MOUNT AUBURN
HOSPITAL

Community Health Needs Assessment
July 2012

Mount Auburn Hospital (MAH) addresses the broad health issues in the community and provides community residents with a wide range of services consistent with our community health mission statement:

Mount Auburn Hospital is committed to improving the health and wellbeing of community members by collaborating with community partners to reduce barriers to health, increase prevention and/or self management of chronic disease and increase the early detection of illness.

The current Community Health Plan has been developed in response to both the Massachusetts Attorney General's and Federal guidelines. A formal community needs assessment was last conducted from May 2009-September 2009 (Appendix 1) and was shared broadly with community organizations and individual members. This current assessment incorporates a review of:

- Population data
- Health indicators
- Current community benefit programming at Mount Auburn Hospital
- Health Services in the area
- Input from Community Members and Public Health Departments

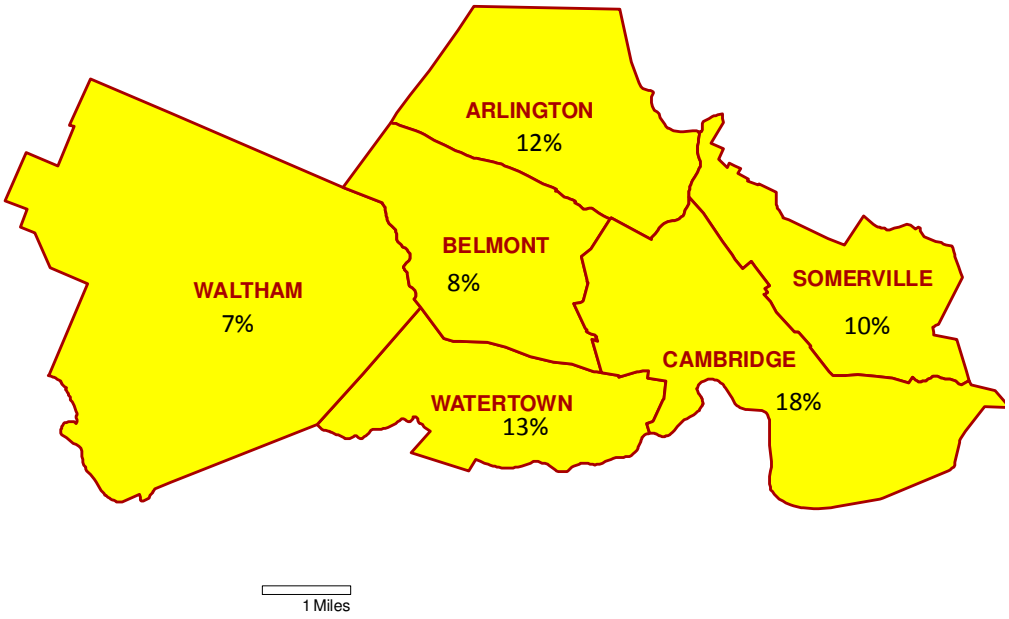
Pertinent assessment material was reviewed with community members including those affiliated with public health departments, community based organizations and with Community Health Network Areas (CHNA) with a focus on the steering committees of CHNAs 7, 15, 17, 18, and 20 as well as the those members who are part of the CHNA17 which serves Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown.

Priorities for the Community Benefit plan were developed by reviewing the current programs and resources, information obtained from the Community Needs Assessment, input from CHNA steering committees and CHNA17 membership and considering the Attorney General's recommended state wide priorities. Recognizing that community benefit planning is ongoing and will change with continued community input the Mount Auburn Hospital Community Benefit plan will evolve. Senior Management and the Board of Trustees are committed to assessing information and updates as needed.

Communities Served By Mount Auburn Hospital

Mount Auburn Hospital Community Benefits are aimed at serving community members who live Arlington, Belmont, Cambridge, Waltham, Watertown and Somerville, community members served by Joseph M. Community Health Center and Community Health Network Areas (CHNA) 7,15, 17, 18 and 20.

This decision was made by reviewing MAH primary discharge data, the needs of the Community Health Network Areas and the needs of the closest federally qualified community health center-Joseph M. Smith Community Health Center (JMSCHC). Towns that represented more than 5% of Mount Auburn Hospital discharges are included an depicted below.

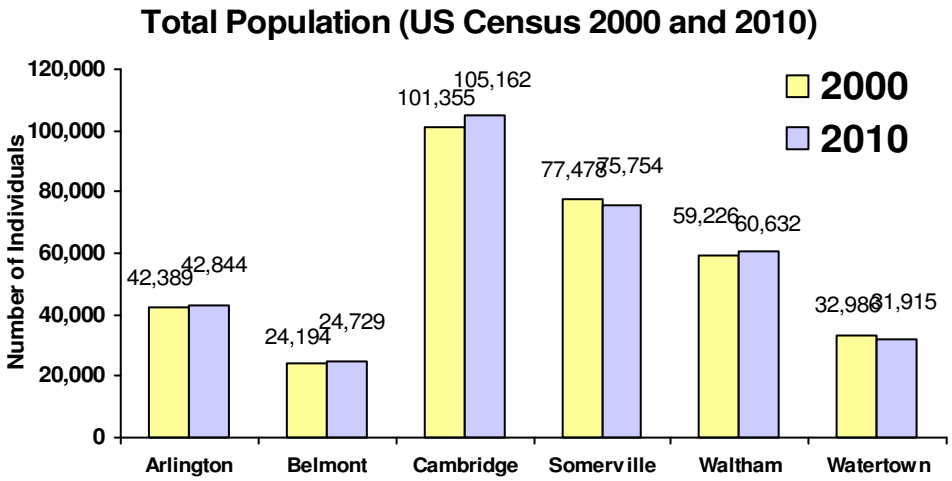


Data

In collaboration with its partner, the Institute of Community Health, MAH has reviewed pertinent demographic and health data which includes recently available 2010 census data.

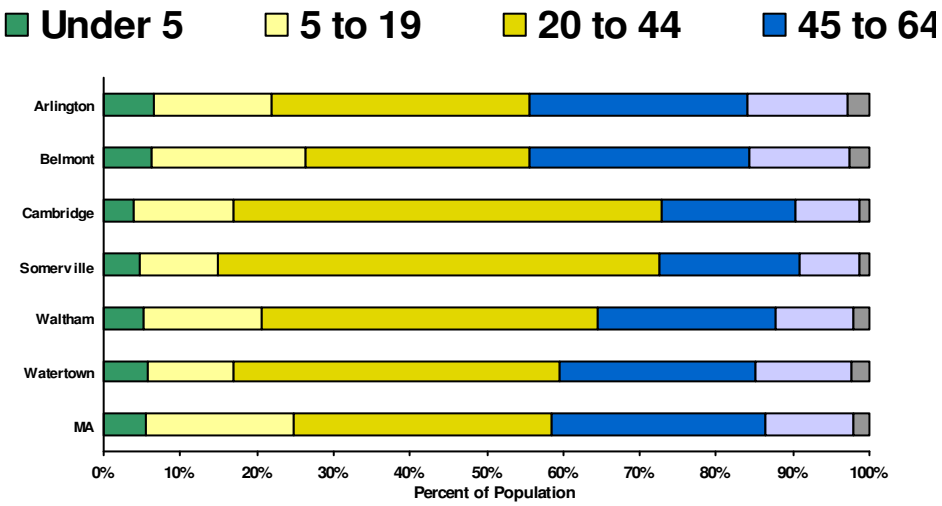
Data: Demographics

A review of recently released 2010 census data revealed relatively little change in **overall census** for these towns. The total population increased 1% from 337,608 in 2000 to 341,036 in 2010.



