dorchester and its patient population.

BACKGROUND

Overview of Codman Square Health Center

Codman Square Health Center (CSHC) is a community-based, outpatient health care and multi-service center located in the Boston neighborhood of Dorchester, MA. Founded in 1979, CSHC's mission is to serve as a resource for improving the physical, mental, and social well-being of the community. Today, CSHC has a staff of over 280 multi-lingual and multi-cultural expert clinicians and employees. CSHC serves over 20,000 patients each year and provides comprehensive services including primary care, urgent care, dental care, eye care, behavioral health, public health, fiscal health, fitness/wellness, and youth programming through various internal and external partnerships. CSHC is a Federally Qualified Health Center (FQHC) and receives federal support through its designation as a Section 330 community health center.

Purpose and Scope of Assessment

In June 2013, CSHC contracted Health Resources in Action (www.hria.org), a non-profit public health organization in Boston, to conduct its community health needs assessment (CHNA). This report describes the process and findings from this effort. In addition to meeting the Health Resources and Services Administration (HRSA) health center program requirements (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act), the CHNA process was undertaken to achieve the following overarching goals:

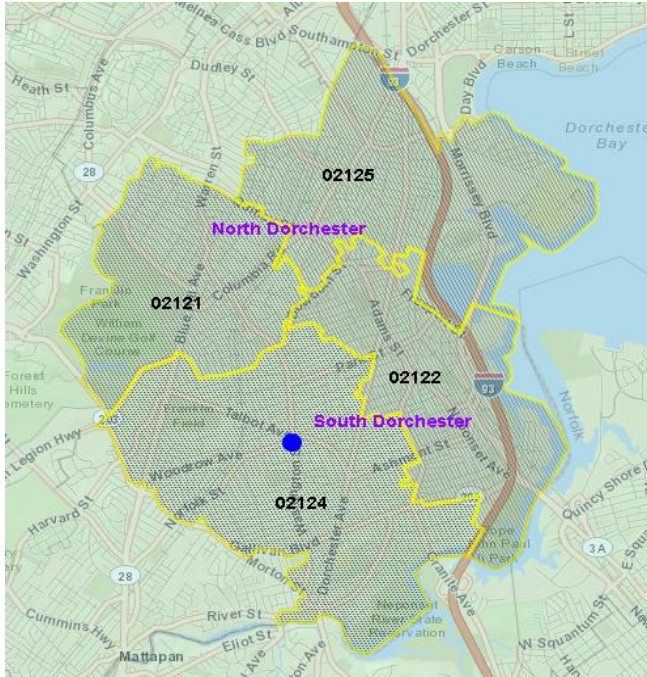
- To identify the health-related needs and assets of CSHC's service area; and
- To determine gaps and potential opportunities for CSHC to address these needs.

Definition of the Community Served by Codman Square Health Center

CSHC has undertaken a community health needs assessment to ensure that it is addressing the most pressing health concerns among residents in Dorchester, who are in close proximity to the health center, as well as its general patient population.

Figure 2 outlines the boundaries of North (02121 and 02125) and South Dorchester (02122 and 02124), which comprise the neighborhood of Dorchester, as defined by the Boston Public Health Commission. CSHC is physically located in zip code 02124.

Figure 2: Geographic Focus Area of CSHC CHNA



DATA SOURCE: Accessed from <http://www.udsmapper.org> on September 19, 2013

Codman Square Health Center

METHODS

The following section describes how data for the community health needs assessment was compiled and analyzed, as well as the broader lens used to guide this process. Specifically, the CHNA defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health — from lifestyle behaviors (e.g., diet and exercise), to clinical care (e.g. access to medical services), to social and economic factors (e.g., employment opportunities), to the physical environment (e.g., air quality). The beginning discussion of this section discusses the larger social determinants of health framework which helped guide this overarching process.

Study Approach and Community Engagement Process

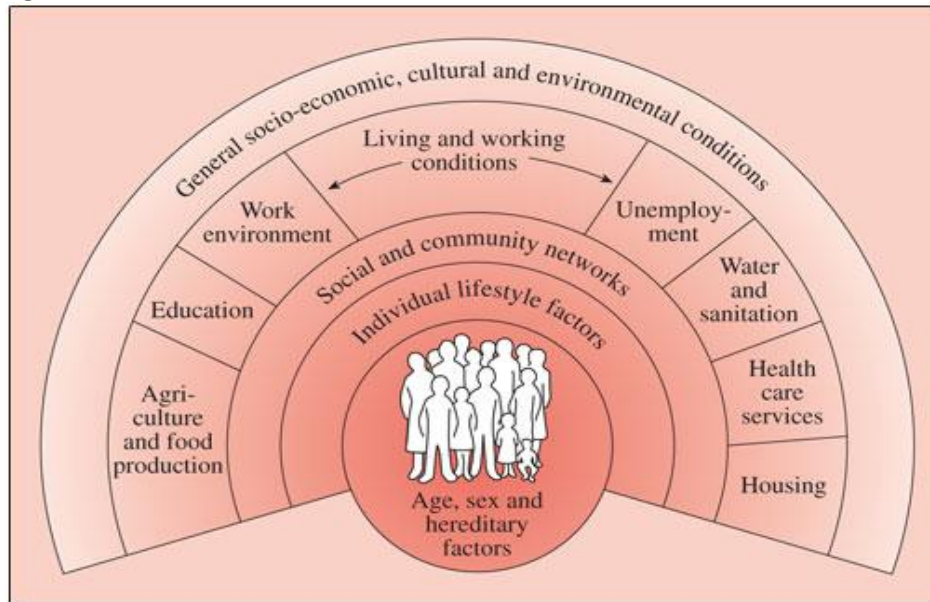
So that the process was informed by diverse perspectives, the community health needs assessment employed a participatory approach, when possible. This type of approach helps guide the research methods and questions so that they are salient to the community as well as aids in building support and buy-in at the community level for both the assessment study and subsequent planning processes. As part of this effort, CSHC sought input from its Board of Directors at multiple stages of the assessment study. CSHC's Board is comprised of community leaders and health center staff, including Dorchester residents. A majority live and/or work in the service area (80%) and are users of the health center (66%). Over half of board members are Black (53.3%) and male (60.0%). Length of service of board members ranges from 3-37 years. Areas of expertise include: academics, business/IT, community leadership, human resources, urban ministry, environmental, finance, health care, legal, senior issues, and social work. The Board participated in two formal meetings to brainstorm a list of potential stakeholders and provide feedback on preliminary findings. A CHNA subcommittee of board members was engaged in weekly conference calls and e-mails throughout assessment planning and implementation, finalized the list of potential stakeholders for interviews, provided suggestions on who to engage, and gave feedback on the stakeholder and focus group guides.

Social Determinants of Health

It is important to recognize that multiple factors have an impact on health and there is a dynamic relationship between real people and their lived environments. Where we are born, grow, live, work, worship, and age—from the environment in the womb to our community environment later in life—and the interconnections among these factors are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as education level, employment status, and quality of housing stock. The social determinants of health framework addresses the distribution of wellness and illness among a population.

The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors such as educational opportunities and the built environment.

Figure 3: Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health: Discussion paper for the Commission on the Social Determinants of Health, 2005.

Quantitative Data

The following section describes the quantitative data sources included in this report.

Review of Secondary Data

In an effort to develop a social, economic, and health portrait of Dorchester and CSHC's patient population, HRiA reviewed existing data drawn from national, state, and local sources. Health center specific data – such as patient demographics, services provided, and clinical indicators – were obtained from the Bureau of Primary Health Care Uniform Data System (UDS). Additional sources of data included the U.S. Census, Massachusetts Department of Public Health, Boston Redevelopment Authority, Boston Public Health Commission, and Boston Police Department, among others. Data analyses were generally conducted by the original data source (e.g., U.S. Census, Boston Public Health Commission). Types of data included self-report of health behaviors from large, population-based surveys such as the Boston Behavioral Risk Factor Surveillance System (BBRFSS), as well as vital statistics.

Qualitative Data

From September – November 2013, focus groups, interviews, and a community dialogue were conducted with leaders from a wide range of organizations in different sectors, community stakeholders, and residents to gauge their perceptions of the community, their health concerns, and what programming, services, or initiatives are most needed to address these concerns. Priority sectors and representative participants were identified based on a brainstorming session with CSHC board members. Ultimately, the qualitative research engaged over 70 individuals in discussion about the health issues they deemed critical in their community.

Focus Groups and Interviews

In total, four focus groups and eleven key informant interviews were conducted with individuals from across Dorchester. Focus groups were conducted with representatives of selected sectors or priority populations, including: CHSC staff, CSHC patients, the faith community, and the civic community. A total of 39 individuals participated in the focus groups. Interviews were conducted by phone or face-to-face

with 12 individuals representing a range of sectors. These included government officials, educational leaders, social service providers, and health care providers, among others.

Focus group discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all discussions to ensure consistency in the topics covered. Each focus group and interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, focus groups lasted 90 minutes and included 6-9 participants, while interviews lasted approximately 30-45 minutes. As an incentive, focus group participants received a \$25 gift card to a local grocery store. Lists of stakeholder interview and focus group participants can be found in Appendix A and B, respectively.

Community Dialogue

A community dialogue session was held with over 30 community members to review preliminary CHNA findings and discuss their perceptions of the communities' health needs and strengths, the environment in which residents are making decisions that impact their health, and gaps in the current programming and servicing environment. Participants represented a range of population groups, youth, seniors, and health providers, among others. The dialogue was held at the Great Hall, as part of the Codman Square Neighborhood Council's monthly community meeting.

The community dialogue included a welcome by the Chief Executive Officer of CSHC, a brief data presentation on key demographic and health indicators conducted by a HRiA team member, and then small group discussions. The discussions aimed to explore participants' perceptions of their communities, what aspects of the communities make it easier or harder to be healthy, and their suggestions for future programming and services to address their perceived health issues. A semi-structured facilitator's guide was used across the various discussion tables at the community dialogue to ensure consistency in the questions asked and topics covered. Trained HRiA moderators co-facilitated the community dialogue with CSHC representatives. Conversations lasted approximately 35-45 minutes and included anywhere from 7-10 participants.

Analyses

The collected qualitative data were coded and analyzed thematically, where data analysts identified key themes that emerged across all groups and interviews. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. Selected quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

Codman Square Health Center Staff Survey

In order to understand staff perceptions around key community health concerns as well as their primary priorities for services and programming, a brief survey was developed and administered online to CSHC staff. The survey included an automatic skip pattern where non-clinical staff were taken to one section of the survey to answer questions about their perceptions of community health needs and priorities, while clinical staff were taken to a different section to answer similar questions about their patients. CSHC reviewed and provided feedback on the survey and also disseminated the survey link to their staff networks within health center. The survey was administered during the last two weeks of September 2013.

A total of 133 CSHC staff completed the survey (response rate of 59.1%). Among these, 55.9% of respondents represented clinical staff and 44.1% represented non-clinical staff. Table 1 presents the distribution of characteristics among survey respondents.

Table 1: Codman Square Health Center CHNA Staff Survey Respondent Characteristics by All Staff

	All Staff (N=133)
Age	
18-29 years old	15.2%
30-49 years old	43.4%
50-64 years old	35.4%
65 years or older	6.1%
Gender	
Male	19.0%
Female	81.0%
Race/Ethnicity	
White, non-Hispanic	24.1%
Black, non-Hispanic	35.3%
Hispanic, any race	5.3%
Asian, non-Hispanic	3.0%
Other race, non-Hispanic	11.3%
2 or more races, non-Hispanic	2.3%
Educational Attainment	
HS Diploma or Less	8.9%
Some College or Associate's Degree	31.7%
College graduate or more	59.4%
Location	
637 Washington St	90.4%
6 Norfolk St	5.8%
450 Washington St	3.8%
Primary Department	
Finance	7.6%
Executive	7.6%
DotWell	3.8%
Public Health	6.7%
Operations Clinical/Medical	58.1%
Administration	16.2%
Tenure at CSHC	
Less than 1 year	21.9%
1-2 years	20.0%
3-5 years	17.1%
6-10 years	17.1%
More than 10 years	23.8%
Job Description	
Staff	74.0%
Management	26.0%
Type of Work	
Clinical Staff	55.9%
Non Clinical Staff	44.1%

Limitations

As with all research efforts, there are several limitations related to this study's research methods that should be acknowledged. It should be noted that for the secondary data analyses, in several instances, current neighborhood level data were not available. In regard to the Boston Behavioral Risk Factor Survey (BBRFS), neighborhood-level data generally do not include homeless people or people whose neighborhood of residence was not reported in the survey (except in the Boston overall numbers).

Data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. However, it is important to note that the CSHC CHNA Staff Survey, also self-reported data, may be prone to selection bias – that is, staff who had more positive experiences may have been more likely than other staff to complete the survey, so that survey respondents are not representative of the larger staff population. Therefore, the survey findings represent a sub-set of health center staff and may be limited in their generalize ability.

While the focus groups and interviews conducted for this study provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Recruitment for focus groups was conducted by community organizations, and participants were those individuals already involved in community programming. Because of this, it is possible that the responses received only provide one perspective of the issues discussed. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

Codman Square
Health Center

FINDINGS

COMMUNITY SOCIAL AND ECONOMIC CONTEXT

The social, economic, and physical environments are important contextual factors shown to have an impact on the health of individuals and the community. The health of a community is associated with numerous factors including who lives in the community as well as what resources and services are available (e.g., safe green space, access to healthy foods). The section below provides an overview of the CSHC's patient population, the neighborhoods of North and South Dorchester, and Boston overall.

Demographic Diversity

- *"We are an amalgam of cultures and income diversity."* – Focus group participant
- *"I think it is very diverse. I also see a lot more young families in the community than I did before."* – Focus group participant
- *"You can go on any street around here and you will find people of different ethnicities – Spanish, Cape Verdean, Black, White ... you find more diversity here than in other parts of Boston."* – Focus group participant

Nearly every focus group and interview participant highlighted diversity as a key strength of Dorchester, including the range of age, cultural, ethnic, linguistic, and economic groups that characterize the neighborhood. Many participants also noted the multiple immigrant communities that reside in Dorchester ranging from Irish Catholic to Afro-Caribbean.

Population

In 2010, Boston's total population was estimated to be 617,594 people, a growth of almost 5% since 2000, when the city's population was 589,141 (Table 2). However, both North and South Dorchester experienced a decrease in their populations over the past decade (-2.4 and -3.1%, respectively). According to UDS data, CSHC served a total of 20,643 patients in 2012, over half of whom resided in Dorchester (53.6%).

Table 2: Total Population by City and Neighborhood, 2010

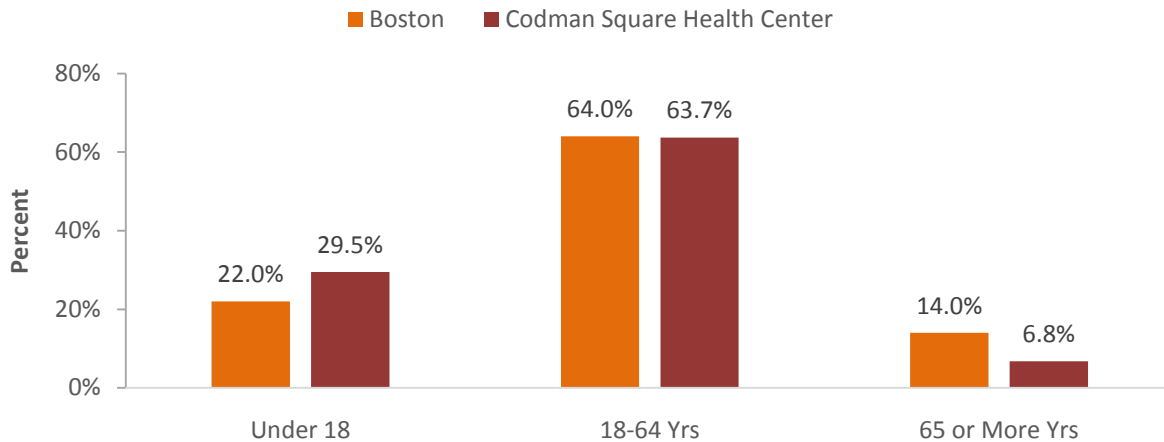
Geography	2000 Population	2010 Population	% Change
Boston	589,141	617,594	4.8%
North Dorchester	83,212	81,241	-2.4%
South Dorchester	45,291	43,870	-3.1%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2000 and 2010 Census as reported by Health of Boston 2012-2013

Age Distribution

Quantitative data illustrate that the majority of Boston's and CSHC's patient population was between the ages of 18 and 64 years (64.0% and 64.7%, respectively) (Figure 4). The youth population (under 18 years) comprised (22%) of Boston's total population; whereas the proportion of seniors (14%) is nearly half that of youth. CSHC served a higher proportion of youth (29.5%) and a lower proportion of seniors (6.8%) than reside in the city.

