Partnering with Communities to Improve Health

Community Health Needs Assessment & Strategic Planning Report 2012

MASSACHUSETTS GENERAL HOSPITAL

CENTER FOR COMMUNITY HEALTH IMPROVEMENT

Table of Contents

Acknowledgements

Special thanks to Leslie Aldrich, Associate Director, MGH Center for Community Health Improvement (CCHI), for overseeing the assessment process in three communities simultaneously. She couldn't have done it without the leadership of Beth Rosenshein, director of the Charlestown Substance Abuse Coalition (CSAC), Kitty Bowman, director of Revere CARES Coalition, and Sarah Oo, director of MGH Chelsea Community Health Improvement and their staff. Thanks to Rebecca Kaiser, director of Community Relations at Spaulding Rehabilitation Hospital, who helped organize and convene the process in Charlestown. Also thank you to Jay Ash, Chelsea City Manager, for his leadership of this process in Chelsea. Thank you to friends and colleagues Steve Ridini, EdD, Vice President of Community Health, Health Resources in Action, for consultation and facilitation of various community meetings and Janet Smith, PhD of Edscape Consulting for her help with data analysis.

Also, thank you to key MGH staff and colleagues who helped implement and communicate the process. Susan Leahy, CCHI Communications Manager; Eileen Manning, director of MGH Community Health Associates and her staff; and the medical and administrative directors of the MGH community health centers Roger Pasinski, MD and Debra Jacobson of Revere; Dean Xerras, MD and Jeannette McWilliams of Chelsea; and Lorenzo Lewis, MD and Jean Bernhardt, PhD of Charlestown.

Data collection and analysis would not have been possible without the CCHI Evaluation Team and volunteers from the MGH Institute for Health Professions. Thank you to Danelle Marable, Director of Evaluation, Erica Clarke, Sr. Project Manager, Nessa Regan, Project Manager, Maddie Eagan, Research Assistant, and Patrick Hagan, Research Assistant who prepared data collection tools, organized and ran focus groups and events, and analyzed and prepared data and Margaret Mahoney, PhD, Assistant Professor at the MGH Institute of Health Professions and her students who contributed to the data collection process.

Most importantly, thank you to assessment committee members, residents and leaders of the communities of Revere, Chelsea and Charlestown who dedicated so much time and talent over the course of a year to implement this process. This report would not have been possible without their contributions.

For more information about this report or the center's assessment process, please visit www.massgeneral.org/cchi or email Leslie Aldrich at laldrich@partners.org.

Joan Quinlan
Executive Director
MGH Center for Community Health Improvement
101 Merrimac Street
Boston, MA 02114
jquinlan1@partners.org

Executive Summary

Massachusetts General Hospital: A Tradition of Caring
MGH recognizes that access to high-quality health care is necessary, but by no means sufficient, to improving health status. We are also committed to engaging in deep and transformative relationships with local communities to address the social determinants of health. The MGH Center for Community Health Improvement (CCHI) conducted its first community health needs assessments (CHNA) in 1995 in Revere, Chelsea and Charlestown, where MGH has had health centers for more than 40 years, and has done so periodically over the past 17 years. As a result of these assessments and together with our community partners, we have made substantial progress on preventing and reducing substance abuse, improving access to care for vulnerable populations, expanding opportunities for youth and more.

- **75% of Revere Public School students qualify for free or reduced lunch**
- **In 2011, Chelsea had 502 new public school students -155 were immigrants from 24 different countries**
- **While Charlestown has the highest median income of Boston neighborhoods, 37% of Charlestown youth live below poverty**

2012 Community Health Needs Assessment
The Patient Protection and Affordable Care Act now requires hospitals to conduct CHNA's every three years. CCHI used this new requirement as an opportunity to formalize our assessment methods using the MAPP framework (Mobilizing for Action through Planning and Partnerships, created by the CDC in 2000). MAPP recommends that assessments be community driven, involve diverse sectors of the community, and that data be collected through multiple sources such as focus groups, key informant interviews and public health sources. CCHI collaborated with the communities of Revere, Chelsea and Charlestown to conduct the assessment. Almost 3,000 people across the three communities had input into this process through the following methods:

"Overall health (physical and mental) tends to depend on whether the people in a community feel they are part of it." – Chelsea survey respondent

1. **A Quality of Life Survey** - 2,260 surveys received;
2. **Community Forums** - 320 participants attended three forums;
3. **Assessment Committee Members** - Three assessment committees with a combined total of 110 members guided the process and shared their perceptions of community strengths, threats and the forces of change that affect health;
4. **Focus Group**s - 35 focus groups reached 359 participants;
5. **Public Health Data** - from sources such as the U.S. Census, MA Department of Education and Boston Public Health Commission.

Priorities & Strategies
By a significant margin, all three communities identified **substance abuse**, and the effects it has on quality of life including perceptions of **violence and public safety**, as their top two issues. **Obesity/healthy living, cancer prevention/early detection, and access to care for vulnerable populations** were also identified by all three communities. Finally, developing the assets of **youth and encouraging educational attainment** were also identified to protect against multiple high risk behaviors. These are CCHI's six priority areas for at least the next three years.

Initial strategies to date include setting up a new navigation outreach model to help build provider relationships and connect youth and families to needed services in Charlestown, and a comprehensive community-wide substance abuse prevention/intervention plan will be developed in the Chelsea community over the next year under the guidance of a new senior prevention manager to be hired. Both communities will work with new community-wide assessment committees to plan and oversee this work. Evidence-based models to build healthy relationships and decrease violence among youth and adults are being explored through a new Healthy Relationship task force within the Revere CARES Coalition.

MGH: A Tradition of Caring

Massachusetts General Hospital (MGH) has a long legacy of caring for the underserved in the local community. Founded in 1811 to care for the "sick poor," today that commitment is demonstrated through caring for all regardless of ability to pay, supporting three community health centers for more than 40 years and a comprehensive approach to addressing social determinants of health. MGH Trustees affirmed this commitment in 2007 by expanding the hospital's mission to include "…improve the health and well-being of the diverse communities we serve."

MGH recognizes that access to high-quality health care is necessary, but by no means sufficient, to improving health status. We must also engage in deep and transformative relationships with local communities to address the social determinants of health. Thus, MGH created the Center for Community Health Improvement (CCHI) in 1995, with the mission of collaborating with communities to achieve measurable, sustainable improvements to key indicators of the community's health and well-being. Since 1995 MGH has partnered with the neighboring communities of Charlestown, Chelsea and Revere to identify and make measurable improvements in health.

Partnering with Communities: 1995-2012

CCHI conducted its first community health needs assessments (CHNA) in Revere, Chelsea and Charlestown in 1995, and has done so periodically thereafter. While each community is unique, they also share challenges and opportunities. MGH health centers are in each of these communities and provide comprehensive health care to more than 63,000 primarily low-income individuals and families annually. CCHI has partnered with these communities to make measurable improvements to complex and long-standing health problems. Many of these problems are associated with high rates of poverty, low educational attainment and other social and economic determinants. These communities have undergone rapid demographic transformation as new populations from across the globe bring extraordinary diversity to these communities.