There were some changes in **Age Distribution**. The greatest change these towns are as follows:

- Arlington (-6.2) and Belmont (-4.8) was a decrease in 20 to 44 year olds compared to the state average of (-4.0).
- Cambridge (-2.3) and Somerville (-3.2) both had decreased in 5-19 year olds compared to state (-.9).
- Waltham (+3.0) and Watertown (+5.6) both had increases in 45-64% compared to state (+5.3)-largest change for the state.



All towns shifted toward **more diverse multiracial populations** (except Somerville) and had an increase in their **Asian** population between 2000 and 2010

- Arlington had an increase in their Asian population mainly among Chinese and Asian Indian groups

- Belmont had an increase in their Asian mainly among Chinese and Korean populations
- Cambridge had an increase in their Asian population, mainly among Chinese, Asian Indian, and other Asian groups
- Somerville saw an increase in their Asian population (up 2.3% to 8.7%) mainly among Chinese, Asian Indian, and other Asian groups
- Waltham had increases in both their Asian (up 2.4% to 9.7%) and Hispanic populations (up 5.2% to 13.7%) mainly among Asian Indian and Chinese
- Watertown saw an increase in their Asian population (up 3.3% to 7.2%) mainly among Chinese, Asian Indian, and other Asian groups

	Arlington		Belmont		Cambridge		MA	
	2010	Δ From 2000	2010	Δ From 2000	2010	Δ From 2000	2010	Δ From 2000
White, %	85.7	-5.3	83.5	-7.7	66.6	-1.5	80.4	-4.1
Black, %	2.4	+0.7	1.8	+0.7	11.7	-0.2	6.6	+1.2
AI/AN, %	0.1	0.0	0.1	0.0	0.2	-0.1	0.3	+0.1
Asian, %	8.3	+3.3	11.1	+5.3	15.1	+3.2	5.3	+1.5
NH/PI, %	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.0
Multiracial, %	2.5	+0.9	2.7	+1.3	4.3	-0.3	2.6	+0.3
Hispanic (of any race), %	3.3	+1.4	3.0	+1.2	7.6	+0.2	9.6	+2.8

	Somerville		Waltham		Watertown		MA	
	2010	Δ From 2000	2010	Δ From 2000	2010	Δ From 2000	2010	Δ From 2000
White, %	73.9	-3.1	75.4	-7.6	84.9	-6.5	80.4	-4.1
Black, %	6.8	+0.3	6.0	+1.6	3.0	+1.3	6.6	+1.2
AI/AN, %	0.3	+0.1	0.2	0.0	0.1	-0.1	0.3	+0.1
Asian, %	8.7	+2.3	9.7	+2.4	7.2	+3.3	5.3	+1.5
NH/PI, %	0.0	-0.1	0.1	0.0	0.0	0.0	0.0	0.0
Multiracial, %	3.6	-1.2	2.5	+0.6	2.7	+0.8	2.6	+0.3
Hispanic (of any race), %	10.6	+1.8	13.7	+5.2	5.3	+2.6	9.6	+2.8

According to the American Community Survey 2009, MAH towns average 73.16% of those ages 5 and above who **only speak English at home**. Arlington is the only town with higher than the state average.

	State	MAH Town Average	Watertown	Waltham	Arlington	Belmont	Cambridge	Somerville
Language at Home English Only	79.60%	73.16%	73.20%	70%	**82%**	75.90%	69.50%	67.30%

Four out of six of MAH's towns have a higher percentage of high school graduates than the state while all six towns have a higher percentage of bachelor's degrees.

	State	MAH Town Average	Watertown	Waltham	Arlington	Belmont	Cambridge	Somerville
% High School grad or higher (25 y.o +)	88.40%	**93.07%**	**92.00%**	88.00%	**95%**	**96.3%**	**94.50%**	87.90%
% Bachelors degree or higher (25 y.o +)	37.80%	60.54%	**53.00%**	**42.40%**	**61%**	**68.00%**	**71.40%**	**50.50%**

From the American Community Survey (2009) the Median Household Income in 2009 ranged from Somerville $62,575 to Belmont $95,377 with all except Somerville above the national median of $62,363. With the exception of Somerville (10%) all towns have a percentage of families below the poverty level less than the average of 9.9%. For individuals below the poverty level both Cambridge (15%) and Somerville (14.9%) are above the national percentage of 13.5%. Otherwise all towns are below that rate with Belmont at the lowest (3.1%).

	National	MAH Town Average	Watertown	Waltham	Arlington	Belmont	Cambridge	Somerville
Median Household Income 2009	$62,363	$80,400	$71,377	$81,733	$83,740	$95,377	$87,595	$62,575
Families below poverty level	9.90%	5.58%	3.50%	6.20%	2.50%	2.20%	9.10%	10.00%
Individuals below poverty level	13.50%	9.28%	6.30%	11.90%	4.50%	3.10%	15.00%	14.90%

Data: Health Indicators

A review of public health data for MAH community benefit towns was done in collaboration with the Institute of Community Health. Health indicators were Substance Abuse, Mental Health, Sexual Health, Diabetes, Cardiovascular Disease and Cancer, and Maternal Child Health. Data sources reviewed included:

- Bureau of Health Information, Statistics, Research, and Evaluation, Division of Research and Epidemiology, "Massachusetts Births 2009", MDPH
- Bureau of Substance Abuse Services (BSAS), Substance Abuse Treatment Programs, MDPH
- Epidemiology Program, Bureau of Communicable Disease Control Registries, MDPH
- HIV/AIDS Surveillance Program, Bureau of Communicable Disease Control Registries, MDPH
- Massachusetts Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System
- Registry of Vital Records and Statistics, Bureau of Health Information, Statistics, Research and Evaluation, MDPH (MassChip)
- Sexually Transmitted Disease Program, Bureau of Communicable Disease Control Registries, MDPH
- US Census Bureau, Decennial Census 2000 & 2010

A summary of data follows. For each chart:

- **Bold-underlined** indicates rate/percent/count is statistically significantly "**worse"** than State
- **Bold** indicates rate/percent/count is statistically significantly '**better**' than State
- Regular **(font)** indicates rate/percent/count is '**not statistically different**' from the State.
- 'Worse' can mean higher or lower depending upon the indicator.
- 'NA' means cell suppressed as number of cases is too small to calculate reliable results.

Substance Abuse

- Hospitalizations and ED visits due to alcohol and substance abuse are higher than the state in Cambridge
- Opioids, specifically a problem in Somerville

- However, rates of admission to state funded treatment programs are not generally higher than the state

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Alcohol/Substance related hospitalizations (2009); age-adjusted rate per 100,000	**264.3**	**156.7**	**396.5**	357.0	368.3	312.3	331.0
Alcohol/Substance related ED visits (2008); age-adjusted rate per 100,000	**579.7**	**502.9**	**1,560.1**	829.3	758.3	**355.3**	579.7
Opioid-related fatal overdose (2006-2008); age-adjusted rate per 100,000	7.6	**1.6**	**4.8**	7.5	8.7	8.6	9.4
Opioid-related ED visits (2008); age-adjusted rate per 100,000	139.8	130.4	115.8	**250.1**	126.7	83.5	212.2

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
MDPH-funded Substance Abuse Treatment Admissions. all ages (2010); rate per 100,000	**540.3**	**383.7**	**700.3**	**1,145.0**	**695.1**	**787.5**	1,589.9
MDPH-funded Substance Abuse Treatment Admissions, age 15-19 yrs (2010); age-specific rate per 100,000	739.0	891.0	**205.7**	**672.8**	**320.8**	NA	1,043.5
MDPH-funded Substance Abuse Treatment Admissions, age 20-24 yrs (2010); age-specific rate per 100,000	4,655.4	3,843.2	**518.6**	**1,792.3**	**976.4**	**2,688.4**	4,008.5

