Blue Hills Community Health Alliance
CHNA 20
Community Health Assessment Report
2011

This image is made from the words most often used by community residents during interviews and surveys to describe the greatest strengths of the region. The larger the word, the more often it was used.

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Thank you also to the Regional Center for Healthy Communities (Metrowest) for providing models, tools and planning to facilitate the assessment process.

Thank you to our funders who allow this work to continue, including South Shore Hospital, Weymouth MRI, Caritas PET Imaging and Harvard Vanguard Medical Associates.

Thank you to the Massachusetts Department of Public Health and the Office of Healthy Communities for ongoing support and encouragement.

Executive Summary

The Blue Hills Community Health Alliance, otherwise known as Community Health Network Area 20 (CHNA 20) is a collaborative of thirteen towns and cities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth. From June 2010 to October 2011, the Blue Hills Community Health Alliance carried out a comprehensive community health assessment in order to determine priorities for action and inform the use of CHNA 20's funds.

What is a CHNA?

Community Health Network Areas (CHNAs) are volunteer coalitions of public, nonprofit and private sector agencies working together to build healthier communities through community-based prevention planning and health promotion.

The Massachusetts Department of Public Health (DPH) established CHNAs (pronounced chah-NAH) in 1992. Today, CHNAs involve each of the state's 351 towns and cities through 27 networks. CHNAs play an important role in addressing DPH's statewide public health priorities:

- Eliminating racial and ethnic health disparities and their social determinants;
- Promoting wellness in the home, workplace, school, and community; and
- Preventing and managing chronic disease.

CHNAs collaboratively identify local and regional health priorities, design community-based prevention plans, and track success in achieving healthier communities. When projects are completed, CHNAs work to identify new areas for health improvement and develop strategies to address them.

About the Blue Hills Community Health Alliance (CHNA 20)

The mission of the Blue Hills Community Health Alliance is to improve the overall health of local residents through coordination and delivery of existing services, expansion of community actions, and mobilization of community resources.

CHNA 20 focuses on establishing a broader, more comprehensive approach to developing healthier communities in the 13 towns it represents. For CHNA 20, the definition of a healthy community is one that supports the health and welfare of its members by:

- Helping to address health disparities by embracing diversity through respect and concern;
- Knowing itself;
- Generating leadership everywhere;
- Connecting people and resources;
- Creating a sense of community;
- Shaping its future;
- Practicing ongoing dialogue;
- Planning for a safe and clean environment; and
- Implementing the design and use of communal spaces.

Membership is open to any person interested in furthering and supporting CHNA 20's mission. CHNA 20 strives to engage individuals who reflect the age, racial, ethnic, gender, sexual orientation, and linguistic diversity of its 13 communities. Members must live and/or work in one of the cities and towns.

CHNA 20 members have opportunities to:

- Work with others to enrich their community;
- Network and share ideas with people interested in building healthier communities;
- Gain knowledge about a range of health-related issues and topics;
- Participate in designing and implementing health-improvement projects;
- Advise the Department of Public Health on programs and the funding process;
- Advocate for health issues that are important to their community; and
- Give back to their community.

CHNA 20's Role in Creating Healthier Communities

CHNA 20 is a catalyst for bringing together persons who are interested in making its 13 communities healthier places to live and work. CHNA 20 volunteers focus their efforts in four areas:

Networking: Bringing together individuals to share information and resources in support of healthy communities.
Education: Equipping members with qualitative and quantitative data, evidence-based practices, and other tools to help them create healthier communities.
Advocacy: Bringing together individuals and groups to develop sustainable policy, system and environmental changes in support of healthier communities.
Funding: Funding initiatives that support CHNA 20's health priorities for action to produce sustainable, measurable improvements in community health through program, policy and system changes.

Governance

The Blue Hills Community Health Alliance is governed by a volunteer Steering Committee, which reflects the views and needs of the general membership. The Steering Committee is vested with administrative and strategic oversight of CHNA 20 and is comprised of between 7 to 15 members. Representatives from DPH and the Regional Center for Healthy Communities (Metrowest) serve as Advisory Members.

Funding

The Blue Hills Community Health Alliance receives its funding through DPH's Determination of Need (DoN) Program. DoN was established by the Legislature in 1971 to encourage equitable geographic and socioeconomic access to health care services, to help maintain standards of quality, and to constrain overall health care costs by eliminating duplication of expensive technologies, facilities and services.

Before hospitals and other health care providers may offer or expand certain services — or acquire advanced clinical technologies — they must demonstrate to the Massachusetts Public Health Council that there is a pressing community need for the project that cannot be addressed in other ways. If the Public Health Council "determines the need" for a project, hospitals and other health providers must agree to contribute five percent of the project's maximum capital investment to address public health priorities. This contribution is called DoN Community Health Initiative (CHI) funding.

CHNA 20 currently receives DoN funding from the following organizations: Weymouth MRI, Caritas PET Imaging, Harvard Vanguard Medical Associates and South Shore Hospital. Bay State Community Services

of Quincy acts as CHNA 20's fiscal sponsor. A portion of these funds was used for this assessment.

Purpose of the Assessment

This assessment is intended to identify community health priorities for action and inform CHNA 20's use of funds. Additionally, the assessment provides an opportunity to reach out to new partners and increase the engagement of CHNA 20's membership. The assessment process increased connectedness and collaboration and will hopefully inspire future collaboration among agencies and institutions within the CHNA 20 catchment area. Finally, the assessment provides valuable data that can be used to guide CHNA 20's work in the coming years, increase fundraising by member organizations, and inform local programming.

Assessment Framework

The assessment was carried out by an Assessment Guidance Group (AGG) comprised of more than 50 CHNA members representing many different sectors and cities. The group met in person 13 times and spoke by phone to design the assessment process, collect data through surveys and interviews, discuss the findings and guide the use of the assessment results. Collectively, this group and the steering committee volunteered more than 2,000 hours of time to conducting the assessment.

The Regional Center for Healthy Communities (Metrowest) coordinated the assessment. In this role, the Center provided more than 500 hours of paid technical assistance, data analysis and facilitation.

The assessment began in June 2010. By August, the AGG had identified key issues to explore, developed criteria for prioritizing the findings for action, and designed a process for data collection. Existing data were collected between September 2010 and March 2011, and interviews, surveys and focus groups were conducted between September 2010 and July 2011. Preliminary results were shared with the community at regular intervals for additional input. CHNA 20 was able to use preliminary results to inform activities and presentations as early as July 2011. The assessment report was finalized and released in May of 2012.

Methodology

Data collection began by gathering existing information from public sources. This provided a sense of the scale and nature of health concerns within the CHNA. New information was then collected from key informants and other residents through interviews, online surveys and focus groups. The comments provided a second perspective on issues already identified and highlighted additional issues that were of concern to community members. The comments also included information about the strengths and assets of CHNA 20 communities.

Findings

Greatest Strengths: In looking at the information collected on CHNA 20's strengths and assets, it is clear that the region has a strong base of involved residents, varied services and valuable knowledge to use as a foundation for addressing the health concerns identified through this assessment. Community assets include diversity, natural resources, local businesses, vibrant local culture, a wide array of human services and strong community collaborations.

Areas of Concern: The areas that emerged as ongoing concerns were challenges related to diversity and cultural competency, access to care and other services, chronic disease and its drivers (including disparities, economy and education), substance abuse, mental health and crime. Two types of challenges were raised most often in terms of accessing services: transportation and language barriers. Topic-specific concerns were also raised and explored. Notable areas of concern and interest among community members are quality of and access to food, domestic violence, mental health, substance abuse and crime.

Establishing Priorities for Action

The Assessment Guidance Group applied the following criteria to each health issue:

1) Relevance to all 13 communities;
2) Trend or whether the problem is increasing;
3) CHNA 20's ability to make a measurable difference in five years;
4) Size and magnitude of the problem; and
5) Whether the issue will get worse if not addressed.

The issues that ranked highest according to these criteria were identified as priorities. They are:

- Access to Care & Services (including issues that involve transportation, linguistic services and navigating through systems for treatment)
- Chronic Disease & Wellness
- Mental Health
- Substance Abuse

Discussion of Findings

Health is impacted by all of the things that we do, the people we know, the way we live, and the environments around us. It is shaped by where we live, work and play. Many of the issues explored in this assessment fall into the category of social determinants of health. Social determinants are those things that influence our health without being measured or diagnosed in a doctor's office.

Existing data as well as key informant interviews highlighted a number of social determinants of health. The ones that are striking for their impact on health and well-being within CHNA 20 are education, racism, economy and housing.

Interviews and surveys elicited a variety of suggestions and identified challenges about issues that CHNA 20 could address. Suggestions ranged from those that were specific to a particular health concern to those that addressed broad changes in approach. The majority related to the underlying themes of disparities and focusing on prevention. Three broader approaches that were recommended in different ways by many respondents were advocacy, increased civic engagement and collaboration.

The suggestions from key informant interviews and surveys are rich and well-informed. They point to programs that CHNA 20 could run, develop or fund. A wealth of strategies and approaches can be adapted and replicated in towns with similar struggles. It is necessary to review the evidence to learn what efforts might be effective and to learn about what has and has not worked in similar communities.

Beyond the need for developing, funding and implementing programs, much of the data supports a need for advocacy, and for CHNA 20 to support communities in having a voice in the decisions that are

made at organizational, local and state levels. CHNA 20 is in a unique position to support or carry out advocacy. As a collaborative, it has tremendously deep knowledge of needs and a significant reach into communities, including connections to vulnerable populations. Unlike some nonprofit agencies and governmental organizations that are limited in their ability to advocate, CHNA 20 has flexibility to voice opinions and mobilize its individual members to change the way that decisions are made.

CHNA 20 also has a role in building and strengthening collaborations to address our challenges collectively. The collaborations and new working relationships that come out of CHNA 20 can increase impact, efficiency and reach of existing organizations, in turn improving health outcomes.

The lack of easily accessible, community-level public data was a concern and a challenge throughout the assessment process. This is an area where CHNA 20 might also play a role, either in collecting data or in advocating for more consistent collection and release of data.

Moving Forward

This detailed report recommends that CHNA 20 should focus its efforts and financial resources over the coming years on the priorities of Access to Care and Services, Chronic Disease and Wellness, Mental Health and Substance Abuse.

CHNA members who were interviewed and surveyed as part of the assessment had wonderful suggestions for ways to address the health assessment's findings. These are community-generated and locally-informed suggestions that should be incorporated when possible as CHNA 20 explores ways to use its time and dollars to make CHNA 20 communities healthier. The AGG made a number of additional recommendations to steering committee. Among their recommendations, they suggested that all those involved with CHNA 20 should work collaboratively to:

1. Identify feasible solutions to address the needs identified in the assessment, including creating plans to translate needs and related solutions into policy and programs ;
2. Disseminate results of assessment and policy actions to communities; and
3. Collaborate with civil society, governmental agencies and the private sector in order to promote support for program and policy proposals.

CHNA leadership should:

4. Construct initial funding formulas based on assessment and present to stakeholders (when possible, supporting community-led initiatives to address the selected issue areas);
5. Develop monitoring and evaluation plans for CHNA initiatives; and
6. Reassess needs on an ongoing basis.

CHNA 20 has formed four working groups, each of which will address a priority area. CHNA leadership also plans to compile a comprehensive list of existing resources and organizations in the region. These will be mapped and used to publicize resources, identify gaps in service and inform collaborations.

The efforts of the four working groups and the findings contained in this report will inform CHNA 20's decisions about funding allocations, inform the design of CHNA networking opportunities, educate CHNA members about needs and assets, and inspire advocacy at many levels. CHNA 20 will use the resources at its disposal to address the four priority areas identified through this assessment and will make this report available to CHNA members and the general public.

Community Assessment Report

Introduction

What is a CHNA?

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CHNAs collaboratively identify local and regional health priorities, design community-based prevention plans, and track successes in achieving healthier communities. When projects are completed, CHNAs develop work to identify new areas for health improvement.

About the Blue Hills Community Health Alliance

The Blue Hills Community Health Alliance (CHNA 20) includes thirteen towns and cities, including Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth. The mission of the Blue Hills Community Health Alliance is to improve the overall health of local residents through coordination and delivery of existing services, expansion of community actions, and mobilization of community resources.

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- Creating a sense of community;
- Shaping its future;
- Practicing ongoing dialogue;
- Planning for a safe and clean environment; and
- Implementing the design and use of communal spaces.

CHNA 20 strives to engage individuals who reflect the age, racial, ethnic, gender, sexual orientation, and linguistic diversity of its 13 communities. Membership is open to any person interested in furthering and supporting CHNA 20's mission. Members must live or work in one of the 13 communities. They also may be affiliated with an organization that serves those living in CHNA 20, such as representatives from:

- Boards of health
- Businesses

- City and local governments
- Community coalitions
- Community-based agencies
- Faith communities
- Grassroots organizations
- Health and human service agencies
- DPH Regional Centers for Healthy Communities
- Public housing/transportation
- Schools, colleges and universities

CHNA 20 members have opportunities to:

- Work with others to enrich their community;
- Network and share ideas with people interested in building healthier communities;
- Gain knowledge about a range of health-related issues and topics;
- Participate in designing and implementing health-improvement projects;
- Advise DPH on programs and the funding process;
- Advocate for health issues that are important to their community; and
- Give back to their community.

What Is the Role of CHNA 20 In Creating Healthier Communities?

CHNA 20 is a catalyst for bringing together people interested in making its 13 communities healthier places to live and work. The volunteers involved with CHNA 20 focus their efforts in four areas:

Networking: Bringing together individuals to share information and resources in support of healthy communities.
Education: Equipping members with qualitative and quantitative data, evidence-based practices, and other tools to help them create healthier communities.
Advocacy: Bringing together individuals and groups to develop sustainable policy, system and environmental changes in support of healthier communities.
Funding: Funding initiatives focused on CHNA 20's health priorities for action to produce sustainable, measurable improvements in community health through program, policy and system changes.

How is CHNA 20 Governed?

The Blue Hills Community Health Alliance is governed by a volunteer Steering Committee, which reflects the views and needs of the general membership. The Steering Committee is vested with:

- All administrative oversight of the CHNA;
- Strategic planning for the CHNA;
- Oversight of the CHNA's community needs assessment process;
- Oversight of CHNA financial matters, including budget development and monitoring;
- Establishment of all contractual arrangements for the CHNA;
- The selection, evaluation and termination, if necessary, of the Fiscal Sponsor;
- Ensuring that the CHNA and the steering committee are comprised of recruited, engaged, diverse and responsive members that work across disciplines serving all cohorts (infants, children, adolescents, adults, elders);
- Having at least one member attend Inter-CHNA meetings and debrief the committee; and
- Monitoring the performance of the coordinator and other consultants, if applicable.

The Steering Committee is comprised of between seven to fifteen members. Representatives from DPH and the Regional Center for Healthy Communities (Metrowest) serve as Advisory Members.

How is CHNA 20 Funded?

The Blue Hills Community Health Alliance receives its funding through DPH's Determination of Need (DoN) Program. The DoN Program promotes the availability and accessibility of cost-effective quality health care services to the citizens of Massachusetts and assists in controlling health care costs. DoN was established by the legislature in 1971 to encourage equitable geographic and socioeconomic access to health care services, help maintain standards of quality, and constrain overall health care costs by eliminating duplication of expensive technologies, facilities and services.

Before hospitals and other health care providers may offer or expand certain services — or acquire advanced clinical technologies — they must demonstrate to the Massachusetts Public Health Council that there is a pressing community need for the project that cannot be addressed in other ways. If the Public Health Council "determines the need" for a project, hospitals and other health providers must agree to contribute five percent of the project's maximum capital investment to address public health priorities. This contribution is called DoN Community Health Initiative (CHI) funding.

CHNA 20 received funding during the assessment from the following organizations:

Weymouth MRI
Funding that Weymouth MRI currently provides to CHNA 20 is linked to the following project:

- Acquisition of a mobile Magnetic Resonance Imaging (MRI) unit: Total contribution of $55,000 (or $11,000 for five years) to CHNA 20, commencing in 2009.

Caritas PET Imaging
Funding that Caritas PET Imaging currently provides to CHNA 20 is linked to the following projects:

- Conversion of mobile MRI to a fixed unit: Total contribution of $23,050 (or $4,610 for five years), commencing in 2006 and concluding in 2011.
- Acquisition of a mobile combination PET and CT scanner: Total contribution of $25,000 (or $5,000 for five years).

Harvard Vanguard Medical Associates
Funding that Harvard Vanguard Medical Associates currently provides to CHNA 20 is linked to the following project:

- Expansion of radiation therapy service with the addition of a second linear accelerator unit: Total contribution of $203,050 (or $40,610 for five years), commencing in 2010 and concluding in 2014.

South Shore Hospital

Funding that South Shore Hospital currently provides to CHNA 20 is linked to four projects:

- Neonatal Intensive Care Unit five-bed expansion: South Shore Hospital has pledged a total contribution of $69,000 (or $13,800 for five years), commencing in 2009 and concluding in 2013.
- Fixed MRI unit acquisition: South Shore Hospital has pledged a total contribution of $35,000 (or $7,000/year for five years), commencing in 2010 and concluding in 2014.
- Mobile MRI unit acquisition. South Shore Hospital has pledged a total contribution of $20,000 (or $4,000/year for five years), commencing in 2010 and concluding in 2014.
- Emerson building 60 inpatient bed expansion: South Shore Hospital has pledged a total contribution of $550,000 (or $110,000/year for five years), commencing in 2013 and concluding in 2017.

Purpose of the Assessment

On June 3, 2010, CHNA 20 began a comprehensive community health assessment which was completed in October 2011. The CHNA 20 Steering Committee designed the assessment process to accomplish a number of different goals. First, it responded to guidance from DPH that recipients of new DoN funds should carry out an assessment to inform the use of the funds. Second, it provided an opportunity to reach out to new partners and increase CHNA 20's membership. Third, it provided an opportunity for CHNA 20 and local hospitals to collaborate on a document that could be used by both organizations. Fourth, it aimed to improve the community's health by increasing connectedness and collaboration within the 13 towns and cities that make up CHNA 20. Finally, it provided baseline data that can be used not only to guide CHNA 20's work during the coming years, but also to strengthen fundraising, interventions and potential collaboration for agencies and institutions within the CHNA 20 catchment area. The assessment was designed to identify the assets and needs of the communities as well as behaviors that encourage healthy communities in order to guide the development of evidence-based strategies to address the unique issues that affect the CHNA 20 community.

Funding for the assessment was provided by South Shore Hospital, Weymouth MRI, Caritas PET Imaging and Harvard Vanguard.

Assessment Planning Process

As CHNA 20 began to outline an assessment process, the steering committee realized that they would need to establish an advisory team to guide the community health assessment. They set parameters for the assessment and recruited key stakeholders from the community to participate in an Assessment Guidance Group (AGG). The AGG was given the following responsibilities:

- Create and communicate the vision and goals of the community health assessment with the CHNA 20 community;
- Establish organizational structure and processes;
- Recruit members;
- Collect data and suggest data sources;
- Facilitate collaboration and planning;
- Assist in logistical and administrative support;
- Identify priorities for action; and
- Provide oversight for report writing, production and dissemination.

This group led the process of designing the assessment, gathering data from local communities, analyzing the information collected, and prioritizing the issues that emerged.

The group included steering committee members, representatives of the CHNA 20 executive committee (including Chair, Vice-Chair and Secretary), general members, and community members, who joined the Assessment Guidance Group before becoming members of CHNA 20. Throughout the process, the assessment team presented progress reports to the steering committee and to the general membership, providing opportunities for input, engagement and course-correction. While this group set the course for the assessment, the process was organized and facilitated by the Regional Center for Healthy Communities (Metrowest). The Regional Center spent more than 550 hours planning meetings, managing agendas, leading conversations, compiling and analyzing data, and documenting the process. Support from the Regional Center was paid, totaling nearly $40,000 over two years.

AGG meetings were open to the public and members continually sought additional participants for the assessment. There were 13 in-person AGG meetings during the 18 months of the assessment. Ad-hoc subcommittees were formed to assist with the creation of surveys and to reach a wider population. AGG members represented social service agencies, healthcare, schools, boards of health, and local government agencies. Members had years of experience in data collection, needs and market assessment, program development and community activity and mobilization. Members' areas of expertise included, but were not limited to, youth development, substance abuse prevention, community health management, marketing, housing stabilization, women and infant social service support, domestic violence advocacy, senior program administration, mental health counseling, disparities reduction, advocacy and cultural competence. For specific names and details of AGG members, please refer to the acknowledgements section of this report. The group was comprised primarily of white women aged 50-59, with English as their native language. Members represented many different CHNA cities and towns. Efforts were made to diversify the AGG on an ongoing basis.

Criteria for prioritizing health issues

As previously mentioned, the assessment was designed to serve a number of different purposes, one of which was to gather information about community health that could be used by individuals, agencies and coalitions across CHNA 20 to target efforts, seek additional funding and identify needs. The other primary purpose was to help CHNA 20 direct its resources and energy toward issues identified collaboratively through a comprehensive, data-driven look at member communities. It was important to gain consensus among stakeholders to support CHNA 20's decisions and new directions. In order to prioritize in a streamlined way, the AGG spent some time before the data was collected deciding how they would give precedence to the issues they explored. Through this, the group identified five criteria that would be used to determine priority areas for CHNA 20 at the end of the assessment.

The group began with a list of more than 30 possible criteria (see appendix for the initial list). After adding their own suggestions to the list, members worked together to narrow the list to five criteria that they would use to rank the issues that emerged from the needs assessment. In addition to creating an important list of criteria, the process built camaraderie and trust among the AGG members.

The criteria that they chose were:

1) Relevance to all 13 communities;
2) Trend or whether the problem is increasing;
3) CHNA 20's ability to make a measurable difference in five years;
4) Size and magnitude of the problem; and
5) Whether the issue will get worse if not addressed.

The group decided that in addition to these five criteria, the underlying themes of the assessment were to address issues that affect vulnerable populations and engage in prevention.

As a starting point for collecting data, the AGG then selected issues based on their own interests, concerns and experience in the community. The issues selected were: access to health care, mental health services, substance abuse, housing, domestic violence and crime. Other issue areas of concern would later be identified through conversations with key informants.

Methodology

Data collection

Data from Secondary Sources

The AGG began data collection by exploring topics it already believed to be of concern to CHNA 20 communities: access to health care, mental health services, substance abuse, housing, domestic violence and crime. They broke into small groups based on their expertise to decide which indicators to research as possible data sources. Much of the data that the group hoped to collect proved difficult to obtain through quantitative data collection methods, so the group complemented secondary data with key informant interviews and surveys to gain a more complete and current picture of local needs.

The primary sources for quantitative data were Mass Community Health Information Profile (MassCHIP), the U.S. Census Bureau, Behavioral Risk Factor Surveillance System (BRFSS), Kids Count, U.S. Health and Human Services, Federal Bureau of Investigation (FBI) and Metropolitan Data Common.

Key Informant Interviews, Focus Groups & Surveys

Qualitative data came from key informant interviews, focus groups and surveys. AGG members identified key informants who could provide a broad overview of the strengths and needs in their communities and deeper knowledge of certain populations or sectors. The AGG attempted to contact individuals representing a variety of sectors and living in many member communities. They identified key informants who they believed would be able to accurately and knowledgeably represent the views of community members. The service sectors identified were schools , health care providers, public safety, business, senior centers or councils on aging, faith-based (houses of worship and assemblies), government and social service providers.

These key informants were contacted to participate in semi-structured interviews. The interviews were primarily conducted by the Regional Center for Healthy Communities and members of the AGG, with particularly significant participation from the Weymouth Health Department, Norwood Council on Aging, Norfolk District Attorney's Office, Congressman Keating's Office, Quincy Asian Resources, Inc., South Shore Hospital's Home Care Division and South Shore Visiting Nurses Association.