Revere	Chelsea	Charlestown
Population	**Population**	**Population**
• 51,755 • 24% Latino • 43% speak language other than English	• 35,177 • 62% Latino • 68% speak language other than English	• 16,439 • 76% White • 16% speak language other than English
Student Body	**Student Body**	**Student Body**
• 43% Latino • 71% Graduation Rate • 75% of students receive free or reduced lunch	• 81% Latino • 55% Graduation Rate • 89% of students receive free or reduced lunch	• Data not available
Poverty & Education	**Poverty & Education**	**Poverty & Education**
• 16% live below poverty • Median income $50,592 • 21% have less than a high school education	• 23% live below poverty • Median income $43,155 • 35% have less than a high school education	• 17% live below poverty • Median income $76,898 • 10% have less than a high school education

Source: Quick Facts US Census 2007-2011 & 2011 Department of Education Data

Partnering with Communities: 1995-2012

Since 1995, CCHI has collaborated with our community partners and health centers to assess health status and identify and address priorities which have included:

Preventing and Reducing Substance Abuse
Interrupting the Cycle of Family Violence
Eliminating Racial and Ethnic Disparities in Health Care
Expanding Opportunities for Boston Youth
Improving Access to Care for Vulnerable Populations
Promoting Healthy Living
Prevention and Early Detection of Cancer

Considerable progress has been made toward addressing these priorities. Recent outcomes and awards include:

- Substance Abuse: Calls to Emergency Medical Services in Charlestown for heroin overdoses were reduced by 62% between 2003 and 2010. Drinking by high school students in Revere decreased from 59% in 1999 to 40% in 2011 (a 33% reduction), and lifetime drinking decreased from 80% in 1999 to 62% in 2011 (a 25% reduction), which is below the state average.
- Youth Development: The MGH Bicentennial Scholars program was created in 2011 to support college completion for youth interested in health and science careers.
- Healthy Living: A ban on trans fat prohibiting the use of partially hydrogenated ingredients was passed by the Chelsea Board of Health in 2012 with support from the Healthy Chelsea Coalition.
- Early Cancer Detection: Since 2009 breast care screening rates for Serbo-Croation women increased from 44% to 67% due to patient navigation.
- Recognition: The Revere CARES coalition received the 2010 Community Anti-Drug Coalitions of America *Got Outcomes Coalition of the Year Award* for achieving measurable reductions in teen substance abuse. In 2011, MGH received the Spencer Foreman Award for Outstanding Community Service from the American Association for Medical Colleges, and was a finalist for the prestigious Foster G. McGaw Prize from the American Hospital Association.

2012 Community Health Needs Assessment: The MAPP Process

Since CCHI's last assessment in 2009, the Patient Protection and Affordable Care Act was passed requiring hospitals to conduct CHNA's every three years, reportable to the Internal Revenue Service (IRS). Guidelines require diverse community participation in the assessment process, the goal of which is to identify health priorities and develop a strategic implementation plan to address them. This plan must be approved by the governing board of the hospital and reported

every three years to the IRS. MGH CCHI viewed these requirements as an opportunity. After review of methods, we selected MAPP: Mobilizing for Action through Planning and Partnerships. MAPP is a community-driven strategic planning process for improving health, developed in 2000 by the Centers for Disease Control and Prevention (CDC). Similar to IRS guidelines, the process recommends that assessments be community driven, involve diverse sectors of the community, and that data is collected through multiple sources such as focus groups, key informant interviews and public health data. The framework recommends data to collect in order to identify a broad array of health indicators, including behavioral and environmental factors, as well as tools for collecting that data.

MAPP recommended phases and assessments:

Phase 1: Organize for success and develop partners

Phase 2: Collaborate and create a common language/vision

Phase 3: Assess needs and strengths of the community by measuring:

- *Community Themes and Strengths*: Qualitative data collection that aims to find out what is important in the community, how quality of life is perceived and what assets and resources are available to improve quality of life
- *Forces of Change:* The positive and negative external forces that impact the promotion and protection of the public's health
- *Community Health Status:* The overall health as measured by public health data and community perceptions

Phase 4: Identify strategic issues

Phase 5: Formulate goals and strategies

Phase 6: Plan, implement and evaluate the community's strategic plan

MAPP Implementation

Phase 1 & 2: Partnership Development

In the fall and winter of 2011/2012, CCHI convened assessment committees in Charlestown, Chelsea and Revere in alignment with community processes already underway in order to create a vision and oversee the assessment process.

In Charlestown, several ongoing initiatives helped leverage the process. The Charlestown Substance Abuse Coalition was preparing for its next strategic plan and the Spaulding Rehabilitation Network was preparing to conduct a community needs assessment in connection with its approval by the Massachusetts Department of Public Health to construct a new facility in Charlestown.

In Chelsea, the City Manager contacted MGH in August, 2011 to request help developing a human services plan for the city. There was strong alignment between the goals of this project and the upcoming assessment process, so MGH and the City of Chelsea

collaborated to form the assessment committee. The two groups identified participants from across sectors, and the City Manager personally invited members to join in order to demonstrate his strong commitment to the project.

In Revere, the award winning substance abuse coalition Revere CARES became the backbone of the process, and additional participants were invited to join to assure broad community representation. Over its 15 years, Revere CARES has earned the trust of the community with the ability to manage effective cross-sector collaborations.

For each committee, careful efforts were made to include community leaders, residents and organizations across sectors, and focused outreach was conducted to engage community members and cultural groups who might not otherwise be involved. *See Appendix A for lists of members and organizations.*

In each community, committee members reviewed and agreed to the following job description:

1. Oversee the community health needs assessment and planning process
2. Provide guidance about how to best gather community input and data
3. Assist in convening the community
4. Assist in data collection through focus groups, key informant interviews, and/or other sources
5. Participate in identifying key community issues and assets
6. Prioritize the community's key issues after data gathering and analysis is complete
7. Create a community strategic plan

Phase 3: Data Collection

Charlestown Community Forum, December, 2011

Following the initial planning phase, community members developed a collective vision of their ideal community that guided the distinct assessment phases. CCHI provided training to assessment committee members, and worked with them to conduct a comprehensive information gathering process incorporating both quantitative and qualitative community health data.

Our methodology included:

1. A Quality of Life survey adapted with input from committee members. The survey was translated into Spanish, Arabic, Cantonese and Portuguese and distributed widely via the web and in person within each community. A total of 2,260 surveys were returned, including 959 in Chelsea, 756 in Revere, and 545 in Charlestown. *See Appendix B & C for survey sample demographics and select survey questions.*
2. Public forums in each community to distribute the survey and talk openly about health. The forums drew 150 participants in Charlestown, 122 in Chelsea and 50 in Revere.
3. Focused discussions during community assessment committee meetings about the community's strengths, threats and opportunities, characteristics of a healthy community and the forces of change within each community that affect health.
4. A total of 35 focus groups engaged underrepresented individuals. The groups were co-facilitated by CCHI and community assessment committee members, and were attended by a total of 354 participants including 161 in Charlestown, 109 in Chelsea and 84 in Revere. Attendees received a $20 gift card to a local supermarket or Target in appreciation for their participation. *See Appendix D, E & F for group characteristics, summary and tools.*
5. Public health data gathered from the U.S. Census, MA Department of Education, Boston Public Health Commission, MA Department of Public Health, local police departments and community based organizations. *See Appendix G for data summary.*

Phase 4, 5 & 6: Identifying Strategic Issues, Planning and Implementation

CCHI analyzed all of the data and presented it at committee and community-wide meetings. Participants identified priorities and discussed how or if their organization was already addressing the priorities, what additional resources, if any, were needed, and recommended possible solutions. Each community then formulated goals, objectives and strategies. A Community Health Committee of the MGH Board of Trustees was formed in 2011 and met twice to review the plan. The final report was presented to the full MGH Board of Trustees on September 21, 2012 and it was approved unanimously. *See Appendix H for summary of the problems, goals, objectives and potential strategies for each of the six priority areas.*

Assessment outcomes and strategic plans will be reported in a community-wide forum in each community in 2013. Additionally, assessment results are available to the public via the MGH CCHI website, and will be made available to communities on other public websites. Media outlets such as radio, television, and local newspapers will also be used to disseminate this information in each community as the assessment committees see fit.