Maternal/Child Health

- Teen birth rate is lower than the state in all these communities
- Adequacy of prenatal care is generally as good or better than the state
- Low birth they weight is similar to the state rate among most communities

- Waltham has a higher rate and Belmont has a lower rate than the state
- C-section delivery rates are similar or lower than the state rate among all communities
- All communities have less than 1,000 infants and children participating in WIC (except Cambridge and Somerville)

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Births to Teens age 15-19 yrs (2008-2009); Rate per 1,000	**5.7**	**4.1**	**4.8**	16.8	**12.2**	**8.3**	19.8
Adequate Prenatal Care, 15-19 yrs (2008-2009); Percent of total births	55.6	NA	75.7	68.1	79.0	83.3	72.2
Adequate Prenatal Care, all ages (2009); Percent of total births	**91.3**	**89.0**	**86.7**	85.5	85.0	85.7	84.3
Low Birth Weight <2500 grams (2008); % of births	8.1	**3.9**	8.1	8.3	**10.1**	6.8	7.8
Cesarean Delivery, primary or repeat (2008); % of births	32.4	29.8	**26.7**	**29.6**	33.1	37.6	33.7
WIC participants, infants and children (2007); count	154	68	1,076	1,265	705	232	100,224

Sexual Health

- Chlamydia incidence was lower than the state in all communities over all ages, including teens, except Somerville, which has similar rates to the state overall and among teens.

- HIV/AIDS prevalence is higher than the state in Somerville, Cambridge, and Waltham. This prevalence is similar or lower than the state in the other communities
- Hepatitis C incidence is lower than the state among these communities

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Chlamydia Incidence (2010); rate per 100,000	**82.4**	**85.3**	**271.8**	311.8	**213.2**	**111.6**	322.1
Chlamydia Incidence age 15-19 yrs (2010); age specific rate per 1,000	**492.7**	NA	**912.6**	1020.9	**513.3**	**396.0**	1,310.9
HIV/AIDS Incidence (2009); rate per 100,000	NA	NA	NA	NA	NA	NA	NA
HIV/AIDS Prevalence (2009); rate per 100,000	**126.0**	**89.5**	**394.0**	**421.9**	**320.7**	223.2	261.0
Hepatitis C Incidence (2009); rate per 100,000	**36.3**	NA	57.1	**46.4**	**16.8**	**34.1**	68.0

Mental Health

- Mortality due to mental disorders is similar or lower than the state

- Hospitalizations due to mental disorders are higher in Cambridge, Somerville, and Waltham
- ED visits due to mental disorders are higher in Cambridge and Somerville
- Mortality due to suicide is similar to the state in all communities

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Mental Disorder Mortality (2006-2008); age-adjusted rate per 100,000	32.8	32.4	**28.4**	34.1	**26.6**	**21.9**	36.7
Mental-disorder hospitalizations (2009); age-adjusted rate per 100,000	763.9	**480.5**	**1,005.0**	**955.8**	**964.5**	710.7	786.5
Mental-disorder ED visits (2008); age-adjusted rate per 100,000	2,017.9	**1,063.1**	**2,600.7**	**2,119.2**	**1,511.6**	**1,160.8**	1,854.7
Suicide Mortality (2006-2008); age-adjusted rate per 100,000	5.6	8.3	7.9	8.2	7.2	6.6	7.1

Diabetes

- Mortality due to diabetes is similar to the state in all communities, except Belmont which has a lower mortality rate than the state
- Diabetes-related hospitalizations however, is higher in Somerville
- Diabetes-related ED visits are similar or lower than the state in all communities

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Diabetes Mortality (2006-2008); age-adjusted rate per 100,000	10.4	**7.5**	17.8	17.4	12.2	11.7	15.4
Diabetes-related hospitalizations (2009); age-adjusted rate per 100,000	**1,317.3**	**950.7**	**1,735.8**	**2,088.3**	**1,698.6**	**1,379.1**	1,968.8
Diabetes-related ED visits (2008); age-adjusted rate per 100,000	**497.3**	**224.0**	**552.5**	**963.8**	**827.3**	**406.0**	1,228.1

Cardiovascular disease-Overall, indicators are similar to the state or lower among all these communities

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
All Circulatory Disease Mortality (2006-2008); age-adjusted rate per 100,000	**172.9**	**160.1**	**177.3**	**186.9**	**187.9**	**165.1**	216.0
All Circulatory Disease Hospitalizations (2009); age-adjusted rate per 100,000	**1,264.6**	**1,103.2**	**1,262.9**	**1,338.7**	**1,254.4**	**1,222.0**	1,502.1
Coronary Heart Disease Mortality (2006-2008); age-adjusted rate per 100,000	**130.0**	**117.7**	**131.1**	**146.6**	**142.6**	**126.4**	164.9
Coronary Heart Disease Hospitalizations (2009); age-adjusted rate per 100,000	**852.4**	**762.6**	**834.2**	**889.8**	**852.7**	**811.8**	1,027.6
Stroke Mortality (2006-2008); age-adjusted rate per 100,000	29.0	36.7	29.1	28.6	37.0	33.2	35.0
Stroke Hospitalizations (2009); age-adjusted rate per 100,000	**183.2**	**152.2**	214.8	202.8	216.0	**176.7**	228.9

Hypertension-Hospitalizations and ED visits related to hypertension are lower than the state among all these communities

Renal failure disorders-Hospitalizations related to renal failure disorders are lower than the state in all these communities

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Hypertension-related hospitalizations (2009); age-adjusted rate per 100,000	**3,293.9**	**2,818.8**	**3,766.3**	**3,866.7**	**3,947.0**	**3,545.1**	4,303.2
Hypertension-related ED visits (2008); age-adjusted rate per 100,000	**1,216.8**	**503.0**	**862.2**	**1,805.0**	**1,822.2**	**891.9**	2,414.5
Renal Failure/Disorder-related Hospitalizations (2009); age-adjusted rate per 100,000	**920.1**	**754.0**	**1,211.1**	**1,326.8**	**1,264.2**	**994.9**	1,465.9

Cancer

- Incidence and mortality due to breast cancer are similar to the state for all communities except in Cambridge
    - Cambridge has lower incidence of breast cancer than the state
- Incidence and mortality due to prostate cancer are similar to the state for all communities with except in Arlington
    - Arlington has lower prostate cancer incidence than the state

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Breast Cancer Mortality (2006-2008); age-adjusted rate per 100,000	19.0	23.9	19.1	19.0	19.0	29.8	21.5
Breast Cancer Incidence (2007); age-adjusted rate per 100,000	129.4	129.0	**99.7**	100.0	127.6	123.4	133.4
Prostate Cancer Mortality (2006-2008); age-adjusted rate per 100,000	32.2	19.5	29.5	26.1	17.6	25.0	23.4
Prostate Cancer Incidence (2007); age-adjusted rate per 100,000	**95.7**	219.2	209.0	123.9	138.2	181.7	168.7

- **Colorectal cancer incidence and mortality is similar to the state in all communities with the exception of Waltham**
    - **Waltham has lower colorectal cancer incidence and colorectal cancer mortality than the state**
- **Lung cancer incidence and mortality is similar to the state with exception of Belmont and Cambridge**
    - **Lung cancer mortality in Belmont and Cambridge is significantly lower than the state**

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	MA
Colorectal Cancer Mortality (2006-2008); age-adjusted rate per 100,000	14.5	12.0	14.0	18.2	**9.9**	10.2	16.1
Colorectal Cancer Incidence (2007); age-adjusted rate per 100,000	47.9	35.6	38.5	43.7	**29.2**	40.7	45.3
Lung Cancer Mortality (2006-2008); age-adjusted rate per 100,000	42.1	**26.1**	**36.6**	52.7	49.8	42.3	50.9
Lung Cancer Incidence (2007); age-adjusted rate per 100,000	69.0	55.7	54.6	86.7	80.9	54.3	69.8

MAH Community Health staff surveyed providers of services to the homeless about need including health education topics. The following chart illustrates the ranking of priorities set by these organizations.