The interviews were used to identify strengths and areas of concern as well as suggestions for health improvements. Interviews were also used to explore issues relevant to the assessment topics. The AGG strove to identify the assets and needs of the CHNA 20 community without biasing or limiting the scope

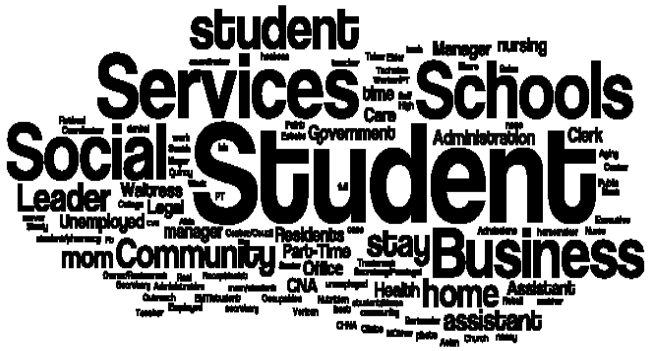
of responses. To accomplish this, the two questions asked to respondents were broad. *What do you see as the greatest strength in the CHNA 20 community where you live?*" and "*What do you see as the greatest concern in the CHNA 20 community where you live?*" The AGG decided that face-to-face interviews would be best, but telephone and online interviews would be used if face-to-face was not possible. Face-to-face interviews were preferred because they provided the most flexibility in data collection and because interviewers could request clarification as needed. During the key informant interviews, interviewees were asked to identify others who should be included in the community health assessment. For further detail, please see the interview instrument in the appendix.

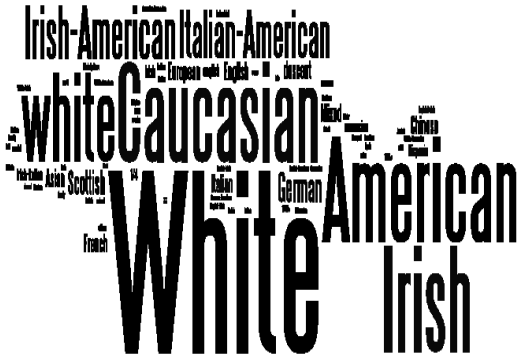
All interviews took an average of 20-45 minutes to complete. A total of 65 interviews were conducted. Additionally, three focus groups were held using the interview guide as a discussion guide. After the interviews were conducted, respondents were given the opportunity to review their responses to ensure accuracy. Respondents were allowed to make changes or delete their interviews. Two focus groups were held with translators as a way to include the Chinese-speaking population in Quincy. The other convened students at a local community college.

In order to compliment the key informant interviews and produce a more credible result, the AGG also decided to speak directly with residents. They created a community survey that closely resembled the key informant question guide. The survey was distributed on paper and using Survey Monkey, an online survey site, thereby allowing the AGG to gain more responses with smaller investment of time.

In total, 154 people participated in interviews or surveys, ranging in age from 16 to over 70 years-old and representing 12 of CHNA 20's cities and towns (Cohasset was not represented). Of these, 65 were contacted through key informant interviews and 89 completed surveys. In the early stages of data collection, the AGG compared responses between the interviews and surveys. By the end, the responses were so similar that further distinction was deemed unnecessary and they were combined for analysis.

Below is a visualization of information about the people who participated in interviews, focus groups and surveys. The words that are largest are the ones that more people used to describe themselves and their affiliations. These visualizations give a sense of who we were able to reach.





Data Analysis

The first step in analyzing the quantitative and qualitative data was to ensure accuracy and logic. Both qualitative and quantitative data were organized into spreadsheets that organized responses by the questions asked or by topic of interest. On two occasions, the data was presented to AGG for feedback. A selection of the data was shared with CHNA membership in July 2011, in order to gather feedback and initiate conversations about the issues highlighted by the assessment.

Prioritization

Beginning in August 2011, the AGG reviewed the qualitative and quantitative raw data as a group. The AGG identified themes, compared the secondary data to the data collected through interviews and surveys, and discussed issues that emerged. Then the AGG rated each of the top issues according to how well it met each of the five criteria. For example, the group rated the issue of substance abuse according to whether it was relevant to all member communities, whether the data indicated that the problem is increasing, whether they felt that CHNA 20 can make a measurable difference on it in five years, the magnitude of the problem is, and whether it will get worse if not addressed.

AGG members divided into two teams to rank the issue on a scale of 1-5 (with 1 representing "Definitely does not meet this criterion" and 5 representing "Definitely meets this criterion"). The first team ranked the following issues: crime, domestic violence, substance abuse, mental health and infectious diseases. The second team ranked the following issues: access to care and services, chronic disease and wellness, housing, other and perinatal issues. Both teams were comprised of experts within their respective issue-based teams. (Please see the appendix for a chart of the rankings.) After reaching a consensus on the rankings, the scores were added and the totals for each topic were compared. Since trend data was mostly lacking for the data gathered, the AGG rested the decisions heavily on the following criteria: whether we can make a measurable difference within five years and whether the issue will get worse if not addressed. Those issues that ranked highest overall in terms of meeting the group's criteria were selected as priorities for CHNA 20's work over the coming years. As a result of this process, the following issue areas were identified as priorities for CHNA 20's involvement:

- Access to Care & Services (including issues that involve transportation, cultural and language services, literacy, and way-finding or navigating through systems for treatment)
- Chronic Disease & Wellness
- Mental Health
- Substance Abuse

Although this level of analysis accomplished CHNA 20's goal of identifying priorities, the data was further analyzed to make it presentable and usable by CHNA members and their organizations. To analyze the qualitative data, the Regional Center identified themes and coded the responses in stakeholder interviews according to these themes. The data relevant to each theme were then summarized.

The Regional Center reviewed the quantitative results to identify cases in which the data for CHNA 20 varied significantly from what was seen throughout Massachusetts. The Regional Center also considered where there were significant variations among CHNA communities or striking disparities within CHNA 20, or where the quantitative data supported the concerns and challenges that were being collected through qualitative techniques. For each topic, the Regional Center selected two or three indicators that would later be incorporated into this report as a complement to the interview and survey results.

Results

The following data were selected to provide a broad sense of the results relevant to each topic area. Additional data can be found in the appendix. Direct quotes from respondents are in italics. Other information is summarized or generalized.

Greatest Strengths

Collaboration: In describing the community's greatest strengths, CHNA 20 members described many communities where "*our weakness is our strength in that we are a small town and people, individuals and agencies will reach out to people and help*." They describe significant collaboration and coordination between agencies, with an impressive number of established networks and organized groups through churches, town government and affinity groups. Beyond the formal collaborations, CHNA members describe police and town officials as approachable, many mayors as collaborative and interested, and people who are friendly and willing to get involved.

Services: There are a dizzying variety of services available to help residents, ranging from hospitals and health centers to food pantries, farmer's markets, elder services, housing authorities, youth centers and supportive veteran's agencies. There are many structures in place to support the use of these services, including some good town websites, town blogs, notably "Milton's Patch", and cable stations. There are also strong schools with high-quality, well-respected teachers, and some of the state's best police, fire departments and EMTs. One resident explains that they are "*not only EMTs, they are also trained to handle people*." While not every CHNA community has public transportation available, those that do mentioned it as strength of their community.

Support for Community Initiatives: Support for community initiatives comes from a variety of sources. Members describe their local businesses as contributors to local events, they explain that many residents have only one job, and therefore have time to volunteer for the things they are passionate about. A number of people mentioned that they appreciate their town's decorations for the holidays and acknowledge that they could not happen without the support of many parts of the community. Others described vibrant cultural activities that happen at festival time and town celebrations as highlights of their town.

Natural Resources: Natural resources are another significant strength of CHNA 20. Some communities have beaches, parks, lakes and other natural areas that support recreation, tourism, and exercise. These are seen as tremendously important. A variety of interviewees described sustainability and "greening" projects as strengths in their communities. One person mentioned bike lanes as a strength, another mentioned an organized effort called "Sustainable Braintree" and another explained that in one community a significant asset is the overall commitment to maintain open space.

Economics: Economically, CHNA 20's member communities are diverse. A number of strengths related to economics were mentioned. Some of these were first -time homebuyer programs, a mall that brings people from neighboring communities, and the beach, which draws many tourists in the summer.

Diversity: A theme that ran through the responses was a valuing of diversity. Many people described diversity itself as a strength of the communities, and others described the benefits that diversity brings.

They mentioned strong inter-faith activity, a multi-generational community, and a place where there's "*great diverse food"*. They also described success of anti-bias projects, including the Laramie project, which increased awareness of anti-gay biases in their community.

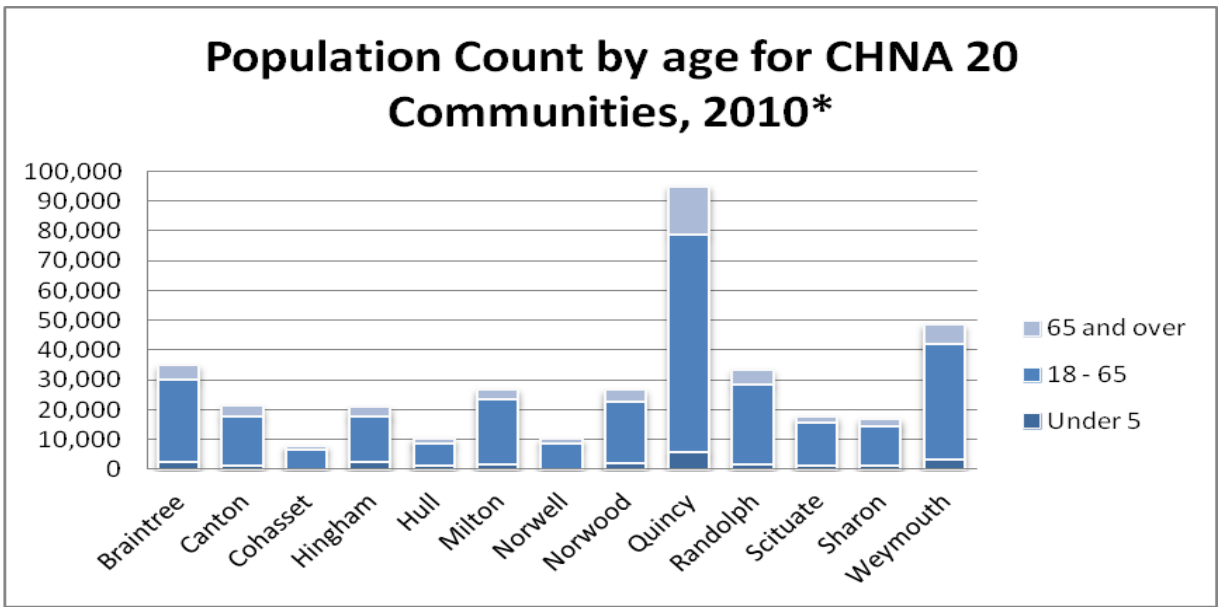
Overall, CHNA members described a variety of communities with tremendous assets. The assets run the gamut from programming to human resources and rely heavily on strong communication.

Areas of Concern

In general, there was consistency between the areas of concern that the AGG identified preliminarily and the areas mentioned by CHNA 20 members during interviews, focus groups and surveys. The areas that emerged as ongoing themes were challenges related to diversity and cultural competency, access to care and access to other services, chronic disease and its drivers (including disparities, economy and education), substance abuse, mental health and crime.

Diversity: Diversity is seen as both a strength and concern. On the side of challenges, residents note that while the demographics of their towns are changing with more and more people joining the community who are non-white and do not speak English as their first language, the same diversity is not often reflected in town meetings or other decision-making bodies. One resident explained, "A*s we become increasingly diverse, we need to attain skills to be a more inclusive community. We need to learn to communicate respectfully when we are not likely to agree.*" Another resident hopes to assure that "*whites are not overlooked in our zeal to find equality for other ethnicities*." In terms of the ethnic diversity, Milton has a relatively large population of Latino origin, Quincy has a large Asian population and there are a large percentage of both Asian and African-American residents in Randolph. For a more detailed description of ethnic diversity in the area, see the chart titled "Population by Race/Ethnicity" below.

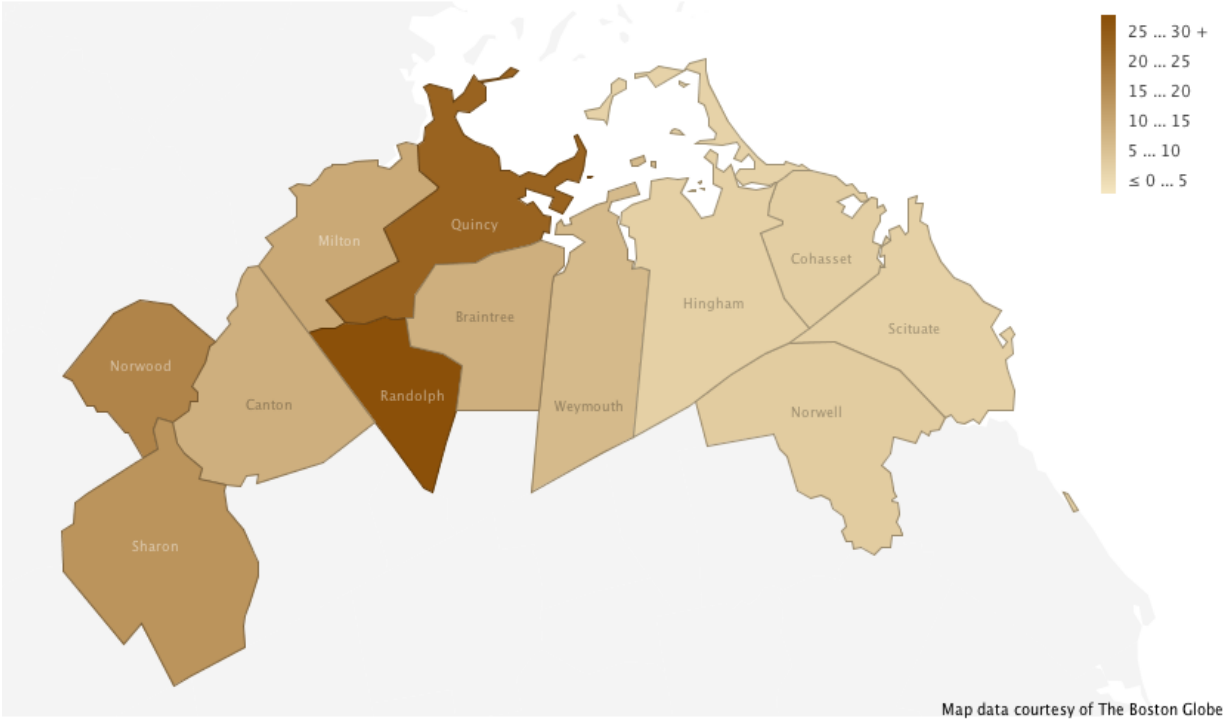
The population size among CHNA member communities varies greatly, from Cohasset, CHNA 20's smallest town, to Quincy, the largest. The age distribution does not vary greatly from one community to another, but Quincy does have a proportionally larger number of elders than the other communities.



*2010 U.S. Census-Secretary of State

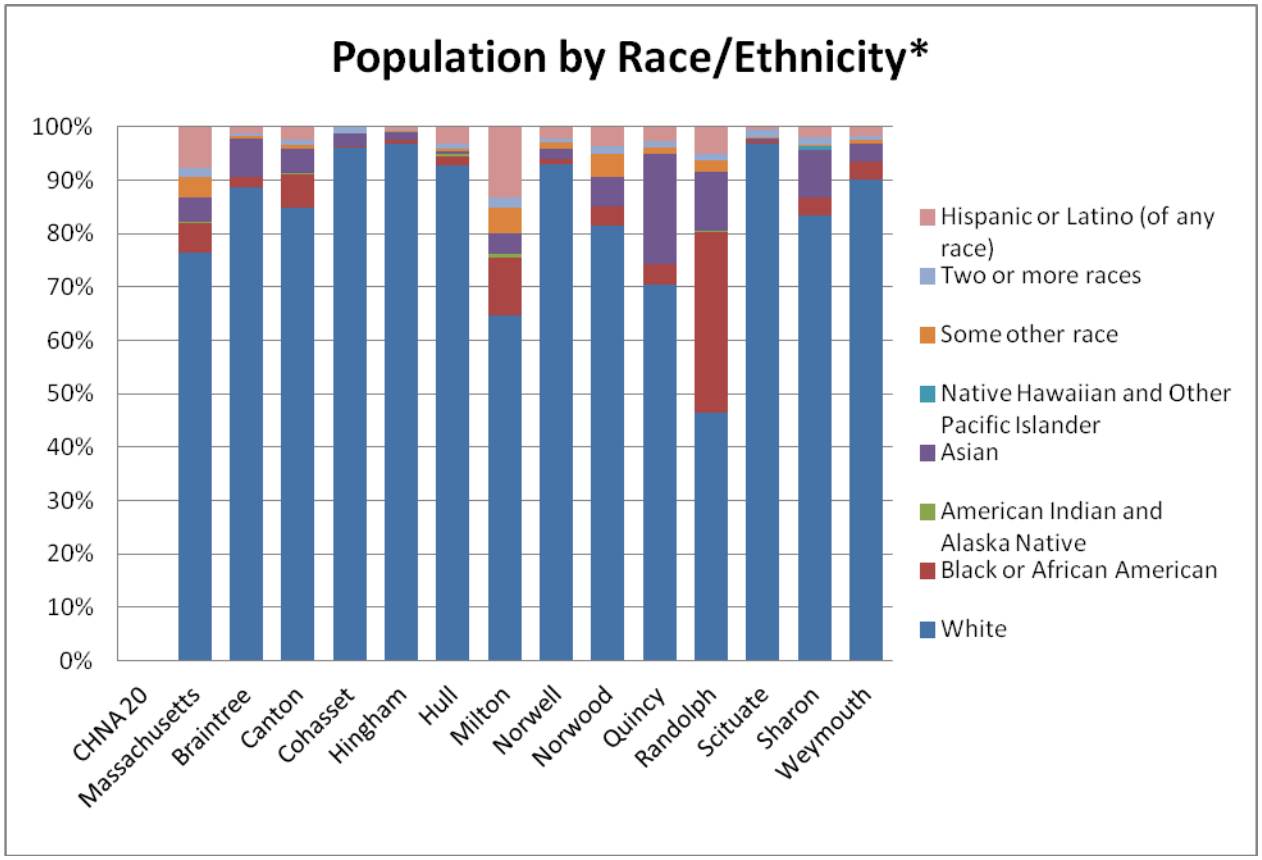
The following map indicates the relative percentage of people in each town who are foreign-born. The darker colors indicate a higher percentage of foreign-born residents.

Percent Foreign-born*



*U.S. Census Bureau, 2005-2009 American Community Survey

The population of each CHNA 20 member community is diverse. As indicated in the chart below, some of the communities have more significant racial and ethnic diversity than others. Some communities like Randolph, Sharon and Milton have larger percentages of non-White residents than does Massachusetts as a whole. Randolph is the only CHNA 20 community that is "majority minority", having less than 50% white residents.



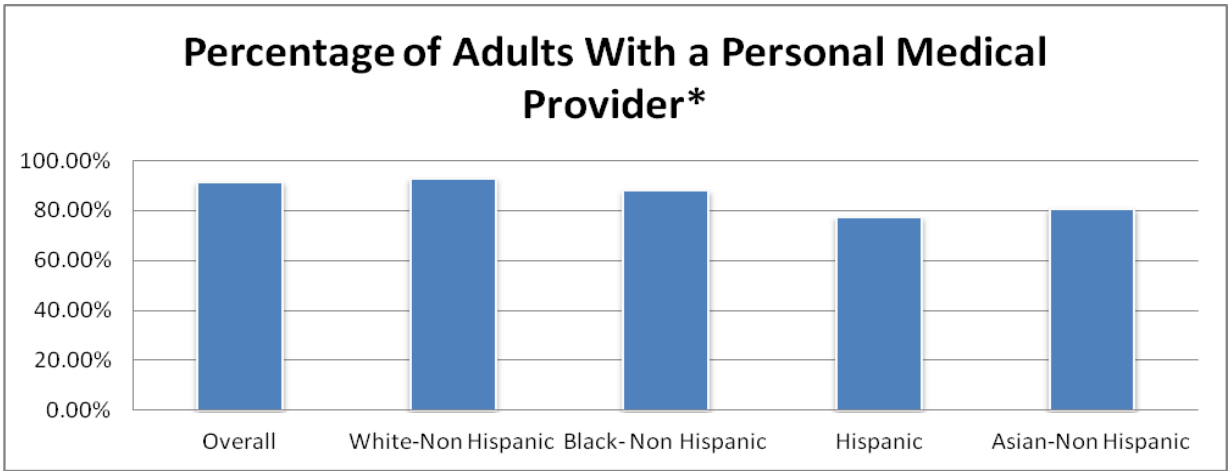
*U.S. Census Bureau, 2005-2009 American Community Survey

Access to care and services: While some services do exist, there are other services that are missing for some communities, and other services that are difficult to access. Residents mentioned a need for access to HIV education, medication and treatment, affordable healthcare, counseling, activities for youth such as more local youth centers, teen centers, community centers, and referral pathways to physicians, particularly for people who do not have a primary care doctor or knowledge on how to obtain health insurance coverage.

Two significant limitations to access were described. The first is transportation. Many people described challenges due to lack of trains or buses, and others explained that even for families with a car, paying rent and other bills can leave you without a way to pay for gas. Someone explained, "*The poor people who do not have cars are the ones who suffer… it is a class issue.*" The second barrier is a need for translation and interpretation services. These came up particularly for the elderly population.

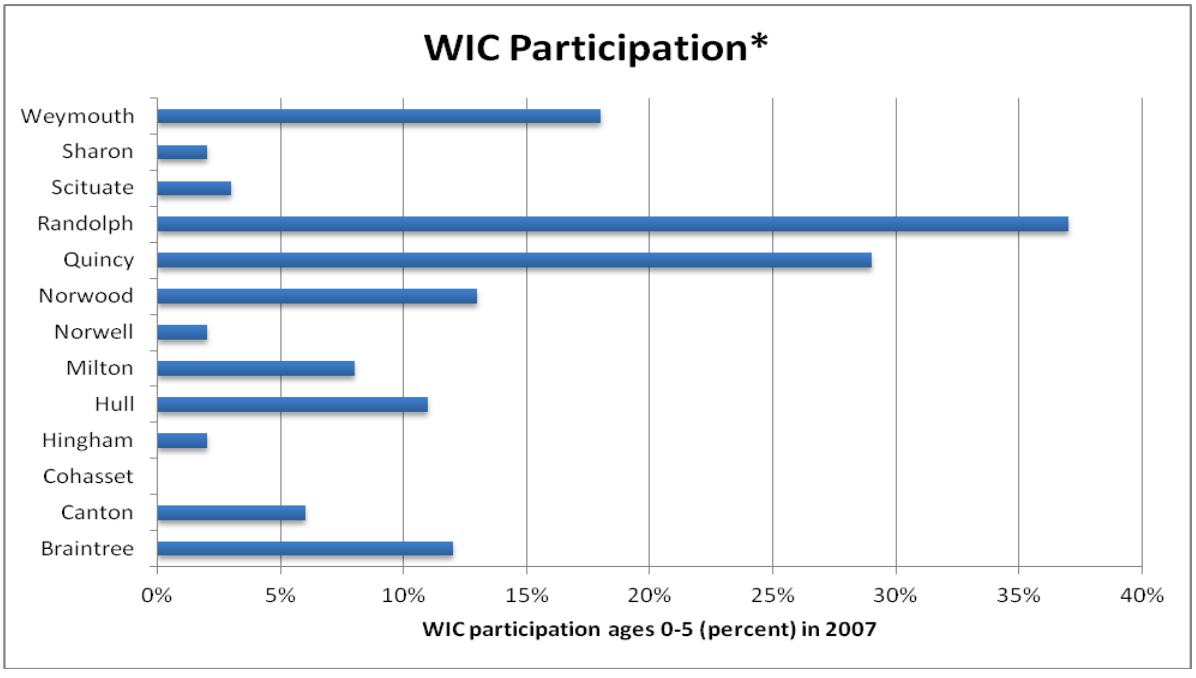
The following chart indicates the percentage of adults who have a primary care provider. This is often connected to whether a person has a "medical home" or a place where they can receive care from

providers who have their medical records and can provide continuity of care rather than depending on the Emergency Room in times of illness. Some racial and ethnic groups in CHNA 20 are less connected to primary care providers than others.