MAPP Timetable

The MAPP process followed the following timetable across communities:

Form three community assessment committees	October 2011
Committees create vision of a healthy community	October – February 2012
Data collection in all three communities	February – April
MGH Board of Trustees subcommittee meetings	April 6 and August 8
Data analysis & report preparation for presentation for communities	April
Data review and interpretation by the assessment committees	May – June
Communities establish community health priorities	May – June
Communities establish broad goals and strategies	June – July
Committees begin creating action plans for each community	July – September
MGH Board of Trustees reviews & adopts community action plans	September 21
Committees report the action plan to each community	Spring / Summer 2013
Implementation of the action plan begins in each community	Summer / Fall 2013

Assessment Results

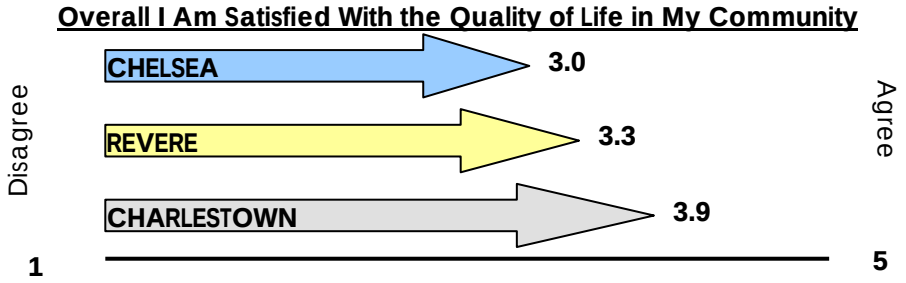
Characteristics of a Healthy Community

In all three communities the most important attributes of a healthy community identified by residents and committee members were: low crime and safe neighborhoods so that residents can be active in their community without fear; good schools and educational opportunities for youth and adults, and; easy access to health care. These attributes help define each community's vision and shaped their goals.

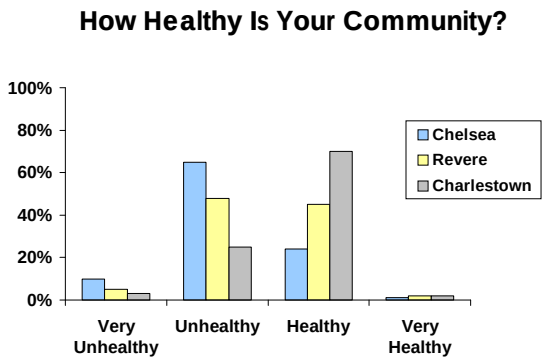
"A lot of people like to say crime is a problem down in the projects, but it is everywhere." - Charlestown resident

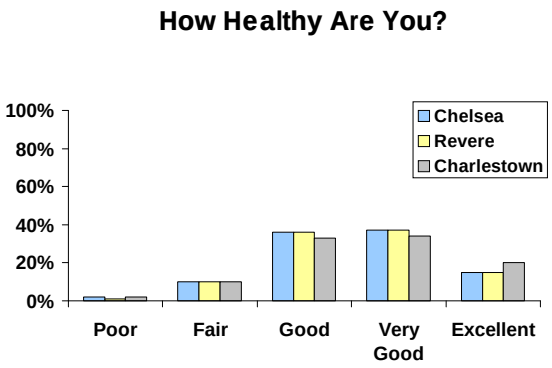
Community Themes & Strengths

Community thoughts, opinions, concerns and solutions were gathered from community members through the quality of life survey and focus groups.



Each of the three communities ranked their health very differently across a spectrum of unhealthy to healthy. However, all individuals stated that they believe their health is average to above average, with more Charlestown residents believing they are in excellent health.





Participants had many positive things to say about their communities despite the challenges each faces. All three communities named diversity, culture, dedicated and compassionate people, existing community services, location, size and transportation as positive attributes. Major concerns included substance abuse, crime and violence, obesity, hunger and malnutrition, mental health, domestic violence, low educational attainment, teen pregnancy and access to health care. Understanding both the assets and challenges of each community was essential to developing sustainable solutions.

Revere	Chelsea	Charlestown
• Neighborliness - open to all people, friendly	• People – resilient, welcoming, tolerant	• People – passionate, dedicated, committed
• Declining crime rates	• Sense of community	• Sense of community
• Schools	• Community services	• Diversity
• Public transportation	• Partnerships	• Tradition & culture
• MGH	• MGH	• Education (till grade 8)
• Outdoor resources (beach, parks, etc.)	• Leadership	• Youth services
• Free lunch program	• Activities for children	• Outdoor resources (parks & fields)
• Diversity	• Diversity	• small geography
• Grocery stores	• Location	• Public transportation
• Cost of living	• Small geography	• Increased development
• Cost of food	• Transportation	• Business / services / agencies
	• Good neighborhoods	• Elder care
	• Growth	• MGH
	• Inexpensive housing	

Forces that Affect Health

When assessment committees were asked, "What is occurring or might occur that affects the health of your community?" a list of threats and opportunities were identified. These issues were important to identify and discuss in order to select priorities and strategies that are responsive and relevant to the changing environment.

Forces that Affect Health	
• Change in population	• Increase in Poverty / % Unemployment
• Housing	• Physical environment
• Leadership (new)	• Community Resources
• New Businesses / Casino	• Healthcare reform / Medicare / Insurance

Community Health Status Assessment – Public Health Data

Public health data was analyzed by CCHI and presented alongside residents' perceptions of the issues collected from focus groups, forums and surveys. Public health data that indicated a problem that was not identified by the community, such as teen pregnancy in Revere, were highlighted and presented to community members as an issue of possible concern.

Data sources vary by community. For Charlestown (a neighborhood of the City of Boston) data was obtained primarily from the Boston Public Health Commission (BPHC). It is difficult to obtain data on school-aged children in Charlestown because they do not necessarily attend schools in the neighborhood, due to the Boston Public School assignment process. Revere and Chelsea (independent municipalities) data were obtained primarily from the Massachusetts Department of Public Health (MDPH) and Department of Education (DOE).

Frequently used measurement tools noted in many of the data charts are:

- Behavioral Risk Factor Surveillance System (BRFSS) – A CDC survey administered by MDPH to assess a range of health behaviors
- State (MDPH), city (BPHC) and local public health data
- Youth Risk Behavior Survey (YRBS) – A CDC tool, administered by most school departments in the state; MDPH collects and publishes the information, and CCHI analyzes the data for the Revere School Department and conducts its own version in the Charlestown middle schools and high schools
- MGH Patient Data – Used for patient navigation and access programs
- Efforts to Outcomes (ETO) - A universal database that tracks progress of CCHI programs
- Community surveys, such as the Quality of Life Survey, interviews, and focus groups conducted periodically by CCHI

Following the MAPP process, communities came together to analyze the data and determine priorities that were most relevant and important to them. Priorities were selected using the following criteria: 1) community need; 2) potential for impact; 3) community interest, will and readiness, and; 4) an assessment of the need for additional resources. Residents were divided about how to address issues if a coalition or agency was already doing so. Many members believed leveraging existing work would make the greatest impact in the community while others believed resources should be used to work on new priorities not already addressed. The following priorities selected by each community reflect this dilemma:

- The Chelsea assessment committee identified substance abuse as their sole community priority with the belief that working on one issue collectively would make the greatest impact, and that by addressing the risk and protective factors for substance abuse other health issues would also be impacted.

- The Revere assessment committee chose to continue the Revere CARES Coalition's work addressing both substance abuse and healthy living, and recommended that the coalition take on the additional goals of healthy teen relationships and public safety as new priority areas.