Directors of Homeless Shelter Survey	
1st	Heart health
	Diabetes
	Healthy eating/nutrition
2nd	High blood pressure
	Sun safety/skin cancer
3rd	General women's health
	General men's health
	Lung cancer
	Flu/H1N1
4th	Breast cancer
	Cervical cancer
	Colorectal cancer
	Prostate cancer
	Smoking cessation
	Stroke
5th	Testicular cancer

Data:
MAH Internal

As part of this assessment MAH has reviewed the following internal data:

Readmission Rate: A review of the hospital's data reveals that MAH has an overall readmissions' rate of 16.2%, which is lower than the national average of 20%. However, for congestive heart failure (CHF) and acute myocardial infarctions (AMI), MAH ranks in the fourth quartile for readmission, with rates of 27.9%, and 25.9%, respectively. An extensive root cause analysis using the STAAR and Institute for Healthcare Improvement Tool revealed three main categories of causes for readmissions: patient-level causes, system-level causes, and disease-specific causes. Patient level causes include patients who have low activation in acting in regards to their health status. For various reasons, they lack the ability to advocate for their own needs due to mental or physical debilitations; they also lack social systems to support their health needs. These patients are generally chronic disease patients with complex needs. System level causes include issues such as poor discharge planning, inadequate or confusing information, a lack of support outside of the hospital, and inaccurate or conflicting information. Condition specific causes include disease states such as congestive heart failure, renal failure, or chronic obstructive pulmonary disease which often require close monitoring and adequate medical support outside of the hospital setting in order to prevent readmission. This category would also include patients with much co-morbidity who require extensive and highly problematic medications, contributing to high-risk for readmission and patients requiring end of life care. Condition-specific readmissions generally relate to less than adequate clinical case management after discharge. MAH reached out to colleagues at Cambridge Health Alliance, and the local Aging Service Access Points: Springwell, Somerville-Cambridge and Minuteman Elder services to better understand the need for Community Based interventions to reduce avoidable readmissions.

Top ED diagnosis for 2009 and 2010: The chart below lists the top 20 ED diagnosis for 2009 and 2010. The diagnoses that correlate to the health indicators reviewed are:

1) Alcohol Abuse, which appears in the top 10 for both years
2) Depressive Disorder which is #14 in 2009 and not in the top 20 in 2010
3) Asthma, a commonly evaluated ED diagnosis is not seen in the top 20 diagnoses for either year

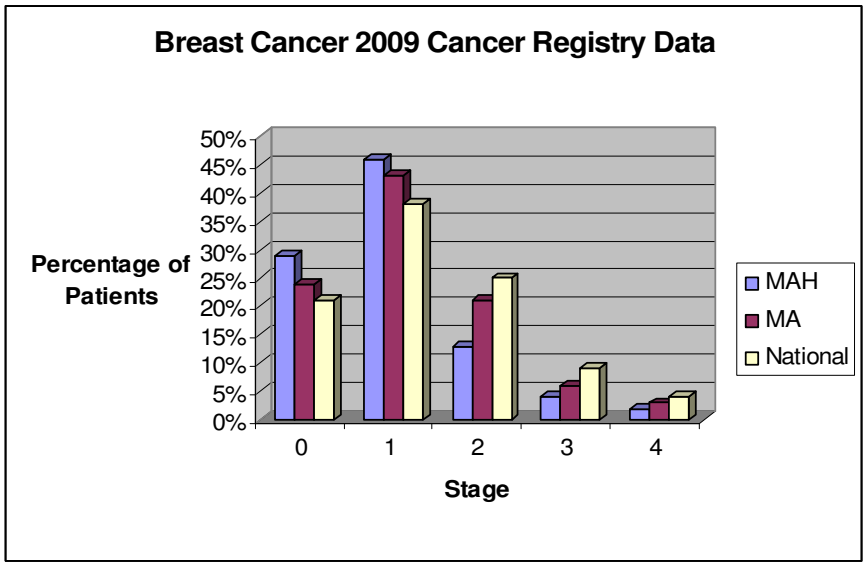
	2009	2010
1	Open Wound of Finger	Open Wound of Finger
2	Chest Pain NOS	Abdominal Pain, Unspecified Site
3	Abdominal Pain, Unspecified Site	Head Injury, NOS
4	Sprain of Neck	Chest Pain NOS
5	Urinary Tract Infection NOS	Headache
6	Headache	Alcohol Abuse-Unspec
7	Head Injury, NOS	Lower Leg Injury NOS
8	Alcohol Abuse-Unspec	Sprain of Neck
9	Backache NOS	Urinary Tract Infection NOS
10	Abdominal Pain, Other Specified Site	Dizziness and Giddiness
11	Acute URI NOS	Lumbago
12	Sprain of Ankle NOS	Pain in Limb
13	Lower Leg Injury NOS	Syncope and Collapse
14	Depressive Disorder NEC	Nausea with Vomiting
15	Calculus of Kidney	Open Wound of Forehead
16	Syncope and Collapse	Acute URI NOS
17	Diarrhea	Open Wound of Hand
18	Pain in Limb	Acute Pharyngitis
19	Viral Diseases NEC	Sprain of Ankle NOS
20	Pneumonia, Organism NOS	Viral Infection NOS

Race, Ethnicity, Languages Spoke MAH service area is rich with culture and diversity. MAH registration data reveals that our patients self report over 170 ethnicities. A review of ED registration data reveals that Spanish is the most commonly requested language for our Limited English Proficient patients. The chart below is a review of First Language Not English, MAH Registration and Interpreter Department Data.

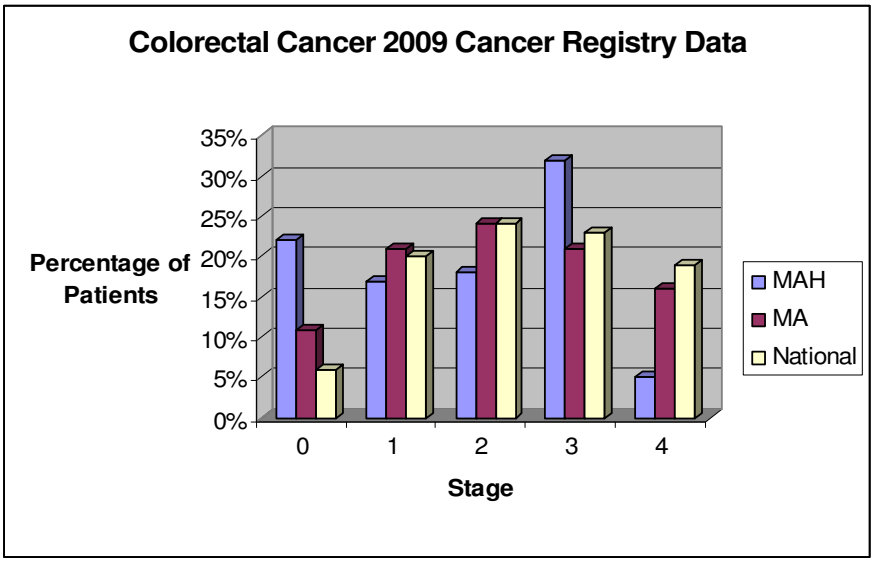
Languages		ALL Interpreter Encounters (F2F, phone) 2011 data		MAH Registration Data (not individual patients) 2011 data		2010 FLNE Data MAH towns (Arlington, Belmont, Cambridge, Lexington, Somerville, Waltham and Watertown)	
		% of total Interpreter Encounters	#	% of total registrations	#	% of total students enrolled	#
Full Time	**Spanish**	28.00%	3027	1.110%	3902	2.50%	835
	Armenian	15.90%	1717	0.270%	968	0.14%	49
	Portuguese	15.30%	1657	0.367%	1284	0.83%	276
	Russian	8.83%	952	0.096%	336	0.16%	52
Per Diem	**Korean**	14.15%	1525	0.148%	519	0.41%	140
	Haitian Creole	3.39%	366	0.127%	445	0.55%	183
	Mandarin	4.60%	506	0.122%	430	0.08%	28
Telephonic	Chinese	0.01%	1	0.045%	163	0.45%	151
	Cantonese	0.58%	63	0.018%	64	see Chinese	18
	Greek	1.70%	191	0.103%	362	0.02%	9
	Turkish	0.79%	86	0.050%	205	0.03%	11
	Farsi	0.62%	67	0.000%	28	0.02%	7
	Vietnamese	0.62%	67	0.000%	79	0.90%	11
	Japanese	0.14%	146	0.035%	123	0.24%	80
	Punjabi	0.07%	8	0.000%	31	0.10%	33
	Cape Verdean	0.01%	2	0.000%	3	1%	15
	Other	5.00%		0.50%	1468	7%	2313
	English	N/A	N/A	97%	339409		