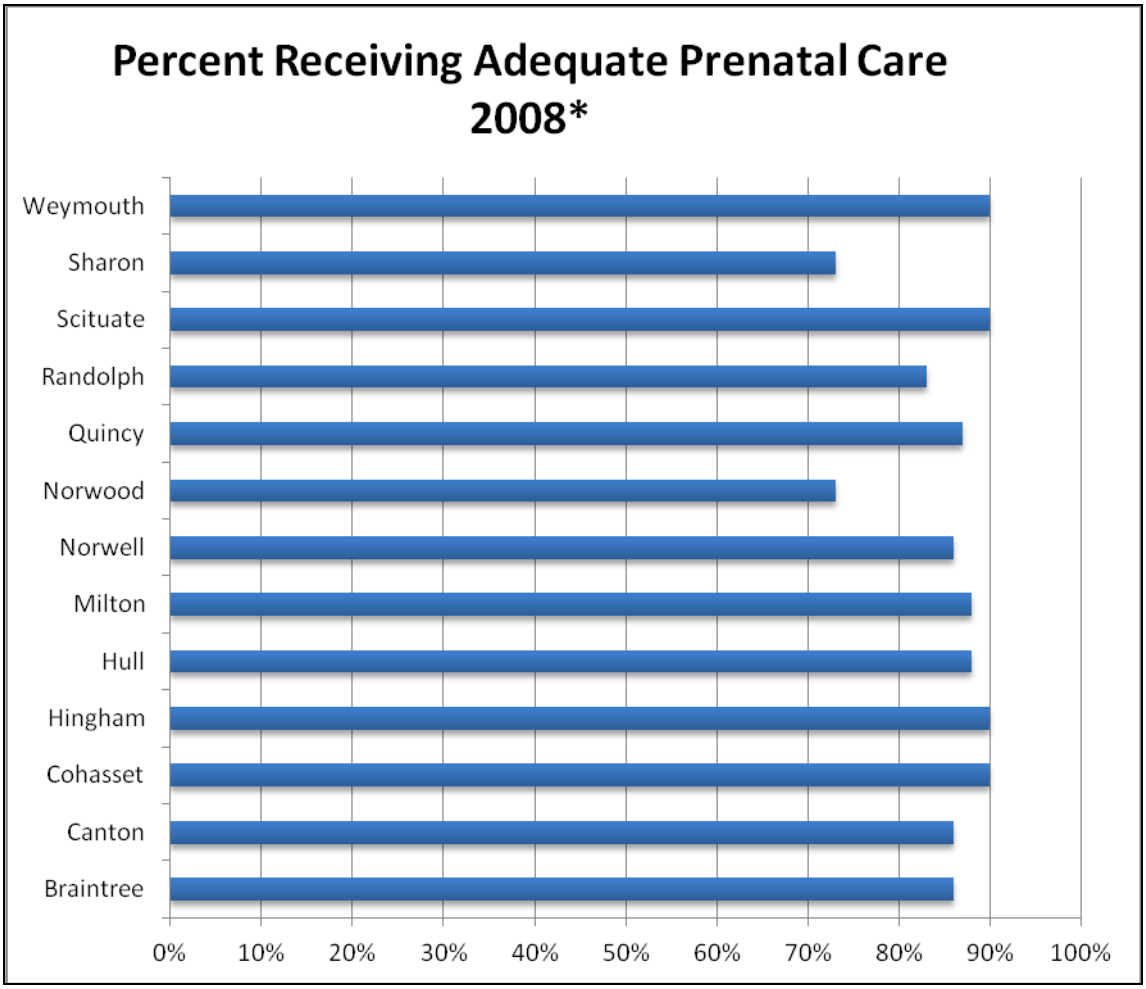
*MassCHIP 2003-2007

Women Infants and Children (WIC) is a program that serves pregnant and breastfeeding women, new moms, and kids under age five. WIC provides personalized nutrition information, consultations and support, support to obtain free or buy healthy food, and referrals for medical and dental care, health insurance, child care, housing and fuel assistance. WIC participation rates can be an indicator of the relative poverty in a community. Moreover, by comparing WIC rates with the known number of poorer families with young children living in a certain community, it can be determined if young families are "left behind" without the availability or access to supportive services such as WIC.



*Kids Count 2007

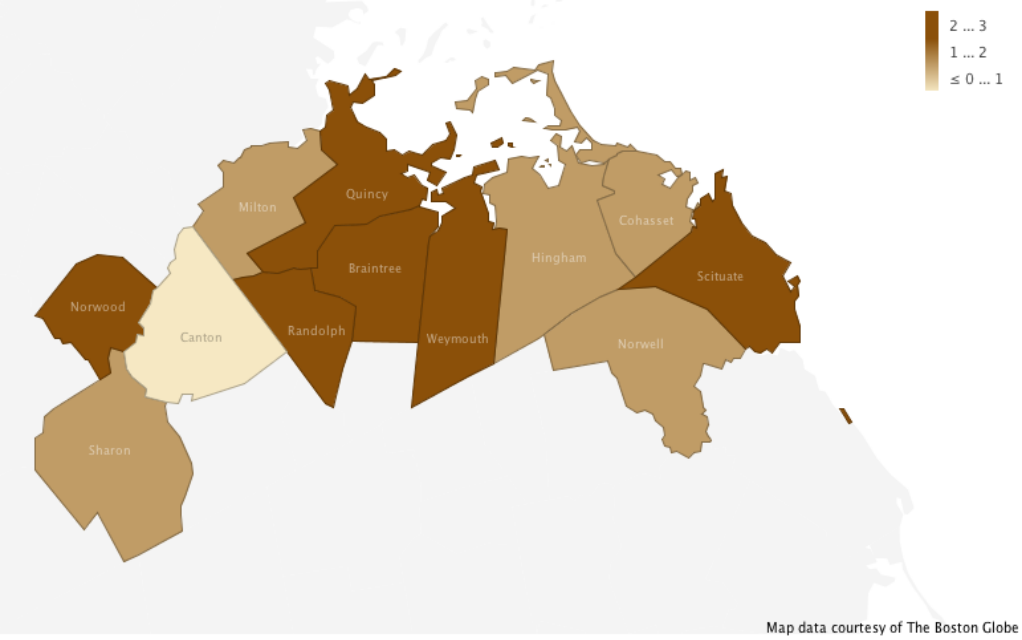
Assuming that all pregnant women should be receiving prenatal care, the following chart indicates that some communities are not successfully connecting women with needed health services. Sharon and Norwood in particular show a need to connect women with prenatal care.



*Mass CHIP 2002-2008

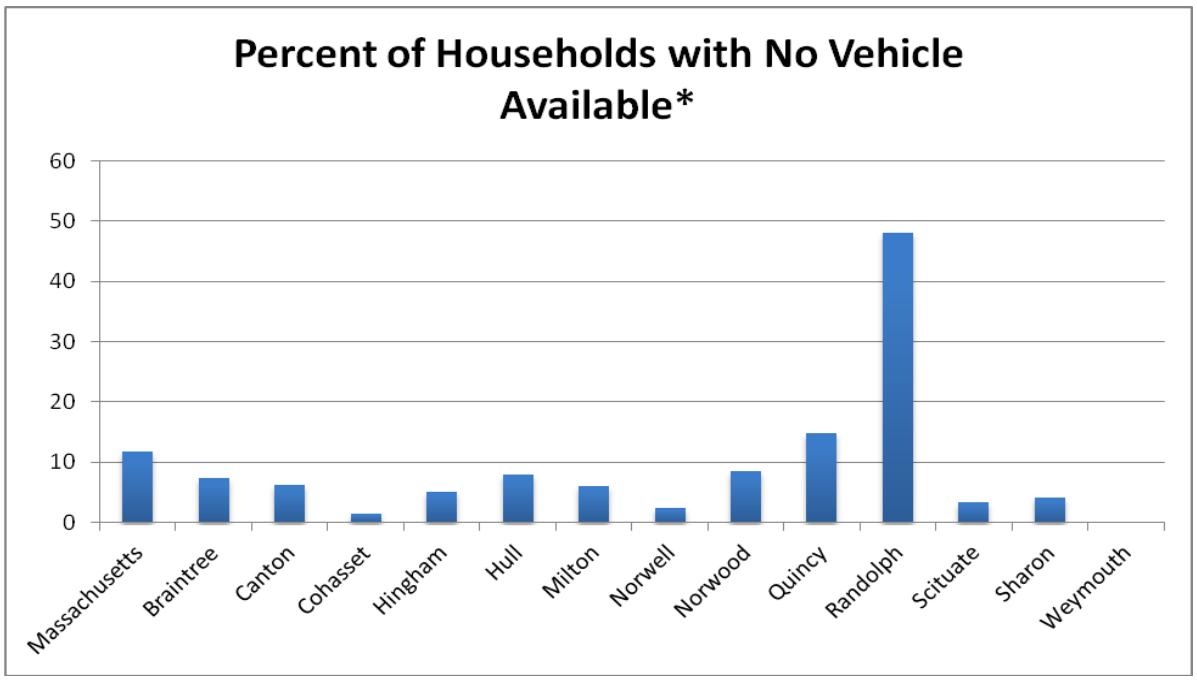
Transportation is difficult to measure, but one way to assess it is to look at how many common forms of public transportation are available in a given community. The AGG looked at the availability of trains (particularly Red Line MBTA trains), public buses and MBTA commuter rail stops within each community and charted the number of these that were available for each community. In the following map, the darkest towns have the most forms of public transportation available and the lightest have the least. Notably, Canton has no forms of public transportation.

Number of Types of Public Transportation Available (Train, Commuter Rail, Buses)*



*Interview with MBTA officials 6/26/2011

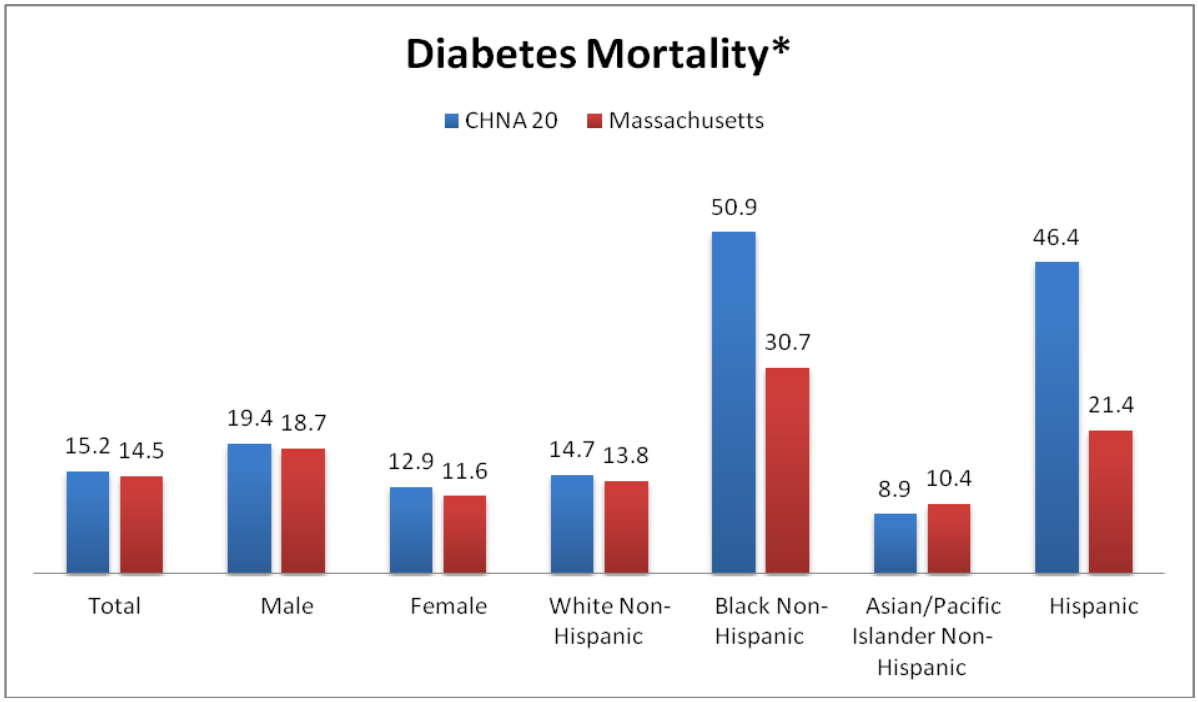
Many households in each of CHNA 20's cities and towns have no vehicle available. Only two towns, Randolph and Quincy, have percentages of families without a vehicle available that are higher than the percentage for the state overall.



*US Census Bureau 2005-2009 American Community Survey

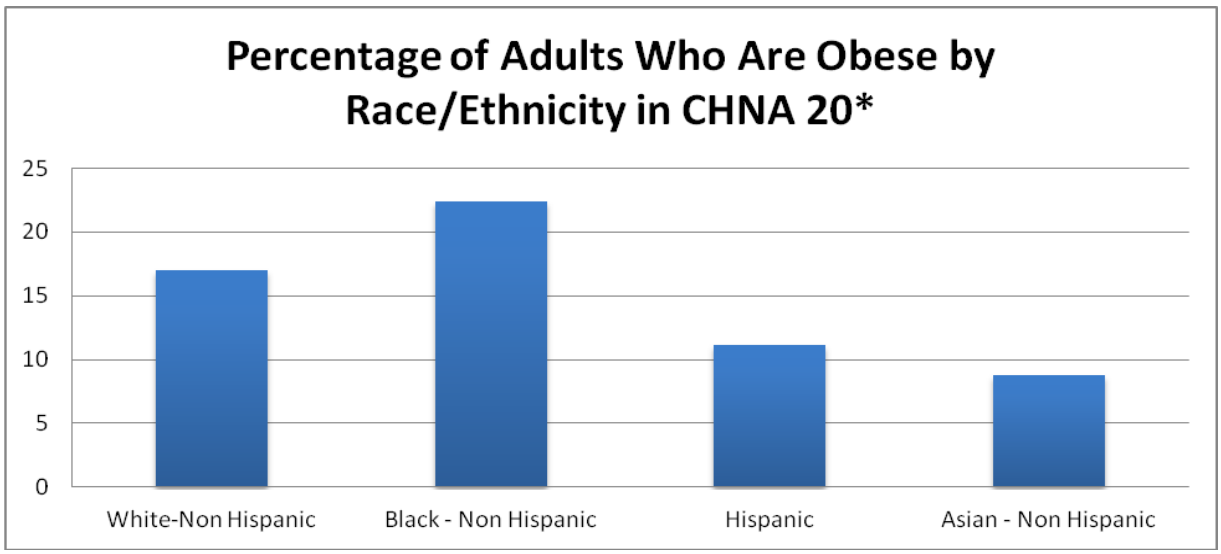
Access to healthy food was a significant concern for CHNA 20 members. Many people mentioned that access to fresh, local fruits and vegetables can be difficult, and becomes even more difficult when the food has to be affordable. There are food pantries, but some people were not sure how to find them. Those who work with the food pantries explained that utilization has increased recently, saying that in one town "*there are many more families using the food pantry. There is a bin at Town Hall collecting food for the pantry. There may be around 170 families using this service. It's gone up with these tough economic times.*" There is a noted absence of affordable supermarkets and farmers markets. While availability of healthy food was the issue that was raised most often with respect to food, informants' concerns about healthy eating were broader, including obesity rates and opportunities to be active, particularly for elders.

Chronic Disease and Wellness: In general, the diabetes mortality rate is similar for CHNA 20 and statewide. However, diabetes mortality numbers are higher in CHNA 20 than in the state for two populations: Black and Hispanic. The overall numbers for these populations are higher for both the state and CHNA 20, showing a striking disparity with the White and Asian populations.



*MassCHIP 2002-2007

Rates of Obesity, linked to both heart disease and diabetes, varied for different racial and ethnic populations in CHNA 20. The highest rates are among Black non-Hispanic residents and White residents, and the lowest rates are among Asian non-Hispanic residents.

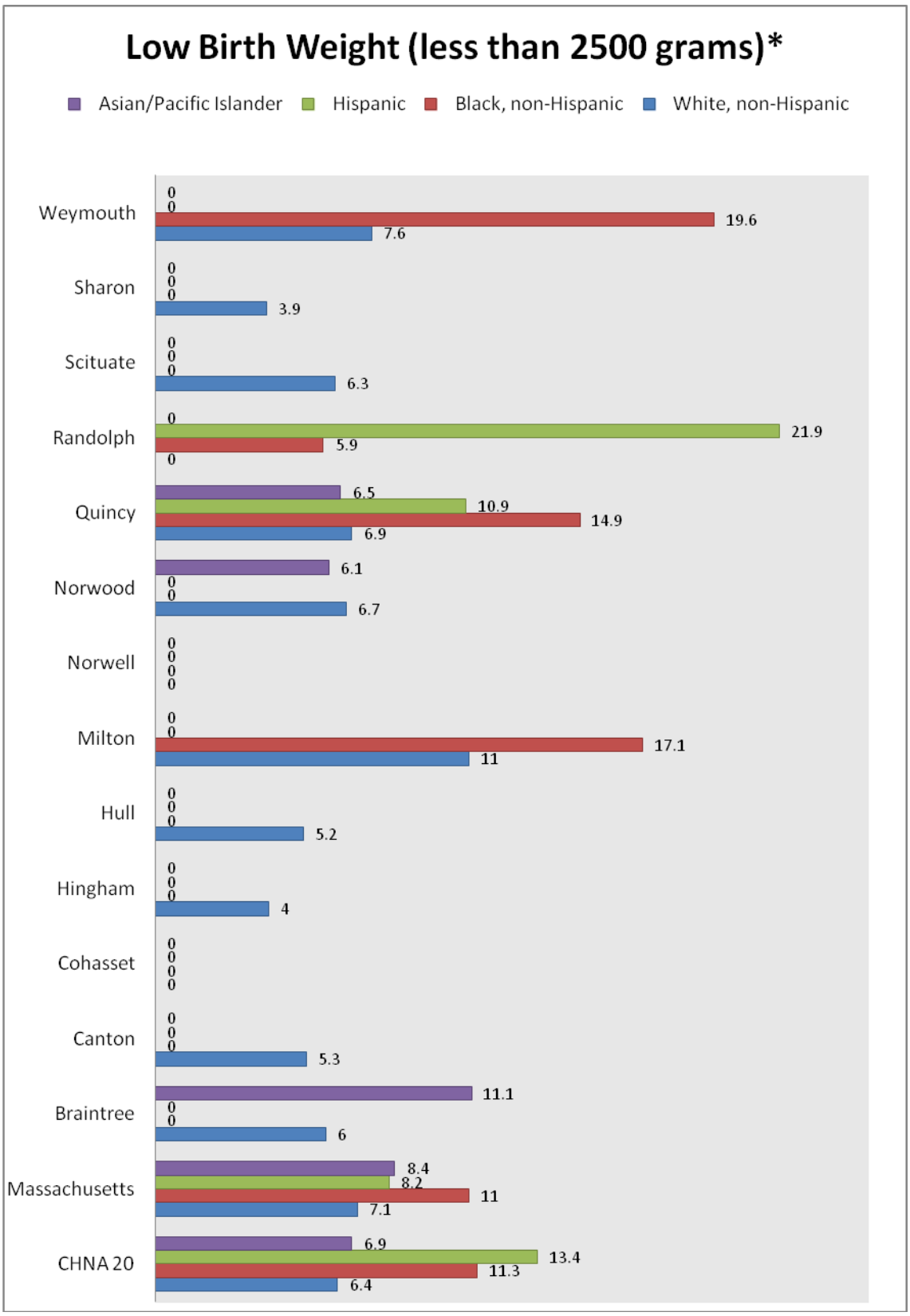


*MassCHIP 2002-2007

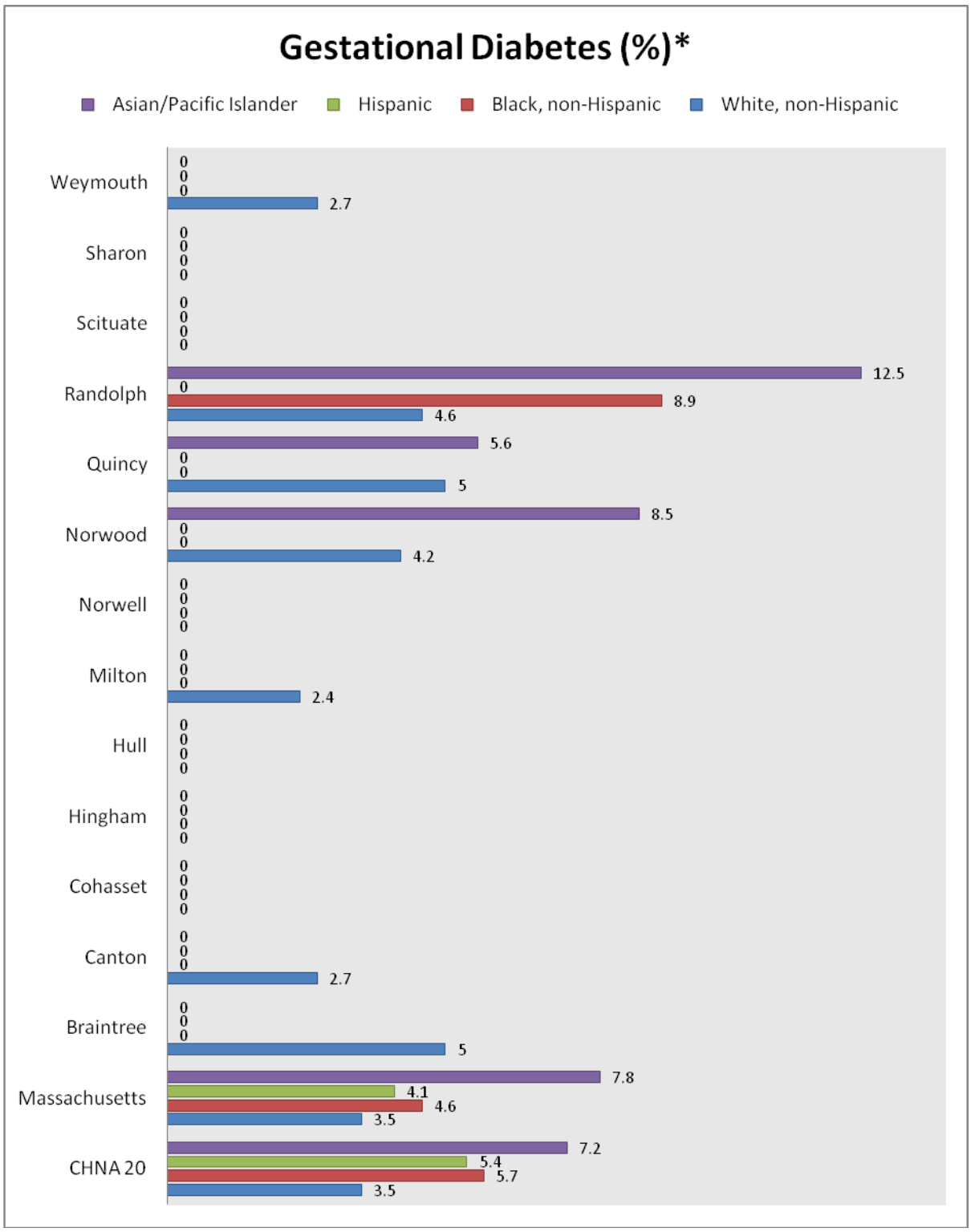
Racism is a significant concern for some residents of CHNA 20 communities. One person explains, "*When I tried to get an apartment, they tried to put me in [a community] where there are drugs and they tried to put me there because of my race.*" Another says, "*They're leaving people out on purpose*." Some are concerned that Asians receive a lot of attention in some communities, and that Blacks and Puerto Ricans are ignored. In addition to the overt racism described above, one person mentions that CHNA 20 communities are becoming more diverse and says:

"[It's not clear whether] bodies of power are accurately reflecting their community racially and ethnically… Decisions are being made about the space where they physically live and issues in the city that clearly affect them that they do not have a voice in and does not include their cultural perspective." The person continued, "*Folks from other cultures do not fit in standardized service provider model."*

Low birth weight can be an indicator for many things, including, among others, lack of adequate prenatal care, the effects of racism, health concerns for mothers, and health of babies. Overall, the rates of low birth weight for Black and Hispanic babies in the CHNA 20 area are notably higher than those for White and Asian babies. Gestational diabetes rates vary widely by race and ethnicity.