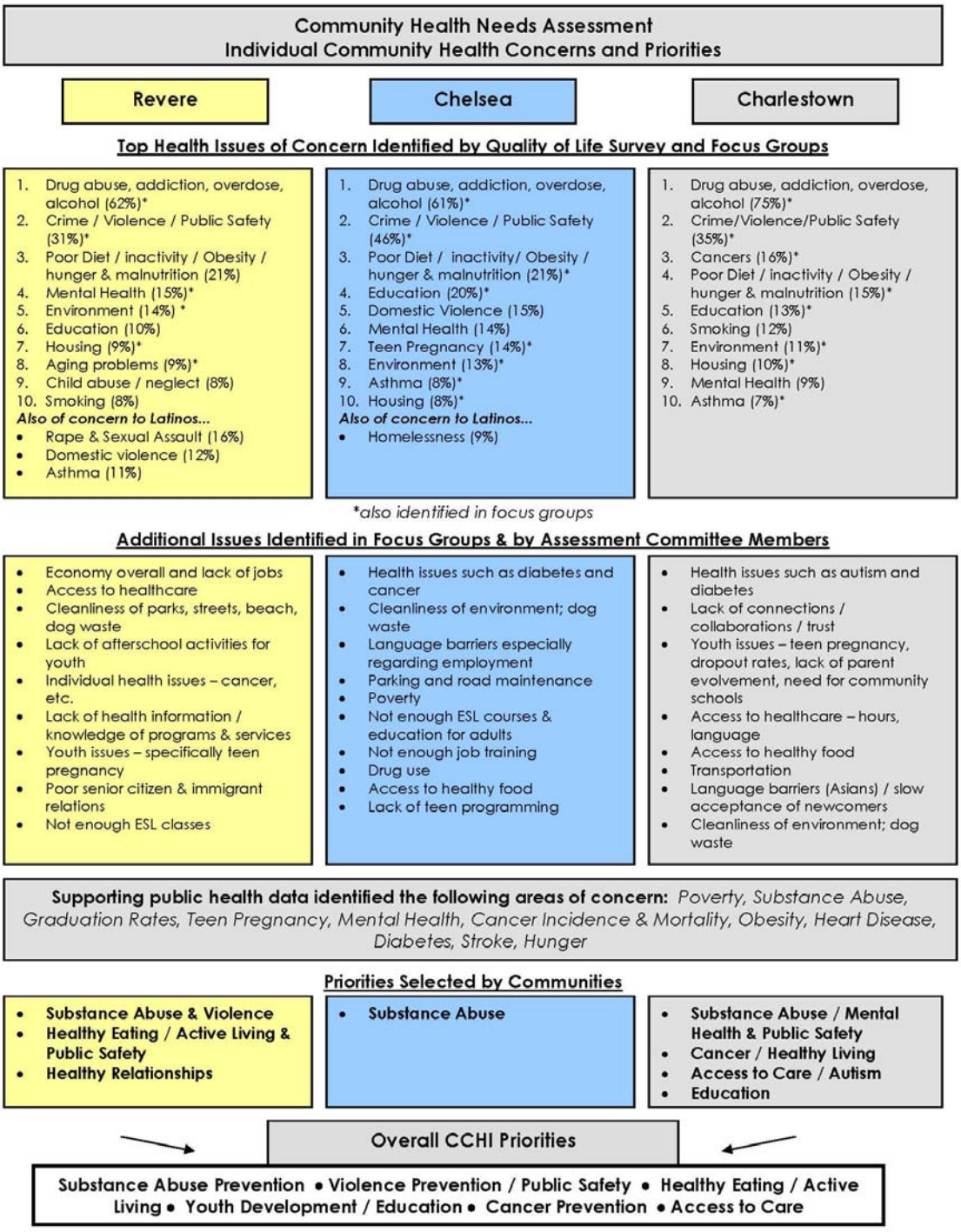
- Charlestown decided to continue its substance abuse efforts in the neighborhood, and added cancer prevention/healthy living, access to care with an emphasis on families with autistic youth, and educational opportunities for all residents.

By a significant margin, all three communities identified **substance abuse**, and the effects it has on quality of life including perceptions of **violence and public safety**, as their top two issues. **Obesity/healthy living, cancer prevention/early detection, and access to care for vulnerable populations,** were all acknowledged as top health concerns in each community. In addition, developing the assets of **youth and encouraging educational attainment** were recognized as important issues or strategies to protect against multiple high risk behaviors. The table on the next page displays the health issues supported by both qualitative and quantitative data and the priorities selected, resulting in CCHI's six priority areas.

Issues Identified But Not Prioritized

Issues such as housing, mental health, the environment as it relates to air quality and asthma, and teen pregnancy are among the issues that we will not directly address at this time because: other groups and organizations are working on them; and/or the community is not ready to address them; and/or resources are limited and dedicated to the top priorities that emerged. However, efforts are being made by each community to select strategies that may impact these other issues

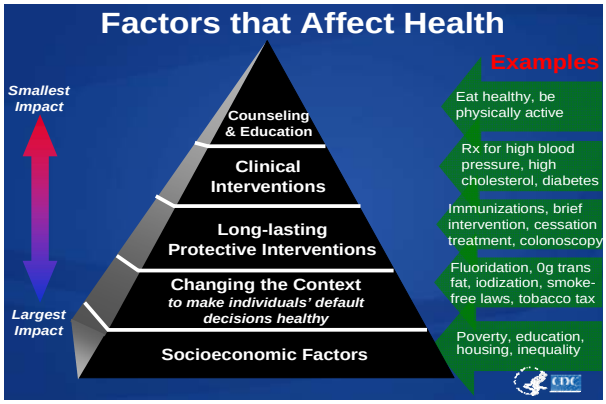
Six Key Priorities Identified



Strategic Planning & Implementation

After the community assessment committees identified priorities, they participated in strategic planning to develop goals, objectives and desired outcomes for each priority area. Goals statements and objectives were then reviewed by subcommittees, which also discussed the infrastructure needed to accomplish the proposed plans. This process enabled all three communities to engage in broad cross-sector coordination and collaboration. *See Appendix H for summary of the problems, goals, objectives and potential strategies for each of the six priority areas.*

Currently each community is refining and prioritizing evidence-based strategies that span all levels of the Health Impact Pyramid, created by Dr. Thomas Frieden at the Center for Disease Control, to address community priorities. These strategies range from educating community residents, developing clinical interventions, and altering the environmental and socioeconomic factors that affect health through policy and systems change. Communities realize that often more than one strategy is needed to impact health and that one strategy impacts various health outcomes.



Among the new strategies are setting up a new navigation outreach model to help build provider relationships and connect youth and families to needed services in Charlestown. A comprehensive community-wide substance abuse prevention/intervention plan will be developed in the Chelsea community over the next year under the guidance of a new senior Prevention Manager to be hired. Both communities will work with new community-wide assessment committees to help plan and oversee this work. Evidence-based models to build healthy relationships and decrease violence among youth and adults are being explored through a new Healthy Relationship task force within Revere CARES.

Revere Community Forum
May 2012

Chelsea City Manager Jay Ash
Chelsea Community Forum
March 2012

Strategic Planning & Implementation

As the work develops, priority will be given to those strategies that impact multiple areas (for example, early childhood home visiting reduces risk factors for substance abuse, violence, obesity, school drop out, etc.), and/or cut across multiple communities. The box below indicates some of these cross cutting strategies, many of which are already in place but could be better coordinated.