Cancer Registry Data As part of this assessment the Cancer Registry data was also reviewed by the Cancer Management Committee. The committee choose to look at breast and colorectal data, because of the possible opportunities for community education regarding screening.

Breast Cancer-MAH has higher than state and national percentages of earlier stage breast cancers-Stages 0 and 1 and lower than state and national percentages of later stage breast cancers-Stages 2, 3 and 4.



Colorectal Cancer-The results for colorectal cancer are mixed. MAH has a significantly higher percentage of the earliest-Stage 0-cancers-usually detected by screening modalities and a significantly lower percentage of the latest-Stage 4 cancers. Further investigation is being conducted by the Cancer Management committee to better understand the patients represented in the Stage 3 cohort and any potential clinical or community based implications.



MAH current CB Programs Discussion with community members, MAH staff and the MAH Patient and Family Advisory Council resulted in changes to the current community benefit plan. In each case the following questions were asked:

- Is the program meeting its goals?
- Do community Members, community based organizations continue to see this as a benefit?
- Are the resources still available to continue the program?

Program	Description	Plan
Regional Center for Healthy Communities	MAH has secured Bureau of Substance Abuse funding (most recent 2007) to provide services to the Metrowest region through the Regional Center for Healthy Communities to address health promotion and prevention concerns. Specific programs are aimed at reducing alcohol, tobacco and other drug use.	Continue with CHNA support as the Bureau of Substance Abuse no longer funds this program. Work with Waltham Partnership for Youth to apply for Drug Free Communities Grant.
Bridge to Healthcare	Bridge is targeted to uninsured/underinsured and LEP residents. Materials and presentations are translated into other languages. Health education topics are Coordinated with ESOL program directors.	Continue
Waltham Wellness	The Waltham Wellness program fills a vital role for the health and well-being of students in the Waltham community. By working with school food personnel and others strategies are aimed to increase availability and accessibility of healthy food option in Waltham schools. Ultimate goals are to improve nutrition and exercise among Waltham youth to prevent illness.	Discontinue as program has concluded
Promoting Health of the Homeless	Brings basic health education to the homeless. These encounters foster relationships with health care providers and improve health seeking behaviors.	Continue
Addressing Hunger	In an effort to address hunger this program conducts food drives and provides opportunities for SNAP enrollment to improve nutritional status in vulnerable populations.	Continue
Medical House Calls to homebound seniors	In response to a working group consisting of homecare providers, home bound elders and their families, and geriatricians; this program	Continue

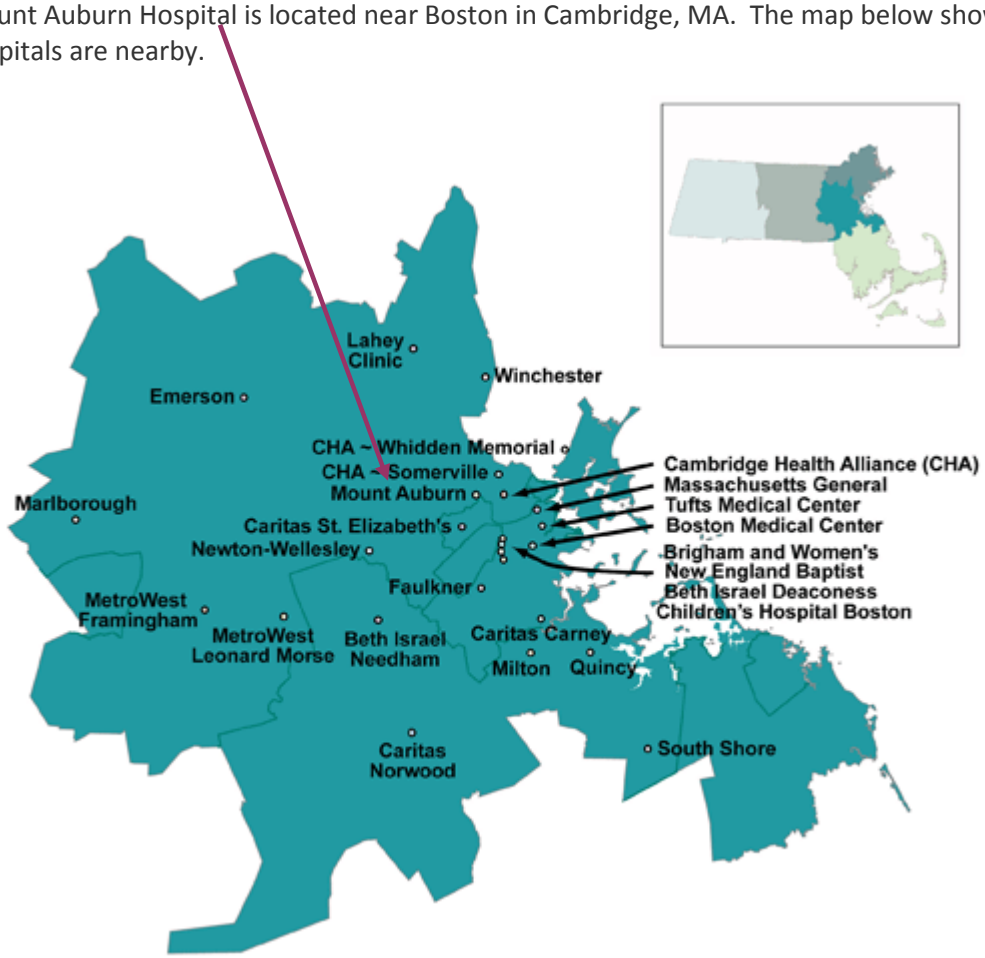
	addresses barriers to health care by taking geriatricians out of the office to care for vulnerable elders in their own homes.	
Lack of Transportation	Explores ways to address transportation when it is a barrier to medical care.	Continue
Midwifery Program at Joseph M. Smith Community Health Center	This program improves birth outcomes by improving access to peri-natal care.	Continue
Financial Counselors at Joseph M. Smith Community Health Center	Provides financial counselors to augment health care center staff.	Continue
Men's Urological Health	Provides urological health services to men who otherwise would not have access to these services.	Continue
Community Health Network Area 17	MAH staff works closely with the CHNA 17 to promote the provision of primary and preventative health care services for underserved populations in the CHNA's service area.	Continue
Listen and Learn: Breast Health	To identify and understand cultural barriers to breast cancer screening, create and support a Learning Community comprised of immigrant women and oncology nurses, community health care workers, and social workers to learn together about beliefs and barriers to breast cancer screening among immigrants.	Continue
Elder Cardiovascular Health	In this program MAH nurses reach out to elders in the community for blood pressure screenings and education.	Continue
Tobacco Free Peer Leader Development-A Social Norms Approach	Mount Auburn Hospital works closely with the Arlington Enrichment Collaborative (AEC) and the Arlington Youth Health and Safety Coalition (AYHSC) to bring tobacco awareness as well as educational tools and materials to develop middle school peer leader educators, building essential steps in developing an ongoing tobacco-free social norm for middle school students.	Continue