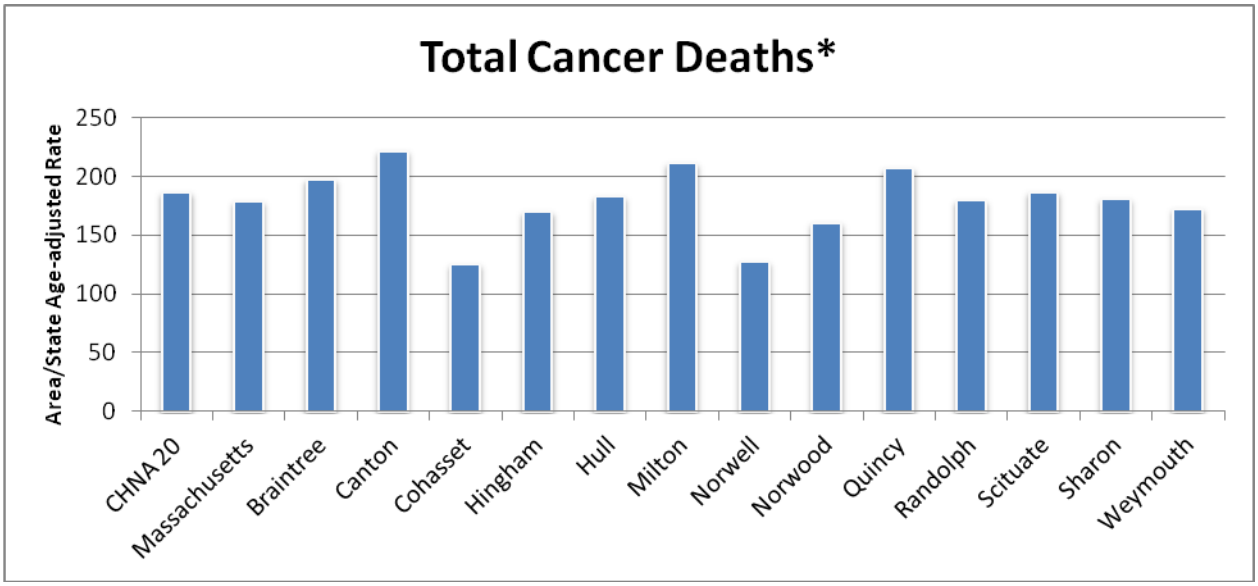


*2008 Vital Records



*2008 Vital Records

The rates of cancer deaths do not vary widely between CHNA communities. However, the lowest rates are in Cohasset and Norwell, and the highest rates are in Canton, Quincy and Milton.

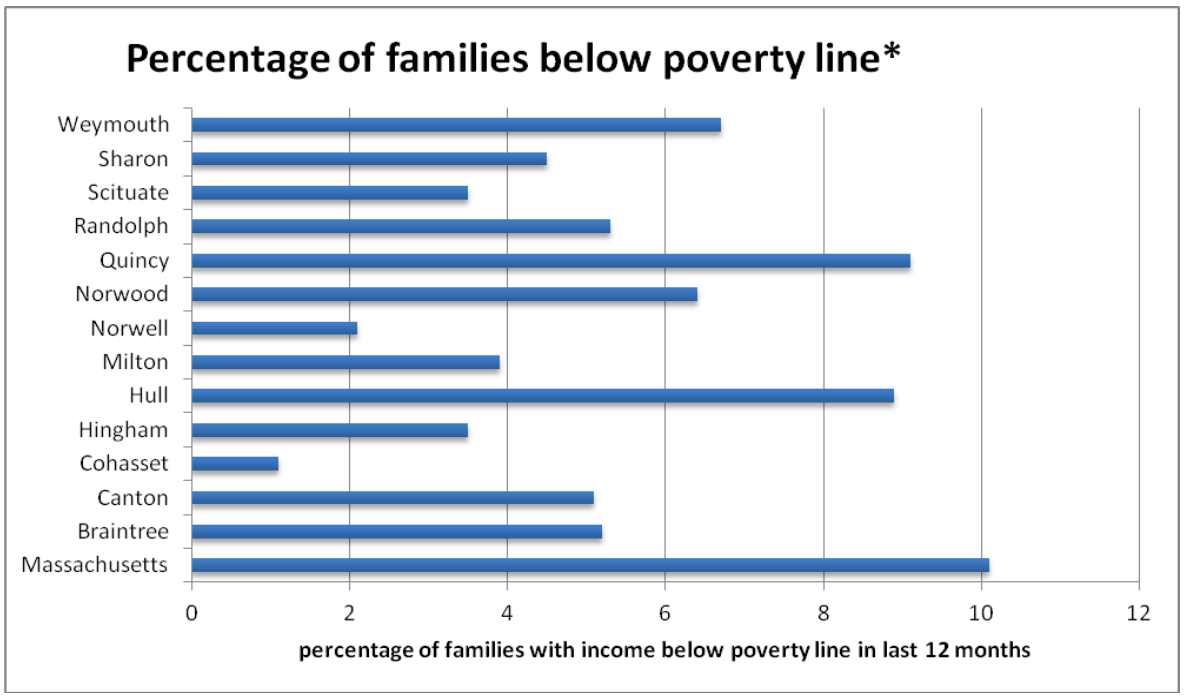


*2007 MassCHIP

Other Drivers of Chronic Disease: Economy and Education

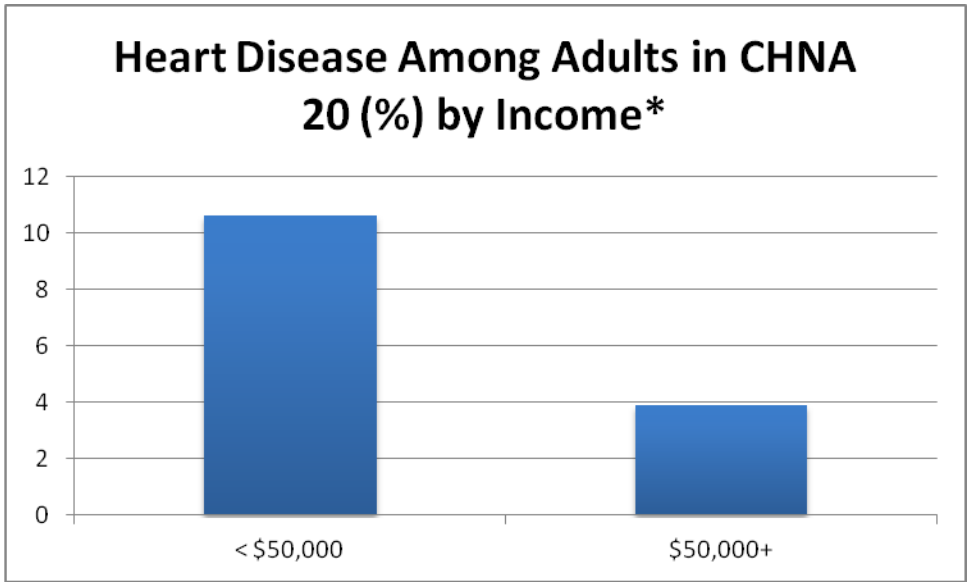
The economy was mentioned in many interviews, both indirectly and directly. CHNA members recognize the economy as a driver for the availability of services, needed repairs to town infrastructure and school finance, as well as impacting the availability of jobs. They describe a need for job training, a lack of secure income, and the loss of employment, homes and health insurance that can result. This was identified as one issue that particularly affects elders, because they tend to live on a fixed income and are not able to adjust to changes as easily. One person explains, "*They may have to make the following choice; do I buy my prescription drugs or pay for oil to heat my home?*" Others recognize that the middle class is in a difficult situation because they are not eligible for certain assistance but do not have enough income to live comfortably. For some people, economic strain and the nature of local economies combine to force them to go out of town to buy basic necessities such as food and clothing.

The percentage of families with income below the poverty line in the last 12 months gives a sense of the relative wealth of CHNA 20 communities as well as the number of families who are economically vulnerable. Interestingly, there is no community in the CHNA 20 area that has a greater percentage of families living below the poverty line than the state as a whole.



*U.S. Census Bureau, 2005-2009 American Community Survey

Income is also inversely correlated with heart disease. Heart disease is more common among those with lower incomes in CHNA 20 communities.

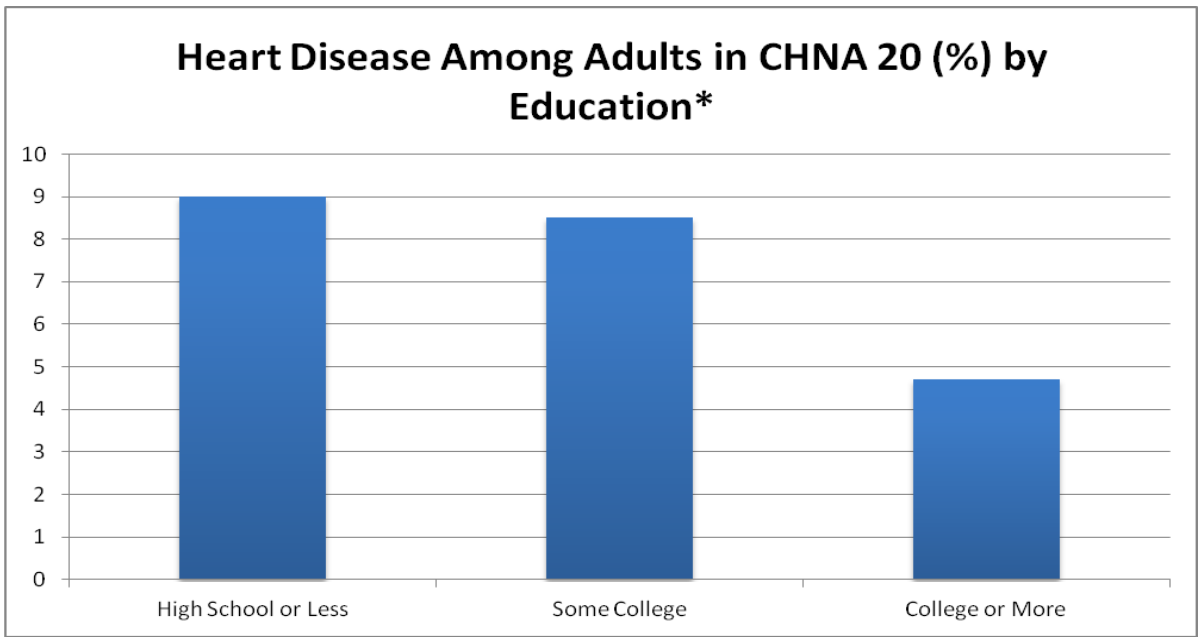


*MassCHIP 2002-2007

The educational system is seen by respondents as stressed and under-resourced. Residents describe an educational and extra-curricular system that is losing resources and is now "*a mere shadow of itself*." The teacher-to-student ratio at some public high schools is low, and residents cite a need for increased

education within the schools on a number of topics. Some people would like to see more sex education, suicide and prevention classes, financial literacy and information on problem solving. Many people describe a need for substance abuse prevention education at all levels of the school system, from elementary to High School.

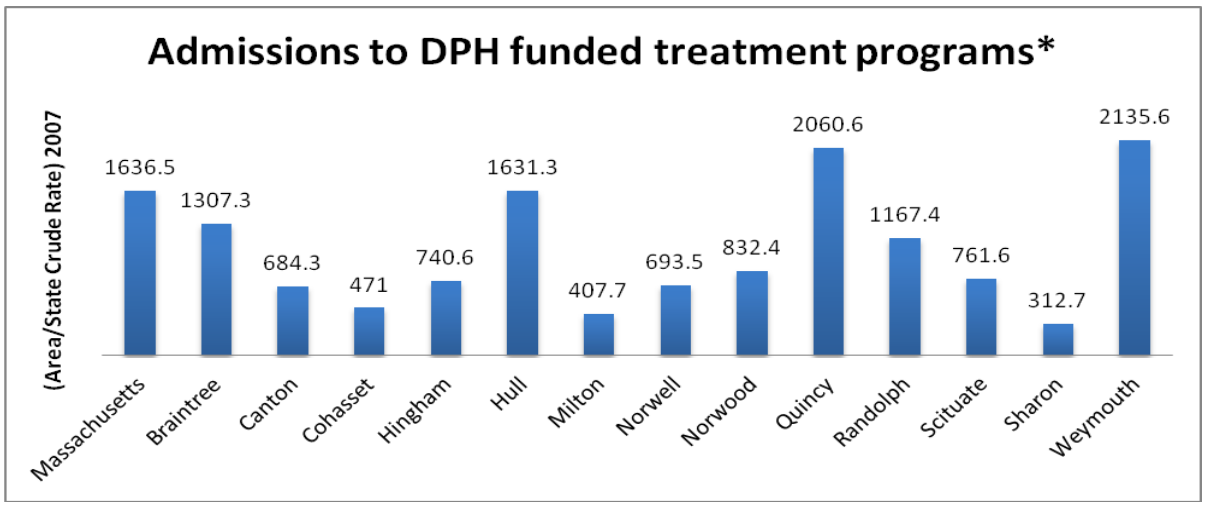
As in many places, heart disease rates in CHNA 20 are inversely correlated with an increase in education, meaning those people who have completed more education are less likely to be diagnosed with heart disease.



*MassCHIP 2002-2007

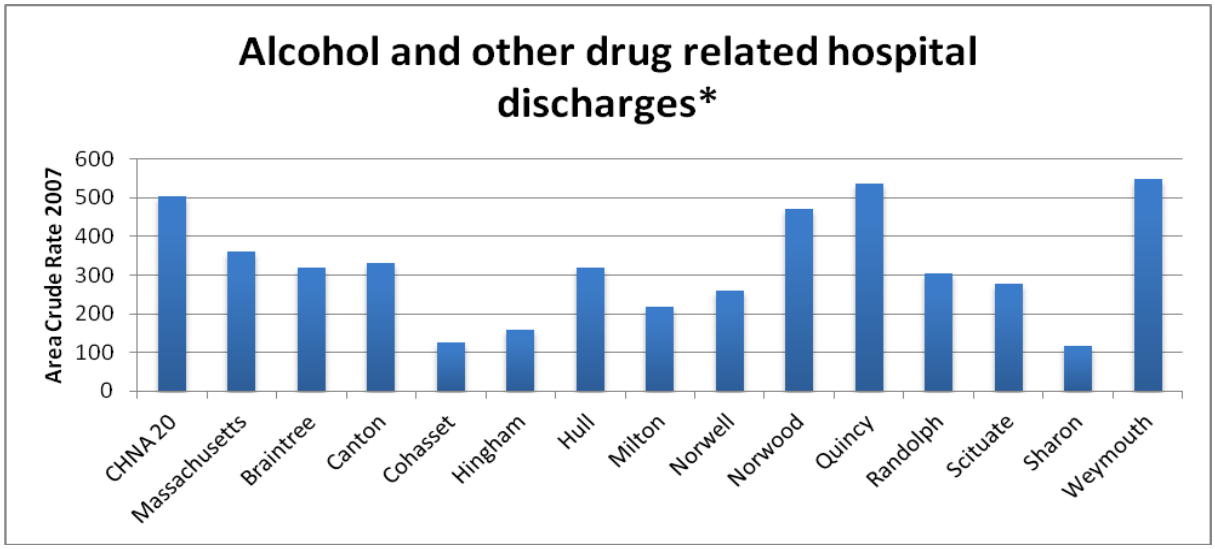
Substance Abuse: Concerns about substance abuse were raised consistently throughout the surveys and interviews. People are concerned about the amount of drug use, young people becoming addicted to prescription drugs like oxycontin and Percocet and then becoming addicted to heroin, some high school girls using cocaine for weight loss, and the dangers of used needles being scattered on streets and in parks. Respondents are also concerned that there is a lack of education for parents about the signs of drug use, and about the connection between drugs and crime. Alcohol is also a concern, particularly underage drinking. One person mentioned that the de-criminalization of marijuana has brought marijuana use to the forefront as an issue as well.

In general, rates of admission to substance abuse treatment programs are higher in the larger communities. An exception to this is Hull, where the population is not large, but the rate of admission to treatment programs is among the highest in CHNA 20. Weymouth has the highest rates of admission. It is important to note that the data are from 2007, and rates may have changed in the past four years.



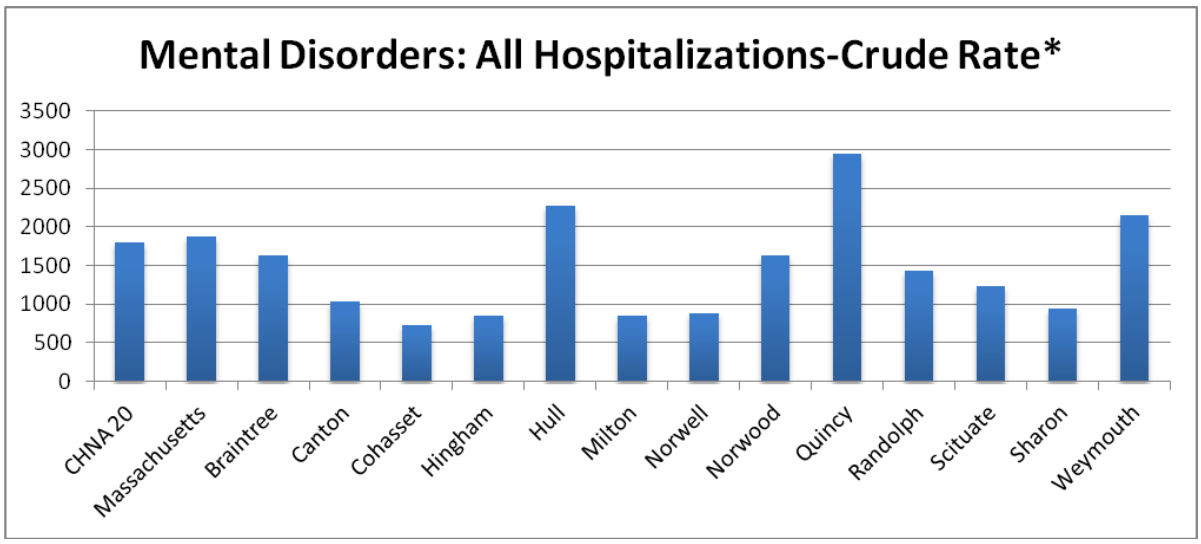
*BSAS 2007

The rates for alcohol and other drug-related discharges mirror the rates for admission to substance abuse treatment programs, meaning that the communities with higher admission rates tend to also have higher substance abuse related hospital discharges.



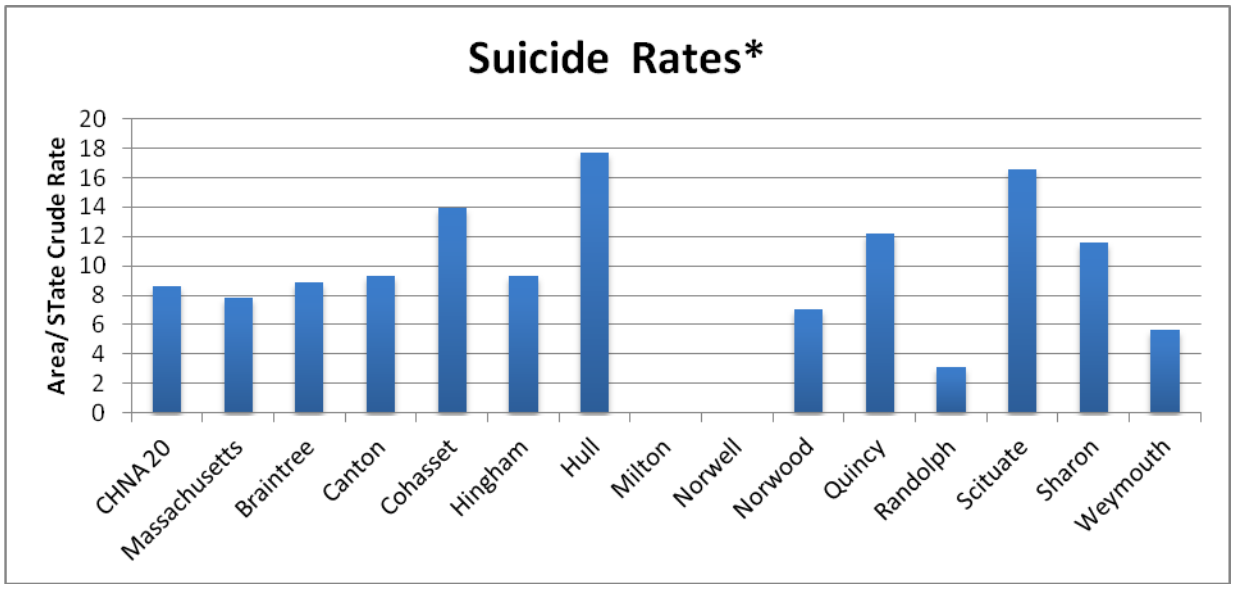
*2007 BSAS

Mental Health: Mental health is a concern for many people in CHNA 20. Respondents identified issues of concern including hoarding (which can be particularly complicated for the Boards of Health to handle), stress and suicide. Hospitalizations for mental health disorders are higher in Hull, Quincy and Weymouth than in other CHNA 20 towns.



*MassCHIP 2008

Suicide rates do not mirror the mental health hospitalizations for most communities. Cohasset, Hull and Scituate have the highest suicide rates in CHNA 20.