Figure 4: Age Distribution by City and Codman Square Health Center Patients, 2010* and 2012**



*DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

**DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

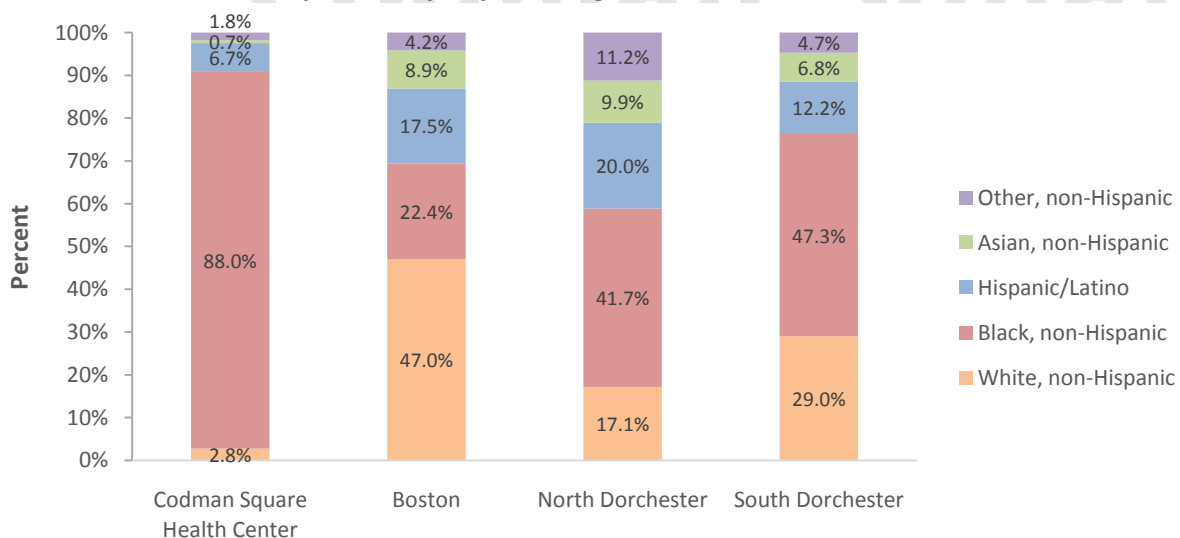
NOTE: Boston data is from 2010 while Codman Square patient data is from 2012

NOTE: Data not available by neighborhood

Racial and Ethnic Composition

Quantitative results support qualitative descriptions of racial and ethnic diversity. Figure 5 specifies the racial and ethnic composition of the city of Boston, Dorchester, and CHSC's patient population. Although nearly half of all Boston residents were White (47%) in 2010, there is substantial variation in the racial and ethnic diversity stratified by neighborhood. Blacks represent the largest racial/ethnic group in N. and S. Dorchester (41.7% and 47.3%), followed by Hispanic/Latinos in N. Dorchester (20.0%) and Whites in S. Dorchester (29.0%). Similarly, a majority of CSHC's patient population self-identified as Black (88.0%).

Figure 5: Racial/Ethnic Composition by City and Neighborhood, 2010* and 2012**



*DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

**DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

NOTE: Boston data is from 2010 while Codman Square patient data is from 2012

NOTE: 'Other Race' consists of American Indians/Alaskan Natives and Some Other Races

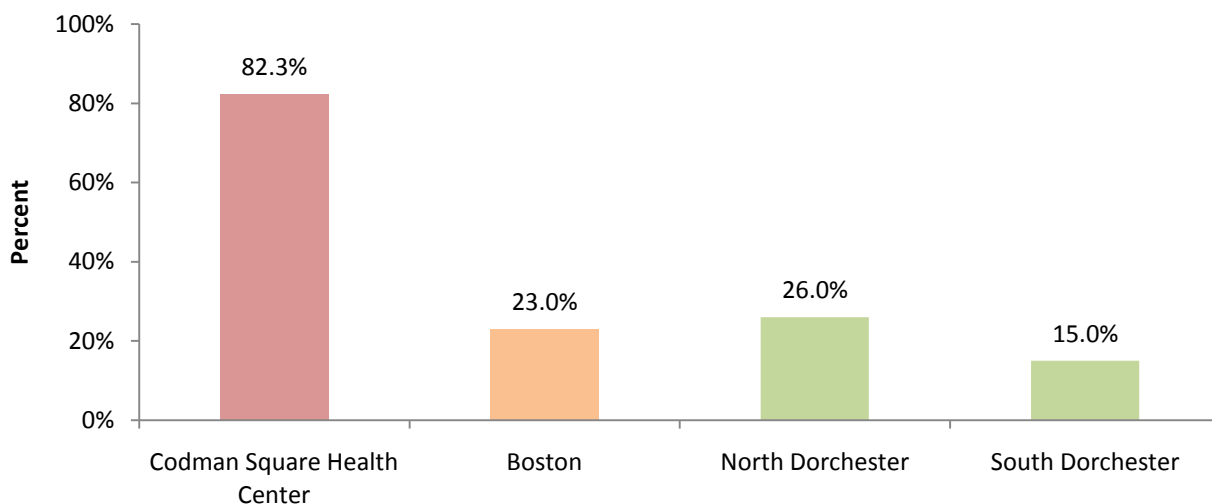
Income, Poverty, and Employment

- *A mix of socioeconomic groups but a disproportionate number of low income residents.* – Interview participant
- *“The economic piece is important. I have a lot of clients that are on fixed income, so some get \$600 a month and if they spend \$200 on their rent and then have three medications – that is limiting.”* – Focus group participant
- *“A lot of people don’t have jobs...”* – Interview participant

Several participants spoke of the economic challenges facing residents in the community, including underemployment. While they indicated that there are pockets of affluence, participants emphasized the needs of disadvantaged groups. They spoke of residents struggling to make ends meet due to the rising cost of living, such as parents having to decide whether to put food on the table or pay the bills.

Economic data confirm that considerable proportions of neighborhood residents are poor. In 2010, the median household income in Boston was \$49,893. Yet, the median income for Latino households (\$23,243) was less than half that of White households (\$61,636). The percentage of families below the poverty line in Boston in 2010 was 23% (Figure 6). Female-headed households, especially those with children, were found to be particularly vulnerable. When stratified by neighborhood, the data show that North Dorchester (26%) had a higher proportion of families living below the federal poverty line compared to the city over all; more than one in four families in North Dorchester are living below poverty. In 2012, over 80% of the health center’s patient population was comprised of individuals living in poverty (at or below 100% of poverty).

Figure 6: Percent of Families below Poverty by Health Center, City, and Neighborhood, 2010* and 2012**



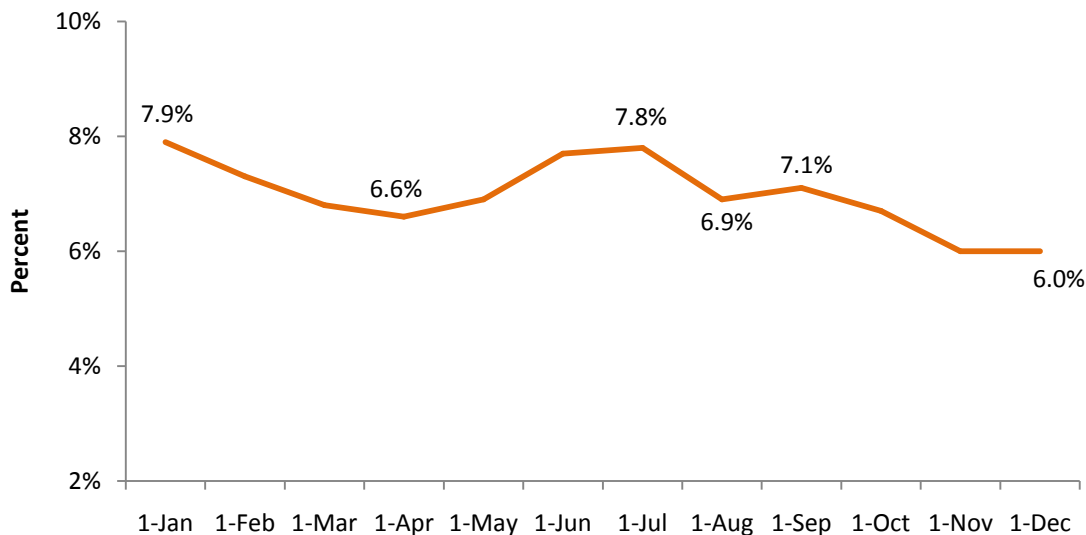
*DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

**DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

NOTE: Boston data is from 2010 while Codman Square Health Center patient data is from 2012

In 2011, though the unemployment rate in Boston fluctuated throughout the year, there was an overall downward trend from 7.9% in January to 6.0% in December (Figure 7). However, unemployment disparately affects racial/ethnic groups. For example, Black males (32%) experienced unemployment at almost four times the rate of White males (9%).

Figure 7: Unemployment Rate in Boston, 2011

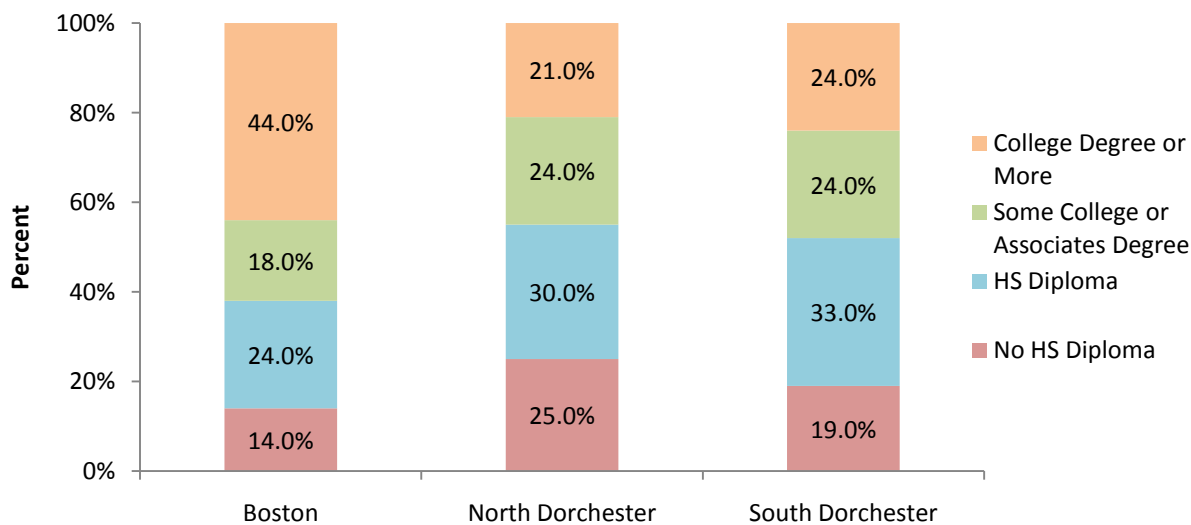


DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, as reported by Health of Boston 2012-2013

Education

Quantitative data show high educational attainment among Boston’s adult residents aged 25 years and older, with 44% having earned a college degree or more; whereas less than 25% of Dorchester residents have a college degree or higher (Figure 8). One in four adult residents in North Dorchester had no high school diploma (25.0%).

Figure 8: Educational Attainment of Adults 25 Years and Older by City and Neighborhood, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census

Housing and Transportation

- *“Rent prices are an issue. It is hard to afford to live here as it is and the prices are only going up for both rent and homeownership. Affordable housing is an issue.”* – Focus group participant
- *“It is easy to get to places from here, so transportation in this area is a plus.”* – Focus group participant
- *“Traffic. It has increased tremendously here. I think the city has to invest more in the infrastructure to deal with the traffic flow.”* – Focus group participant

The lack of affordable housing was identified as an important issue in the community. Several participants noted that the cost of housing has increased, which is causing people to move out. Some participants described clients struggling with long waiting lists for housing and the resulting economic instability.

In 2010, a majority (66%) of housing units in Boston were renter-occupied. This distribution was similar across North and South Dorchester (Figure 9); although, South Dorchester (42.0%) had a greater proportion of homeowners compared to Boston and North Dorchester (34.0% and 31.0%, respectively).

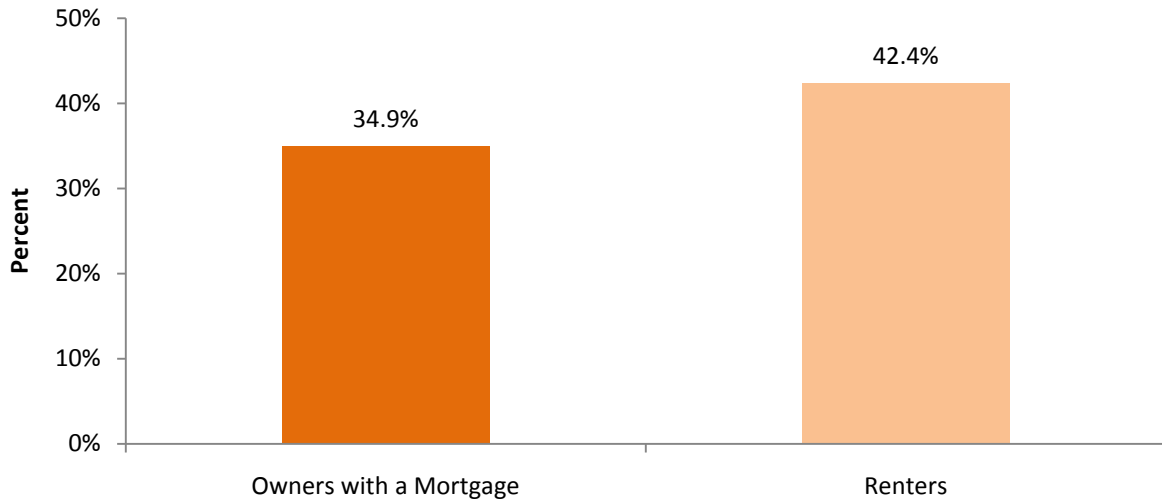
Figure 9: Housing Tenure by City and Neighborhood, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

Figure 10 illustrates the proportion of Boston renters and owners whose housing costs comprise 35% or more of their household income. Over 40% of renters contribute 35% or more of their income to housing costs, compared to 34.9% of homeowners.

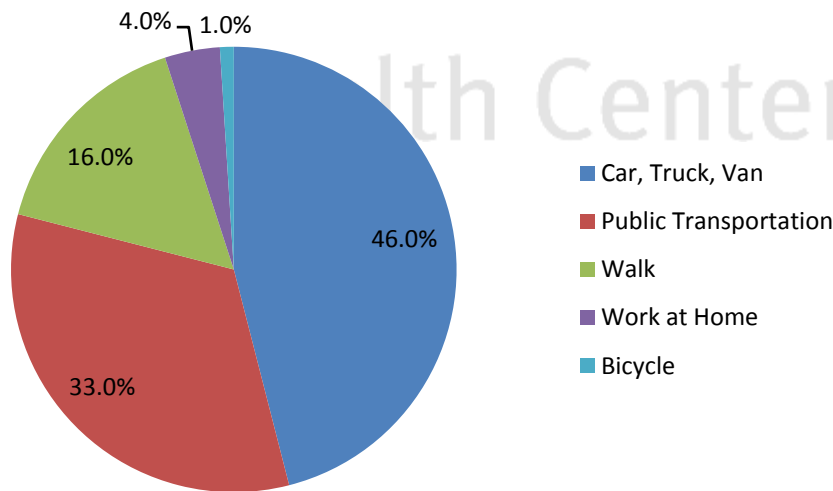
Figure 10: Percent of Residents Whose Housing Costs are 35% or more of Household Income in Boston, 2007-2011



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2011 American Community Survey

While some viewed the transportation in the area as an asset, others identified challenges with transportation (e.g., “there’s no direct route from Field’s Corner to the health center”). Some participants noted that a lack of transportation poses barriers to accessing care. Issues related to congestion and parking was also mentioned by some participants concerned with an increase in traffic. According to the 2010 American Community Survey administered by the Bureau of the Census, the primary mode of transportation for Boston residents was a car, truck, or van (46%), followed by public transportation (33%), and walking (16%). However, the Boston Indicator Project reports that more than one out of five workers residing in Dorchester – which lack access to MBTA subways or commuter lines – spend an hour or more getting to work each day.