Safe Beds	In partnership with the local Police Departments Mount Auburn Hospital provides temporary "Safe Beds" for victims of domestic violence. The expenses associated with this program are in-kind by MAH.	Continue
Emergency Response Systems to Underserved Elders and Disabled Adults	This program provides personal emergency response services (Lifeline) to underserved elders and disabled adults.	Continue
Listen and Learn: Stroke	Following the Listen and Learn model, this program aims to better understand barriers to emergent care for elders at risk for stroke.	Continue
Listen and Learn: Type 2 Diabetes	Following the Listen and Learn model, this program aims to better understand barriers to Type 2 Diabetes prevention among underserved community members.	Continue
Smoking Cessation	This free program provides Smoking Cessation education to those in need of quitting	Continue and add goal to become Tobacco Free Campus in Cambridge.
Matter of Balance-Fall Prevention Program	To improve the health of seniors, Mount Auburn Hospital offers this evidenced based program to senior community members at risk for falls.	Continue
Salvation Army Support	MAH staff provides support to Salvation Army initiatives.	Continue
Social Worker Support for Watertown Community Members	MAH Social Workers meets regularly with Watertown DPH and Social Worker to provide optimum communication about the needs of Watertown Community Members.	Continue
Support for Community Members with Cancer	This program works with cancer patients to create a sense of support, confidence, courage, and community among cancer patients.	Continue
In Kind space for local Alcohol Support Groups	Provide handicapped accessible space for AA and SMART recovery programs to meet.	Continue

Overdose Prevention Program	Work with OPEN to increase communication with MAH providers in particular with ED providers and Community members at risk for overdose.	Continue
Community Based Medication Management	Medication Management for seniors is a concern consistently expressed in the community needs assessment. In an effort to reduce medication errors for elders, this program worked with community leaders and hospital staff to plan interventions which include community education and outreach.	Discontinue as volume has been low and community based organizations do not see benefit.
Community Education Forums	These forums provide health education to community members.	Continue

Existing health care facilities and resources within the community

Mount Auburn Hospital is located near Boston in Cambridge, MA. The map below shows that many hospitals are nearby.



Cambridge Health Alliance (CHA) is also located in Cambridge, MA. As a public hospital; Cambridge Health Alliance (CHA) provides a wide range of clinical services with a special focus on primary care, community wellness and prevention. In addition to its strong primary care network, CHA has an array of specialty services, innovative planned care programs for chronic disease, behavioral health services, and an emergency department. The system also has highly integrated personal and population health functions. CHA operates the Public Health Department for the City of Cambridge and has a large community outreach team. Its public and community health staff work closely with clinicians, municipalities, and community groups to address issues like breast health, obesity, and depression.

The chart below compares the services at Mount Auburn Hospital and Cambridge Health Alliance.

Hospital Services	CHA	MAH	Hospital Services	CHA	MAH
Addictions	X	X	Mental Health	X	X
Addictions — Adolescent/Child	X		Mental Health — Adolescent/Child	X	
Allergy		X	Neurology	X	X
Arthritis Treatment	X	X	Nuclear Medicine	X	X
Audiology	X	X	Obstetrics/Gynecology	X	X
Cancer — Oncology	X	X	Occupational Health	X	X
Medical Oncology	X	X	Ophthalmology — Optometry	X	X
Radiation Oncology		X	Orthopedic Medicine	X	X
Cardiology	X	X	Pain Management	X	X
Cardiac Catherization		X	Pediatric Medicine	X	
Dentistry	X		Pharmacy	X	X
Dermatology/Skin Care	X	X	Physician Office	X	X
Diagnostic Imaging	X	X	Podiatry	X	X
Diagnostic Tests	X	X	Pulmonary Medicine	X	X
Dialysis	X	X	Rehabilitation and Physical Medicine	X	X
Ear/Nose/Throat Disease	X	X	Respiratory Care	X	X
Emergency Department	X	X	Sleep Studies		X
Endoscopy	X	X	Stomach/Intestinal Treatment	X	X
Family Practice	X	X	Surgery — Cardiac		X
General Inpatient	X	X	Surgery — General	X	X
General Outpatient	X	X	Surgery — Neurosurgery		X
Glands/Hormone Disorders	X	X	Surgery — Oral Maxillofacial	X	X
Hematology		X	Surgery — Orthopedic	X	X
Home Health Care		X	Surgery — Plastic	X	X
Infectious Diseases	X	X	Surgery — Podiatric	X	X
Infusion Therapy	X	X	Surgery — Thoracic	X	X
Intensive Care	X	X	Telehealth	X	X
Internal Medicine	X	X	Telemetry	X	X
Kidney Disease		X	Urology	X	X
Kidney/Gall Stone Treatment	X	X	Vascular Medicine	X	X
Mental Health	X	X	Women's Health	X	X
http://www.mass.gov/eohhs/consumer/physical-health-treatment/quality-cost/data/hospitals/services					

The closest Federally Qualified Community Health Center is Joseph M. Smith Community Health Center (JMSCHC) with locations in both Waltham and Alston, MA. JMSCHC provides the highest quality, comprehensive, culturally-competent and affordable primary health care services and selected specialties to families and individuals in Allston, Brighton, Waltham and surrounding communities. Specialties include vision, mental health services and a patient pharmacy. This health care is provided to children and adults, the insured and uninsured, the employed and unemployed, and to all who dwell within our communities, including long- and short-term residents and recently arrived immigrants.

MAH works with JMSCHC to support care for underserved community members. A review of 2011 data reveals the following profile of JMSCHC patients.

- 52.4% require Interpreter services
- 62.4% are $\leq$ 100% of Federal Poverty Level

- 94% are < 200% of Federal Poverty Level 94%
- 48.5% are uninsured
- 37.6% have Mass Health or public insurance
- 3.1% have Medicare
- 10.8% have private insurance
- 58.5% self-identify as Hispanic
- 8.5% self-identify as Asian
- 8.3% self-identify as Black
- 20% self-identify as White, Non-Hispanic

In particular JMSCHC staff expressed concern over the long wait, 6-8 months for urology appointments at other institutions.

The area surrounding MAH is rich with resources. Over 1100 Community Based Organizations are listed in the Cambridge Somerville Resource Guide (see Appendix II). These organizations provide a wide range of services to community members in Mount Auburn Hospital's catchment area. Mount Auburn Hospital has partnered with many of these community based organizations to improve the health of community members. These partnerships are outlined in the Implementation Plan.

ASSESSMENT COLLABORATION WITH LOCAL COMMUNITY HEALTH NETWORK AREAS

A Community Health Network is a local coalition of public, non-profit, and private sector organizations working together to build healthier communities in Massachusetts through community-based prevention planning and health promotion. The Massachusetts Department of Public Health established the Community Health Network Area (CHNA) effort in 1992. Today this initiative involves all 351 towns and cities through 27 Community Health Networks. (www.mass.gov)

Mount Auburn Hospital's Regional Center for Healthy Communities (MAHRCHC) staff works directly with Community Health Network Areas to help communities realize their vision for a healthier place to live. The Center does this by 1) supporting and encouraging CHNAs to design and implement inclusive community health planning and assessment processes; and 2) providing tools and templates, training, facilitation, and opportunities for sharing and collaboration among the CHNAs. The RCHC develops leadership for regional health planning through its work with Community Health Network Areas 7, 15, 17, 18, 20 and the Community Health Coalition of Metrowest.