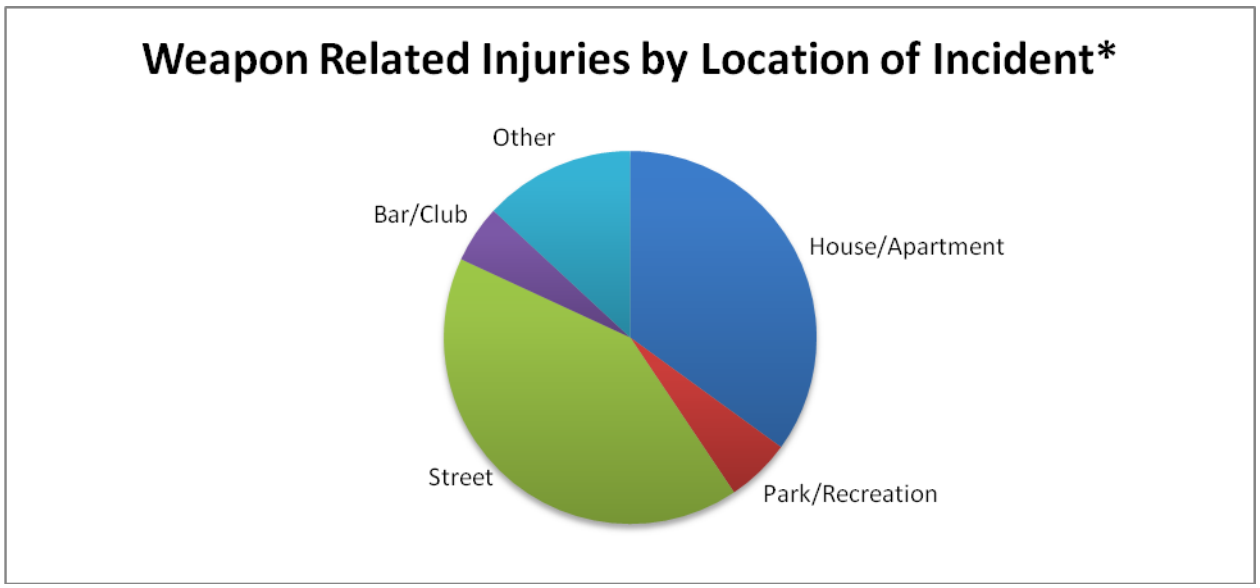


*Vital Records 2007

Violence and Crime: Concerns about crime surfaced in many of the key informant interviews and surveys. Some of the types of crime mentioned were bullying and dating violence, vandalism, domestic violence, homicide, drug use and suicide. Respondents linked crime to safety concerns, describing vandalism and refuse at the parks and crime at the mall as making them feel unsafe. Some of the concerns about vandalism and drug use were ascribed to youth, but others were not connected with particular age groups. In terms of domestic violence, it was mentioned that at least one CHNA community has been one of the cities in the state with the highest number of restraining orders requested for the last three years. A respondent explains, "*There's a report from DPH that is looking at*

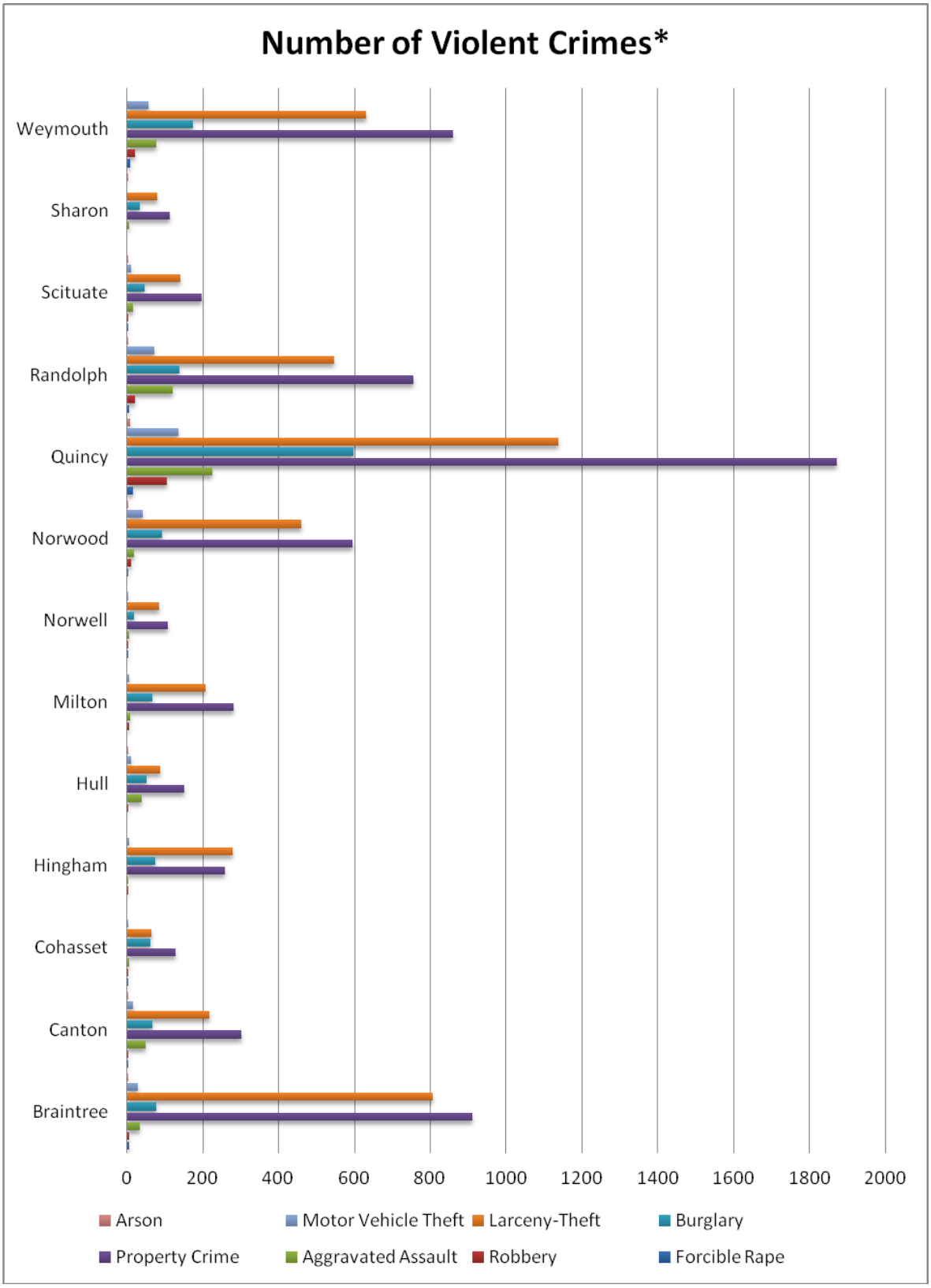
youth that are victims of bullying and they have experienced family violence. National and local data are showing us that as well. DV rates in our community and people's search for help are going up." One police contact shared that in their town domestic violence and stress issues are increasing and they're seeing an increase in the number of cases of people wanting to hurt themselves or others.

The chart below indicates the location of most of the violence occurring in the CHNA 20 region. Small percentages took place in bars, clubs, parks and other locations. The majority took place on the street or in a house or an apartment. The violent incidents that took place in houses or apartments could include domestic violence incidents.



*2007-2009 Weapons Related Injury Surveillance System (WRISS)

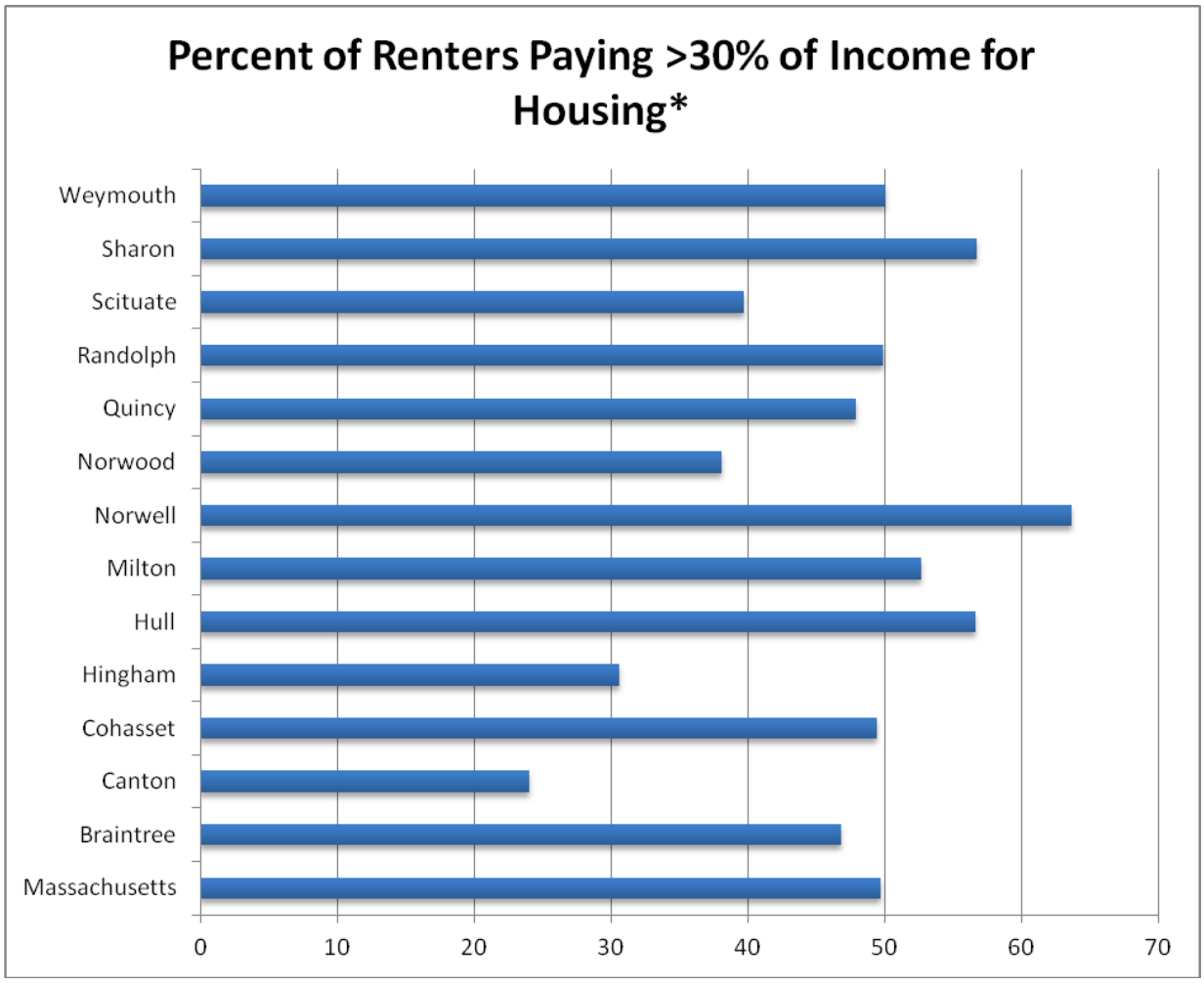
The chart on the next page shows both the number of crimes and the type of crime reported in each CHNA community. The majority of crimes were property crimes and theft or larceny, and a much smaller number were crimes against an individual. In general, the number of crimes is relative to the size of the population of each community.


Number of Violent Crimes*
Weymouth
Sharon
Scituate
Randolph
Quincy
Norwood
Norwell
Milton
Hull
Hingham
Cohasset
Canton
Braintree
0
200
400
600
800
1000
1200
1400
1600
1800
2000
Arson
Motor Vehicle Theft
Larceny-Theft
Burglary
Property Crime
Aggravated Assault
Robbery
Forcible Rape

*2008 FBI

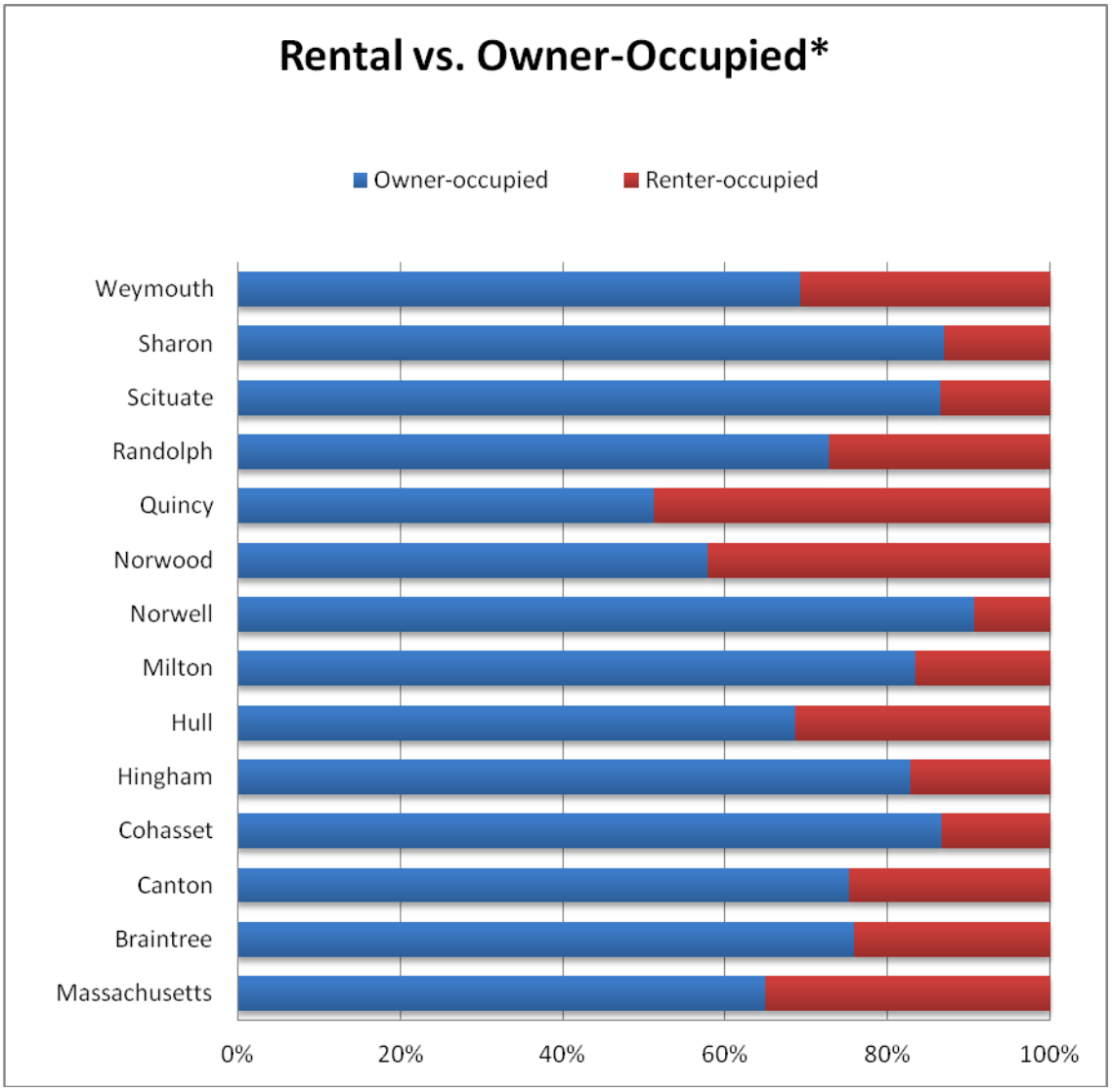
Housing: Housing was raised again and again by informants. The primary concern is that there is not enough affordable housing available. In some cases the greatest challenge is in accessing housing, but in most cases, concerns centered on the fact that there are not enough affordable housing units and that there are not programs to help people move into unsubsidized low-rent alternatives to Section 8. Some populations of concern are elders, those who are currently homeless and middle-income families who are not eligible for assistance. One person shared, "*When my husband died they said I made too much money with social security so I couldn't get into a shelter (about $48 too much)".*

It is commonly recommended that a family should not spend more than 30% of its income on housing. The following data show the percentage of renters in each community who spend more than 30% of their income on housing. Weymouth, Sharon, Randolph, Norwell, Milton and Hull all have higher percentage than Massachusetts, with Norwell having a significantly higher percentage than the rest.



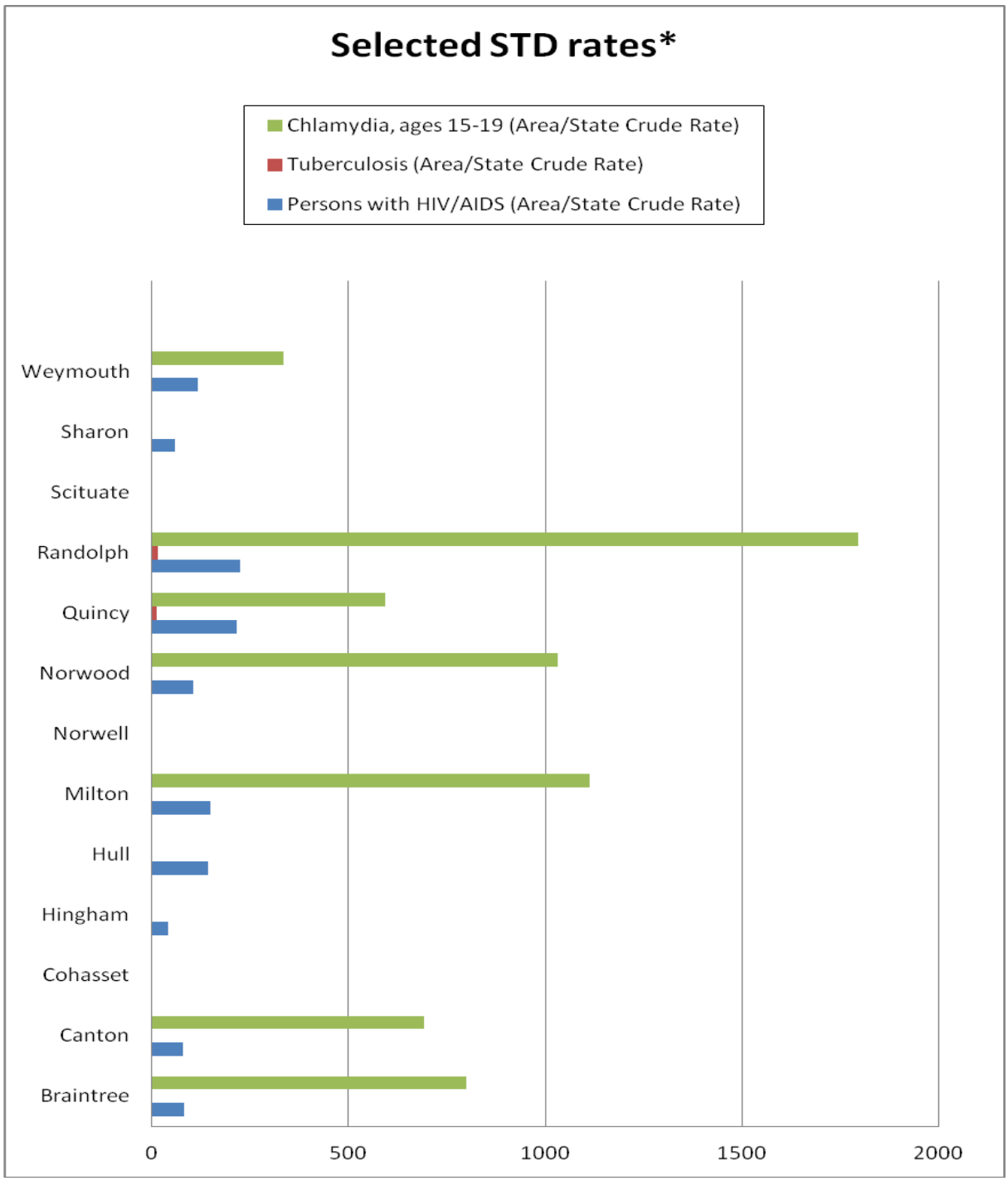
*US Census 2005-2009

There is significant variation in the ratio of rental to owner-occupied units in CHNA communities. Most are more heavily owner-occupied than the state as a whole, with the exception of Quincy and Norwood where the rental rate is high.



*US Census 2005-2009

Infectious Disease: Below is a sampling of infectious disease rates, including Chlamydia, Tuberculosis and HIV/AIDS. Notably, Chlamydia, an easily treatable sexually-transmitted disease, has the highest rates. Tuberculosis has the lowest rates and is present only in the towns with the largest populations, and HIV/AIDS is present in nearly all CHNA 20 member communities. For information about rates of other infectious diseases, please see the appendix.



*MassCHIP 2007

Other Areas of Note: Less common but important other concerns raised by respondents included a lack of affordable and accessible oral health services with accompanying education, terrible road conditions in some communities and the possibility that transient populations are draining the resources and time of services that are available.

Suggestions for comprehensive ways to address issues

Interviews and surveys elicited a variety of suggestions, identified challenges, and made recommendations about issues that CHNA 20 could address. Suggestions that came from respondents ranged from those that were extremely specific to a particular health concern to others that recommended broad changes in approach. The majority related in some way to the underlying themes identified early on by the AGG of addressing disparities and focusing on prevention. Three of the broader approaches that were recommended in different ways by many respondents were advocacy, increased civic engagement and collaboration.

Advocacy

Advocacy was discussed at many levels. At a local level, CHNA 20 members suggested guiding the expenditure of local funds to support teachers' salaries, encouraging greater transparency about what departments are doing and how they work together, getting the town to put better lights on the football field, investing in music and the arts, and supporting free social services. Residents encourage their neighbors to reach out to local leaders and officials, saying, "*You need to contact local town officials, and local organizations to help.*"

At a state level, a few different people suggested that CHNA 20 can encourage the state of Massachusetts not to cut funding for programs and services that are important to community health. Others suggested making sure that the systems in place support our interests. For example, one service provider explained the system and the need for change thus: "*We at the Elder Dental Program strive to help low income elders access quality affordable dental care but we are a Band-Aid on a much larger problem. Systemic change is needed to insure elders have access to oral health care."* They mention reinstating full dental benefits for those receiving Mass Health benefits. Another person explains that there's a need to hold the state accountable:

> *I just received a report from the M.A.S.S. (Massachusetts Association of School Superintendents) where they are asking to properly fund education and all the requirements put upon schools today. · The report suggests that the formulas for paying for education should be fixed. If we value something, we should be valuing it as a state and funding it. · The State needs to look at education as a priority. The bullying prevention programs in the school will be implemented in the schools and we're working on integrating it somewhere into the day, into curriculum or into professional development but it involves both cost and time. · The prevention plan requires funding and training that is supposed to be provided by the State. · The State promised free training but it hasn't come in and we're on our own.*

Civic Engagement

In terms of civic engagement, many people called for greater community participation, particularly in the decision-making process. One person explained, "*The community needs to become more actively involved. The children need to be part of the action plan as well as the parents/guardians. In order for these new laws to be effective the community, students, parents/guardians and schools need to be working together.*" Another person explains,

> "*If the CHNA gave a million dollars, I'd want the community to develop the skills to have a respectful community. This will allow people who usually do not work together to do so. Individual programs are lovely but when they're done it's over. For people to do social justice*

> *work over time they must have those difficult conversations that require skills, doing old-fashioned community organizing.*"

A third explains that we have to:

> "*try to figure out vehicles where people who are not the mainstream white majority have the opportunity to engage the system and engage with those in the city council positions who we might identify strong community leaders [who are] from the vulnerable population community and understand the community and support their candidacy."*

Stronger Collaborations

A third suggestion is to build stronger collaborations. One organization explains that they "*attempt to partner with other community organizations to creatively address dwindling resources."* Others talk about the possibility of working together on issues as a community even though they say that it's not the way that government usually works. In one example that was mentioned, a community works with an elder dental program to match seniors and dentists who are willing to work at lower rates.

Topic-specific recommendations

Food

Many respondents requested the creation and expansion of farmers markets in their communities to be open year-round. Others suggested inviting low-cost supermarkets like Market Basket to open, and still others suggested encouraging more healthy food chains with low-cost menus. One person suggested contacting local farmers to address price increases. Some communities like Weymouth were described as possible models because they have a group that includes the health department, local organizations, restaurants, supermarkets, businesses and cable working together to make policy changes related to healthy eating. Someone from this collaborative (called *Healthy Wey)* explains that among their initiatives, *"We have put in place a policy for town workplace meetings with a guide to follow for healthy snacks and lunches. We are in the school systems working on healthy policy changes for the children. We have a farmers market. We are looking at town property available for farming or community gardens."* Other CHNA members suggest providing programs with the Department of Public Health to help families learn to grow their own food and test the soil, improvements to the nutrition offered by "Meals on Wheels," and making stronger connection between farmers and restaurants so that they can buy in-season vegetables at low prices to increase the number of local vegetables on menus. In addition to addressing food access, respondents mentioned programs that could be replicated to reduce obesity in other ways. These included "Weight Watchers at Work" programs, the willingness to open gyms in the winter, and free exercise classes for teens.

Substance Abuse

Substance Abuse is a complex problem, but many CHNA members had suggestions for how to address the issue. Many of the suggestions centered on including educational components in the school curriculum for all ages. Someone suggested focusing underage drinking programs on middle school ages because that's when many young people start drinking. Someone else specified that the programs at the elementary level should be good decision-making programs and at the older ages should be specific to substance use. Others also suggested providing parents with education about drug use, including

teaching youth how to stay safe if they are using substances. Others suggested creating resource manuals and community-based supports and increasing access to treatment. One person explained that CHNA 20 needs "*to decrease the stigma associated with substance abuse and mental health issues so people will seek help and support.*" Someone suggested that the courts should be tougher on people who use drugs. Another suggestion is to increase awareness of laws related to substance use by posting them on the Internet and having guidance counselors teach students about them. Some people suggested that providing alternatives to substance use, like a teen center, would alleviate boredom and decrease substance abuse.

Many people referred to the coalition work happening in Quincy and Weymouth as a model. In Quincy they described, "*The Mayor's Office works with Impact Quincy, the Police, the DA's office on drug take back days, and a task force. DPH provides grant money for Nasal Narcan to save lives*." Someone from a coalition described their work; "*We work closely with police, city government, health department, corrections, judicial, community members/parents and schools. There have been and will be various community events to raise awareness, educate, and hopefully change perceptions*."