Figure 11: Workers' Means of Transportation to Workplace in Boston, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 American Community Survey, as reported by Health of Boston 2012-2013

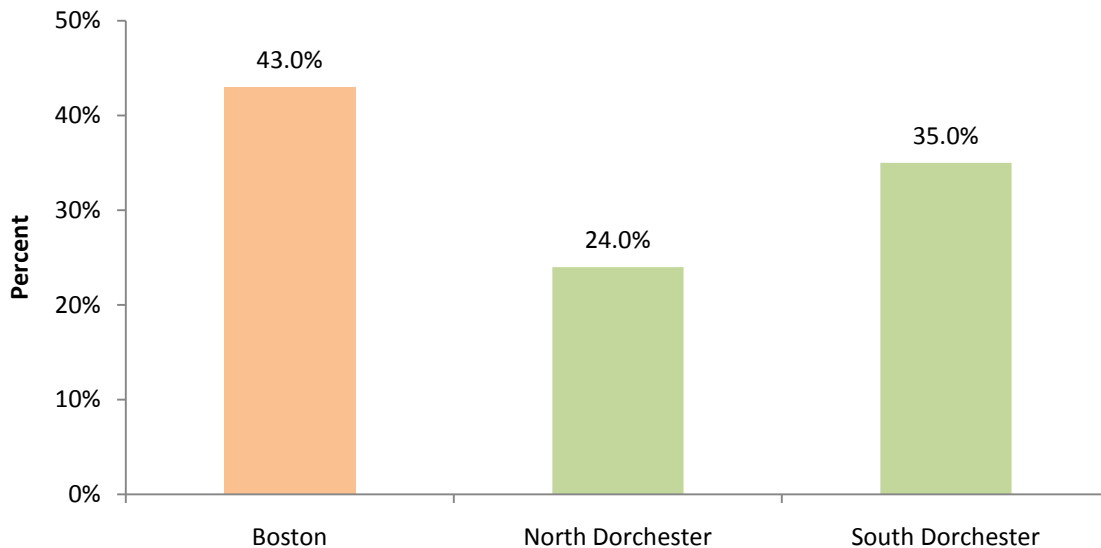
Violence and Neighborhood Safety

- *“Security is definitely up, before I would never walk in the dark but now I feel safer. And there are police patrolling.” – Focus group participant*
- *“We don’t have trust in our police officers. There’s a lot of violence going on right now.” – Focus group participant*
- *“Violence continues to be a problem and contributes to lack of physical activity; parents worry about the kids playing outside and elders worry about walking to the stores.” – Interview participant*

Concerns regarding neighborhood safety were a prominent theme across interviews and focus groups. While some indicated that crime and security has improved, many participants considered gun violence and the resulting trauma to be an important community issue. Perceptions of safety were described as affecting resident’s mobility and ability to engage in an active and healthy lifestyle.

Participant comments around neighborhood safety are consistent with responses from the most recent 2008 Boston Neighborhood Survey, a neighborhood-representative sample survey. Fewer than half of Boston adults perceived their neighborhood to be safe (Figure 12). Residents of North and South Dorchester were less likely to think their neighborhood was safe than residents citywide; slightly over one-third of South Dorchester residents (35.0%) and less than one quarter of North Dorchester (24.0%) residents reported positive perceptions of neighborhood safety.

Figure 12: Percent of Adults Who Think Their Neighborhood is Safe by City and Neighborhood, 2008



DATA SOURCE: Boston Neighborhood Survey, 2008; Harvard Youth Prevention Center through cooperative agreement with the Center for Disease Control and Prevention, as cited in the Health of Boston Report, 2011

Boston Police Department crime statistics confirm high rates of crimes in particular neighborhoods. Table illustrates violent and property crime rate in Boston overall and police districts B-3 (Mattapan, portions of Dorchester) and C-11 (Dorchester). Between January and November 2013, the City of Boston experienced 701.4 violent crimes and 2,462 property crimes per 100,000 population. District C-11 reported violent and property crime rates below that of Boston, 599.5 and 1,244.5 per 100,000 population, respectively. However, district B-3, which includes portions of Dorchester, experienced a disproportionate rate of violent and property crime compared to Boston and district C-11.

Table 3: Rate of Offenses Known to Law Enforcement per 100,000 Population by City and Neighborhood, January 1-November 17, 2013

Geography	Violent Crime Rate*	Property Crime Rate**
Boston	701.4	2,462.3
Mattapan, portions of Dorchester (B-3)	3,170.5	5,047.2
Dorchester (C-11)	599.5	1,244.5

DATA SOURCE: Part One crime Reported by the Boston Police Department by Offense and by District/Area, The Boston Police Department, Office Research and Development, Office of Police Commissioner, 2013

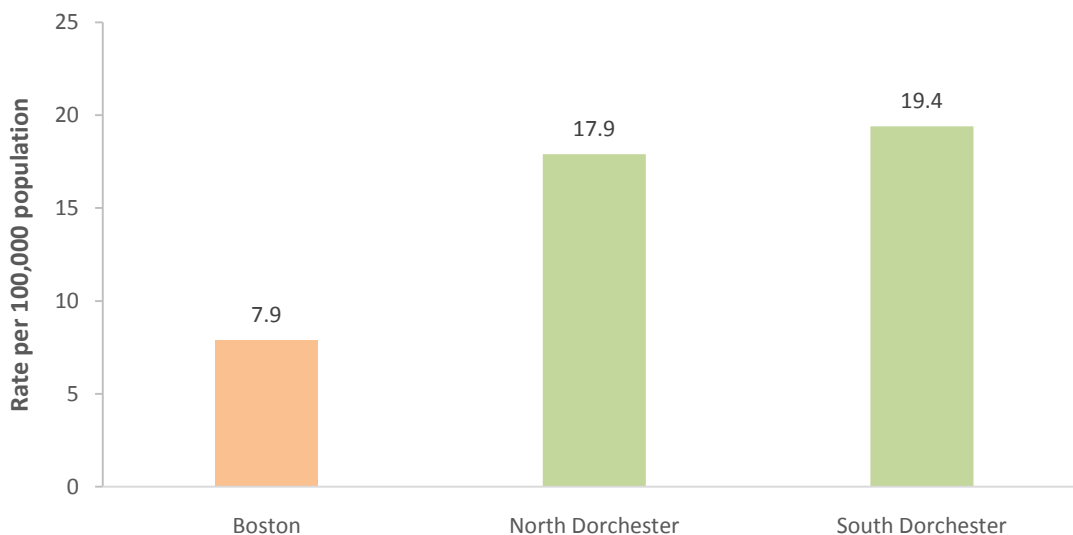
NOTE: Rates standardized to U.S. Department of Commerce, Bureau of the Census, 2010 Census Population data

* Violent crime includes: murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault

**Property crime includes: burglary; larceny-theft; motor vehicle theft; and arson

Figure 13 further demonstrates that North and South Dorchester experience disproportionately higher rates of violent crime compared to Boston. North and South Dorchester reported an annual homicide rate of 17.9 and 19.4 homicides per 100,000 residents, respectively – more than double the city-wide rate (7.9 homicides per 100,000 residents).

Figure 13: Average Annual Homicide Rate per 100,000 Residents by City and Neighborhood, 2005-2011



DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health as reported by Health of Boston 2012-2013

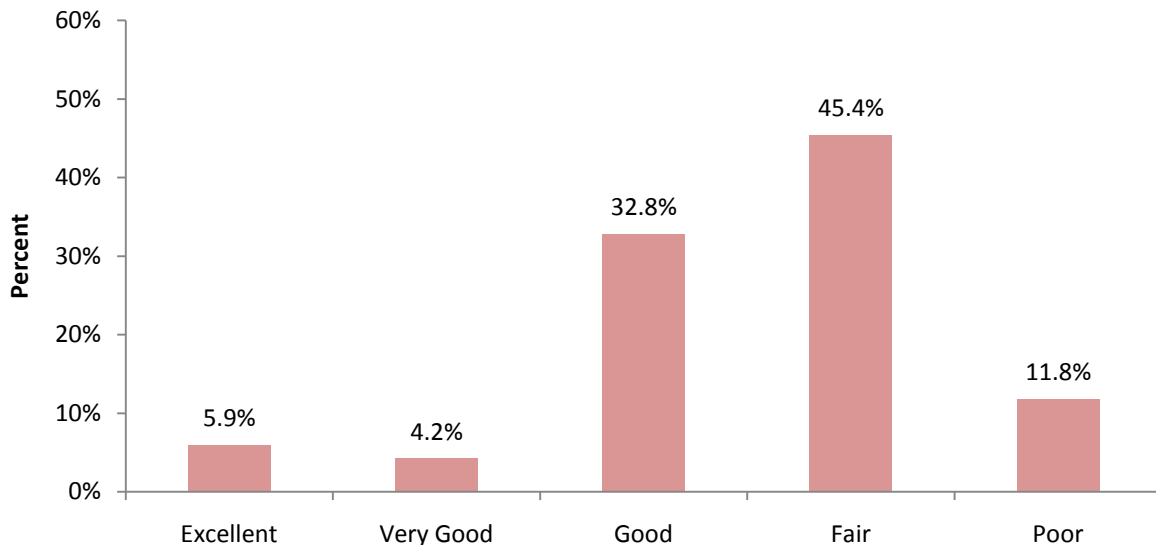
COMMUNITY HEALTH ISSUES

This section focuses on the health issues and concerns that emerged as the most prominent in CSHC's community health needs assessment process. Specifically, areas that rose to the top as far as severity and magnitude from the quantitative data, as well as issues of greatest concern and opportunity among interview, focus group, survey, and dialogue participants included: chronic diseases – such as diabetes and asthma – and related behaviors, namely obesity, physical activity, and nutrition; mental and behavioral health, especially issues related to violence; sexual health and teen pregnancy; and access to care.

Perceived Community Health Status

In the CSHC CHNA survey, staff respondents were asked to comment on the health of the community they serve. Over half of all staff described the community's health as fair/poor (57.2%) and nearly one-third considered the community's health to be good (32.8%); whereas, approximately 10% reported the community's health as excellent/very good (Figure 14).

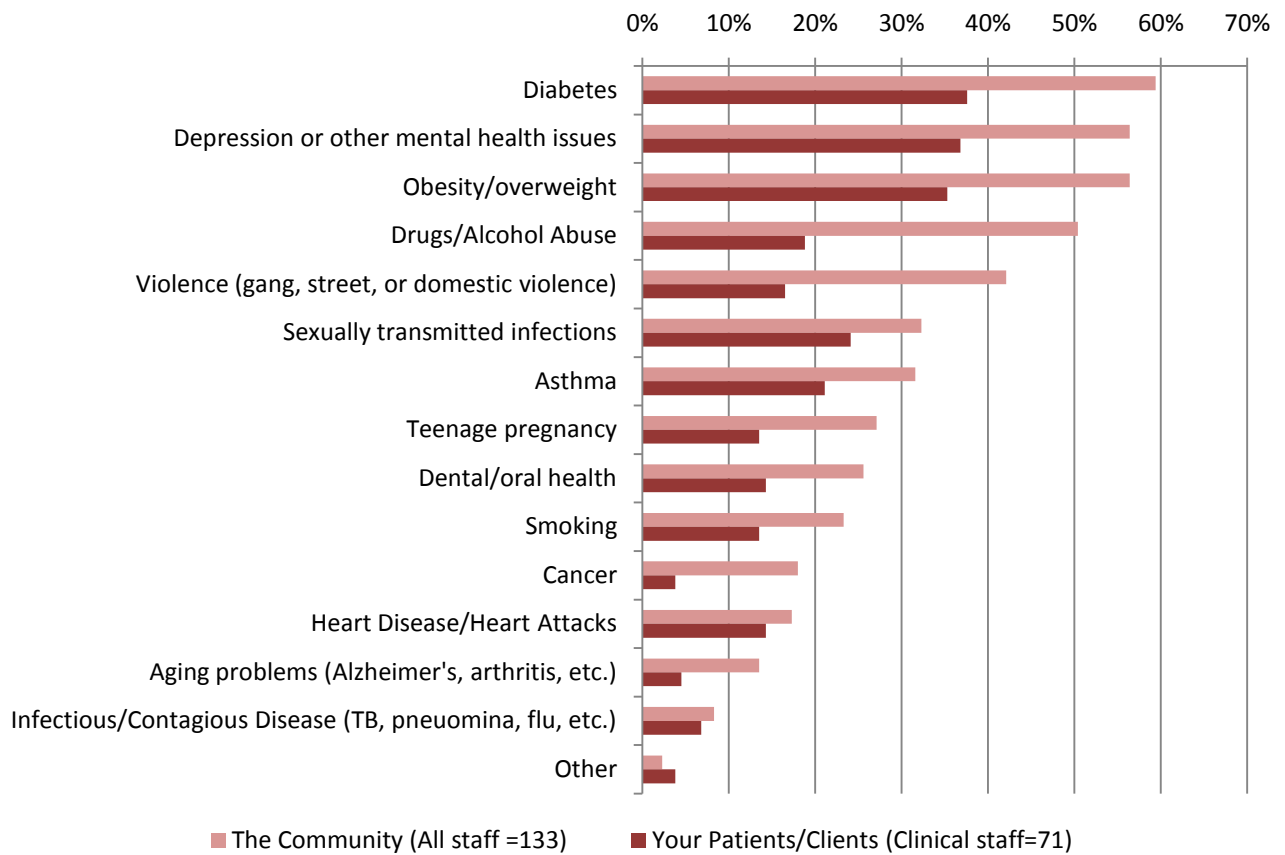
Figure 14: Perceived Health Status of Community Served by All Staff, 2013



DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

All survey respondents were asked to identify the primary issues that have the largest impact on the community they serve; clinical staff were also asked about the top issues that affect their patients/clients (Figure 15). Among all staff, diabetes, mental health, and obesity were viewed as the top health issues of concern for both the community at large (nearly 60% of all staff) and CSHC's patient population (nearly 40% of clinical staff). Among all staff, substance abuse and violence were also viewed as key concerns for the community; whereas, sexually transmitted infections and asthma were viewed as key concerns for patients according to clinical staff (Table 4).

Figure 15: Top Health Issues with the Largest Impact on the Codman Square Community and Patients/Clients Served, 2013



DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013
 Note: Arranged in descending order by "The Community"

Table 4: Top Health Concerns Perceived to Have Largest Impact on the Community and Patients/Clients Served, 2013

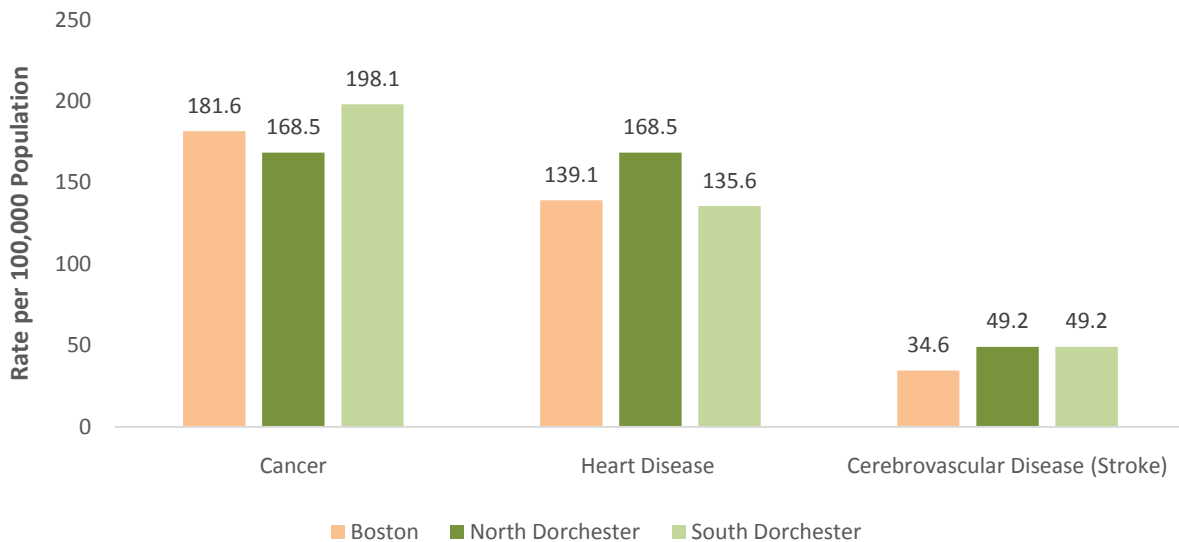
Rank	The Community (All Staff=133)	Patients/Clients Served (Clinical Staff=71)
1	Diabetes	Diabetes
2	Depression or other mental health issues	Depression or other mental health issues
3	Obesity/overweight	Obesity/overweight
4	Drugs/Alcohol abuse	Sexually transmitted infections
5	Violence (gang, street, or domestic violence)	Asthma

DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

Mortality and Morbidity

Quantitative data indicate that cancer is the leading cause of death in Boston, followed by heart and cerebrovascular disease (including stroke) (Figure 16). A similar pattern is seen in the neighborhoods of North and South Dorchester; although, in North Dorchester the mortality rates for cancer and heart disease are both 168.5 deaths per 100,000 population.