Cross Cutting Strategies

- **Community Health Workers / Navigation:** Connect patients to preventative services and treatment
- **Education / Mentorship:** Evidence-based prevention curricula in schools; STEM education; youth asset development; support for college completion; parent engagement
- **Safety / Law Enforcement:** Collaborate with community organizations / police to reduce drug activity in neighborhoods and increase perception of safety (Chelsea)
- **Early childhood home visiting:** Build resiliency, increase protective and decrease risk factors among children and families (Chelsea & Revere)
- **Coordination of Community-based Services:** Comprehensive models to coordinate community-based services to youth, track progress and measure results (Charlestown), while simultaneously changing the way community-based organizations work together
- **Social Marketing/ Communication:** Community-wide messages to change attitudes, knowledge, behaviors and social norms
- **Policy Development:** Advocate and support state and local policy changes that positively impact identified health priorities (e.g. local trans fat bans)

Conclusion

CCHI has been privileged to work with a wide range of diverse partners in each community, and will continue to work with stakeholders in Revere, Chelsea and Charlestown who are committed to addressing substance abuse, violence, healthy eating, active living, youth development, cancer prevention and access to health care. We will be guided by lessons learned over the past 17 years, as well as the unique concerns that surface in each community as we move forward. Progress toward our outcomes is essential. CCHI will work with internal program and evaluation staff and community members to monitor progress and improve quality as the work develops. We have created a new dashboard to measure progress and will report bi-annually to the hospital and annually to the community in order to be accountable on this work. *See Appendix I.* We are grateful for our many talented partners and are confident in our collective ability to make lasting and positive change in our communities.

Appendix

A. Assessment Committee Members

B. Survey Sample Demographics

C. Select Survey Questions – Vision, Mission (priorities) & Goals

D. Focus Group Characteristics

E. Focus Group Facilitator Guide

F. Focus Group Summary

G. Select Public Health Data

H. Six Priority Areas - Problems, Goals, Objectives and Potential Strategies

I. CCHI Dashboard

Appendix A

Community Health Needs Assessment Committee Members

Revere

Cate Blackford	Manager of Healthy Community Initiatives, City of Revere
Kitty Bowman	Director, Revere CARES Coalition
Nick Catinazzo	Revere Health Department
Sylvia Chiang	Manager, Revere on the Move / Revere CARES Coalition
Joan Cho-Sik	CRW Elder Services
Jim Cunningham	CRW Elder Services
Carol Donovan	Revere Health Department
Lillian Guido	Revere Public Schools
Fernando Gonzalez	Resident
Rev. Nick Granitsas	First Congregational Church
Carol Haney	Revere Beautification Committee
Kim Hanton	Director of Diversionary Addiction Services, North Suffolk Mental Health Association
Paul Hyman	CHA Revere Family Health Center
Debbie Jacobson	Administrative Director, MGH Revere HealthCare Center
Gary Langis	City of Revere/MassCALL2 Opioid Overdose Prevention
Judy Lawler	Chelsea District Court
Bernice Macintyre	MGH Revere HealthCare Center
Eileen Manning	Director, MGH Community Health Associates
Ira Novoselsky	City Council (Ward 2)
Lanre Olusekun	Resident
Roger Pasinski, M.D.	Medical Director, MGH Revere HealthCare Center
Jocelyn Perez	Bicentennial Scholar
Kourou Pich	HarborCOV
Jay Picariello	Revere Fire Department
Robert Repucci	CAPIC
George Reuter	The Neighborhood Developers
Daniel Rizzo	Mayor
Linda Rohrer	Career Source
Adrienne Sacco-Maguire	Revere Parks & Recreation Dept./Youth Center
Catherine Sugarman	Assistant Director, Revere CARES Coalition
Ming Sun	MGH Community Health Associates
Carole Smith	Happy Day Pre-School
Joanne Stone-Libon	CAPIC Head Start
Elizabeth Tanefis	Health Resources in Action
Carol Tye	Revere Public Schools, School Committee
Michael Vatalaro	Rep. Robert DeLeo's Office

Appendix A

Community Health Needs Assessment Committee Members

Chelsea

Jay Ash	City Manager, City of Chelsea
Molly Baldwin	Executive Director, Roca, Inc.
Barry Berman	Executive Director, Chelsea Jewish Nursing Home
Dana Betts	Director of Programming, Roca, Inc.
Roseann Bongiovanni	Co-Director, Chelsea Collaborative/Greenspace
Mary Bourque	Superintendent, Chelsea Public Schools
Rosemarie Carlisle	Chelsea School Committee
Sue Clark	Director, Choice Thru Education
Corinna Culler	BU/Chelsea Dental Program
Clifford Cunningham	Chelsea City Council
Jim Cunningham	Chelsea Revere Winthrop Home Care
Al Ewing	Chelsea Housing Authority
Jovanna Garcia Soto	Cheslea Colloborative/Greenspace
Fr. Edgar Gutierrez-Duarte	St. Luke's Church and the Chelsea Food Bank
Amy Harris	Director, Chelsea ASAP
Kim Hanton	Director of Diversionary Addiction Services, North Suffolk Mental Health Association
Ann Houston	Director, The Neighborhood Developers
Brian Kyes	Chief, Chelsea Police Department
Catherine Maas	Chelsea Board of Health
Genie Meca	Chelsea Community Connections
Jeannette McWilliams	Administrative Director, MGH Chelsea
Chris Miller	Chelsea Board of Health
MaryAnne Miller	Dean, Bunker Hill Community College Chelsea Campus
Paul Nowicki	Chelsea Housing Authority
Sarah Oo	Director, MGH Chelsea Community Health
Captain Scott Peabody	Salvation Army
Lynn Peters	HarborCOV
Michelle Perez	Boys & Girls Club
Kourou Ptch	HarborCOV
Luis Prado	Director, Chelsea Health and Human Services Department
Robert Repucci	Executive Director, CAPIC
Leo Robinson	Chelsea City Council
Linda Alioto Robinson	Director, Chelsea Reach Program
Angie Rodriquez	Roca, Inc.
Madeleine Scammell	Chelsea Board of Health
Gladys Vega	Director, Chelsea Collaborative/Greenspace
Juan Vega	Executive Director, Centro Latino
Dean Xerras, MD	Medical Director, MGH Chelsea, Chelsea Board of Health

Appendix A

Community Health Needs Assessment Committee Members

Charlestown

Rebecca Kaiser	Director of Government and Community Relations, Spaulding Rehabilitation Hospital
Sherri Adams	Boston Housing Authority Management Office
Jean Bernhardt	Administrative Director, MGH Charlestown Healthcare Center
Peggy Bradley	Charlestown Neighborhood Council/ Resident
Wilma Burgos	Boston Housing Authority
Pam Campbell	Warren Prescott School/Resident
Peggy Carolan	Charlestown Recovery House
Al Carrier	Charlestown Little League / Resident
Michael Charbonnier	Charlestown Against Drugs, Charlestown Neighborhood Council, Boston Police Department / Resident
Tom Cunha	Chairman, Charlestown Neighborhood Council/ Resident
Michelle Davis	Principal Warren Prescott School/ Boston Public School
Elaine Donovan	Charlestown Substance Abuse Coalition/Resident
Ann-Marie Duffy-Keane	MGH Community Health Associates
Danielle Valle Fitzgerald	City of Boston – Mayor's Office/ Residents
Jason Gallagher	Principal Harvard Kent Elementary/ Boston Public School/ Resident
Sean Getchell	Rep. O'Flaherty's office/ Resident
Beverly Gibbons	City of Boston/Elder Affairs/ Resident
Diane Grant	Charlestown Chamber of Commerce/ Resident
Nea Hoyt	Warren Prescott School/ Charlestown Boys & Girls Club/ Resident
Deborah Hughes	Special Townies Organization/ Resident
Leigh Hurd	President, Charlestown Mothers Association/ Resident
Greg Jackson	Executive Director, Charlestown Boys and Girls Club
Jack Kelly	Charlestown Substance Abuse Coalition/Resident
Terry Kennedy	Executive Director, John F. Kennedy Family Center, Inc./ Resident
Rosemary Kverek	Harvard Kent Elementary School/ Resident
Rebecca Love	President, Charlestown Mothers Association/ Resident
Doug MacDonald	Warren Prescott School/ Resident
Virginia Mansfield	Charlestown Community Center/ Resident
Kelly Pellagrini	Charlestown Nursery/Charlestown Promise Charlestown Sports Collaborative/ Resident
Father James Ronan	St. Mary/St. Catherine Parish/ Resident
Beth Rosenshein	Director, Charlestown Substance Abuse Coalition/ Resident
Mark Rosenshein	Charlestown Neighborhood Council/ Resident
Danny Ryan	Neighborhood Rep. Congressman Capuano/ Charlestown Substance Abuse Coalition/Resident
Karen Scales	Special Townies Organization/Resident
Jim Travers	President, Charlestown Recovery House/Resident
Dave Whelan	Charlestown Neighborhood Council/Resident