Transportation

To address the challenges of transportation in the region, people suggested increasing bus lines, adding a commuter rail, having trains come more frequently, and getting state and local governments to repair potholes in the roads so that car travel is easier. Small bus service was suggested particularly for places where public transportation is not available to connect people to train stations and hospitals.

Economy

Among the suggestions for improving the local economy was building collaborations for internships with stipends and apprenticeships between businesses, rotary, church groups and hospitals. Another suggestion was to bring new businesses into CHNA 20 communities. In order to do this, someone suggested lowering the tax rates in their community. Many people are interested in encouraging locally owned businesses to take over empty storefronts. Some suggested providing incentives for local businesses. Another suggestion was to help less wealthy people with job readiness and preparation to enter the workforce.

Housing

Housing suggestions varied from those aimed at addressing homelessness to those related to the high cost of housing. One program that was held up as an example "*has a strong contingent of people who are working with the homeless population, with the emphasis on assisting with getting into shelters, and teaching them to follow rules, attend programs as offered, and work toward getting back on their feet.* " Many people had suggestions that had to do with providing alternatives to subsidized public housing. One person suggests making low-priced apartments available. Another person with similar suggestions points out that creating more moderately priced apartments would also stimulate the economy. One person describes a program that exists in the CHNA area in which "*some apartment complexes will let people in for a limited period of time. The rent starts low and goes up more as you become more economically self-sufficient which helps with the transition.*" This issue hit a nerve with some people who live in public housing. One person explains, "*I was looking up statistics to see how much the state pays for me to live in Germantown and wouldn't it be better for me to find an apartment and be credited?"* Another model was presented from Duxbury, where they're,

"*making a portion of the taxes be available to preservation which includes affordable housing (such as 40B and Habitat for Humanity). There's an attachment to the deed if the house is sold at any period it will be categorized as affordable housing. The house would be sold at an affordable housing rate.*"

Mental Health and Social Connections

As a way to increase local community involvement and social connections and also as a way to address mental health concerns, respondents suggested involving more community organizations in local community service. They also suggested providing travel learning experiences and infusing outreach and programming for elders with current affairs, culture, exercise and enrichment to appeal to aging baby boomers in a way that other more traditional elder services activities might not. One person recommended that housing developments have shared spaces like water parks so that low income families can mix with families who aren't living in public housing.

There were few suggestions for ways to address isolation that explicitly address mental health concerns, but one person suggested that "*health education beginning in Kindergarten should address the stress, anxiety and social skills within the classroom*." As well as "*Extending physical education, adding more extracurricular activities that promote overall wellbeing and fitness and not-so-much sporting programs since not everyone likes sports.*" Another person pointed out that it would help to have more mental health providers.

Elders

Elders were a population mentioned as being particularly vulnerable. A number of suggestions were made for how to better serve this population. One person suggested having a program to assist elders with housing issues like repairs that can be hard to afford on a fixed income. Others mentioned that elders are not all served by senior centers; they suggested that Council on Aging (COA) outreach workers reach out to the population that doesn't use the centers. A program to help manage medications safely would help, as would social workers who can spend significant time with elders who are court-involved. Others suggested having more available food in the food pantries. Recognizing that increased outreach and services will take additional funds, there were suggestions to write more grants.

Environment

A variety of people recommended ways to improve and sustain the environment in their community. One person suggested working on sustainable energy, another recommended increasing open space. A third said that bike lanes would encourage more people to ride bikes and cut down on traffic, and a fourth suggested that sewage solutions that have been discussed could be done more locally.

Variety of Services

A tremendous variety of services do exist in the CHNA 20 area. Interviewees mentioned that many of the challenges faced in their communities are already being addressed by existing services, but they requested even more. The majority of people who suggested new programming suggested building, expanding or opening a teen center or community center. They'd like to see academic activities as well as cross-generational activities. In one instance, the respondent had a very specific idea about where the teen center could be. Specifically, we heard, "*If I won a million dollars I would build a community center on [a local] lot with a teen center, a pool that the seniors could use during the day. There would*

be multipurpose rooms with equipment. And a good turf field next to it because we need it." Others suggested family events, a continuum of services during summer and vacations, domestic violence services that are accessible to all communities, more affordable permanent housing, and increased space and capacity for existing programs. Someone else mentioned adapting and using a domestic violence prevention program from Dorchester called "Close to Home."

Accessing Services

While new services might help, there were many suggestions that focused on improving knowledge of and access to existing services rather than creating new programs. Someone suggested focusing on specific populations like Asians and non-English-speaking seniors for healthcare programs. Someone else described how much it would help people access healthcare to have extended primary care hours outside of the standard workday so that people don't have to go to the emergency room and can connect to a primary care doctor. One agency describes their efforts to diversify their staff and engage people in their own native language. Others discussed having programming be offered where people already congregate, rather than at hospitals and agencies. Someone gave an example of how this can look in practice, saying, "*A senior drives by a senior center because they do not feel that they are that old but would feel more comfortable if that same event was done at the library or restaurant*."
Someone else shared an example of a community health center that goes to the board of health offices twice each month to enroll residents in health insurance.
Smaller communities in the CHNA area discussed having more people who speak Haitian Creole so that their clients don't have to go to Quincy for services. A volunteer program called SHINE (Serving the Health Information Needs of Elders) provides seniors with health information. Someone suggested increasing the number of volunteers in this program and paying them for their work.

Education

Education was not raised often as a concern, but was suggested as a solution to many of the other concerns that were raised. For example, people suggested interactive education that would simulate the dangers of driving and texting, courses on financial education to help with financial literacy, educational discussions about race relations to address racism and discrimination, and prevention education for a variety of other issues that impact health.

Other

A number of suggestions were made that were not echoed by many other respondents but were connected to some of the concerns raised in the interviews. One person recommended new school building. Another suggested that under-utilized buildings could be shared with medical clinics, and a third person suggested that information about all services and community events should be centralized in a place that's accessible. Another recommended keeping the T stops open late at night so that the areas are less dangerous.

Discussion

Some of the most wonderful pieces of information collected were the comments about strengths and assets of CHNA 20 communities. From them, it is clear that the CHNA 20 region has a strong base of

involved residents, varied services and valuable knowledge to use as a foundation in addressing the concerns that were unearthed as part of this assessment.

People recognize that there are a vast number of services and organizations in the CHNA area, and they also know that there are a number of barriers to accessing those services. The data indicate that there are indeed populations who are not accessing needed services like prenatal care. Two types of challenges were raised most often in terms of accessing services: transportation and language barriers.

The challenge of transportation is supported by the quantitative data that was collected. Looking at the map of which communities have public transportation available and how many types they each have, it is clear that there are some towns where having a car would be the only easy way to get groceries, services and care. By looking at both the availability of public transportation and the number of families without car, it is clear that in a community like Canton where there is no public transportation at all there are a significant number of families without any easy form of transportation.

Language barriers are challenging for anyone with low- to limited-English proficiency. By looking at the percentage of resident who are foreign-born in each community, we can see that in some communities there are many residents for whom English is not their first language. Interviewees noted that among these people, elders are often the ones who have the most difficulty with language barriers, which might be due to their families being the ones who learn English for jobs and school while they do not have an opportunity to learn. Language barriers combine with social and economic factors to create health disparities. For example, the diabetes mortality data for CHNA 20 indicate that the Hispanic population is disproportionately affected by Diabetes.

While language and ethnic diversity do exist within CHNA 20, the diversity mentioned in interviews was primarily about age and socio-economic differences. The percentages of foreign-born residents and the ethnic composition of the communities show that indeed many CHNA communities are primarily White and American-born. Any population, whether White or Black, English-speaking or Chinese-speaking, is diverse in terms of age, gender, religion, ability, income, education and interests. For this reason, it is important to consider diversity and access to services for all populations along multiple axes of diversity.

Social determinants of health:

Health is impacted by all of the things that we do, the people we know, the way we live, and the environments around us. It is shaped by where we live, work and play. Many of the issues explored in this assessment fall into the category of social determinants of health. Social determinants are those things that influence our health without being measured or diagnosed in a doctor's office.

One social determinant is education. We can see from the correlation of heart disease with levels of educational attainment in the CHNA area that education is linked to health. While in some communities there are requests for improvements to school buildings, school curricula and school systems, for the most part, in CHNA 20 communities people value the quality of schools they have.

Racism, another important social determinant of health, is raised in the interviews. The information we have about obesity by race and gestational diabetes by race for CHNA 20 indicates the correlations (present not just in CHNA 20 but in most communities in the United States) between race and health outcomes. Low birth weight is different based on race and ethnicity, and diabetes mortality rates show a correlation between race and health. Racism can be institutional, personal and internalized, and at all

of these levels can impact health. CHNA 20 has an opportunity to address racism at all of these levels. Suggestions for addressing racism include increasing discussions about racism and holding more activities to connect community members to one another.

Economy influences the way that people live, their emotional and social well-being, their insurance status. These things in turn affect health. One piece of information that we have to show the connection between economics and health are the data showing obesity rates for those earning less than $50,000/year compared to obesity levels for those earning more than $50,000/year. While poverty levels in CHNA 20 show that economic stability is varied among towns, CHNA members talked a lot about the recent changes in the economy. Even relatively affluent towns have concerns about families struggling to pay for basic necessities and worries about graduates finding jobs.

Housing also affects health. The availability of housing, the quality of housing and the affordability of housing all affect physical and mental health. Our data show that many people in CHNA 20 are spending more than 30% of their income on rent. Because the economy is so tight for so many individuals and families now, the cost of housing matters more than ever. Not only renters, but families with mortgages who face job loss can be hard-hit in time of economic instability. Many CHNA communities have high rates of owner-occupancy. Many interviewees suggested creative programs to address the high cost and low availability of public housing. In order to make them happen in the CHNA 20 area, we'd have to work with housing developers and lenders in ways that CHNA 20 has traditionally not done.

Specific health concerns:

There is very rich information about specific health topics in both the quantitative and qualitative results of this assessment. There are a few important notes to consider as the data is explored. There are some topics that do not lend themselves easily to quantitative data collection. In some cases the numbers are simply not being collected. In others it takes time and resources to compile the data in to a usable format, the data is not made public, or the topics are considered taboo and private that information is not easily and comfortably shared outside the home. For example; one case for which the collection and compilation of data is challenging is food access. We have proxy measures for food access including WIC utilization, but geocoding and mapping food access points take time that this assessment did not have. However, even without this level of data, the qualitative results make it clear that community members are concerned about quality of and access to food and are interested in addressing it.

In terms of crime, the lack of easily accessible, community-level public data was a concern and a challenge throughout the assessment process. The issue of domestic violence was raised in a number of interviews. Accurate domestic violence information is difficult to gather. Those experiencing domestic violence may hesitate to report crimes to protect their own safety, and data collected by agencies are sometimes not released to the public out of respect for the privacy and safety of victims and survivors. When available at all, data are not often available by CHNA region. This is an area where CHNA 20 might play a role, either in collecting data or in advocating for more consistent collection and release of data.

Mental health was not explored in very much detail, and one of the reasons for this is that hospital admissions are only one small part of the picture of mental health concerns. In interviews, mental health came up in terms of specific issues like hoarding, depression and suicide. The consequences of

comprised mental health and mental health access can be more complex, influencing other concerns like substance abuse and crime. A number of people recommended school based programs and social programming as ways to improve mental health and prevent depression.

Many CHNA 20 members are concerned about substance abuse and its impact on communities, including crime and dangerousness of parks. Substance abuse rates vary greatly, with high numbers in Hull and Weymouth, communities of significantly different sizes, so the issue is not limited to large urban areas or small towns. Key informants recognize that education about decision making and substance abuse needs to start early and be age-appropriate and that parents need to be involved. Many other suggestions were made as far as how best to address substance abuse in the CHNA area. It will be important to look at the substance abuse evidence base for proposed interventions, and to look at local data, to confirm concerns and make sure that time and money will be effectively spent before implementing particular programs or interventions.

The Role of the Blue Hills Community Health Alliance

The suggestions that came from key informant interviews and surveys are rich and well-informed. They are a wonderful starting point for CHNA 20 or for any CHNA 20 community in thinking about how to address the issues or concerns raised. In addition to these ideas, they offer a wealth of local strategies and approaches that can be adapted and replicated in towns facing similar struggles. In all cases, consulting the evidence base is paramount to learn what efforts might be most effective, whether programs have been evaluated and what has and has not worked in similar communities.

Beyond the need for development, funding and implementation of programs, much of the data supports a need for advocacy, and for CHNA 20 to support communities in having a voice in the decisions that are made at organizational, local and state levels. Civic engagement and advocacy are tied together in that the more voice community members have and the more representative the decision-making bodies are of the population at large, the better the decisions should be for the people who live in a community. CHNA 20 is in a unique position to support or carry out advocacy. As a collaborative, CHNA 20 has tremendously deep knowledge of needs and a significant reach into communities, including connections to vulnerable populations. Unlike some non-profit agencies and governmental organizations that are limited in their ability to advocate, CHNA 20 can have and voice public opinions, and can mobilize its individual members and membership to change the way that decisions are made.

A final role that was raised for CHNA 20 is that of building and strengthening collaborations. The fact that the challenges and the strengths in each of the CHNA 20 communities are <u>not</u> identical begs the question: why can't we share our existing strengths with surrounding communities and address our challenges collectively? There are few opportunities in busy schedules to work across borders and CHNA 20 meetings provide these occasions by design. The collaborations and new working relationships that come out of CHNA 20 can increase impact, efficiency, reach, and in turn improve health outcomes.

Recommendations, Conclusion and Next Steps

The Assessment Guidance Group formally recommended to the steering committee that CHNA 20 should focus its work on the following issue areas:

- Access to Care & Services (including issues that involve transportation, cultural and language services and navigating through systems for treatment);
- Chronic Disease & Wellness;
- Mental Health; and
- Substance Abuse.

These issue areas of concern were selected as priorities with two recurring themes to be kept in mind: addressing disparities and maintain a focus on prevention.

The AGG made a number of additional recommendations to the CHNA 20 steering committee as a result of the assessment process. These include that all those involved work collaboratively to:

1. Identify feasible solutions to address the needs identified in the assessment, including creating plans to translate needs and related solutions into policy and programs;
2. Disseminate results of assessment and policy actions to communities; and
3. Collaborate with civil society, governmental agencies and the private sector in order to promote support for program and policy proposals.

CHNA leadership should:

4. Construct initial funding formulas based on assessment and present to stakeholders (when possible, supporting community-led initiatives to address the selected issue areas);
5. Develop monitoring and evaluation plans for CHNA initiatives; and
6. Reassess needs on an ongoing basis.

Although many needs were identified through the community health assessment surveys, the interviews also generated a long list of assets within the member communities. CHNA 20 has an opportunity to foster cross-border collaborations, to make the best possible use of existing services, and to increase accessibility across town lines.

CHNA members who were interviewed and surveyed as part of the assessment had wonderful suggestions for ways to address the concerns of CHNA 20. These are community-generated and locally-informed suggestions that should be incorporated when possible as CHNA 20 explores ways to use its time and dollars to make CHNA 20 communities healthier.

Following the conclusion of the assessment, CHNA 20 will bring the results and the priority areas to CHNA members and solicit ideas for ways to use CHNA 20 to address the four priority areas. Although the whole CHNA will be involved, a committee will be formed to guide the development and implementation of ideas.

Limitations

The Blue Hills Community Health Alliance assessment process was a truly collaborative and challenging effort. The coordinators and the AGG strove to achieve a balanced, representative sample of CHNA communities in all aspect of the project. Following are some challenges that should be noted.

The demographic composition of those surveyed differed from CHNA 20's demography in regards to ethnic and racial percentages. According to the U.S. Census Bureau, The total population of CHNA 20 is 377,279, and every attempt was made to ensure that the 150 person sample interviewed for this community health assessment was representative of the CHNA's demographic make-up to the greatest extent possible. A comparison of the racial and ethnic breakdown of those interviewed with overall CHNA demographics is shown below.

	% of People Surveyed in CHNA 20 (n = 150)	**Total CHNA % (n = 377,279)**
White*	72.3%	85.8%
Black	1.29%	5.7%
American Indian and Alaska Native	0%	0.2%
Asian	2.6%	5.7%
Native Hawaiian and Other Pacific Islander	0%	0.1%
Two or More Races**	3.2%	0.8%
Hispanic or Latino (of any race)	1.9%	1.6%
Did not specify	18.7%	Not Applicable

Given limitations on resources and time and the wish to genuinely incorporate the voice of community, CHNA 20's community health assessment utilized stratified convenience sampling for key informant interviews. The AGG developed a sample that was as representative as possible of the county's sector demographics. A list of target key informant populations to be surveyed was created. For surveying the general population, a straightforward convenience sampling method was used. An obvious drawback of using this sampling method is that the sample is not fully representative of the population that we wanted to study. As noted in the figure above, some of the units for study were over-selected, while others were under-selected and never totally representative of the diverse communities of CHNA 20. Since the goal of this assessment was not to provide a statistically representative portrait of the CHNA 20 region, but instead provide a snapshot in time of the issues that are voiced as concerns from community members, convenience sampling was the most convenient and efficient. The focus groups are one example of an area where we would have liked to do a more thorough and detailed process for all CHNA member communities. Unfortunately, focus groups were held in Quincy and not throughout the rest of the 13 CHNA 20 communities.

Approximately half of those reached actually responded to the assessment. Those that were more likely to respond may have influenced the types of feedback that received. We recognize that individuals with strong feelings about a subject are more likely than others to respond.

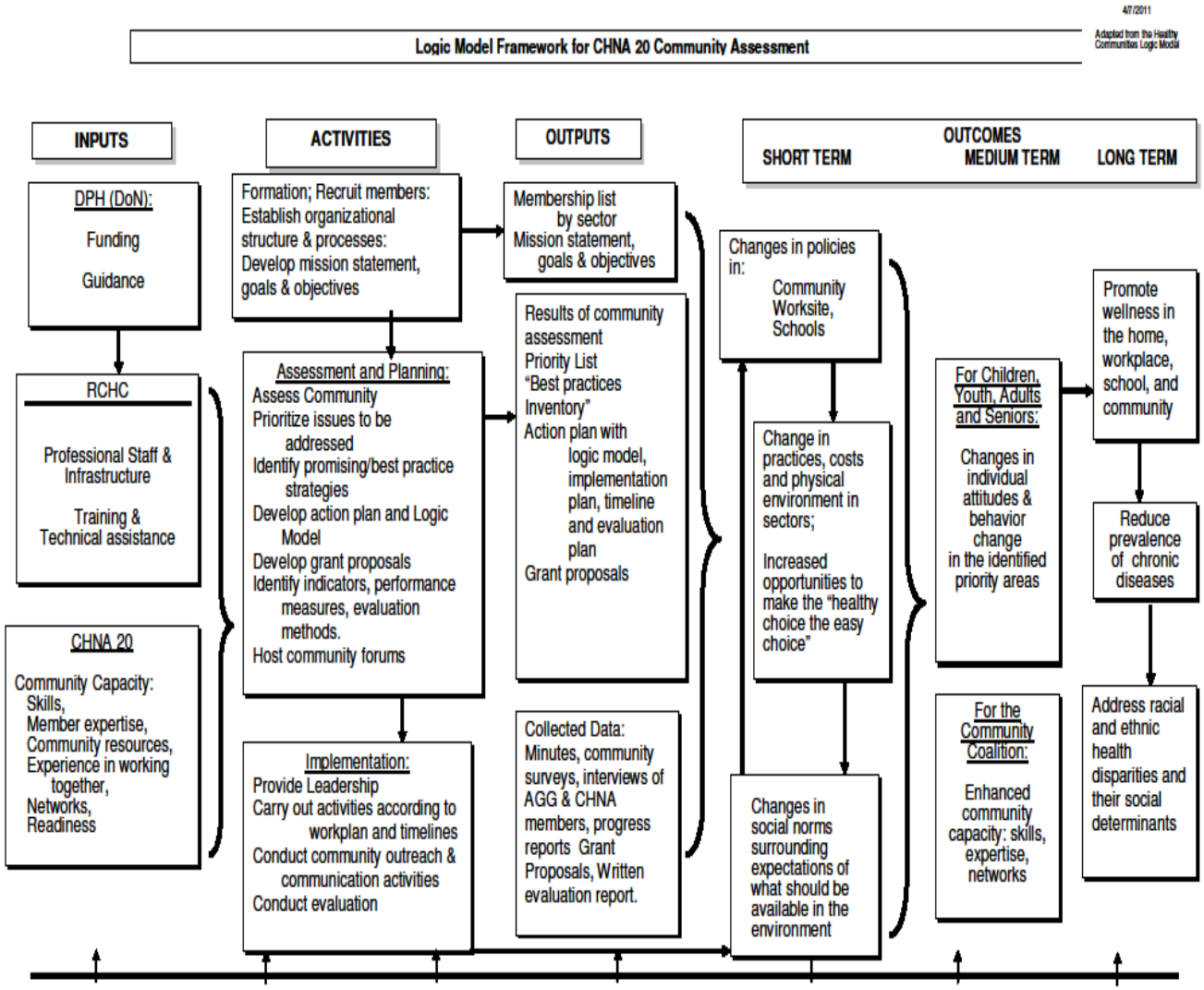
Several methods were used in administering the survey. Phone, online, email, in-person and self-administered questionnaires were employed. Most of the interviewees were originally contacted by email but more responses to the surveys were achieved via phone calls which may have eliminated certain groups that were unable to be reached by phone or email for the interviews.

Also, since the assessment questions were mostly provided in English there may have been some misunderstanding of the questions to those for whom English is not their first language. Similarly, there may have been inconsistencies in the way questions were translated in one of the focus groups, which was conducted in Chinese by a volunteer.

There were significant challenges in finding the data that we were interested in for certain individual communities. In those instances we continued seeking the 'low hanging fruit' that seemed like a possible link to what we wanted to know through other sources. This may have been due to the small population size of some communities and the need to suppress public data in order to maintain anonymity. The data gathered was sometimes out of date. To address this, and in order to provide a fuller picture of CHNA 20, aggregated and single year data from the past ten years was included. The search for additional data continued throughout the months of the assessment. CHNA 20 hopes that more data will be available in the coming years that will help provide a more complete picture of CHNA 20's communities.