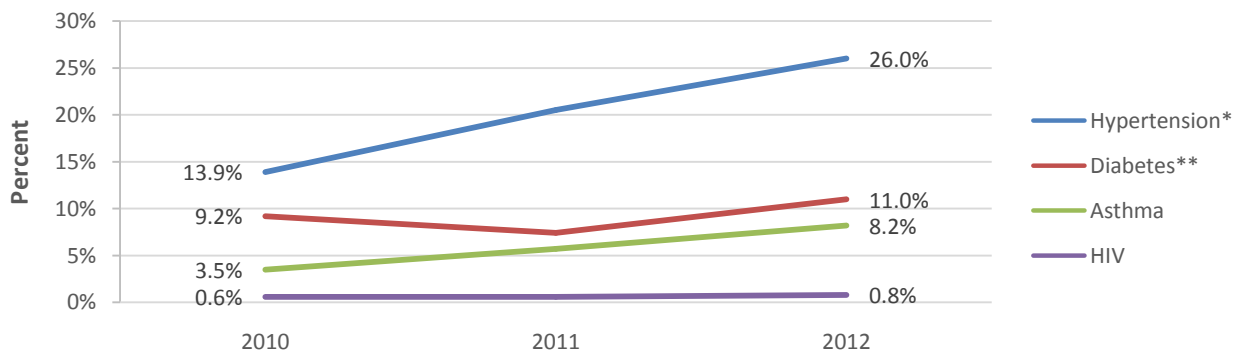
Figure 16: Rate of the Leading Causes of Death per 100,000 Population by City and Neighborhood, 2010



DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office as reported by Health of Boston 2012-2013

Examining CSHC clinical data reported to the Uniform Data Reporting System provides the medical conditions of its patient population between 2010 and 2012 (Figure 17). The percent of adult medical patients (18 years of age and older) with hypertension has nearly doubled over the past three years from 13.9% in 2010 to 26.0% in 2012. The proportion of all medical patients with asthma has experienced a similar trend; whereas, the proportions of adult diabetic patients and HIV patients have seen more gradual increases.

Figure 17: Percent of Codman Square Health Center Patients with Specific Medical Conditions, 2010-2012



DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

*Hypertensive adults as a percent of estimated adult medical patients of ages 18

**Diabetic adults as a percent of estimated adult medical patients of ages 18

Chronic Diseases and Related Risk Factors

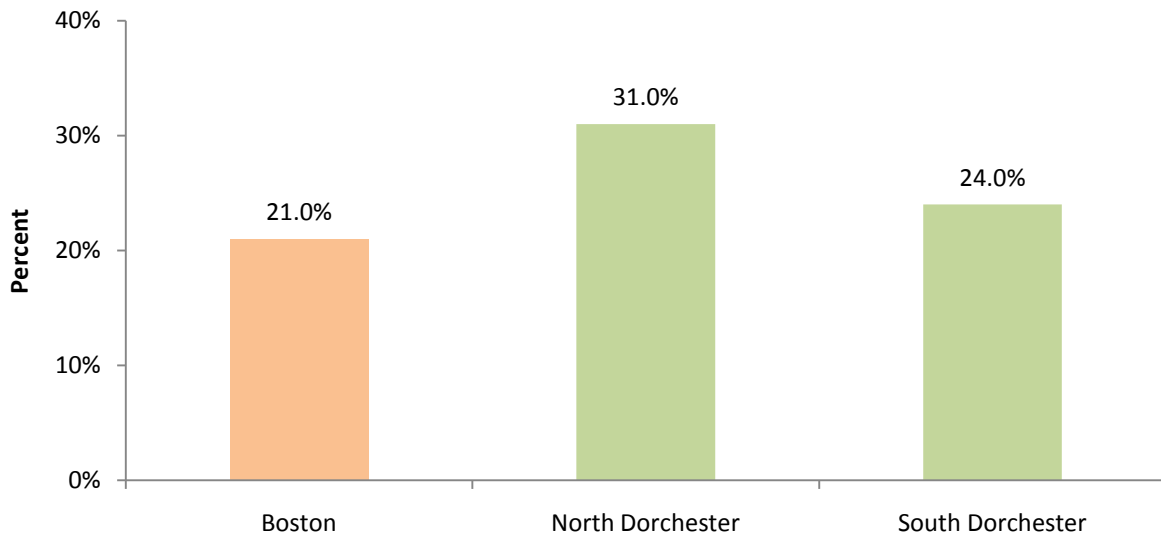
- *“The most pressing health issues are diabetes, hypertension, obesity, cholesterol, asthma, and other issues related to excess weight.”* – Interview participant
- *“I think a lot of it is you can’t afford the healthy foods so you buy what you can to fill you up.”* – Focus group participant
- *“As a community we need to be more conscious about healthy eating, and diet, and physical activity.”* – Focus group participant

Similar to staff survey results, chronic conditions were also top of mind concerns for focus group and interview participants, namely diabetes, obesity, and asthma. They emphasized the important role of lifestyle behaviors – such as healthy eating and active living –in preventing and reducing these conditions.

Obesity, Healthy Eating, and Physical Activity

Quantitative data demonstrate that obesity and overweight is a pervasive problem in Boston. The Boston Behavioral Risk Factor Survey (BBRFS), a telephone survey of Boston residents, asks respondents to comment on a variety of health topics such as chronic diseases and behaviors that impact one’s health such as diet, exercise and tobacco use. In 2010, North and South Dorchester had a higher proportion of obese adults compared to Boston overall (21.0%) ; nearly one in four adults in S. Dorchester (24.0%) and one in three adults in N. Dorchester (31.0%) were considered obese (Figure 18).

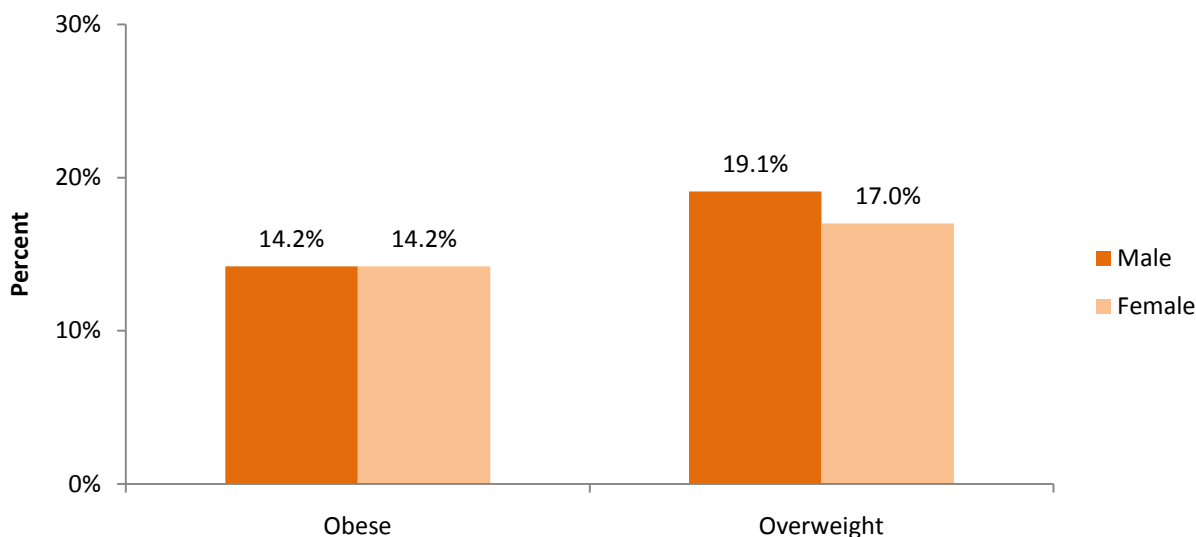
Figure 18: Percent of Obese Adults by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Figure 19 presents the percent of obese and overweight youth in Boston by gender. Based on responses from the 2011 Youth Risk Behavior Survey (YRBS), 14% of Boston’s youth were obese; male youth were slightly more likely to be overweight than female youth. Additionally, 29% of youth reported regularly engaging in physical activity. Data were not available by neighborhood.

Figure 19: Percent of Obesity and Overweight among Boston Secondary School Students by Gender, 2011



DATA SOURCE: Centers for Disease Control and Prevention, Youth Online: High School YRBS, Boston, MA 2011 Results

Table 5 presents CHSC’s preventive health screening and services related to obesity. In 2011 and 2012, at least 25.0% of CSHC’s adult patient population received weight screening and follow up compared to less than 2.0% of its adolescent patient population.

Table 5: Obesity Prevention and Counseling among Adolescent and Adult Codman Square Health Center Patients, 2011-2012

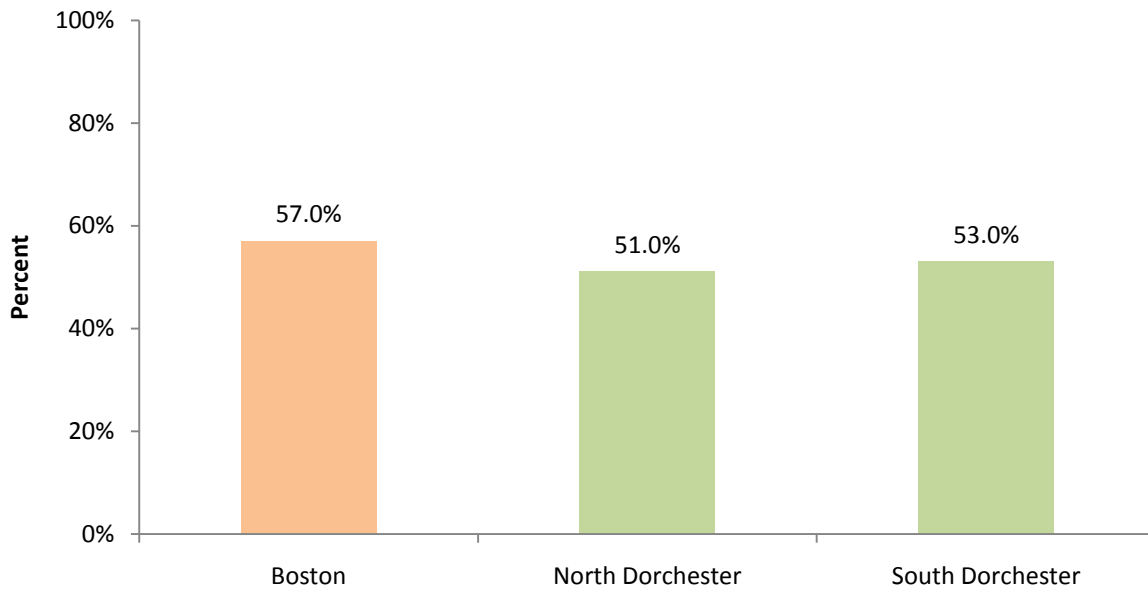
	2011	2012
Adolescent Weight Screening and Follow Up	0.0%	1.3%
Adult Weight Screening and Follow Up	24.7%	29.4%

DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

Participants also noted the barriers that residents face in addressing obesity, particularly access to healthy food and physical activity. The prevalence of fast food and perceptions of safety were viewed as preventing healthy lifestyle behaviors. As one participant shared, *“Food deserts are also a problem. It’s hard to find fresh produce and certain foods. There are many convenience stores.”* Another participant shared that, *“Parents don’t let their kids go out to play after school because they want them to be safe. So they’re inside watching TV and getting obese.”*

BBRFS data presented in Figure 20 show that 57% of adults in the city of Boston reported engaging in regular physical activity. Adults in North and South Dorchester (51.0% and 53.0%, respectively), were less likely to be physically active, compared to adults citywide. Furthermore, approximately one in four adults (26%) in Boston reported consuming the recommended daily servings of fruits and vegetables.

Figure 20: Adults who engage in Regular Physical Activity* by City and Neighborhood, 2008 and 2010 Combined



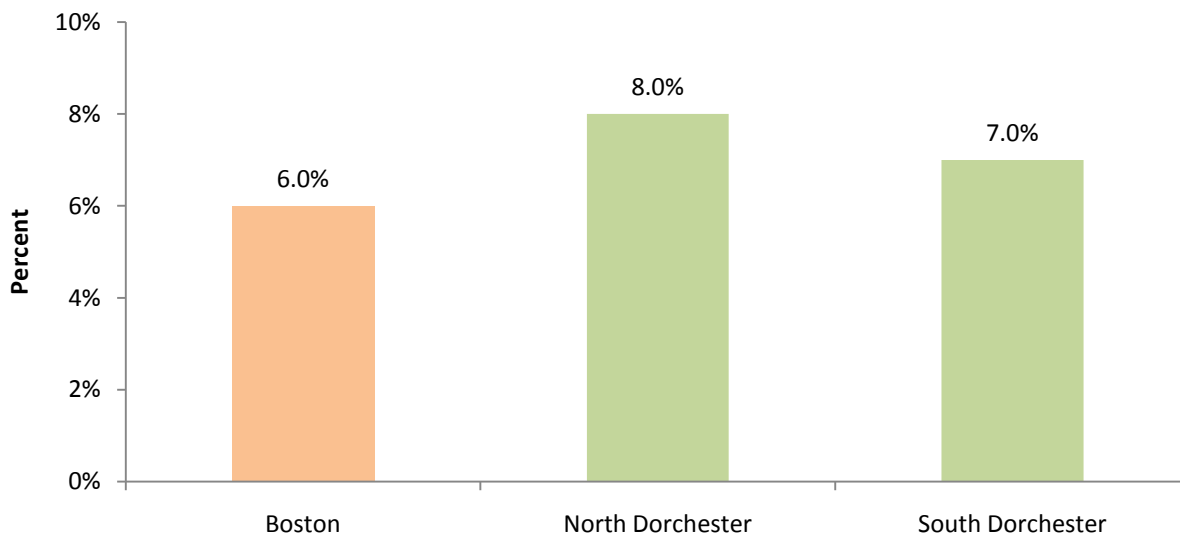
DATA SOURCE: Boston Behavioral Risk Factor Survey 2006 and 2008, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2011

*For adults, regular physical activity is defined as vigorous activity for 20minutes per day on 3 or more days a week or moderate activity for 30minutes per day on 5 or more days a week.

Diabetes

While diabetes was a frequently cited health issue during focus groups and interviews, it was not discussed at length. Quantitative data demonstrate that diabetes disproportionately affects residents in certain neighborhoods. In 2010, North and South Dorchester had a higher proportion of adult residents with diabetes (8.0 and 7.0%, respectively) compared to Boston (6%) (Figure 21).

Figure 21: Percent of Adults with Diabetes by City and Neighborhood, 2010

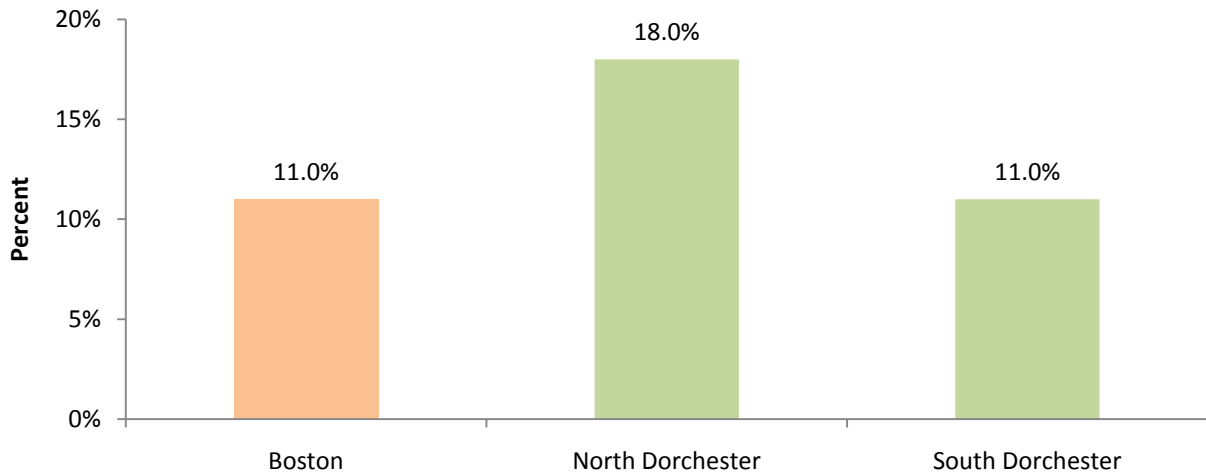


DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Asthma

Participants also noted the high rates of asthma in their community, which they described as being exacerbated by poor air quality and housing conditions. In Boston, the disease burden of asthma is distributed differentially by neighborhood (Figure 22). In 2010, the prevalence of asthma was particularly high in North Dorchester – where nearly one in five adults in N. Dorchester have asthma (18%) – and well above that of Boston (11%). Residents in South Dorchester experience asthma at the same rate as residents citywide.