Quality of Life Survey Respondent Demographics Compared to 2010 Census Data

Revere Quality of Life Survey Respondents (n=756)

- 75% White (compared to 62% white, 24% Latino)
- 55% 40-64 Years (compared to 25%)
- 4% Less than High School (compared to 23%)
- 26% Associates or Bachelor's Degree (compared to 18%)
- 32% Graduate Degree (compared to 5%)
- 5% Unemployed (compared to 8%)
- 29% Male
- 62% Employed full time
- 34% have lived in Revere their entire life

Overall survey respondents are more educated, older, women

Chelsea Quality of Life Survey Respondents (n=959)

- 32% Hispanic, 62% White (compared to 62% Latino, 25% White)
- 25% Foreign Born (compared to 46%)
- 41% are less than 40 years (compared to 71% ages 0 – 44)
- 6% less than High School (compared to 36%)
- 21% have a Bachelor's Degree
- 59% Bachelor Degree or higher (compared to 14%)
- 3% Unemployed (compared to 10%)
- 67% Female
- 74% Employed full time
- 24% lived in Chelsea all life
- 39% lived in Chelsea 10+ years

Overall survey respondents are more educated, older, women

Charlestown Quality of Life Survey Respondents (n=545)

- 75% White, 6% Hispanic (compared to 75% White, 10% Hispanic)
- 41% are 40-64 Years (compared to 22% ages 45 – 64)
- 12% less than High School (compared to 10%)
- 26% have an Associates or Bachelor's Degree (compared to 36%)
- 28% Graduate Degree (compared to 25%)
- 9% Unemployed (compared to 5%)
- 32% Male
- 43% Employed full time
- 31% have lived in Charlestown their entire life

Overall survey respondents are slightly more educated, older, women

Appendix C

Select Quality of Life Survey Questions

Vision: Healthy Community

Think about your ideal community...From the following list, what do you think are the THREE MOST IMPORTANT factors that define a "Healthy Community"? *(Only check three)*

- ❑ Access to health care
- ❑ Access to healthy food
- ❑ Accessible public transportation
- ❑ Affordable housing
- ❑ Arts and cultural events
- ❑ Clean environment
- ❑ Good jobs and a healthy economy
- ❑ Good roads/infrastructure
- ❑ Good schools
- ❑ Healthy behaviors and lifestyles
- ❑ Low crime/safe neighborhoods
- ❑ Low death and disease rates
- ❑ Low infant deaths
- ❑ Low level of child abuse
- ❑ Parks and recreation
- ❑ Religious or spiritual values
- ❑ Strong family life
- ❑ Strong leadership
- ❑ Strong sense of community
- ❑ Other (please specify)

Mission: Health Priorities

From the following list, what do you think are the THREE MOST IMPORTANT health problems in Chelsea? *(Those problems which have the greatest impact on overall community health.) (Only check three)*

- ❑ Aging problems (arthritis, falls, hearing/vision loss, etc.)
- ❑ Alcohol abuse / addiction
- ❑ Asthma
- ❑ Autism
- ❑ Cancers
- ❑ Child abuse/neglect
- ❑ Crime & violence
- ❑ Dental problems
- ❑ Diabetes
- ❑ Domestic violence
- ❑ Drug abuse / addiction / overdose
- ❑ Education (low graduation rates, quality of education, etc.)
- ❑ Environment (air quality, traffic, noise, etc.)
- ❑ Heart disease and stroke
- ❑ High blood pressure
- ❑ Homelessness
- ❑ Housing
- ❑ Hunger/malnutrition
- ❑ Infant death
- ❑ Infectious diseases (Hepatitis, TB, etc.)
- ❑ Mental health (anxiety, depression, etc.)
- ❑ Obesity
- ❑ Poor diet / inactivity
- ❑ Rape/sexual assault
- ❑ Respiratory/lung disease
- ❑ Sexually transmitted diseases (STDs)
- ❑ Smoking
- ❑ Suicide
- ❑ Teenage pregnancy

Goals: Perception of health, connectedness & social capital

Using a scale of 1-5 (as shown below), please rate how much you agree or disagree with the following statements: Strongly Disagree (1) Strongly Agree (5) Don't know / Unsure

1. Chelsea is a good place to raise children
2. Chelsea is a good place to grow old
3. There is economic opportunity in Chelsea. (Consider locally owned businesses, jobs with career growth, job training, higher education, etc.)
4. Chelsea is a safe place to live
5. There are networks of support for individuals and families in Chelsea during times of stress and need
6. I feel connected to my neighbors and my community
7. The businesses, agencies and organizations in Chelsea contribute to making the community a better place to live
8. All residents have the opportunity to contribute to and participate in making Chelsea a better place to live. (Consider minority populations, new residents, etc.)
9. I believe I can contribute to and participate in making Chelsea a better place to live
10. Overall, I am satisfied with the quality of life in Chelsea

Appendix D

Focus Group Characteristics

Revere Focus Group Summary

Focus group Location	Characteristics of Participants	Total	Gender
MGH Senior Wellness Program	Senior Citizens	11	Males = 1; Females = 10
MGH Senior Wellness Program	Senior Citizens	10	Males = 4; Females = 6
CAPIC] Head Start	Latinos (Spanish speakers)	7	Males = 0; Females = 7
CAPIC Head Start	English speakers (included non-Latino immigrants)	4	Males = 0; Females = 4
First Congregational Church ESL students	Latinos (Spanish speakers)	9	Males = 3; Females = 6
First Congregational Church Food Pantry clients	English speakers (included non-Latino immigrants, people with developmental disabilities)	25	Males = 9; Females = 16
MGH/Revere	Muslims	8	Males = 6; Females = 2
North Suffolk Mental Health/ Revere Counseling Center	Cambodians	10	Males = 4; Females = 6
Total: 8	**Total Participants:**	**84**	**Males = 27; Females = 57**

Chelsea Focus Group Summary

Focus Group Location	Characteristics of participants	Total	Gender
MGH Chelsea	Arab/Iraqi refugees. New comers in past 3-4 years.	12	Female: 10 Male: 2
Chelsea	MGH Employees and long-term residents Some in Chelsea over 20 years.	10	Female: 8 Male: 2
CAPIC Head Start	Parents with children in program. Spanish.	14	Female: 14
CAPIC Head Start	Parents with children in program. English.	14	Female: 13 Male: 1
CAPIC Family Network	Parents with children in program.	10	Female: 10
Chelsea Neighborhood Developers	Residents (Spanish speakers)	10	Female: 8 Male: 2
Chelsea Collaborative	Residents	12	Female: 8 Male: 4
Roca	Youth Star participants	12	Female: 9 Male: 3
MGH Chelsea	Somali refugees. Arrived in the past 5-10 years.	9	Female: 8 Male: 1
CND housing	Residents who received tax prep help.	6	Female: 3 Male: 3
Total: 10	**Total participants:**	**109**	**Female: 91 Male: 18**