The RCHC fosters strategies that:

- Have been rigorously evaluated and are shown to be effective. This is often referred to as "evidence-based prevention".
- Are developed to reduce 'risk' factors and enhance 'protective' factors for community members.
- Build upon the strengths and resources of diverse community members.

The towns in CHNA 17 are Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown. Because all of the towns in CHNA 17 are the same town in MAH's primary discharge area, as part of this broader Community Health Assessment, MAH has conducted an in-depth assessment and prioritization process with the community members of this CHNA.

This assessment, which includes both qualitative and quantitative methods, reviewed health indicators and most importantly engaged community members in the assessment and prioritization process. A summary of the CHNA 17 Community Health Needs Assessment follows.

ASSESSMENT COLLABORATION WITH LOCAL COMMUNITY HEALTH NETWORK AREA 17

Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown

Community Health Network Area (CHNA) 17 is a collaborative of organizations and residents from 6 cities and towns; Cambridge, Somerville, Arlington, Watertown, Belmont and Waltham.

CHNA 17 receives funding from Mount Auburn Hospital. In order to guide the CHNA's use of MAH funds, the CHNA carried out a broad community health assessment to identify shared health priorities. The CHNA is founded on the concept that good health requires the broad and engaged participation of all members of a community. Throughout the assessment process, the CHNA made an effort to think about health not only as the physical health of the people who live in its member communities, but also as the spiritual, social, physical and emotional well-being of community members and of the community as a whole. Implicit in this approach is an understanding that health is not determined by healthcare, but by the social supports, environmental opportunities, policies and norms of the community and by the underlying economic factors and well-being of where people live. The assessment will inform the group's health promotion efforts for 5 years.

The assessment was carried out by MAHRCHC staff in collaboration with a group of coalition members including residents, non-Governmental Organizations, schools, hospitals and health departments. The assessment was funded by Mount Auburn Hospital. Mount Auburn Hospital's funding of the CHNA also supported the CHNA coordinator's time on the project and allowed the CHNA to hire the Institute for Community Health as an outside evaluator to help with data compilation and analysis, process design and evaluation design. In addition, a small portion of a federal grant from Healthy People 2020 allowed the CHNA to incorporate social determinants of health into the assessment process in a way that was deliberate and also allowed the group to offer stipends to unaffiliated community members to participate in the process.

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

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

- Develop a prioritization process for community needs
- Develop and finalize an expenditure plan based on the information that's collected

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

The CHNA coordinator organized meetings of the assessment team, co-facilitated many of the discussions, captured decisions, shared the process with the larger membership, and connected the steering committee to the process. MAH RCHC staff worked with the coordinator to: 1) develop a process and a timeline for the assessment, 2) co-facilitate meetings, and 3) participate in documentation and trouble-shooting. The Institute for Community Health was contracted as an evaluator for the project. They participated in assessment meetings, helped to gather, analyze and compile data, and supported the group in planning a process to solicit further community input. After priorities had been chosen, they helped to craft evaluation plans.

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

- Mount Auburn Hospital's 2009 community needs assessment,
- MassChip (an online data repository created by the Massachusetts Department of Public Health),
- Cambridge Homeless Census,
- Cambridge Youth Healthy Survey and Parent Survey administered by the Cambridge Prevention Coalition,
- MA disabilities and disparities report,
- Youth Risk Behavior Surveys from Somerville, Arlington and Watertown,
- Waltham youth survey,
- Walkscore.com
- Waltham Partnership for Youth.

Quantitative Data collection Members of the assessment guidance group helped to access information and reports from their communities and helped put the coordinator in touch with the right people in their towns. Their goal was to collect quantitative information about each subject for each of the 6 CHNA member communities.

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

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

With help from the MAHRCHC staff and the Institute for Community Health, the assessment team decided what type of information they would need to collect in order to be able to decide how they will any particular health topic met the criteria:

- To answer the question of whether people in the community see it as a problem, they would need to ask community members what they saw as important issues.
- To know whether the issue affects all 6 communities they would need to look at quantitative data about magnitude and incidence of problems.
- To know whether they can make measureable change on a topic in 5 years they decided that members of the assessment team would be able to use their collective knowledge to decide.
- To know whether there are resources to build on, they decided that if the assessment team was diverse in terms of communities and agencies represented, the members could use their own knowledge to decide. This would avoid having to spend a significant amount of time and energy compiling a list of all of the resources available in every community.
- The question of whether the issue affects vulnerable populations was more difficult, but the group decided that the assessment team could also answer this question. As above, members would use their own knowledge to decide.

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

Qualitative Data Collection The question of whether people in the communities see each particular issue as problem required the assessment team to collect new local data about what issues are most

relevant to community members and their lives. The team decided to ask a wide sample of community members in all 6 communities' two questions:

1. What concerns you most about your community today?

2. What would make your community a better place to live?

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

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

To accomplish three things 1) bring the assessment questions out to community members, 2) build a larger base of support for the CHNA, and 3) raise awareness of the social determinants of health; the assessment team showed the segment *Place Matters* from the Unnatural Causes video series. (www.unnaturalcauses.org) In the video Harvard's David Williams reminds us, "Everything that we can do to improve the quality of life for individuals in our society has an impact on their health and is a health policy."

At a general CHNA meeting each of the 6 member communities were encouraged to hold at least one screening of this video episode or a conversation about health and community building in their city. Three such screenings were held in Waltham and one was held at a CHNA general meeting. At each of the screenings that were held, the organizer posed the CHNA's questions and documented the responses.

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

CHNA 17
Data Sheets
By Town

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

Community Data Indicators—Top Areas of Concern

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

What Have Community Members Told Us Are Their Top Concerns?
(Feedback gathered from 11 people at community meetings)

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

What Have Community Leaders and Service Providers Told Us Are the Top Community Issues?
(Interviews with 2 community leaders from health department and older adult-serving agency)

- **Mental health**
  - **Lack of mental health services available to all populations**
  - **Recent increase in youth behavioral and family problems, domestic violence and suicides**
- **Older adults**
  - **Isolation, especially among immigrant elders**
  - **Lack of financial resources for housing and long-term care**
- **Working adults**
  - **Economic stress**
  - **Lack of access to health care**

    - **Lack of preventative health practices**

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

<u>Does This Reflect Your Reality?</u>
<u>Further feedback gathered from community stakeholders after viewing the data presented above</u>

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

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

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

Community Data Indicators—Top Areas of Concern

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

What Have Community Members Told Us Are Their Top Concerns?
(Feedback gathered from 23 older adults)

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

What Have Community Leaders and Service Providers Told Us Are the Top Community Issues?
(Interviews with 4 leaders from food assistance agency, health department, and 2 older adult-serving agencies)

- **Low income residents**
  - **Lack of services**
- **Older adults**
  - **Lack of affordable homecare**
  - **Lack of transportation to medical appointments**
  - **Need for increased heat, housing and nutrition assistance for frail older adults**
- **Youth**
  - **Lack of pediatricians**
  - **Youth substance abuse**

Does This Reflect Your Reality?
Further feedback gathered from community stakeholders after viewing the data presented above

(Feedback from staff person from the Board of Health)

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

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

Community Data Indicators—Top Areas of Concern

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

What Have Community Members Told Us Are Their Top Concerns?