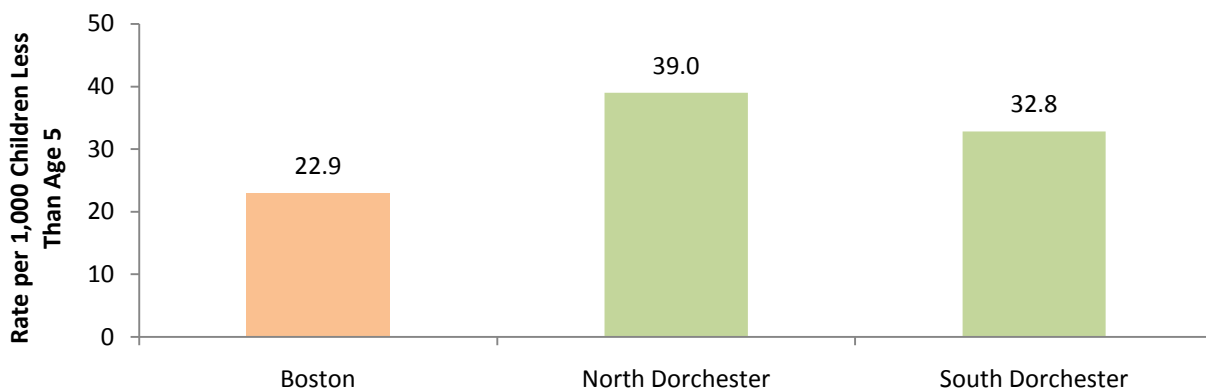
Figure 22: Asthma Prevalence among Adults by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

As illustrated in Figure, among children less than five years old, the rate of asthma emergency department (ED) visits in the city of Boston was 22.9 per 1,000 children in 2011. Children under age five in North Dorchester (39.0 ED visits per 1,000 children) and South Dorchester (32.8 ED visits per 1,000 children) experienced higher rates of visits to the ED due to asthma, compared to children citywide.

Figure 23: Rate of Asthma Emergency Department Visits per 1,000 Children Less Than Age 5 by City and Neighborhood, 2011



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Chronic Disease Management

CSHC clinical data presented in Table 6 shows chronic disease management among its patient population. In 2012, a majority of asthma, ischemic vascular disease, and diabetic patients (83.3%, 82.2%, and 73.2%, respectively) had their diseases effectively managed. Less than half of hypertensive and coronary artery disease patients (49.5% and 39.4%, respectively) had their diseases effectively managed.

Table 6: Chronic Disease Management among Codman Square Health Center Patients, 2012

Type	Percent
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease patients)	39.4%
Blood pressure control (Hypertensive patients with blood pressure <140/90)	49.5%
Diabetes control (diabetic patients with HbA1c<=9%)	73.2%
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	82.2%
Asthma Treatment (Appropriate Treatment Plan)	83.3%

DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

Mental and Behavioral Health

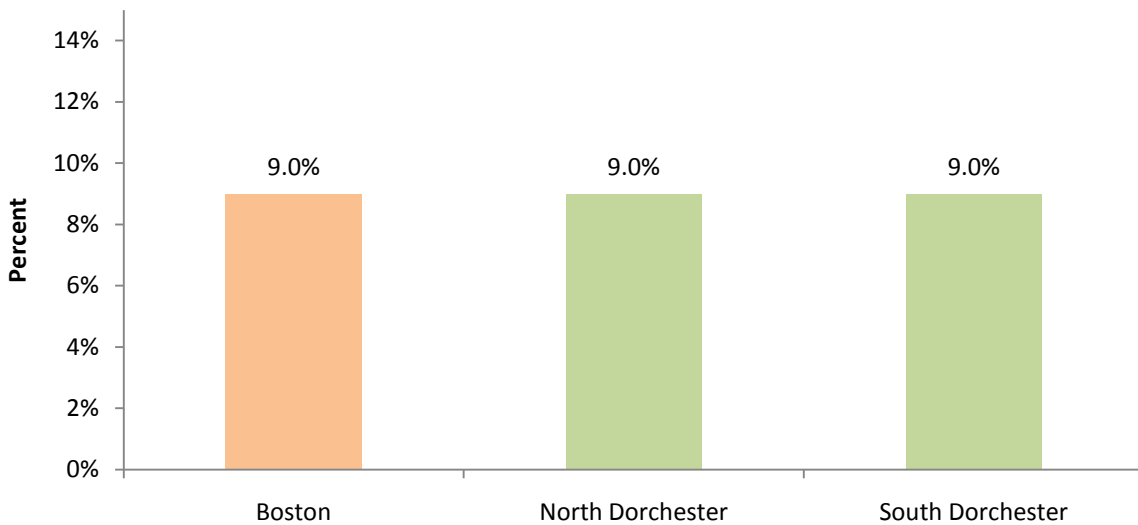
- *“Mental health is a huge problem; there’s a lot of depression and anxiety.”* – Interview participant
- *“I think people need to know that it is okay to access behavioral health services, but there is a lot of stigma attached to it so people avoid it. I think people need to know it is okay to seek services when you are feeling stressed.”* – Focus group participant
- *“There are also mental health issues in low income communities. So many kids grow up with PTSD and we don’t do a good job with behavioral health... We wait too long to intervene.”* – Interview participant

Mental health emerged as a pressing issue among focus group and interview participants as well. Participants described mental health conditions ranging from stress and anxiety to depression and Post Traumatic Stress Disorder, which were often related to community violence and substance abuse. They also discussed the stigma associated with mental health and insufficient services as key barriers to addressing mental health.

Self-Reported Mental Health Status

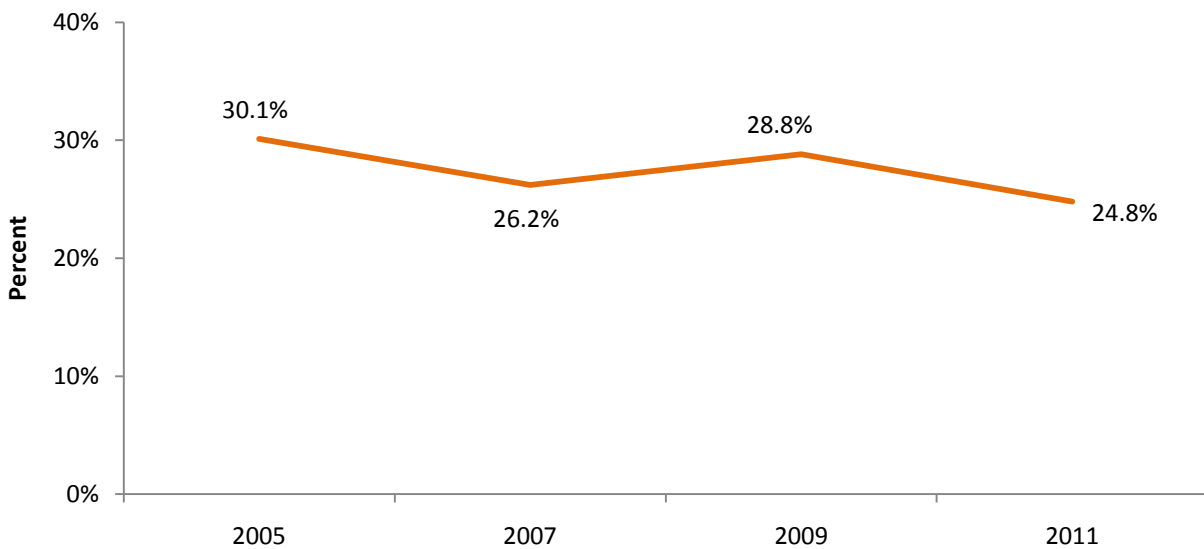
Depressive symptoms affect both youth and adults in Boston. As illustrated in Figure, North and South Dorchester had same proportion of adults reporting persistent sadness (feeling sad, blue, or depressed 15 or more of the past 30 days) as Boston (9%). Figure 25 demonstrates that in 2011, nearly 25% of Boston youth reported feeling sad or hopeless; however, this percentage has decreased since 2005.

Figure 24: Percent of Adults Reporting Persistent Sadness by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Figure 25: Percent of Boston Youth Reporting Feeling Sad or Hopeless for Two Weeks Straight over a Year, 2005-2011



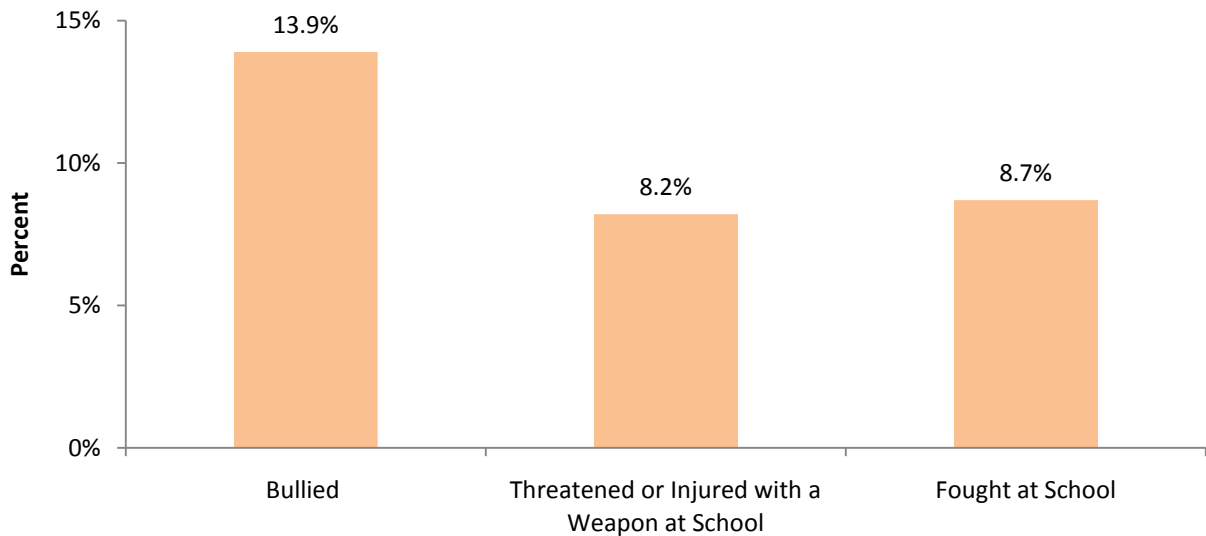
DATA SOURCE: Centers for Disease Control and Prevention, Youth Online: High School YRBS, Boston, MA 2005-2011 Results

Violence and Trauma

As discussed earlier in this report, violence was raised as a key issue permeating the lives of residents. The majority of participants primarily expressed concerns regarding the effects of residents witnessing violence in their neighborhoods and low perceptions of neighborhood safety. Participants were particularly concerned about the toll violence takes on youth. In addition to problems youth may face in the larger community or at home, school can be a protective as well as a harmful setting. According to

the 2011 Youth Risk Behavior Survey, high school students are primarily experiencing school-based violence in the form of bullying (Figure 26). Less than 10% of students reported fighting or being threatened or injured with a weapon at school.

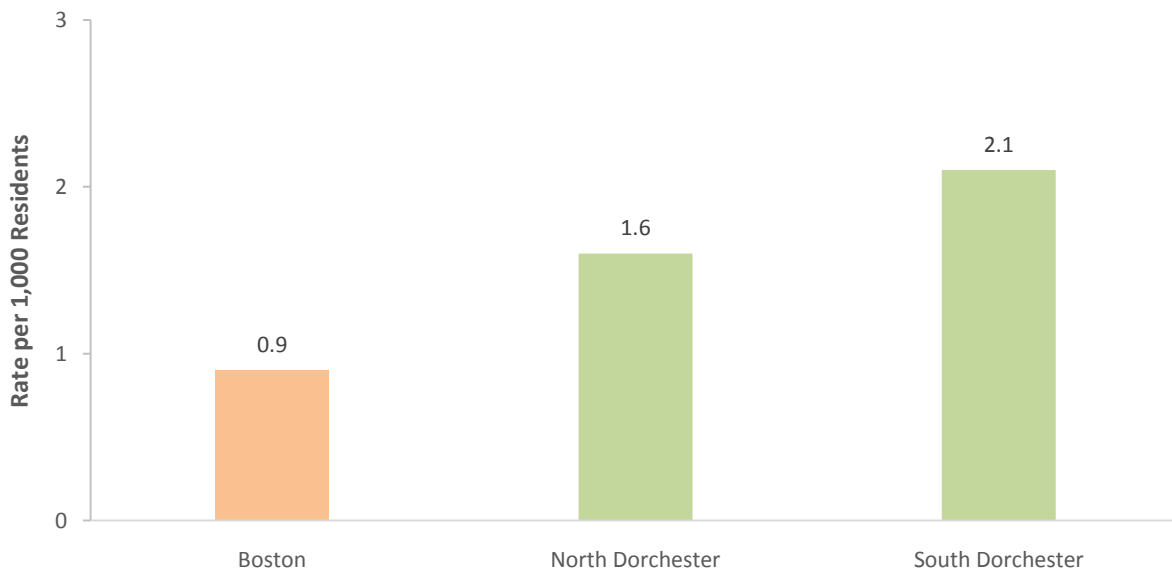
Figure 26: School-Based Experiences of Violence by Boston Youth, 2011



DATA SOURCE: Centers for Disease Control and Prevention, Youth Online: High School YRBS, Boston, MA 2011 Results

Figure 27 shows that rates of emergency department visits for nonfatal stabbing or gunshot wounds are higher in North and South Dorchester (1.6 and 2.1 visits per 1,000 residents, respectively) compared to Boston (0.9 visits per 1,000 residents). Residents in South Dorchester experienced ED visits due to nonfatal gunshot and stab wounds at more than twice the rate of residents citywide.

Figure 27: Rate of Nonfatal Gunshot/Stabbing Emergency Department Visits per 1,000 Residents by City and Neighborhood, 2010

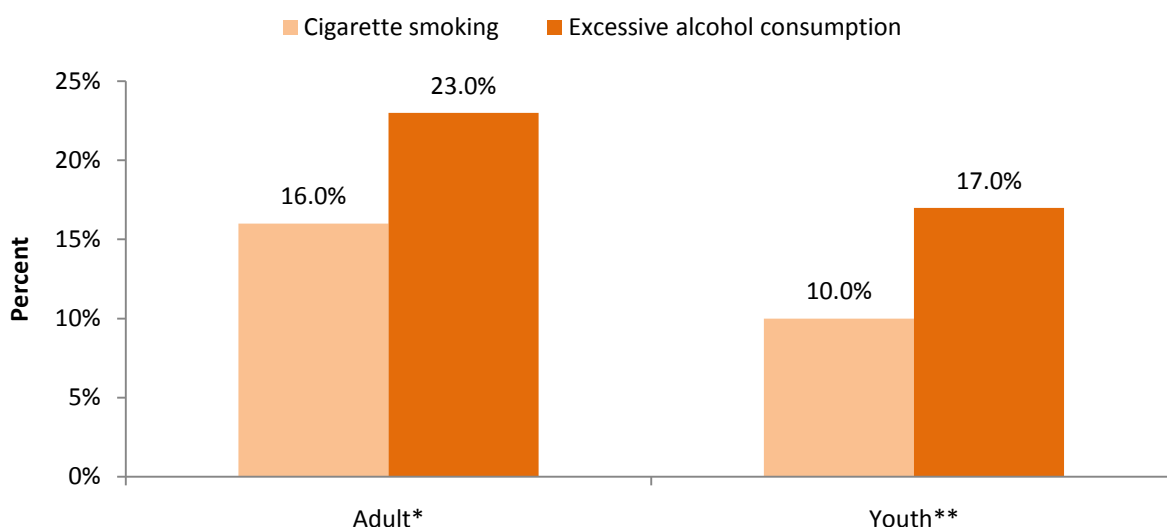


DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Substance Abuse

While substance use was mentioned among assessment participants, it was not heavily discussed. Drug use was often noted in the context of mental health as a means of self-medication. The proportion of Boston adults and youth reporting use of tobacco products has declined over recent years. As illustrated in Figure, 16% of adults and 10.0% of youth in Boston reported smoking cigarettes. Further, 23.0% of adults and 17.0% of youth indicated that they participated in excessive alcohol consumption, defined as consuming an average of more than two drinks per day for men and more than one drink per day for women during a one month period. Data were not available by neighborhood.

Figure 28: Substance Use among Adults and Youth in Boston, 2010 and 2011



*DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission as reported by Health of Boston 2011

**DATA SOURCE: Youth Risk Survey 2011, Youth Risk Behavioral Surveillance System (YRBS), Centers for Disease Control and Prevention (CDC), DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office, as reported by Health of Boston 2012-2013

Table 7 presents CHSC’s preventive health screening and services related to tobacco. While the proportion of CSHC patients screened for tobacco use decreased from 98.4% in 2011 to 81.5% in 2012, the proportion of tobacco users receiving cessation counseling increased from 12.3% to 71.8% during this same time period.