Appendix D

Focus Group Characteristics

Charlestown Focus Group Summary

Focus group Location	Characteristics of participants	Total	Gender
Precinct 2 Navy Yard	Residents (newer)	7	Female: 4 Male: 3
Golden Age Senior Center	Residents/Senior Citizens -3 grps.	29	Female: 21 Male: 8
St. Francis de Sales Parish	CNC members & leaders (Irish-American/Long-Time Residents)	4	Female: 1 Male: 3
Charlestown High School	Teen Residents	8	Not recorded
New Town	Residents -Cantonese speaking	10	Female: 4 Male: 6
Newtown	Residents	13	Female: 11 Male: 2
Newtown	Residents	6	Female: 3 Male: 3
CNC	Elected community leaders	8	Female: 3 Male: 5
Mishawum housing development	Teen Residents (Irish-American/Long-Time Residents)	12	Female: 3 Male: 9
BHA	Residents (Spanish-speaking)?	10	Female: 10 Male: 0
Newtown	Residents (English speaking)	6	Female: 6 Male: 0
Smart from the Start	Residents (English-speaking)	14	Females: 14
Smart from the Start	Residents (Spanish speaking)	6	Female: 6 Male: 0
MGH Charlestown	Key Informants-leaders (Irish-American/Long-Time Residents)	6	Female: 3 Male: 3
Mishawum	Adult Residents (Irish-American/Long-Time Residents)	10	Female: 8 Male: 2
Total: 17	**Total Participants:**	**149**	**Female: 97 Male: 44 Gender not recorded: 8**

Appendix E

Facilitator Guide
Community Assessment

Question 1—Assets
What are some of the biggest strengths of your community...positive things about it? Discuss characteristics of people and places, organizations and programs, community context and environment that you believe contribute to a safe and healthy community.

Probes:
What do families like yours most like about living in this community?
What are this community's best assets (strengths, resources)?
What could change to make this community a better place for families?

Question 2—Challenges
Thinking about the biggest problems or concerns in your community (such as those addressed in the survey), what do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in your community? Please think about which populations are affected by these issues, how much of a concern these issues are to all residents, and why you think they are happening in this community.
What are the root causes of the issue?

Probes:
What populations/groups do you think are most affected by these issues?
In your opinion, how much of a concern are these issues to residents?
Why do you believe these issues are happening in this community / root causes of the issue?
Overall, what do you believe is keeping your community from doing what needs to be done to improve health and quality of life?

Question 3 – Existing Services/Resources
Do people have experience with existing services (name a few)?
Do you believe these services are utilized appropriately – why or why not?
Overall, where do people go to get information about community resources?
How would you bring people together or share information in the community?

Question 4 – Solutions
Thinking of the issues discussed, what are some ideas on how to address them?
Are these totally new efforts or built off of something that already exists?
If new efforts were going to be made in the community, what advice would you have for the planners?

"Extra" questions
For special population Focus Groups: What are some ways that you hear about community events? Probes: flyers/posters (where?), cable TV, radio, through school, online (where, how?), word of mouth]

Appendix F

Revere Focus Group Summary

Looking across questions asked of focus group participants, the wide variety of responses to any given question signals both the variability of the experience of living in Revere, and the thoughtfulness participants showed in their responses. At the same time, participants of all focus groups indicated they had much in common, as evidenced by their shared examples of community assets: Revere schools, outdoor spaces like the beach and parks, and the presence of MGH and its many programs. Also, most participants were well informed about issues of health and savvy in their awareness of services, and they were comprehensive in their thinking about how community information was disseminated and could be improved.

Some patterns were visible in the responses of special sub-groups. For example, Latino focus group participants, many of who were young mothers, focused on issues of safety when walking around the community and being outdoors playing with children. Cambodian participants reported on a variety of positive aspects of their lives in Revere, particularly relative to times in the past when they felt discrimination in the community more strongly. Muslims, Cambodians and Latinos all commented about the importance of having access to ethnic grocers, ostensibly to find food from their own ethnic group. English-speaking focus group participants, including Senior Citizens, were the only groups who stated they used the local *Revere Journal* newspaper as their community-wide information source.

A thread that ran through responses given by Senior Citizens to several different questions was notable: the Senior Citizens frequently linked the presence of immigrants to many challenges the community of Revere faces, possibly indicating a degree of prejudice they hold toward newcomers to Revere from other countries. This is a very important issue to investigate in the future. The leaders of Revere actively welcome immigrants as a means of enriching the community, so discomfort with the changing face of the city might, if left unaddressed, isolate Senior Citizens and limit their active participation of the community when just the opposite would be most desirable, and have a negative impact on immigrants seeking to settle in Revere and contribute to its betterment.

It is also important to note that there were a few topics about which participants had markedly different opinions. For example, some said the Revere crime rate was relatively low while others reported on specific instances of crime, substance abuse widespread and overt, and the perception that Revere was an unsafe place to live. Many participants commented on the presence and important offerings of MGH, while also stating that access was limited because of a lack of doctors and dwindling service. Also, participants' descriptions of public parks varied widely also, with many reporting on the parks as assets and also noting that they were dirty and unsafe. Such differing points of view are not necessarily mutually exclusive, but do invite further investigation in order to understand seeming contradictions and ensure that resources that contribute to health and wellbeing of all of Revere's residents.

Prepared by Janet Smith, PhD

Appendix F

Chelsea Focus Group Summary

Chelsea is a vibrant community where people from a variety of countries have come to settle in the US. Many community services exist in Chelsea in response to the wide variety of needs of residents early in their adjustment to life in a new country. It appears from participants' responses that the community is largely successful in accommodating diversity, although there are still more resources needed in the form of interpreters and translators for those who are not native English-speakers, as well as ESL classes and training programs to help residents increase their abilities in English to create a bridge to better employment opportunities in order to move beyond the limitations of minimum-wage jobs.

In spite of Chelsea's many assets, the perception that the community is unsafe and violent persists among residents. Indeed, many focus group participants indicated that going out in Chelsea at night was a dangerous thing to do. That perception created barriers to residents' full participation in the community, and had likely curtailed opportunities for Chelsea to develop a welcoming nightlife with improved commercial possibilities for the community and in the region. Turning this problem around would seem to promise increased employment opportunities as well.

Several infrastructure improvements to the community would add to Chelsea's development as an attractive and healthy community. This includes improvement to roads and traffic, cleanliness and maintenance standards of landlords and tenants, as well as more carefully monitored laws about litter, trash and cleaning up dog waste. However, being able to counter the potentially negative health impacts of environmental features such as the salt pile and pollutants from industrial sites in the community would seem to require focused collaborative efforts across the community, including between local government, health organizations like MGH and leaders of local industry.

Prepared by Janet Smith, PhD

Appendix F

Charlestown Focus Group Summary

Participants portrayed Charlestown as an intersection of many layers of difference and many distinct pockets of culture and language. It is a community that has experienced large cultural and economic transformation in the past few years, opening its doors to large amounts of new residents from varying socio-economic statuses and backgrounds. Indeed living in Charlestown was experienced quite differently by various focus group participants. Charlestown's sense of neighborhood and community was the asset mentioned most frequently, while the *lack* of a sense of community and collaboration was the most frequently mentioned factor holding the community back, indicating that people might be very neighborly within areas of the community, but not across areas of the city.