Appendices

Assessment Logic Model



Prioritization rankings

Scale for rating the issues:

1=Definitely does not meet this criterion

2= Probably does not meet this criterion

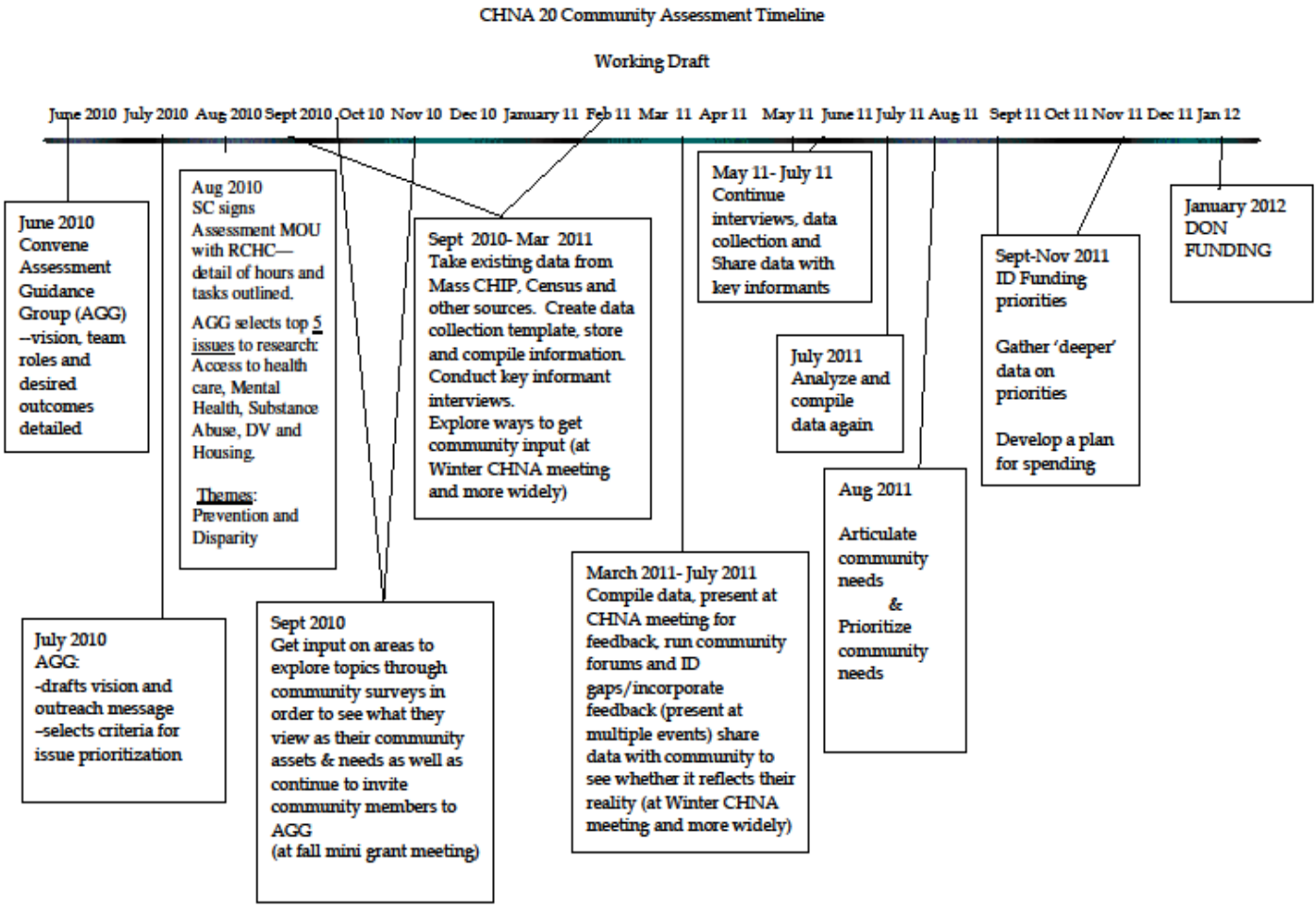
3=Partially meets the criterion

4=Probably meets this criterion

5=Definitely meets this criterion

Criteria	Relevance to all 13 communities	Trend/problem is increasing	We can make a measurable difference in 5 years	Size/magnitude of problem	Issue will get worse if not addressed (in general)	Total
Access to Care and Services	7	7	6	7	7	34
Chronic Disease and Wellness	7	7	5	7	7	33
Mental Health	7	7	6	7	6	33
Substance Abuse	7	7	5	7	6	32
Housing	7	7	2	6	7	29
Domestic Violence	7	6	3.5	3.5	6.5	26.5
Infectious Disease	5	4.5	5.5	3	5	23
Violence/Crime General	6	6	3.5	4	3	22.5
Perinatal	3	3	4	4	5	19
Other	0	0	0	0	0	0

Assessment timeline



Checklist for survey and interview collection

Town_____

Data collection lead_____

We want at least one conversation with someone from each of these sectors. If you complete one of each and want to have more, that's great.

- ☐ Schools
- ☐ Health clinics
- ☐ Public safety
- ☐ Business
- ☐ Senior center or council on aging
- ☐ Faith-based (interfaith if possible)
- ☐ Government
- ☐ Social service providers

We'd like at least 10 conversations with residents of your community. If you can do more, great.

- ☐ Resident
- ☐ Resident
- ☐ Resident
- ☐ Resident
- ☐ Resident
- ☐ Resident
- ☐ Resident
- ☐ Resident
- ☐ Resident

CHNA 20 Community Survey For Community Leaders

Instructions for you:

Thank your interviewee for taking the time to talk to you. Explain what the CHNA is and tell them that what they share will help the group understand the community more deeply and make smart decisions about how the use the CHNA's resources. The "**Introduction**" below will serve as your script.

If you print the survey, you can copy the two pages onto front and back of one sheet.

Please give each of the two questions about 5 to 7 minutes of discussion time. We're not looking for a specific number of indicators so please record whatever indicators/issues come up during this time. We are looking for community specific information so if you hear a concern or asset please make sure you mark the specific community they are describing (ex. Hingham). Try to make people feel comfortable.

Note any names/agencies that are mentioned so that the assessment group may follow up with the individual/agency at a later time.

Be sure to use both pages of the survey. One asks about concerns and one asks about strengths.

Thank you and don't forget to have fun!!!

Introduction:

Thank you for agreeing to speak with me. My name is_____. I'm currently working with the Blue Hills Community Health Network Alliance (CHNA 20) group which is currently in a process to improve our community following a healthy community vision. Our CHNA 20 Group has identified several areas of inquiry and we are interested in hearing from the community.

With a fuller understanding of the challenges, strengths and needs of our community, we hope to be able to support work addressing the issues that arise. The Community Health Assessment Guidance Group (AGG) will guide the planning, implementation and evaluation of initiatives to assess community health assets and challenges.

This conversation will take 15-20 minutes of your time. Your ideas will be shared with the community but your identity will not be connected to your responses. Your responses on the issues that you think and care about will further our understanding of the issue in our community and help determine future resource allocation for CHNA 20. Thank you for your help.

If you'd like to participate/learn more about the Assessment Guidance Group please contact Charlene Julien at cjulien@healthier-communities.org or 617.441.0700. Thank you again for your time, I will send you a brief description of the assessment process and our goals.

The goal of this survey is discover what is happening in each of the 13 communities that make up CHNA 20.* If you don't feel comfortable answering any questions we can skip them.

*CHNA 20 Member Communities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth

For Community Leaders

Circle the sector the person represents (please circle, underline or highlight appropriate sector):

schools, health clinics, public safety, business, seniors, faith-based, government, social service

Ask the person and fill out:

Name and title: _____

Age: _____ **Sex**: Male____ Female _____Other ____

Preferred Language: _____ **Ethnicity**: _____ **Race**: _____

CHNA 20 community of (please mark employment & circle the community):

_____employment: *Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth*

Community Survey:

What do you see as the greatest concern in the CHNA 20 community you serve?

Ask and encourage interviewees to be specific

Ask and encourage interviewee to be specific: what has happened that makes you believe this is a problem? Who does this problem affect? Are there community groups that are not being considered/are there new emerging communities/are there groups in your community that you think are being overlooked? How does this affect them? What are some suggestions for improving this situation? Who should we contact to get a different and similar view? Any more comments? Would you like to share with us any data?

Responses (Don't forget to specify which CHNA 20 community):	**Suggestions on improving or Other comments/who should we contact for info:**
CHNA 20 Member Communities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth	Ex. There are no farmers markets in Canton
Example: There are no farmers markets in Canton. This problem affects the poor and they need help especially those from China.	**Example: Create a community garden. The town officials may disagree with doing this so you may want to speak with them and Mary Smith, a local farmer, would agree to do this so contact her.**

Continued on reverse

For Community Leaders

For Community Leaders p.2

What do see as the greatest strengths in the CHNA 20 community where you live?

Ask and encourage interviewees to be specific: What makes the community special and unique from other towns/cities? How are they strengthening the community? What would you like the community to look like in five years and what assets we have in (insert community name) that can help us with building a bright future.

Responses: *CHNA 20 Member Communities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth*	Suggestions on improving or Other comments/who should we contact for info:
Example: There are several youth centers that help children in Hingham. The children need a place to go to after school since many of their parents work so hard and cannot afford childcare that also tutors.	**Example: The senior centers and the youth centers should collaborate more. John Smith from the ZYX grocery store may disagree so maybe you should contact him. Jaclyn Smith agrees with my observation and you should contact her at XYZ agency. I would like to see our youth receive an excellent education in the sciences.**

Who else should we speak to from the following sectors: _____?

	Community	Name	Organization	Contact Info
Schools				
Business				
Faith Based				
Social Services				
Health Clinics				
Government				
Public Safety				
Senior Center/COA				
Residents				

Additional Notes:

CHNA 20 Community Survey For Residents

Instructions for you:

Thank your interviewee for taking the time to talk to you. Explain what the CHNA is and tell them that what they share will help the group understand the community more deeply and make smart decisions about how the use the CHNA's resources. The "**Introduction**" below will serve as your script.

If you print the survey, you can copy the two pages onto front and back of one sheet.

Please give each of the two questions about 5 to 7 minutes of discussion time. We're not looking for a specific number of indicators so please record whatever indicators/issues come up during this time. We are looking for community specific information so if you hear a concern or asset please make sure you mark the specific community they are describing (ex. Hingham). Try to make people feel comfortable.

Note any names/agencies that are mentioned so that the assessment group may follow up with the individual/agency at a later time.

Be sure to use both pages of the survey. One asks about concerns and one asks about strengths.

Thank you and don't forget to have fun!!!

Introduction:

Thank you for agreeing to speak with me. My name is_____. I'm currently working with the Blue Hills Community Health Network Alliance (CHNA 20) group which is currently in a process to improve our community following a healthy community vision. Our CHNA 20 Group has identified several areas of inquiry and we are interested in hearing from the community.

With a fuller understanding of the challenges, strengths and needs of our community, we hope to be able to support work addressing the issues that arise. The Community Health Assessment Guidance Group (AGG) will guide the planning, implementation and evaluation of initiatives to assess community health assets and challenges.

This conversation will take 15-20 minutes of your time. Your ideas will be shared with the community but your identity will not be connected to your responses. Your responses on the issues that you think and care about will further our understanding of the issue in our community and help determine future resource allocation for CHNA 20. Thank you for your help.

If you'd like to participate/learn more about the Assessment Guidance Group please contact Charlene Julien at cjulien@healthier-communities.org or 617.441.0700. Thank you again for your time, I will send you a brief description of the assessment process and our goals.

The goal of this survey is discover what is happening in each of the 13 communities that make up CHNA 20.* If you don't feel comfortable answering any questions we can skip them.

*CHNA 20 Member Communities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth

For Residents

Ask the person and fill out:

Name and title: _____

Age: _____ **Sex**: Male____ Female _____Other ____

Preferred Language: _____ **Ethnicity**: _____ **Race**: _____

CHNA 20 community of (**please mark residence & circle or underline or highlight the community below**):

_____residence: *Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth*

Community Survey:

What do you see as the greatest concern in the CHNA 20 community where you live?

Ask and encourage interviewees to be specific

Ask and encourage interviewee to be specific: what has happened that makes you believe this is a problem? Who does this problem affect? Are there community groups that are not being considered/are there new emerging communities/are there groups in your community that you think are being overlooked? How does this affect them? What are some suggestions for improving this situation? Who should we contact to get a different and similar view? Any more comments? Would you like to share with us any data?

Name/Id #	**Responses (Don't forget to specify which CHNA 20 community):**	**Suggestions on improving or Other comments/who should contact for info:**
Sally	*CHNA 20 Member Communities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth*	Ex. There are no farmers markets in Canton
	Example: There are no farmers markets in Canton. This problem affects the poor and they need help especially those from China because they do not know English and all the signs are in English.	**Example: Create a community garden. The town officials disagree with doing this so you may want to speak with the Mary Smith, a local farmer, would agree to do this so conta**

For Residents p. 2

What do see as the greatest strengths in the CHNA 20 community where you live?

Ask and encourage interviewees to be specific: What makes the community special and unique from other towns/cities? How are they strengthening the community? What would you like the community to look like in five years and what assets we have in (insert community name) that can help us with building a bright future.

Responses:	Suggestions on improving or Other comments/who should we contact for info:
CHNA 20 Member Communities: Braintree, Canton, Cohasset, Hingham, Hull, Milton, Norwell, Norwood, Quincy, Randolph, Scituate, Sharon and Weymouth	
Example: There are several youth centers that help children in Hingham. The children need a place to go to after school since many of their parents work so hard and cannot afford childcare that also tutors.	**Example: The senior centers and the youth centers should collaborate more. John Smith from the ZYX grocery store may disagree so maybe you should contact him. Jaclyn Smith agrees with my observation and you should contact her at XYZ agency. I would like to see our youth receive an excellent education in the sciences.**

	Community	Name	Organization	Contact Info
Schools				
Business				
Faith Based				
Social Services				
Health Clinics				
Government				
Public Safety				
Senior Center/COA				
Residents				

Additional Notes:

Guide for interviewers

Welcome and thank you for choosing to be a key informant interviewer!

The key informant interview is a standard anthropological method that is widely used in health related and other social development inquiry. This is one method being used in assessing and gathering information from the CHNA 20 community. The term "key informant" refers to anyone who can provide detailed information and opinion based on his/her experience and knowledge of a particular issue. Key informant interviews seek qualitative information that can be narrated and cross checked with quantitative data, a method called triangulation. The words 'key informant' and 'interviewee' will be used interchangeably within this document.

Please read below so you may understand the expectations of your work within the assessment process.

I. Importance of the interviewer

The interviewer has to remain neutral and must refrain from asking biased or leading questions during the interview. Good interviewers exhibit qualities and actions can be seen below:

- Listens carefully
- Is friendly and can easily establish rapport
- Knows and understands the local customs, behaviors and beliefs.
- Can inspire confidence and trust.

II. Identify suitable key informants

Choosing suitable key informants according to the purpose of the interview is important. A key informant can be any person who has a good understanding of t he issue you want to explore. The

informant can be a community resident, teacher, religious leader, social activist, child or others from the targeted community. Interviews should be held during times that are convenient for the informant and tend to take place over the phone due to time constraints.

CHNA 20 has already created a list of key informants to contact. You will contact those in the key informant database which will be provided to you. Most of the names provided do not contain contact information so you must research this information and record it in the spreadsheet titled "**CHNA 20 Key Informants List YV**".

You will be assigned a community to contact each week, so in week one you will contact those listed in Braintree. Please be cognizant of the notes marked in the list, some may state to not contact a key informant until a CHNA 20 member is first told. You will also note a few names as referrers so if the interviewee would like to know who suggested them please let them know if the name is available. Enter any new information in red font (including contact info and suggested key informants) in the CHNA 20 Key Informant List YV so it will be easier to track information.

III. Setting up and following through with the interview

- Based on the information we've collected on CHNA 20's community, we developed community survey questions to ensure that all areas of interest are covered. You will notice that we've used a few open-ended questions in order to encourage answers that are not driven.
- Establish contact by first introducing yourself and the objectives of CHNA 20 by using the survey questionnaire document which contains your introduction.
- Interviews are to be held by phone **not** via email. If you have not received a call back send an email using the format of the "Introduction" in the survey guide as outline, just take out the "Thank you for agreeing to speak with me".
- Hold the interview at a time that is convenient for the informant.
- Once you have a date and time settled, thank the participant for making his or her time available.
- If you do not know the interviewee, you may want to ask start the interview with an ice-breaker such as "tell me about your agency and who it serves". This will give you a chance to get acquainted with each other.
- Go through the community survey form questions, including the prompts, and record the responses within the survey form. **The interview notes should be as close as possible to a transcript.** It's not up to us to write down what we think is important, it needs to be accurate and verbatim as much as possible. Please review the example template of an actual interview which is titled "**Real Example of Survey Answered**".
- The informants' knowledge should be the focus of the interview. Using active listening techniques such as saying "uh-huh" or "can you tell me more about that" is helpful. If the informant knows you are listening they will talk more.

- Never let something you don't understand or hear pass without asking for clarification. You can do this by saying something similar to "I'm sorry but could you please repeat that?" or "if I understand you correctly, you're saying…."
- For each interviewee, note down your own observations about the process and content of the interview.

Remember to:

- Assure the respondent of confidentiality. The responses they provide will not be traced to their name and/or agency.
- Use the appropriate form for each individual (Community Leader vs. Resident). If you are interviewing someone not marked as a 'Resident' in the Key Informant List use the "Community Leader" survey form and the 'Resident' form for those marked as residents.
- Avoid judgmental tones so as not to influence responses.
- Show empathy with the respondent and interest in understanding his/her views.
- Edit for misspellings and typos
- Let the respondent do most of the talking.
- Be an active, attentive listener.
- Pace yourself according to the time you have allocated for the interview.

IV. Crosschecking Responses

After typing up the responses within each community survey form confirm that your notes reflect more than one background or viewpoint. **Confirm your information with the interviewee by emailing your survey notes (only page 2 & 3).** If not, your report may end up one-sided or biased. Also confirm the information such as their name, agency, age, community is correct. Afterwards, be sure to send a thank you note.

V. Send the data

Once you have cross checked the responses, confirmed information please send them to me at cjulien@healthier-communities.org. From there I will review the information with you and then enter the responses you collected in a database. The focus of the study will largely depend on these responses.

**Adapted from Behaviour Change Communication in Emergencies: a Toolkit

Additional data

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**Demographics & Socio-Economics**																
2		**Source & Date**	**CHNA 20**	**Massachusetts**	**Braintree**	**Canton**	**Cohasset**	**Hingham**	**Hull**	**Milton**	**Norwell**	**Norwood**	**Quincy**	**Randolph**	**Scituate**	**Sharon**	**Weymouth**
3	2010 Population-Count	2010 U.S. Census-Secretary of State	377,279	6,547,629	35,744	21,561	7,542	22,157	10,293	27,003	10,506	28,602	92,271	32,112	18,133	17,612	53,743
4	Median household income (dollars)	U.S. Census Bureau, 2005-2009 American Community Survey		64,496	78,206	88,034	112,917	105,870	72,261	96,352	108,526	68,128	60,067	72,734	88,883	115,643	66,280
5	With Food Stamp/SNAP benefits in the past 12 months-Percent			7	3.9	1.2	0.8	1.3	5.5	3.2	2.2	3.1	6	6	1.9	2.6	4.3
6	Percentage of families and people whose income in the past 12 months is below poverty line	U.S. Census Bureau, 2005-2009 American Community Survey		10.1	5.2	5.1	1.1	3.5	8.9	3.9	2.1	6.4	9.1	5.3	3.5	4.5	6.7
7	Place of birth-Percent																
8	Native			85.9	89.2	89.2	95	95.4	95.8	88	94.6	80.9	74.5	70.9	95.4	83.9	91.2
9	Foreign born			14.1	10.8	10.8	5	4.6	4.2	12	5.4	19.1	25.5	29.1	4.6	16.1	8.8
10																	
11	Total population-Count			6,511,176	34,466	21,865	7,323	22,158	11,090	26,333	10,271	28,346	90,120	30,391	18,192	17,365	53,602
12	Male			3,159,175	16,153	10,363	3,595	10,395	5,013	12,674	4,987	14,126	42,671	14,715	8,454	8,724	25,732
13	Female			3,352,001	18,313	11,502	3,728	11,763	6,077	13,659	5,284	14,220	47,449	15,676	9,738	8,641	27,870
14	Median age (years)			38.5	41	40.7	42.8	43.1	45.3	40.6	43.9	41.3	39.6	39.8	42.7	42.3	41.3
15	Under 5 years-Percent			5.9	6	7.3	9.4	8	4.7	7	6.3	6	5	6.1	6.9	6	5.7
16	18 years and over-Percent			77.7	76	76.2	69.4	74	81.1	75.4	71.8	79.5	83.3	78.9	72.8	71.8	79.1
17	65 years and over-Percent			13.4	16.6	16.8	15	18	13.3	12.6	14.7	17.4	15.1	11.8	15.8	12	15.3
18	One race (Percent)			98.1	99.5	98.9	98.7	99.7	98.8	97.8	99.4	98.5	98.8	98.8	98.6	98.4	99.2
19	White			82.8	89.9	87	96.1	97.3	95.6	74.5	95.2	84.6	72.5	48.9	97.3	85.1	91.7
20	Black or African American			6.1	1.8	6.3	0.2	0.8	1.9	12.4	0.9	3.6	3.7	35.6	0.5	3.5	3.2
21	American Indian and Alaska Native			0.2	0.1	0.2	0	0	0.4	0.8	0	0	0.2	0.3	0	0	0.1
22	Asian			4.8	7.3	4.7	2.4	1.4	0.4	4.4	1.9	5.7	21.2	11.7	0.5	9.1	3.4
23	Native Hawaiian and Other Pacific Islander			0	0	0	0	0	0	0.1	0	0	0	0	0	0.6	0
24	Some other race			4.2	0.5	0.7	0	0.2	0.5	5.6	1.4	4.5	1.1	2.3	0.3	0.2	0.8
25	Two or mor races			1.9	0.5	1.1	1.3	0.3	1.2	2.2	0.6	1.5	1.2	1.2	1.4	1.6	0.8
26	Hispanic or Latino (of any race)			8.3	1.2	2.4	0	0.4	3.1	15.1	2.3	3.8	2.8	5.3	0.5	1.9	1.6

1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
27																	
28	Demographic Profile of Adults (2002-2007)-Percent																
29	Gender																
30	Male		45.4	47.5													
31	Female		54.6	52.6													
32	Age																
33	Ages 18-34		24.4	28.9													
34	Ages 35-44		22	21.8													
35	Ages 45-54		18.6	18.3													
36	Ages 55-64		13.9	13.2													
37	Ages 65+		21.1	17.8													
38	Race/Ethnicity	Mass CHIP 2002-2007 (and U.S. Census Bureau 2005-2009)															
39	White - Non Hispanic		88.6	84.9													
40	Black - Non Hispanic		4.3	3.9													
41	Hispanic		2.5	8.1													
42	Asian - Non Hispanic		4.6	3													
43	Education																
44	High School or Less		26	33.3													
45	Some College		25.5	23.4													
46	College or More		48.5	43.2													
47	Income																
48	< $50,000		32.4	44.1													
49	$50,000+		67.6	55.9													

NA

2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
50																	
51	Disability Among Adults (2002-2007)-Percent		18	20													
52	Gender																
53	Male		21	19.4													
54	Female		15.8	20.5													
55	Age																
56	Ages 18-34		9.7	13.8													
57	Ages 35-44		13.4	14.6													
58	Ages 45-54		11.9	20													
59	Ages 55-64		26.9	26.3													
60	Ages 65+		32.2	32.4													
61	Race/Ethnicity	Mass CHIP 2002-2007 (and U.S. Census Bureau 2005-2009)															
62	White - Non Hispanic		19.2	20.5								NA					
63	Black - Non Hispanic		8	17.8													
64	Hispanic		5.6	19.1													
65	Asian - Non Hispanic		NA	6.4													
66	Education																
67	High School or Less		21.1	25.1													
68	Some College		19.7	21.2													
69	College or More		15.6	15.6													
70	Income																
71	< $50,000		31	27.5													
72	$50,000+		13	13.8													
73																	