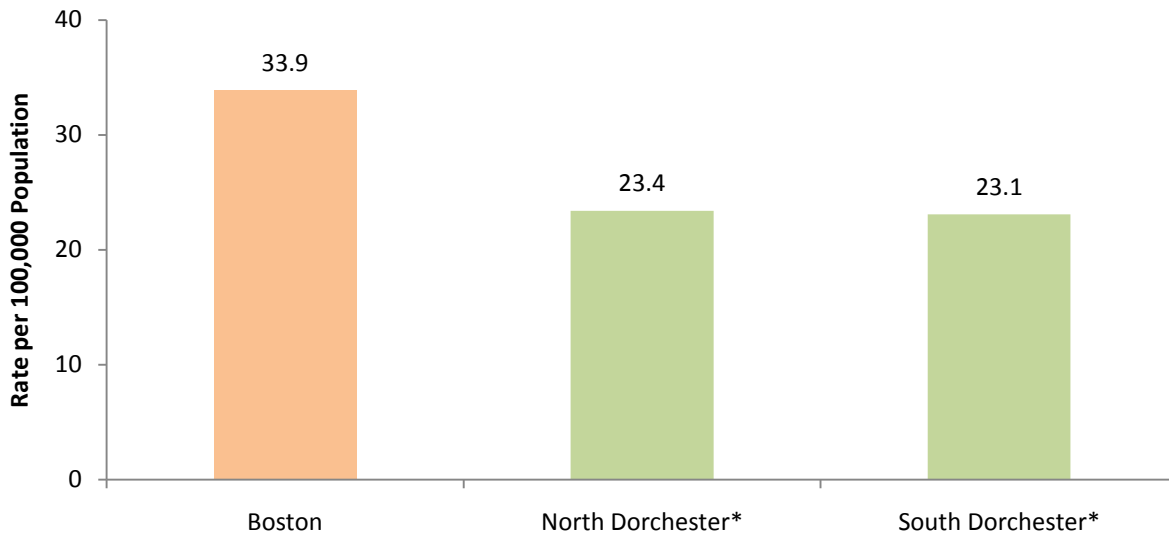
Table 7: Tobacco Screening and Counseling among Codman Square Health Center Patients, 2011-2012

Type	2011	2012
Tobacco Use Screening	98.4%	81.5%
Tobacco Cessation Counseling for Tobacco Users	12.3%	71.8%

DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

According to the Massachusetts Department of Public Health, in 2010, the substance abuse mortality rate in Boston was 33.9 deaths per 100,000 population. The death rate due to substance abuse in North and South Dorchester (23.4 and 23.1 deaths per 100,000 population) was lower than that of Boston.

Figure 29: Age-Adjusted Substance Abuse Mortality Rate per 100,000 Population by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

* NOTE: Rates based on counts less than 20 should be interpreted with caution

Sexual Health, Teenage Pregnancy, and Birth Outcomes

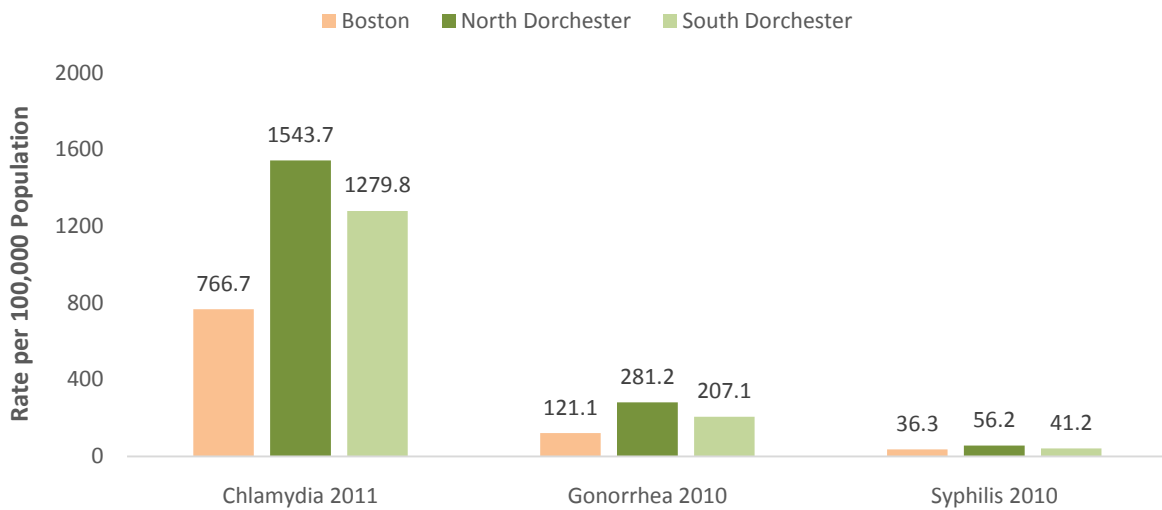
- “[Teenagers] don’t understand that having sex is more than risking pregnancy. It’s the diseases too. The sexually transmitted diseases.” – Focus group participant
- “And you have a lot of these young parents, who have young kids, who then have kids. They don’t know how to parent. It’s babies raising babies.” – Focus group participant
- I see a lot of undesired pregnancies, a lot of unhealthy relationships between men and women...risky behaviors that result in STDS.” – Interview participant

Issues related to sexual health were raised as a concern among some assessment participants, namely sexually transmitted diseases and teen pregnancy. They expressed concern regarding the consequences of unhealthy relationships and risky behaviors for youth.

Sexual Health

As illustrated in Figure 30, rates of sexually transmitted infections are higher in North and South Dorchester compared to Boston overall. While Boston reported a rate of 720.9 cases of Chlamydia per 100,000 population, North and South Dorchester (1,477.9 and 1,264.4 per 100,000 population, respectively) had substantially higher rates. The incidence rates for Chlamydia and Gonorrhea in North Dorchester are more than double those of Boston.

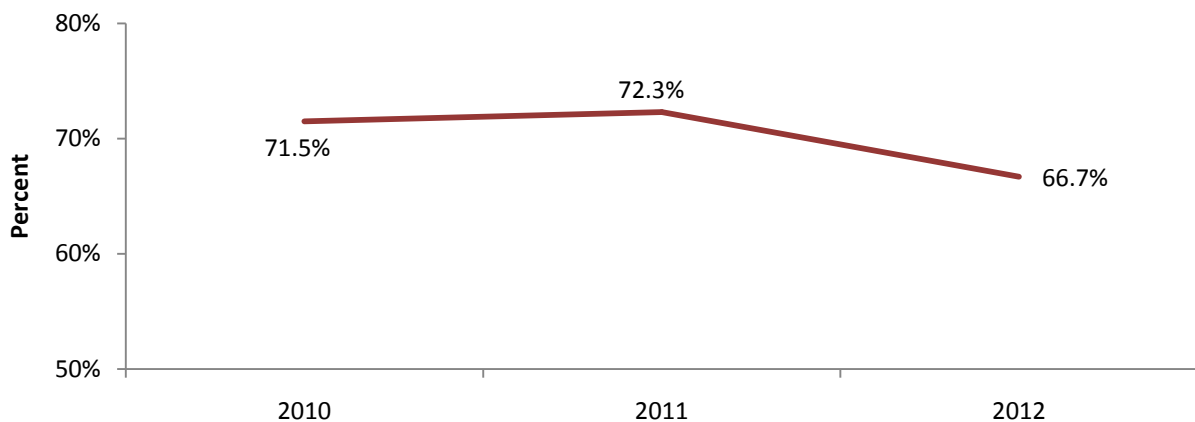
Figure 30: Sexually Transmitted Infection Incidence Rates per 100,000 Population by City and Neighborhood, 2010* and 2011**



*DATA SOURCE: Massachusetts Department of Public Health, STD Division, as reported by Health of Boston 2011
 ** DATA SOURCE: Massachusetts Department of Public Health, STD Division, as cited in BPHC Health of Boston 2012-2013

Figure 31 presents CHSC’s preventive health screening and services related to cervical cancer. The percent of women screened for cervical cancer decreased from 2010 to 2012. In 2012, approximately two-thirds of women had cervical cancer screening (66.7%).

Figure 31: Percent of Women with Cervical Cancer Screening Square Health Center Patients, 2010-2012

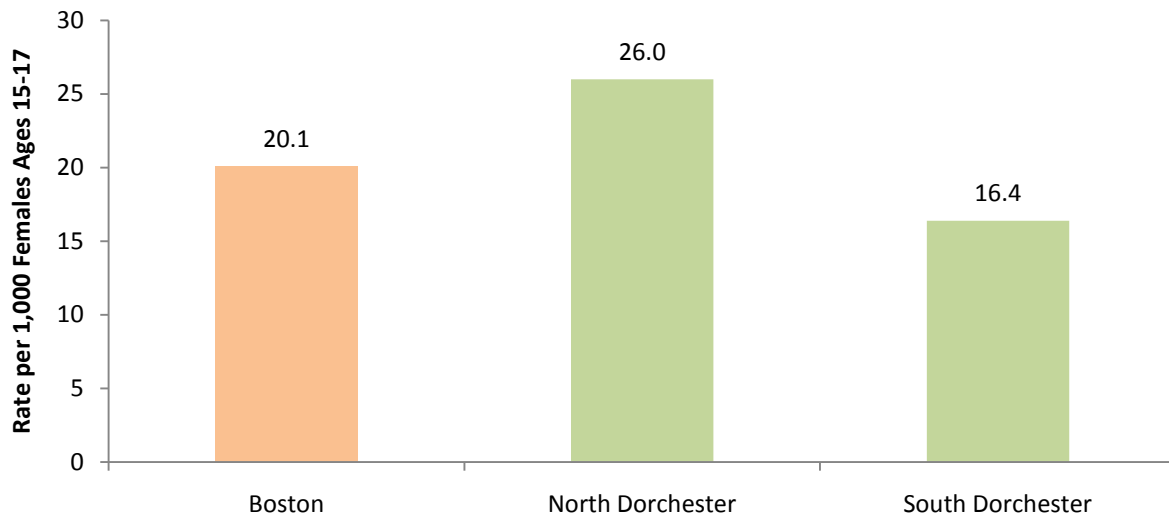


DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

Teenage Pregnancy

According to the 2012 Health of Boston Report, the adolescent birth rate in Boston has decreased since 2005. Figure 32 summarizes city and neighborhood-level data on the rate of teen births per 1,000 females ages 15-17. The rate of teen pregnancy in North Dorchester (26 births per 1,000 females ages 15-17) is above that of Boston (20.1 births per 1,000 females ages 15-17), while the rate of teen pregnancy in South Dorchester (16.4 births per 1,000 females ages 15-17) is below that of Boston.

Figure 32: Rate of Births per 1,000 Females Ages 15-17 by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Prenatal Care and Birth Outcomes

According to CSHC clinical data, prenatal patients comprise less than 3% of CSHC’s total patient population (Table 8). Of these patients, over 70% had their first prenatal visit in the first trimester; this proportion has gradually increased over the past three years from 74.3% in 2010 to 79.0% in 2012.

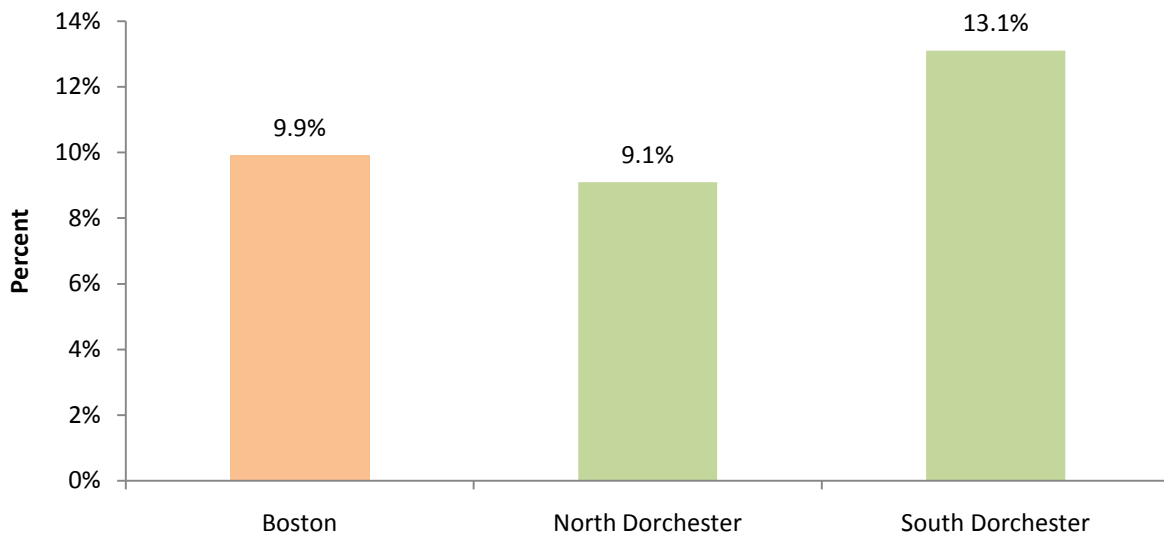
Table 8: Codman Square Health Center Prenatal Data, 2010-2012

	2010	2011	2012
Prenatal patients (among total health center patients)	1.9%	2.6%	2.8%
Had first prenatal visit in 1st Trimester	74.3%	78.6%	79.0%

DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

In Boston, approximately one in ten residents reported a pre-term birth (before 37 weeks gestation) (Figure 33). The percent of pre-term births in North Dorchester (9.1%) was lower than that of Boston, while the percent in South Dorchester (13.1%) was higher.

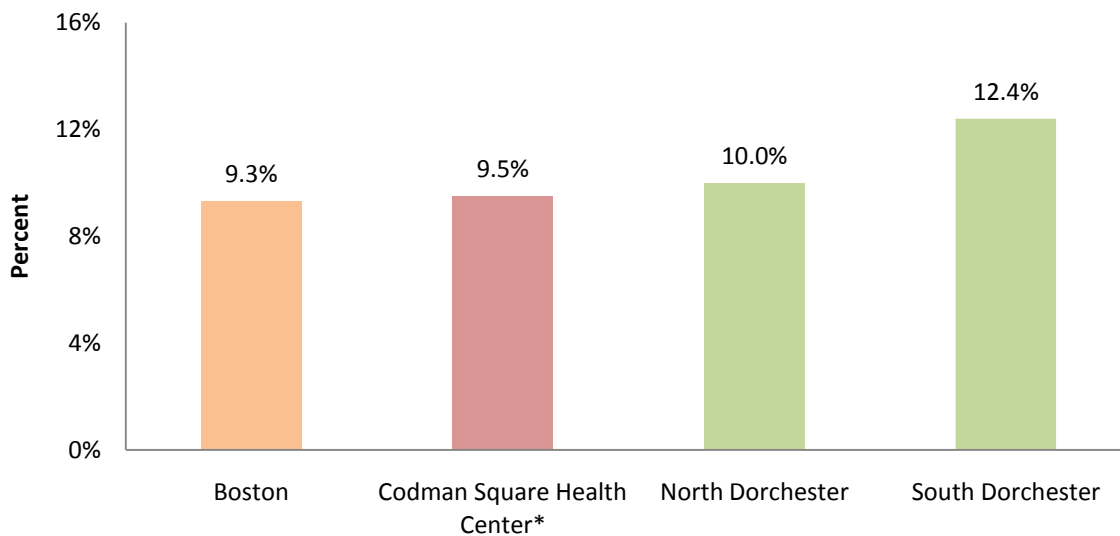
Figure 33: Percent of Preterm Births by City and Neighborhood, 2010



DATA SOURCE: Boston Resident Live Births, Massachusetts Department of Public Health, as reported by Health of Boston 2012-2013

South Dorchester (12.4%) also reported the highest percent of low birth weight babies (less than 2,500 grams) (Figure 34). Codman Square Health Center (9.5%) reported a similar proportion of low birth weight births as Boston (9.3%)

Figure 34: Percent of Low Birth Weight Births by City and Neighborhood, 2010* and 2012**



*DATA SOURCE: Boston Resident Live Births, Massachusetts Department of Public Health, as reported by Health of Boston 2012-2013

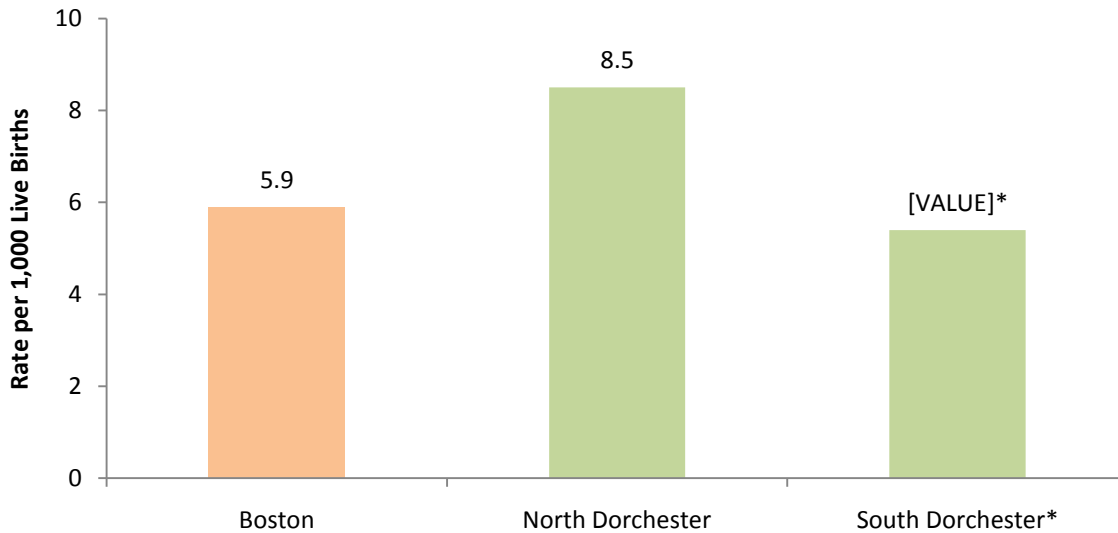
**DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

NOTE: Codman Square Health Center data is from 2012 whereas all other data is from 2010

As illustrated in Figure, the aggregate infant mortality rate between 2006 and 2010 for the city of Boston was 5.9 deaths per 1,000 live births. Stratifying this data by neighborhood show that Dorchester experienced an infant mortality rate (8.5 deaths per 1,000 live births), above that of Boston overall.