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

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

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

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

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

Does This Reflect Your Reality?
Further feedback gathered from community stakeholders after viewing the data presented above

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

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

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

Community Data Indicators—Top Areas of Concern

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

What Have Community Members Told Us Are Their Top Concerns?
(Feedback gathered from 65 youth, adults, and older adults)

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

What Have Community Leaders and Service Providers Told Us Are the Top Issues?
(Interviews with 3 leaders from health department, immigrant-serving agency and older adult-serving agency)

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

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

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

Does This Reflect Your Reality?
Further feedback gathered from community stakeholders after viewing the data presented above
(Feedback gathered from staff from 2 older-adult serving agencies, and 3 city employees)

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

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

Community Data Indicators—Top Areas of Concern

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

What Have Community Members Told Us Are Their Top Concerns?
(Feedback gathered from 6 older adults)

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

What Have Community Leaders and Service Providers Told Us Are the Top Issues?
(Interviews with 5 leaders from community coalition, health care organization, health department, older adult-serving agency and youth-serving agency)

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

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

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

Does This Reflect Your Reality?
Further feedback gathered from community stakeholders after viewing the data presented above
(Feedback gathered from staff from food assistance program and staff person from social service agency)

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

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

Community Data Indicators—Top Areas of Concern

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

What Have Community Members Told Us Are Their Top Concerns?

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

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

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

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

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

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

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

Does This Reflect Your Reality?
Further feedback gathered from community stakeholders after viewing the data presented above
(Feedback gathered from 2 city employees)

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

CHNA 17
Data Sheets
By Topic

Feedback from community surveys and key informant interviews[1]

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

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

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

Source: 1=Census American Community Survey 06-08 estimates

Feedback from community surveys and key informant interviews[1]

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

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

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

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

Feedback from community surveys and key informant interviews[1]

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

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

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

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

Feedback from community surveys and key informant interviews[1]

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

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

Domestic Violence

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

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

Feedback from community surveys and key informant interviews[1]

	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Increase in Domestic Violence	Interviews					

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

Access to Services-- Immigrants

Feedback from community surveys and key informant interviews[1]

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

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

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

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

Feedback from community surveys and key informant interviews[1]

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

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

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

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

Feedback from community surveys and key informant interviews[1]

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

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

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

students that met vigorous physical activity guidelines[6]							
% of adults that vigorous physical activity guidelines			36%	35%			30%
% of high school students that met moderate physical activity guidelines	**60%**		**62%**	**59%**		63%	63%
% of adults that met moderate physical activity guidelines			42%	48%			

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

Feedback from community surveys and key informant interviews[1]

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

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

Feedback from community surveys and key informant interviews[1]

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

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

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

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

Feedback from community surveys and key informant interviews[1]

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

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

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

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

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

Substance Abuse—Adults

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

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

Feedback from community surveys and key informant interviews[1]

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

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

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

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

Feedback from community surveys and key informant interviews[1]

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

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

Feedback from community surveys and key informant interviews[1]

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

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

CHNA 17 Summary

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

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

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

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

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

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

They noted that there are a lot of resources related to obesity and active living to build on. The assessment team mentioned that in addition to the data compiled as part of the assessment, if they pulled data on Somerville's 2-5yr olds the numbers are staggering.

In reflecting on the data related to domestic violence, they noted that it was difficult to get information on the subject, particularly from Belmont. They also noted that in many places people don't really see this issue as a problem. People don't talk about it and it's hidden. In terms of whether the CHNA could make a difference on the issue they discussed the possibility of building on existing programs in the schools in some communities such as Arlington and Watertown. They also noted that the domestic violence tends to increase with economic instability and is also correlated with body issues. These could be opportunities for intervention if the CHNA decides to address domestic violence.

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

The data related to youth Substance abuse was incomplete, with much of Belmont's information missing and binge drinking rates missing for Cambridge. Despite this, they were able to analyze the data that were available and discuss the topic. They noted that there is a lack of substance abuse treatment services, and that the issue is often hidden. They noted that there's a significant difference between what the data say about whether this is an issue for all communities and whether people in the community see it as a problem. This difference could be an opportunity to use the CHNA voice to bring the issue into the public view and help people recognize it as a problem, particularly by publicizing the data in a way that indicates the problem without talking to adults in the community about challenging issues like modeling substance-free living. They noted that there's a similar discrepancy between the data and public opinion, and thus a similar opportunity for the CHNA to help highlight the issue for domestic violence. In exploring whether there are existing resources to build on, the team noted that while there are some, including CASPAR, many are at capacity and there have been significant cuts in services.

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

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

Through this conversation the assessment group rated each of the 15 health issues that rose to the top of the list of concerns (either through the preliminary data, community voiced concerns or both) according to how well they met the criteria that they had chosen for priority issues. For each topic they looked at the data and talked as a group to decide how to rate the topic on a scale of 1-5 for each of the criteria. The criteria were whether:

- **Community members see it as a problem,**
- **It affect s all 6 member communities,**
- **Whether they can make measurable and sustainable change on this in 5 years,**
- **Whether there are resources related to this that they can build on and**
- **Whether it affects vulnerable populations.**

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

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

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

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

The size of assessment team grew as the assessment progressed. Often they think about assessment as a grueling or boring process, but this assessment involved stakeholders in genuine way and allowed the future users of the assessment results to guide and shape the process. In many ways this was wonderful and in others it was challenging. One of the challenges was that people entered the process and joined the team with varying levels of experience and expertise in assessment and data analysis. This forced the members, facilitators and even the consultant evaluators to make language and processes as accessible, practical and simple as possible. This, in turn, made the results more comprehensible and allowed all members of the process to be heard and to own the decisions that followed from the assessment.

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

Some of the topics that the CHNA was interested in exploring can be difficult to talk about. These include Domestic violence, homelessness and others. It's possible that the lack of data and people's discomfort in discussing the issues made them less visible in the CHNA's assessment than they should have been. It was suggested that the CHNA set up funding for these and other stigmatized topics.

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

As a result of the assessment process the CHNA has a shared and articulated direction, CHNA members are more aware of their communities' similarities and differences, the steering committee of the CHNA has grown to include representatives from communities that had traditionally been less involved in the CHNA, and the whole CHNA is actively engaged in the process of deciding how the funds that will be coming to the CHNA should be spent. Regardless of the intricacies of the data that drove the assessment, these are significant accomplishments for the group to have made.

The assessment process with CHNA 17 was completed in November 2011. The full MAH Community Health Needs Assessment was completed in July 2012. MAH community health staff also worked closely with CHNA 17 members to develop the Community Benefit Implementation Plan.

Implementation Plan Pertinent assessment material was reviewed with community members including those affiliated with public health departments, community based organizations and with Community Health Network Areas (CHNA) with a focus on the steering committees of CHNAs 7, 15, 17, 18, and 20 as well as the those members who are part of the CHNA17 which serves Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown.

Priorities for the Community Benefit plan were developed by reviewing the current programs and resources, information obtained from the Community Needs Assessment, input from CHNA steering committees and CHNA17 membership and considering the Attorney General's recommended state wide priorities. Recognizing that community benefit planning is ongoing and will change with continued community input, the Mount Auburn Hospital Community Benefit plan will evolve. Senior Management and the Board of Trustees are committed to assessing information and updates as needed.

A copy of this plan is available on Mount Auburn Hospital's website www.mountauburnhospital.org or by contacting the Community Health Department at 617-499-5625. The implementation plan includes a review of:

- Target areas and priority populations
- A description of how the implementation strategy was developed and adopted
- Major health needs and how priorities were determined
- Community Health needs the hospital intends to address directly and those it will address in collaboration with others.
- Collaborations Planned
- What MAH will do to address community needs
- Community health needs not addressed in the implementation strategy and reasons they are not being addressed.