3

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
75	**Access to Care and Services**																
76	Have Health Care Insurance, by Race/Hispanic Ethnicity (Ages 18 and over) -Percent																
77	White Non-Hispanic	MassCHIP 2002-2007	98.6	97.3													
78	Black Non-Hispanic		96.4	93.5													
79	Hispanic		NA	87.4													
80	Asian/Pacific Islander		NA	98.2													
81																	
82	Percentage of Adults Who Could Not See a Doctor Due to Cost																
83	Overall		5.40%	7.70%													
84	Race/Ethnicity																
85	White-Non Hispanic	MassCHIP 2003-2007	4.90%	6.30%													
86	Black- Non Hispanic		11.90%	13.60%													
87	Hispanic		11.60%	17.10%													
88	Asian-Non Hispanic		3.60%	6.30%													
89	Hispanic		NA	17.1													
90	Asian Pacific Islander		NA	4.5													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
91	Percentage of Adults Who Have a Personal Health Care Provider	MassCHIP, 2002-2007															
92	Overall		91.30%	87.80%													
93	Race/Ethnicity																
94	White-Non Hispanic		92.60%	90.20%													
95	Black- Non Hispanic		87.70%	84.60%													
96	Hispanic		77.30%	68%													
97	Asian-Non Hispanic		80.50%	78.80%													
98	WIC Participation Ages 0-5 (Percent) – 2007	Kids Count 2007	NA		12%	6%	0%	2%	11%	8%	2%	13%	29%	37%	3%	2%	18%
99	Prenatal Care (Percent) – 2008	Kids Count 2008			86%	86%	90%	90%	88%	88%	86%	73%	87%	83%	90%	73%	90%
100	% of children under 3 with food stamp participation	Kids Count 2007			5%	3%	0%	1%	4%	2%	2%	6%	7%	9%	2%	1%	7%
101																	
102																	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
103	**Transportation**																
104	Train				Yes (Red Line)	No	No	No	No	Yes (Red Line)	No	No	Yes (Red Line)	No	No	No	No
105	Bus		Interview with two MBTA officials 6/26/2011		Yes (1 Bus Line)	No	No	No	Yes	No	Yes 2	Yes (1 Bus Line)	Yes (15 bus lines pass through Quincy)	Yes (1 Bus Line)	Yes (1 Stop)	No	Yes (1 Bus Line)
106	Commuter Rail			N/A	No	No	Yes	Yes	No	No	No	Yes (1 Stop)	No	Yes (1 Stop)	Yes (1 Stop)	Yes (1 Stop)	Yes (Two Stop)
107	Notes:						Commuter Rail stops at West	Commuter boat Boston-to			Commuter Rail and a bus that	Red Line subway stops in Quincy				Bus operates	
108	Vehicle Available-Percent																
109	No Vehicles Available	U.S. Census Bureau, 2005-2009 American Community Survey		11.7	7.3	6.2	1.5	5.1	8	6.1	2.4	8.5	14.9	48	3.4	4.2	
110	One-Vehicle available			35.6	32.9	32.3	21.1	26.4	40.6	27.4	18.4	38.9	45.9	33.9	28.2	23	
111	Two vehicles available			37.3	41.7	43.3	58.3	46.7	35.6	44.9	52.7	38.5	30.5	39	47.3	48.7	
112	Three or more vehicles available			15.3	18.1	18.1	19.1	21.8	15.9	21.6	26.5	14.1	8.8	18.8	21.1	24	
113																	
114	**Housing**																
115	% of renters paying >30% of household income for housing		**NA**	49.7	46.8	24	49.4	30.6	56.6	52.7	63.7	38.1	47.9	49.9	39.7	56.7	50.1
116	% of property owners with mortgage paying >30% of household income for housing	U.S. Census 2005-2009		41.4	38.9	37.8	41.1	43.8	45.4	33.6	37.2	39.8	44.7	49	55.2	32.2	39
117	Median Household Income			$64,081	$77,954	$87,207	$105,963	$91,783	$70,503	$96,042	$111,778	$67,909	$56,749	$72,500	$72,267	$94,985	$66,067
118	Built 1939 or earlier-Percent			36.2	14.8	14.8	34.3	28.1	42.5	50.2	12.1	31.9	43.2	13.7	28.7	14.3	27.8
119	Housing Tenure-Percent																
120	Owner-occupied			65	75.9	75.2	86.6	82.8	68.6	83.4	90.7	57.9	51.3	72.8	86.5	87	69.2
121	Renter-occupied			35	24.1	24.8	13.4	17.2	31.4	16.6	9.3	42.1	48.7	27.2	13.5	13	30.8
122	Children Living in Households Where Rent is More than 30% of Income (Percent) – 2006-2008	Kids Count 2006-2008		48	47	48	N/A	48	NA	53	NA	38	47	44	NA	NA	47
123																	
124																	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
125	**Perinatal and Child Health Indicators**																
126	Infant Deaths (less than 1 year)-Area/State Rate	2007-2008 Vital Records	5.4	5		NA	0	0	NA	NA	NA	NA	6.2	NA	0	0	1.5
127	White, non-Hispanic		5.2	3.8		NA	0	0	NA	NA	NA	NA	7.3	NA	0	0	1.8
128	Black, non-Hispanic		NA	11.7		0	0	0	0	0	0	0	0	NA	0	0	0
129	Hispanic		0	7.9		0	0	0	0	0	0	0	0	0	0	0	0
130	Asian/Pacific Islander		8.3	2.7		0	0	0	0	0	NA	NA	NA	0	0	0	0
131	Neonatal Deaths (less than 28 days)		4.5	3.8		NA	0	0	NA	NA	NA	NA	5.4	NA	0	0	1.5
132	White, non-Hispanic		4.9	3		NA	0	0	NA	NA	NA	NA	7.3	NA	0	0	1.8
133	Black, non-Hispanic		NA	8.6		0	0	0	0	0	0	0	0	0	0	0	0
134	Hispanic		0	6		0	0	0	0	0	0	0	0	0	0	0	0
135	Asian/Pacific Islander		5.5	1.7		0	0	0	0	0	NA	0	NA	0	0	0	0
136	Postneonatal deaths (28-364 days)		0.9	1.2		0	0	0	0	0	0	NA	0.8	NA	0	0	0
137	White, non-Hispanic		0.3	0.8		0	0	0	0	0	0	NA	0	0	0	0	0
138	Black, non-Hispanic		NA	3.2		0	0	0	0	0	0	0	0	NA	0	0	0
139	Hispanic		0	1.9		0	0	0	0	0	0	0	0	0	0	0	0
140	Asian/Pacific Islander		2.8	1	NA	0	0	0	0	0	0	NA	NA	0	0	0	0
141	Selected Pregnancy Outcomes by Race/Hispanic Ethnicity-Percent																
142	Prematurity (less than 37 weeks gestation)		8.8	8.8	9.4	9.3	NA	5.7	9.1	10.7	7.7	7.9	7.9	8.7	9.7	5.4	11.9
143	White, non-Hispanic		8.4	8.5	10.3	10.1	NA	5.8	8.3	10	7.1	7.8	7.3	9.2	9	4.7	10.3

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
144	Black, non-Hispanic		12.2	10.6	NA	NA	0	0	0	14.6	0	NA	17	5.9	0	NA	23.2
145	Hispanic		14.8	9.4	NA	0	0	0	NA	NA	0	NA	10.9	21.9	0	0	NA
146	Asian/Pacific Islander		7.6	8	NA	NA	NA	0	0	NA	0	7.3	7	8.3	NA	NA	NA
147	Low birth weight (less than 2500 grams)		7.1	7.8	7	5.5	NA	3.9	5.1	11.8	NA	6.6	7.5	6.4	7.8	4.7	8.5
148	White, non-Hispanic		6.4	7.1	6	5.3	NA	4	5.2	11	NA	6.7	6.9	NA	6.3	3.9	7.6
149	Black, non-Hispanic	2008 Vital Records	11.3	11	NA	NA	0	0	0	17.1	0	0	14.9	5.9	NA	NA	19.6
150	Hispanic		13.4	8.2	NA	0	0	0	0	NA	0	NA	10.9	21.9	0	0	NA
151	Asian/Pacific Islander		6.9	8.4	11.1	NA	NA	0	0	NA	0	6.1	6.5	NA	NA	NA	NA
152																	
153	Multiple Births		4.5	4.5	4.4	6.8	NA	6.1	0	9.2	5.5	3.9	2.6	5.1	7.8	3.4	5.3
155																	
156	White, non-Hispanic		5	5.1													
157	Black, non-Hispanic		4.9	4	0	0	0	0	0	NA	0	0	NA	3.6	0	0	14.3
158	Hispanic		6.7	3	0	0	0	0	0	0	0	NA	0	18.8	0	0	NA
159	Asian/Pacific Islander		2.2	3.1	0	0	NA	0	0	0	0	NA	2.3	0	NA	0	0
160	Gestational Diabetes		4.4	4	5.2	4.6	0	NA	NA	2.2	NA	4.7	5.2	7.4	NA	3.4	3.6
161	White, non-Hispanic		3.5	3.5	5	2.7	0	NA	NA	2.4	NA	4.2	5	4.6	NA	NA	2.7
162	Black, non-Hispanic		5.7	4.6	0	NA	0	0	0	0	0	0	NA	8.9	0	0	NA
163	Hispanic		5.4	4.1	NA	0	0	0	0	0	0	0	NA	0	0	0	NA
164	Asian/Pacific Islander		7.2	7.8	NA	NA	0	0	0	NA	0	8.5	5.6	12.5	0	NA	NA
165	Birth to adolescent mothers- - Area/State Percent	2007 Vital Records		6.4	1.2		0	NA	6	1.8	NA	3.3	3.2	4.6	NA	NA	3.6

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
166	Mothers not receiving prenatal care in first trimester- Area/State Percent	2007 Vital Records		18	9.3	7.9	7.9	6.9	9.5	11.1	11.2	14.7	12.6	15.2	13.3	19.4	10.4
167	Mothers with adequate prenatal care- Area/State Percent			82.1	87.9	88.2	90.8	90.4	92.9	90.2	85.7	73.5	87.9	84.6	90.3	74.7	90.3
168	White, non-Hispanic	Mass CHIP2002-2008		84.6	91.3	85.6	90.5	91.1	87.9	90.4	88.2	76.9	90.4	84.3	91	76.8	90.9
169	Black, non-Hispanic			76.5	78.6	90	0	0	88.5	89.5	0	73.3	85.9	81.2	NA	NA	85.7
170	Hispanic			76.1	66.7	100	NA	NA	0	NA	NA	76.5	81.4	90.3	NA	0	90.5
171	Asian/Pacific Islander			79.3	80	83.3	NA	NA	NA	90.9	NA	63	84.7	90	NA	66.7	93.3
172																	
173	Mothers receiving publicly funded prenatal care- Area/State Percent	Mass CHIP 2002-2007		35.2	21.3	11.9	NA	4.7	26.2	11.4	7.1	22.8	33.2	36.5	9.1	7.4	25.9
174	Lead Poisoning cases (blood lead levels greater than or equal to 25 µg/dL in children ages 6 mos - 5 yrs) - Area/State Percent	MassCHIP 2006		0.4	0	0	0	0	0	0	0	0		0	0	0	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
175	Infectious Disease:																
176																	
177	Newly diagnosed HIV cases (Area/State Crude Rate)	MassCHIP:2006 Surveillance Program		11.7	NA	0	0	0	0	NA	0	NA	12.2	0	0	0	NA
178	Persons with HIV/AIDS (Area/State Crude Rate)	MassCHIP:2006 Surveillance Program		261.6	83.2	79.1	NA	41.9	141.9	148.6	NA	105.4	214.5	224.3	NA	57.9	115.4
179	AIDS and HIV-related deaths (Area/State Crude Rate)	MassCHIP: 2007 Vital Records		2.2	0	4.7	0	0	0	0	0	0	2.2	3.1	0	0	1.9
180	Tuberculosis (Area/State Crude Rate)	MassCHIP 2007: Division of Tuberculosis Prevention and Control	5.4	3.5	0	0	0	0	0	0	0	NA	12.2	15.4	0	NA	NA
181	Pertussis (Area/State Crude Rate)	2007: MassCHIP		18.7	20.8	NA	NA	23.3	0	34.3	48.2	17.6	25.4	NA	33.1	NA	41
182	Hepatitis-B (Area/State Crude Rate)	2007: MassCHIP	9.7	6.9	NA	0	0	0	0	NA	NA	NA	24.3	NA	0	0	NA
183	Syphillis (Area/State Crude Rate)	2007: MassCHIP		6.1	NA	NA	0	0	NA	0	0	0	5.5	NA	0	0	NA
184	Gonorrhea (Area/State Crude Rate)	2007: MassCHIP		37.7	NA	NA	0	NA	NA	19.1	0	17.6	28.7	27.7	NA	NA	20.5
185	Chlamydia (Area/State Crude Rate)	2007: MassCHIP		236.6	NA	93.1	NA	65.2	97.5	194.3	77.1	154.5	162.5	298	55.2	57.9	87.5
186	Syphilis, ages 15-19 (Area/State Crude Rate)	2007: MassCHIP		2.9	0	0	0	0	0	0	0	0	0	0	0	0	0
187	Gonorrhea, ages 15-19 (Area/State Crude Rate)	2007: MassCHIP		110.5	NA	0	0	0	0	NA	0	NA	NA	NA	NA	0	NA
188	Chlamydia, ages 15-19 (Area/State Crude Rate)	2007: MassCHIP		1079.6	798.6	691.3	NA	NA	NA	1113.9	NA	1033.2	592.2	1795	NA	NA	334.5
189	**Violence**																
190	Maltreatment Rates (Children Reported as Maltreated)																
191	Children Reported as Maltreated (Count)	Massachusetts Department of Children and Families 2007		76,747									841				496

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
192	Maltreated (Rate)	of Children and Families 2007	NA	51.2	NA								54.7	NA			41.8
193	Maltreated (Count)	of Children and Families 2009		77,802									893				494
194	Maltreated (Rate)	of Children and Families 2009		51.9									58.1				41.7
195																	
196	Injury Indicators																
197																	
198	Rate)	2007 Vital Records	2.7	2.8	3	0	0	0	0	0	0	0	3.3	12.3	0	0	3.7
199																	
200	Age (Area/State Percent)	Injury Surveillance System															
201	14 or less		7.9	3.6													
202	15-19		27.4	23.1													
203	20-24		26.3	26.7													
204	25-29		14.2	16.3													
205	30-34		7.4	9.0													
206	35 or more		16.8	21.2													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
207	Weapon Related Injuries by Intent of Injury	2007-2009 Weapons Related Injury Surveillance System (WRISS)			CHNA-wide Data Pulled												
208	Unintentional (Accident)-Percent		14.1	8.7													
209	Weapon Related Injuries by Location of Incident	2007-2009 Weapons Related Injury Surveillance System (WRISS)															
210	House/Apartment		35.0	34.2													
211	Park/Recreation		5.6	3.2													
212	Street		41.3	44.6													
213	Bar/Club		5.0	7.0													
214	Other Location		13.1	11.1													
215	Violent Crimes	2008 FBI			45	54	7	7	42	16	10	35	347	150	19	5	106
216	Manslaughter				0	0	0	0	0	2	0	1	2	0	0	0	0
217	Forcible Rape				5	3	1	0	0	0	2	4	15	7	2	0	8
218	Robbery				6	3	1	3	3	6	1	11	105	22	1	0	20
219	Aggravated Assault				34	48	5	4	39	8	7	19	225	121	16	5	78
220	Property Crime				912	301	128	258	150	280	107	594	1872	756	196	114	859
221	Burglary				76	66	62	74	51	67	18	93	598	138	46	34	173
222	Larceny-Theft				806	218	64	279	88	207	85	460	1139	547	140	80	630
223	Motor Vehicle Theft				30	17	2	5	11	6	4	41	135	71	10	0	56
224	Arson				1	3	0	0	1	X	0	3	8	1	2	1	NA

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
225	**Wellness & Chronic Disease**																
226	Total Deaths (all causes)-Area/State Age-adjusted Rate			699.7	684	655.3	647.6	646	782.1	686.5	600.8	685.6	699.8	688.1	704.8	659.6	703
227	Total cancer deaths-Area/State Age-adjusted Rate	2007 Mass CHIP	186.6	178.9	197.7	222	125.3	170	183	211.5	127.3	160.8	207.1	179.8	186.8	181.2	172.8
228	Total Lung cancer deaths-Area/State Age-adjusted Rate		60.2	50.8	61.9	85.8	53.1	53	24.1	58	26.4	48.7	72.2	64	37.4	61.3	60.6
229	Total Breast cancer deaths-Area/State Age-adjusted Rate		19.1	21.4	14.3	17	7.7	18.4	16.8	17.5	22.7	25.9	21.9	16.1	6.3	31.1	21.4
230																	
231	White, non-Hispanic	Mass CHIP 3 Year aggregates 2006-2008	19.8	21.8	15.2	17.7	7.8	15.2	17.4	16.4	23.3	27.5	24.7	17.3	6.3	33.4	21.3
232	Black, non-Hispanic		26.2	29.2	0	0	0	0	0	37.8	0	0	121.2	6.1	0	0	127.6
233	Asian, non-Hispanic		3.7	8.8	0	0	0	0	0	0	0	0	0	34.6	0	0	0
234	Hispanic		6.4	10.6	0	0	0	387.2	0	0	0	0	0	0		0	0
235																	
236	Prostate Cancer Mortality																
237	Total Prostate Cancer Deaths (Area/State Age-adjusted Rate) :	Mass CHIP 2002-2007	19.5	23.4	15.9	18.2	37.6	38.1	25.7	27.0	30.1	18.2	17.3	9.9	21.8	5.9	19.4
238	White, non-Hispanic :		19.7	23.3	16.4	19	38.4	38.7	25.7	24.0	30.6	18.6	17.3	11.9	17.4	6.5	20.1
239	Black, non-Hispanic :		23.5	44.0	0	0	0.0	0	0.0	61.7	0.0	0.0	102.8	0.0	0.0	0.0	0.0
240	Asian, non-Hispanic :		14.9	9.6	0	0	0.0	0	0.0	0.0	0.0	0.0	14.5	0.0	0.0	0.0	0.0
241	Hispanic :		0.0	15.3	0	0	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
242	Prostate Cancer Incidence																
243	Total Prostate Cancer Incidence :		150.1	165.1	164.1	157.5	201.3	153.5	189.2	172.4	126.5	153.3	121.1	150.3	190.8	137.2	148.5
244	White, non-Hispanic :		143.0	160.0	158.4	150.6	193.3	141.2	169.8	152.0	120.0	152.3	120.5	135.7	177.2	135.5	136.3
245	Black, non-Hispanic :		276.5	265.0	NA	NA	0.0	0.0	0.0	399.5	NA	NA	202.9	263.5	0.0	NA	NA
246	Asian, non-Hispanic :		65.7	69.0	NA	0	0.0	NA	0.0	0.0	NA	NA	60.1	NA	NA	0.0	NA
247	Hispanic :		82.5	115.9	0	NA	0.0	NA	0.0	0.0	0.0	0.0	NA	NA	0.0	0.0	NA
248	Cardiovascular disease deaths-Area/State Age-adjusted Rate	Vital Records 2007		214.4	192.3	158.9	215	212.5	248	222.2	146.5	225.5	217.3	194.8	150.9	161.8	231.4
249	Angina (Age-adjusted rate)		14.3	14.5	NA	NA	0	0	NA	NA	NA	17.1	12.6	19.2	NA	na	16.4
250	Diabetes Among Adults-Percent	Mass CHIP 2002-2007	6.50%	6.30%													
251	Diabetes % by Ethnicity																
252	White-Non Hispanic		6.30%	6.00%													
253	Black-Non Hispanic		13.90%	9.70%													
254	Hispanic		n/a	8.10%													
255	Asian-Non Hispanic	Mass CHIP 2002-2007	4.50%	3.50%													
256	Diabetes Mortality (Area/State Adjusted Rate)	Mass CHIP 2008															
257	Total		15.2	14.5													
258	Gender																
259	Male		19.4	18.7													
260	Female		12.9	11.6													
261	Race																
262	White Non-Hispanic		14.7	13.8													
263	Black Non-Hispanic		50.9	30.7													
264	Asian/Pacific Islander Non-Hispanic		8.9	10.4													
265	Hispanic		46.4	21.4													

NA

NA

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
266	Diabetes Related Inpatient Hospitalizations (Area/State Adjusted Rate)	2008 UHDDS															
267	Total		475.3	487.6													
268	Gender																
269	Male		625	610.7													
270	Female		371.9	404.7													
271	Race																
272	White Non-Hispanic		441.4	426.3													
273	Black Non-Hispanic		1626.7	1276													
274	Asian/Pacific Islander Non-Hispanic		334.5	268.6													
275	Hispanic		843.5	821.9													
276	Age																
277	0 to 9 yrs		68	97.4													
278	10 to 19 yrs		37.5	37.2													
279	20 to 24 yrs		128.6	105.8													
280	25 to 44 yrs		134.1	143.4													
281	45 to 64 yrs		398.3	445.1													
282	65 to 74 yrs		1747.8	1697.7													
283	75 or older		3554.2	3531.9													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
284	High Cholesterol % by Ethnicity																
285	White-Non Hispanic		39.20%	35.50%													
286	Black-Non Hispanic		21.60%	27.60%													
287	Hispanic		25.50%	33.10%													
288	Asian-Non Hispanic		7.90%	23.80%													
289	Heart Disease Among Adults (%)																
290	Overall		6.8	6.8													
291	Gender																
292	Male		8.9	8.4													
293	Female		4.9	5.3													
294	Age																
295	Ages 18-34		NA	0.8													
296	Ages 35-44		2.4	1.5													
297	Ages 45-54		2.5	3.7								NA					
298	Ages 55-64		5.7	9.1													
299	Ages 65+		19.2	20.1													
300	Race/Ethnicity																
301	White - Non Hispanic		7.3	6.9													
302	Black - Non Hispanic		4.7	5.8													
303	Hispanic		5.7	5.1													
304	Asian - Non Hispanic		N/A	2.9													
305	Education																
306	High School or Less		9	9.8													
307	Some College		8.5	6.3													
308	College or More		4.7	4.7													
309	Income																
310	< $50,000		10.6	10.7													
311	$50,000+		3.9	3.6													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
312	Overweight Based on Body Mass Index (BMI), by Race/Hispanic Ethnicity (Ages 18 and Over)-Percent				NA												
313	White-Non Hispanic		58.30%	57.10%													
314	Black-Non Hispanic		81.30%	68.70%													
315	Hispanic		NA	63.70%													
316	Asian-Non Hispanic	Mass CHIP 2002-2007	NA	35.10%													
317	Percentage of Adults Who Are Obese																
318	Race/Ethnicity																
319	White-Non Hispanic		17	19													
320	Black - Non Hispanic		**22.4**	**29.7**													
321	Hispanic		11.1	24.1													
322	Asian - Non Hispanic		8.8	5.5													
323																	
324																	

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
325	**Substance Abuse**																
326	Admissions to DPH funded treatment programs (Area/State Crude Rate)	2007 BSAS		1636.5	1307.3	684.3	471	740.6	1631.3	407.7	693.5	832.4	2060.6	1167.4	761.6	312.7	2135.6
327	Injection drug user admissions to DPH funded treatment program (Area/State Crude Rate)	2007 BSAS		504.3	543.7	218.8	NA	228.2	354.6	106.7	173.4	186.2	836.9	430.1	226.3	NA	964.5
328	Alcohol and other drug related hospital discharges (Area Crude Rate)	2007 BSAS	504.3	362	317.9	330.5	124.7	158.4	319.2	217.2	260.1	470.7	537.3	304.1	276	115.8	547.4
329	Used Alcohol in the past year (# of admissions)	2010 BSAS			247	59	28	80	109	106	50	183	1226	193	140	36	561
330	Used Marijuana in the past year (# of admissions)				90	28	N/A	21	37	47	16	71	380	49	52	22	213
331	Used Cocaine in the past year (# of admissions)				90	19	N/A	24	29	32	11	68	468	39	36	18	213
332	Used Crack in the past year (# of admissions)				41	14	N/A	N/A	12	N/A	N/A	36	281	39	13	N/A	85
333	Used Heroin in the past year (# of admissions)				241	52	18	50	81	62	22	164	1396	147	94	30	679
334	Used Injected Drugs in the past year (# of admissions)				227	41	14	48	80	62	22	139	1301	129	79	26	640
335	Alcohol Consumption: Binge Drinking, by Race/Hispanic Ethnicity (Ages 18 and over)- Percent				NA												
336	White-Non Hispanic	Mass CHIP 2002-2007	21.80%	18.7													
337	Black-Non Hispanic		NA	12.2													
338	Hispanic		NA	14.6													
339	Asian-Non Hispanic		NA	6.3													

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
340	**Mental Health**																
341	Mental Disorders: All Hospitalizations-Crude Rate	Mass CHIP 2008	1799.58	1873.29	1622.21	1038.12	720.34	852.36	2269.69	853.57	876.53	1636.72	2937.28	1425.42	1236.29	938.09	2144.92
342	Mental Disorders: All Hospitalizations: Age Adjusted Rate	Mass CHIP 2008	1852.11	1854.7	1744.4	1108.86	875.51	970.88	2242.91	900.79	1136.05	1764.97	2883.26	1431.92	1398.78	1262.63	2260.82
343	Suicide (Area/State Crude Rate)	2007 Vital Records	8.6	7.8	8.9	9.3	13.9	9.3	17.7	0	0	7	12.2	3.1	16.6	11.6	5.6