Stratifying this data by race/ethnicity indicate that Blacks experienced the highest infant mortality rate (10.9 per 1,000 live births), at nearly twice the rate of Boston overall.

Figure 35: Infant Mortality Rate per 1,000 Live Births by City and Neighborhood, 2006-2010



DATA SOURCE: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health as reported by Health of Boston 2012-2013

*NOTE: Represents rate based on counts less than 20 and should be interpreted with caution.

Health Care Access and Utilization

- *“Lack of access to care; without a job there’s no health insurance, without health insurance there’s no health care, there’s poor health.”* – Interview participant
- *“I think it’s navigating the system to find the physician that is the difficult part.”* – Focus group participant
- *“Doctor’s struggle with a large number of no shows due to transportation, child care, work issues...”* – Interview participant

Issues related to healthcare access and utilization were also explored in the staff survey as well as focus group and interviews. Challenges regarding access to care were raised in almost every focus group and interview. Barriers included: health insurance coverage and cost, navigating the complex healthcare system, and culturally sensitive care. The following section describes the use and availability of services in the community, as well as the challenges to accessing them.

Resources and Use of Health Care Services

Table 9 shows the percent of patients using specific services at CSHC from 2010-2012. In 2012, a majority of CSHC’s patient population used its medical services (94.7%), followed by enabling services (i.e., non-clinical services to increase access to health care such as transportation, outreach, and interpretation services), and vision services (30.4% and 20.4%, respectively). With the exception of mental health services, the proportion of patients using each type of service has increased since 2010. Notably, the proportion of patients using CSHC’s enabling services has more than tripled over the past three years.

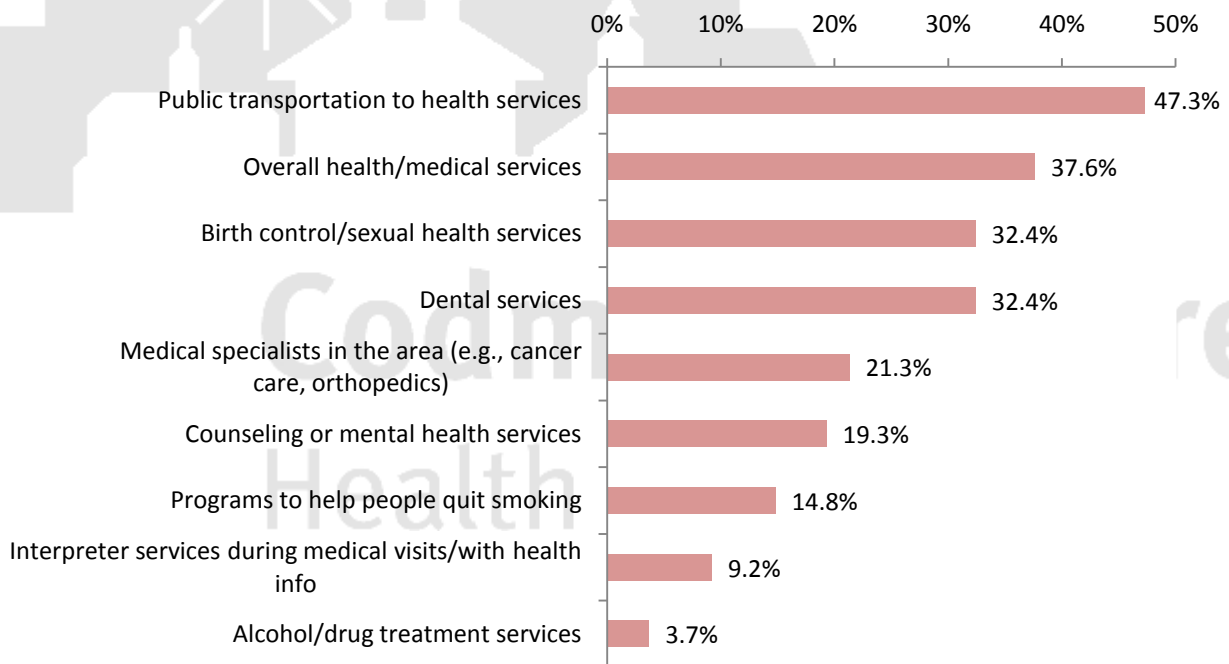
Table 9: Percent of Patients at Codman Square Health Center Using Specific Services, 2010-2012

	2010	2011	2012
Medical Services	92.6%	92.8%	94.7%
Dental Services	13.8%	13.3%	16.5%
Mental Health Services	5.6%	8.4%	5.4%
Vision Services	15.0%	16.4%	20.4%
Enabling Services	8.9%	6.3%	30.4%

DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

CHSC CHNA staff survey respondents were asked to comment on their level of satisfaction with the availability of services (Figure 36). Staff were most satisfied with public transportation to health services and overall health/medical services; more than one-third of staff were very satisfied with the availability of these services in the community. Staff were least satisfied with substance abuse treatment services and interpreter services. Less than 10% of staff were very satisfied with the availability of these services in the community.

Figure 36: All Staff Survey Respondents Very Satisfied with the Availability of Services in Community Served, 2013



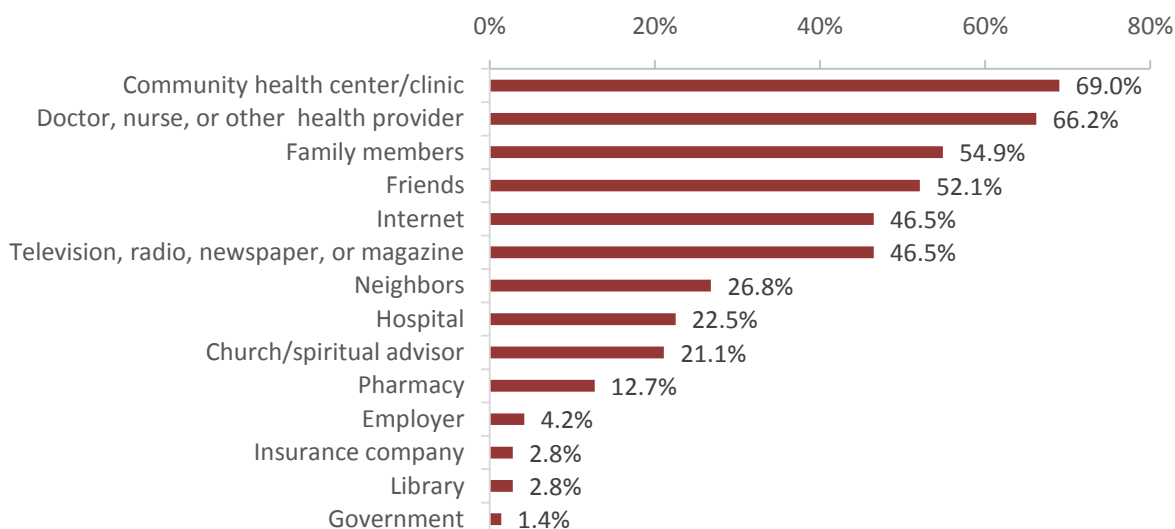
DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

NOTE: Arranged in descending order

Health Information Sources

According to clinical staff survey respondents, patients/clients receive health information from a variety of sources. Among survey respondents, it was perceived that their patients/clients received their health information from a community health center/clinic, doctor/nurse, family members, and friends (Figure 37). Focus group participants recommended disseminating health information through radio stations (e.g., 101.3, 106.1, and WBGH), neighborhood newspapers, health center bulletin boards, workshops at community events (e.g., Russell auditorium), and passing out fliers.

Figure 37: Clinical Staff Survey Participants' Perceptions of where Majority of Their Patients'/Clients' Health Information is Received from, 2013



DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

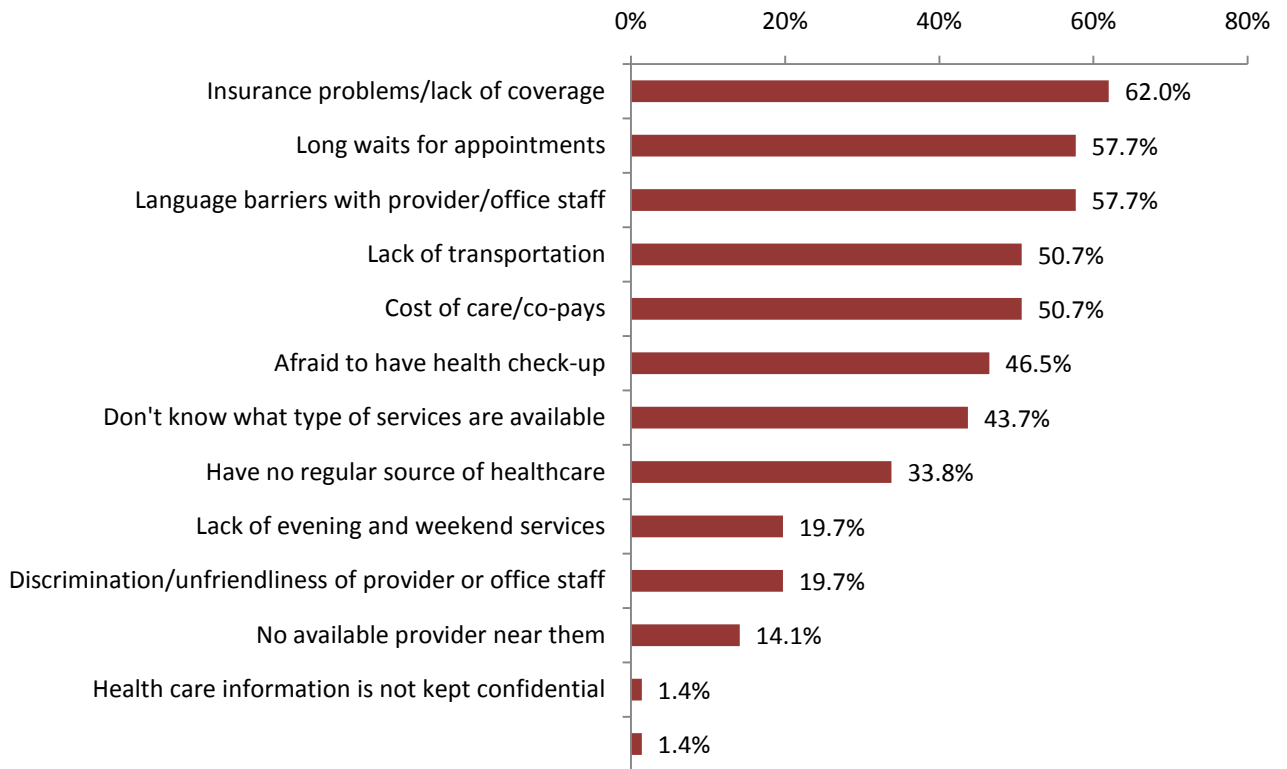
NOTE: Arranged in descending order

Challenges to Accessing Health Care Services

Nearly all clinical staff survey respondents (96.7%) indicated that most of their patients/clients have one person they think of as their personal doctor, nurse practitioner, or health care provider. Furthermore, the majority (88.5%) reported that their patients/clients main medical provider was a health care provider in a community health center or clinic. Clinical staff survey respondents were also asked about their patient's/client's challenges to accessing care (Figure 38).

According to clinical staff survey respondents, insurance coverage, long wait times for appointments, and language barriers were the primary challenges for patients to access care, followed by lack of transportation and cost of care (Figure 38). More than half of clinical staff survey respondents identified these issues as posing barriers to care. Further elaboration on the health care access themes that emerged during the qualitative discussions follow.

Figure 38: Clinical Staff Survey Respondents' Perceived Challenges for Patients/Clients in Accessing Care, 2013



DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013
 NOTE: Arranged in descending order

As illustrated in Table 10, survey respondents were asked more targeted true/false questions on accessing care in the community. All staff survey respondents were most likely to answer true to the statement, “The health or social services in the community should focus more on prevention of disease or health conditions.” Survey respondents were most likely to find the statement “To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their race, ethnicity, or language” to be false.

Table 10: Percent of All Staff Survey Respondents Who Perceived the Following Statements to be True about Health Care Access, 2013

Percent of Survey Respondents Answering True	All Staff (N=133)
The health or social services in the community should focus more on prevention of disease or health conditions	86.2%
To my knowledge, if my patients/clients needed medical services, they would know where to go for them	47.7%
To my knowledge, when trying to get medical care, health center patients/clients have had a negative experience with the staff in the office	29.1%
To my knowledge, the health center patients/clients have not received care needed because the costs were too high	25.2%
It's hard to use public transportation to get to medical/dental services in the community I serve	18.7%
To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their income	16.2%
To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their race, ethnicity, or language	12.8%

DATA SOURCE: Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

NOTE: Arranged in descending order

Additional themes from the qualitative discussions related to barriers to health care included the following:

Health Insurance Coverage and Cost

The challenges to accessing care faced by the under- and uninsured was a common theme raised by assessment participants. Challenges ranged from the inability to afford prescription medications to insufficient coverage for substance abuse treatment. Several participants indicated that due to factors such as citizenship or employment status, many community members are uninsured due to perceived or actual eligibility issues.

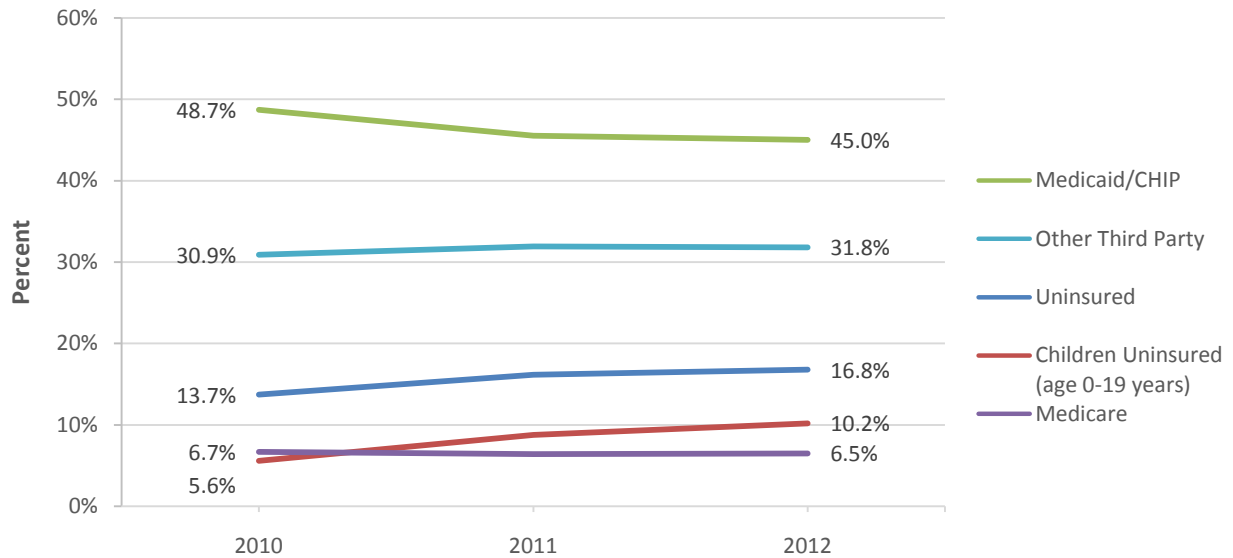
According to CSHC clinical staff survey respondents, the majority of their patients have government insurance (e.g., MassHealth, Medicaid, etc.) and less than 10% have private insurance (Table 11). CSHC data reported to the UDS regarding insurance status indicates that almost half of its patient population are insured through Medicaid (Figure 39). Less than 20% of the patient population is uninsured; however, this proportion has gradually increased from 2010 to 2012. Approximately 10% of children (age 0-19) were uninsured in 2012.

Table 11: Clinical Staff Survey Respondents Reports on their Patients'/Clients' Health Insurance Status, 2013

	Clinical Staff (N=71)
Yes, private insurance (through employer/spouse's employer or bought own)	9.7%
Yes, Medicare	11.3%
Yes, other government plan (MassHealth/Medicaid or other)	79.0%
No health insurance	0.0%

DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

Figure 39: Percent of Patients at Codman Square Health Center by Insurance Status, 2010-2012



DATA SOURCE: Codman Square Health Center, UDS Summary Report, 2012

Navigating the Healthcare System

In addition to health insurance coverage, several participants described the difficulties of navigating an increasingly complex healthcare system. Challenges included scheduling appointments in a timely manner (e.g., waiting six weeks for an appointment) and finding a primary care physician who is accepting new patients. Participants noted how fragmented care and referral networks create confusion for patients, which is compounded by poor communication systems (e.g., health information technology) and a lack of coordinated services.

Culturally Sensitive Care

Assessment participants frequently noted the barriers posed by cultural and linguistic differences between patients and providers. Immigrants were identified as a particularly vulnerable population. In addition to language barriers, citizenship status was described as creating a sense of fear or embarrassment, which prevented them from accessing resources. Participants indicated that greater cultural sensitivity among providers and engaging community members to bridge cultural gaps (e.g., community health workers) would ameliorate these issues.

COMMUNITY ASSETS AND PROGRAMS

- *“There is a real sense of community here. People are always organizing. Codman Square really is very cohesive.”* – Focus group participant
- *“A strong faith community and church organizations provide good community support for people.”* – Interview participant
- *“A lot of people are really invested in the community here.”* – Community Dialogue Participant

Despite the challenges noted previously, assessment participants identified multiple community assets. These included community cohesion and activism, as well as the services provided by local organizations

and businesses. Dorchester was considered as a vibrant and diverse community with a strong sense of pride and ownership among its residents.

Community Cohesion and Activism

Dorchester was described as a neighborhood with a “*strong sense of community*,” where residents know and look out for one another. Similarly, the civic engagement of residents was identified an asset. Participants characterized residents as passionate and invested in the community. They shared how community activists have been able to successfully mobilize residents to advocate for and achieve change. Participants described groups that “*rally*” to improve the community through efforts such as street sanitation and lighting. They also recognized the work of civic organizations such as the Codman Square Neighborhood Council.

Local Organizations and Businesses

Assessment participants indicated that there are numerous resources available to residents in the community. They described the recreational facilities and green spaces present in Dorchester, such as the YMCA, Healthworks, Boys and Girls Club, basketball courts, and parks. Several participants noted the seasonal farmers markets available to neighborhood residents which provides access to fresh produce. Health care resources, including area hospitals and neighborhood health centers, were also identified as community assets. The multitude of faith based organizations was viewed as a source of support for residents. Faith communities were recognized for their strong community outreach efforts and the critical social services they provide such as soup kitchens, food pantries, and shelters.

Several participants observed that Dorchester as experienced a “*face lift*” over the years due to community development efforts, including the attraction of new businesses to the area and improved transportation with the arrival of the commuter rail. They particularly valued the economic potential and entrepreneurship of residents and small businesses.

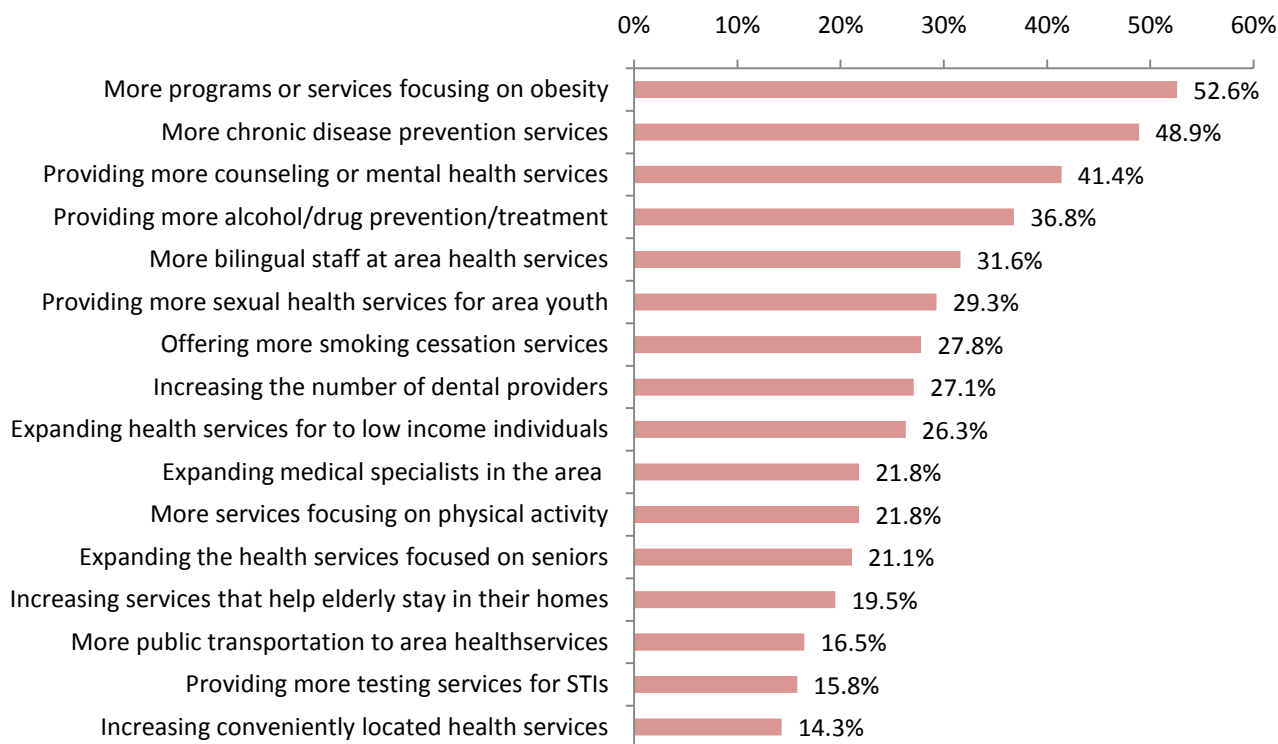
COMMUNITY SUGGESTIONS FOR FUTURE PROGRAMS, SERVICES, AND INITIATIVES

- *“Better access to healthy food is needed. So that corner stores are not so tempting with their crap. Restaurants need to be more educated on nutrition so there are more options for people.”*– Interview participant
- *“Well-lit, well-paved sidewalks would make people want to walk more and be more physically active.”* – Interview participant
- *“Getting the directors of the leading organizations in the community to communicate with one another so that they are aware and able to disseminate information about what is going on in the community.”*– Community Dialogue Participant
- *“We have a slew of resources available, but it’s about communicating the availability of those resources. And the way you get that out is outreach, to bring people into the inner folds.”*– Community Dialogue Participant

Assessment participants were asked about their ideas for future programs and services in their community. Key themes emerging from these conversations were to improve the built environment, support workforce development, connect education and health, increase communication and collaboration, strengthen community outreach and engagement, and provide health education with a focus on prevention.

When thinking about the future, CSHC staff survey respondents saw key areas for action. As shown in Figure, survey respondents were asked to identify the areas they considered to be priorities for addressing in the future. Over half of survey respondents identified offering more programs or services focusing on obesity (52.6%) as a high priority for the future. Providing more chronic disease prevention services as well as more counseling or mental health services were also viewed as top areas of focus.

Figure 40: Percent All Staff Survey Respondents Noting Areas as “High Priority” for the Future, 2013



Codman Square Health Center Community Health Needs Assessment Staff Survey, 2013

NOTE: Arranged in descending order

Other areas that were noted as community dialogue, focus group, and interview participants’ vision for the future were:

Improve the Built Environment

During focus groups, interviews, and the community dialogue, participants emphasized the importance of improving the built environment in order to address health concerns. Specific areas of note included food access, green space, physical infrastructure (e.g., transportation), and housing. Ensuring that healthy food options are accessible and affordable was considered critical. As one community dialogue participant shared, *“Organic produce...is expensive. We can create opportunities for affordable food.”* In order to promote physical activity, creating safe spaces for families and children to be physically active was identified as an important first step. Addressing public safety was identified as important for residents to lead health lifestyles. Suggestions included providing transportation to and from playgrounds, improving street lighting, and implementing traffic calming strategies. Several participants also recommended meeting basic housing needs such as providing emergency housing. As one participant illustrated, *“It’s about housing. You have people living in Dorchester, you go into their homes, they may not have a bed to sleep on, they may not have heat...You have to bring the resources to them.”*

Support Workforce Development

Limited employment opportunities in the community were viewed as a root cause for health issues, ranging from violence and drug abuse to teen pregnancy and obesity. Therefore creating job opportunities and supporting workforce development was encouraged to align skills with employment, particularly among youth. Similarly, providing adequate preparation for students in Boston Public Schools to successfully attain higher education was emphasized. For example, one community dialogue participant stated, *“[I'd like to see] young students at Boston Public Schools getting better prepared to go to all the great schools in the Boston area. Growing up here, you don't know that schools like Harvard are next door.”* Participants specifically recommended increasing opportunities for “vocational education” and creating a “pipeline” for careers in health care, such as nursing, for young residents in Dorchester. Establishing locations that provide access to technology for people of all ages to build skills and search for employment opportunities was also suggested.

Increase Communication and Collaboration

While participants noted that numerous organizations serve the community, they also indicated that better integration and coordination of services was needed. Community members would like to see increased collaboration across sectors and among key stakeholders in Dorchester. Improving communication and the sharing of information and resources across organizations was seen as a critical first step to facilitating this process. As one community dialogue participant elaborated, *“The issue is communication. In Codman Square, we have so many services that we can provide to people, but we often reinvent the wheel.”* Thus, participants recommended convening the leaders of anchor organizations in the community to exchange information. According to participants, increased collaboration would also facilitate the provision of wrap around services and reduce the duplication of services in the community; residents could be connected to a multitude of services in one location, including interpretation, child care, and transportation. Several participants also suggested creating a centralized source of information for residents (e.g., an index of services, information center, etc.).

Strengthen Community Outreach and Engagement

Strengthening community outreach and engagement was recommended by participants in order to improve access to existing resources and overcome cultural and linguistic barriers. Participants strongly encouraged employing community health workers and patient navigators to *“hit the pavement”* and connect residents to services. It was important that these individuals be drawn from the neighborhood, reflect the community, and thus understand the cultural norms and lived experience of residents. According to participants, service providers who reflect the demographics of the community would enable the delivery of culturally competent care, including social services, health care, and public safety. As one focus group participant shared, *“there should be more officers in our neighborhoods that look like us. When you see people you can actually relate to, you're more likely to listen to and respect them.”*

Engaging the faith community in community outreach and dissemination of information was also encouraged. Participants indicated that faith leaders could disseminate information to their congregation and faith communities provide an ideal location for delivering health messages. Similarly, participants stated that inviting non-traditional partners to the table and empowering community residents would bring new ideas and energy to planning efforts.

Expand Health Education and Literacy Efforts with a Focus on Prevention

Many participants mentioned providing health education to the community that focuses on prevention and how to lead a healthy lifestyle (e.g., being physically active, preventing asthma attacks, etc.). Specific topics of interest included healthy eating (e.g., teaching kitchen, cooking classes, etc.), explaining the affordable care act, and preventing chronic diseases. As one participant shared, *“I have high blood pressure. If we can educate our people about the cause of high blood pressure, how we get it,*

what we can do to prevent it.”The schools system was identified as an ideal venue for distribution of health resources and early intervention to promote healthy lifestyles. Suggestions ranged from implementing health education classes to providing a school health clinic.



Codman Square Health Center

KEY THEMES AND CONCLUSIONS

Through a review of the secondary data, a survey of CSHC staff, and discussions with community residents and leaders, this assessment report provides an overview of the social and economic environment of the community served by CSHC, health conditions and behaviors that most affect the population, and perceptions of strengths and gaps in the current environment. Several overarching themes emerged from this synthesis:

- *The social, economic, and physical context of the community underscores all aspects of daily life for residents.* Limited employment and housing opportunities along with low education levels among residents have a significant impact on the social and economic context of the area. Despite considerable socioeconomic challenges, multiple community assets such as community cohesion, activism, and visionary community-based leaders and organizations were considered important neighborhood resources.
- *Chronic diseases and related lifestyle behaviors were viewed as important community health issues which disproportionately affect minority and low-income residents.* Chronic diseases such as diabetes and asthma were concerning health issues among participants and are also conditions that consistently follow social and economic patterns. Obesity was one of the most concerning health issues cited by stakeholders and residents engaged in this assessment, particularly regarding limited access to affordable healthy food and safe spaces for physical activity
- *Mental and behavioral health emerged as a pressing issue for the community, for which there is a lack of services.* Issues related to depression and stress created by economic instability and exposure to violence, were perceived as pressing health concerns. Participants indicated the stigma associated with seeking services combined with insufficient behavioral health services create barriers to care.
- *Despite the expansion of healthcare coverage, insurance status, a complex healthcare system, and cultural and linguistic differences prevent residents from receiving care.* While healthcare coverage is less of a challenge than it once was, financial barriers related to insurance status and the cost of care (e.g., co-pays) remain. Perceptions regarding quality of care, namely long wait times for appointments and language barriers continue to be concerns.

Potential Opportunities and Strategic Directions for CSHC

The subsequent section highlights potential next steps to consider, given the findings from the assessment study. These suggestions focus on how the health center may want to approach future initiatives. It will be critical for CSHC to take into account the issues outlined above (in Key Themes) which can be integrated into each of the approaches and strategic directions discussed in the following section. Also, it is recognized that larger institutional and external factors significantly impact CSHC's efforts, which may render some of these suggestions as not feasible or appropriate at this time.

Marketing and Communication

- *Increasing communication and visibility of CSHC's existing programming.* While CSHC is already working on several community health programs and partnering with community-based organizations, the participants involved in this assessment, were unfamiliar with the breadth of CSHC's community efforts.

For CSHC to take on any new successful initiative or to scale up existing programs, it will be critical for the institution to be seen as playing an active role in the community. Next steps could include

developing a strong communications plan for CSHC that includes increased visibility of the programming internally within CSHC and externally across Dorchester. This plan could include developing a process for information sharing across teams or departments within CSHC to maximize impact and build positive relationships in the community. Increased communication and marketing around CSHC's current community efforts to a wide range of stakeholders and residents, as well as internal staff, and building in a comprehensive marketing plan for any new initiative will be important for CSHC. Equally, if not more important, will be providing more community engagement opportunities in order to receive input from residents at all stages of program development and implementation.

CSHC as Coordinator, Partner and Backbone Support

- *Serving as community partner and supporter.* Stakeholders repeatedly mentioned that existing community health services are fragmented, uncoordinated, and under-funded. This situation provides an opportunity for CSHC to serve as an active coordinator to help support and bolster existing programs. It also allows CSHC to make a larger impact on health issues by employing a more strategic approach.

CSHC could provide backbone support to community-based organizations in their prevention efforts through training, staffing, or funding. In this partner role, CSHC can leverage community assets and strengthen existing relationships with other community-based organizations, help scale up programming from existing organizations and programs in the community, and engage the community in planning and development.

Strengthening Prevention Programming

- *Being a leader in addressing the social determinants of health.* One key theme that emerged from this research was that the health issues that many community members are encountering are complex and impacted by a number of upstream social and economic factors. However, CSHC could expand the reach of its programming to address the larger factors that influence population health on a greater scale.

In addition to increasing communication about CSHC's existing innovative efforts, it may help to engage partners at the community level to help move the agendas forward to address the upstream factors that impact population health. Areas in which CSHC can focus its efforts could include:

- *Changing the built environment to improve food security and prevent obesity.* A neighborhood's current infrastructure has a major impact on health. For example, increasing access to healthy foods and safe, recreational spaces can make a much larger impact on neighborhood health than smaller, individualized programs. To complement these efforts, CSHC could also collaborate with community-based organizations to provide residents with information and classes for healthy eating on a budget.
- *Addressing poverty and violence through workforce and youth development.* Strengthening and expanding current workforce and youth development programs can help address larger social factors such as poverty, underemployment, and violence. CSHC is undertaking important workforce and youth development efforts; however, it will be important to increase the reach of workforce and youth development activities in the community. For example, CSHC could expand local recruitment efforts, adult job training, and youth skill building programs. These efforts could simultaneously build the capacity of CSHC to serve a linguistically diverse client population and conduct community outreach. Current youth programs could be expanded and marketing could be strengthened to improve program visibility in the community.

- *Improving access to community-based primary care.* In order to facilitate resident's access to primary care services CSHC could improve community outreach through the expansion of mobile van, patient navigator, and community health worker programs. In order to complement these efforts, CSHC could bolster community-based health education and literacy efforts, particularly around accessing primary care.

Conclusion

The community served by CSHC faces several social and economic challenges, including neighborhood violence, and limited employment opportunities, which have a significant impact on population health. However, residents are resilient and there are numerous community assets and strengths. In addition to community-based programs and services, community cohesion, activism, and diversity are considered strengths of this community.

Health issues such as chronic diseases and their risk factors—especially diabetes, asthma, obesity, and limited physical activity and healthy nutrition—as well as mental and behavioral health were seen as significant concerns that impact many residents. Furthermore, minority and low income residents are disproportionately affected by these health conditions.

Future opportunities were identified for expansion of CSHC's work in the community and its partnerships with organizations. As CSHC moves forward, it can leverage the assets of the community to improve the health of its patient population and the residents of Dorchester and surrounding communities.

Codman Square Health Center