It appears from the participants' responses that even the very comprehensive networks of community programs serving Charlestown have had varying degrees of success in providing services that Charlestown resident's need. The participants living in Charlestown the longest provided a vivid understanding of quality of life, institutions and resources serving the community, including the strengths and shortcomings of these institutions, across many years. Although this informed view could have built loyalty to these resources, many study participants who were long-time residents focused on the shortcomings of these resources, which seemed to undercut any optimism about possible improvements. Focus group participants that were newest to the area, however, appeared most appreciative of community resources and the possibilities for their success, with those living in subsidized housing focused on possible improvements to basic living conditions and safety, and those living in new homes focused more on increasing aesthetic and recreational opportunities.

Specific differences were prevalent in the responses of the two special sub-groups. For example, Diverse Residents focus groups named as assets health-related community services available through subsidized housing, such as the Newtown Community Center and resources of MGH, and services for low-income families, such as WIC and Head Start, while these were not named as assets by the Irish-American/Long-term Residents focus group. Instead, the Irish-American/Long-time Residents identified different assets, including better-established civic groups like Knights of Columbus and Fireman's Fund and family activities such as theater and cookouts, and these were not named by the Diverse Residents focus groups.

Also, challenges named by Irish-American/Long-time residents were candidly critical of institutional services such as MGH health programs and the Boston Public Schools busing policy, with their criticism based on examples that spanned several years and, at times, multiple generations. The challenges named by Diverse Residents focus groups included issues of discrimination against new residents based on language or ethnicity.

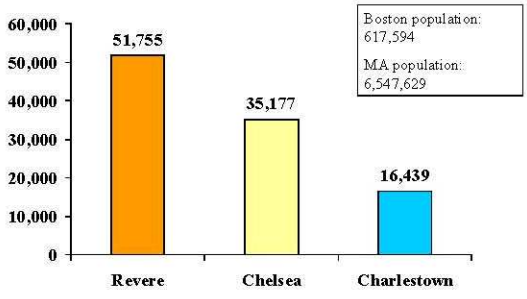
In spite of the many differences between the special subgroups, some similar patterns of response were seen as well, notably concerning public community-based programs for youth (an asset), and substance abuse and the perception of crime in the community (challenges). Additionally, the opportunities for the youth of Charlestown are a high priority of all residents, even within separate cultural or economic pockets of the community. This important shared priority may be the lever needed for residents to lower barriers, reach across differences and advocate together for community improvements via the resources available to serve the community.

*Prepared by Janet Smith, PhD.**

Demographics

Total Population

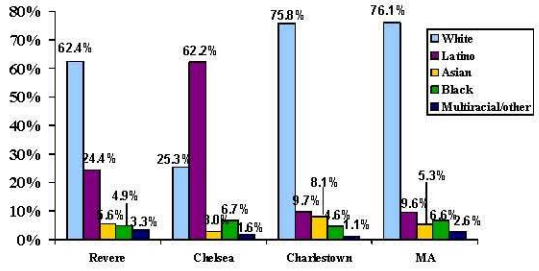
2010



Source: 2010 U.S. Census Bureau

Population by Race/Ethnicity

2010



Source: 2010 US Census Bureau, Charlestown is calculated by combining census tracts: 401, 402, 403, 404.01, 406, 408.01

Population by Age Group

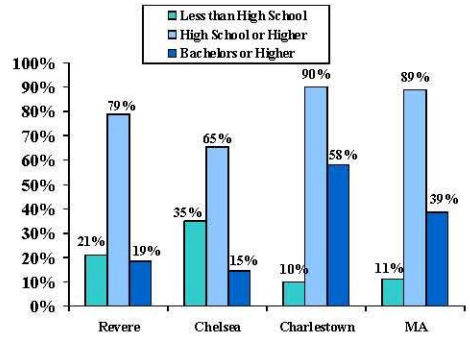
2010

Ages	Revere	Chelsea	Charlestown*	Boston	MA Total
0-19 years	22.8%	27.9%	16%	22.0%	24.8%
20-24 years	6.9%	8.3%	7%	14.3%	7.3%
25-44 years	30.8%	35.1%	45%	33.3%	26.5%
45-64 years	25.0%	20.0%	22%	20.4%	27.7%
65+ years	14.5%	8.8%	10%	10.1%	13.8%

Source: 2010 US Census Bureau
*Charlestown Data calculated by combining the following Census tracts of Suffolk County, MA: 401, 402, 403, 404.01, 406, 408.01; first two age ranges for Charlestown are 0-17 and 18-24

Educational Attainment

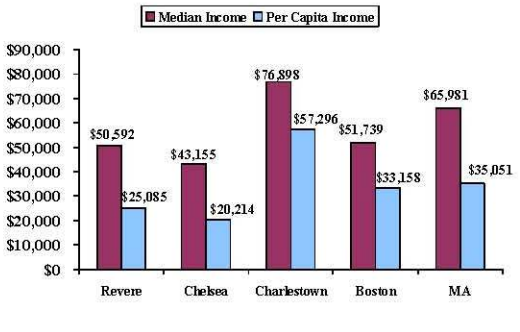
2011



Source: US Census Bureau American Community Survey 2007-2011 Charlestown is calculated by combining census tracts: 401, 402, 403, 404.01, 406, 408.01

Income

2011

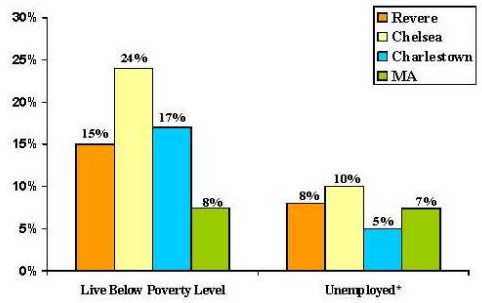


Source: US Census 2007-2011 American Community Survey 5 year estimates in 2011 inflation adjusted dollars *Charlestown is calculated by combining census tracts: 401, 402, 403, 404.01, 406, 408.01

Appendix G

Poverty and Unemployment Rates

2006-2010



Source: US Census Bureau American Community Survey 5 year estimates 2006-2010

Substance Abuse Prevention

Revere Quality of Life Survey

2012

Substance Abuse

- On a scale of 1-5, respondents ranked Revere a 4.3 when asked how much of a problem drug and alcohol abuse is
- 52% reported they had had one more alcoholic drink in past 30 days
- 10% had participated in binge drinking in past 2 weeks
- 4% took prescription drugs not prescribed to them

Mental Health

- 13% reported they have felt sad or hopeless for 2 weeks in the past year
- 1 in 4 families have been affected by depression
- 30% reported that someone in their families needed mental health services
- 45.5% could not access mental health services

"I live in a school zone and have drug addicts that sell drugs all day, every day RIGHT NEXT TO THE SCHOOL" -Revere Survey Respondent

*Data based on 959 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more White, educated, and female perspective.

Chelsea Quality of Life Survey

2012

Substance Abuse

- Drug abuse/addiction and overdose ranked as #1 most important health problem
- 56% have consumed alcohol and 12% have smoked in past 30 days
- 1 in 5 of the Chelsea survey respondents reported they have participated in binge drinking in past 2 weeks (5 or more drinks)

Mental Health

- 14% reported they have felt sad or hopeless for 2 weeks in the past year
- 30% reported that someone in their families needed mental health services
- 41% could not access them

"I am more stressed out about the lack of mental health services for my students than due to any other factor in my life right now."

-Chelsea Survey Respondent

"Chelsea needs to restrict the easy access to alcohol and drugs. It's too easy to get drugs, and easier to obtain alcohol..." -Chelsea Survey Respondent

*Data based on 959 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more White, educated, and female perspective.

Charlestown Quality of Life Survey

2012

Substance Abuse

- Drug abuse/addiction/overdose ranked as #1 most important health problem
- 59% reported they had had one more alcoholic drink in past 30 days
- 17% had participated in binge drinking in past 2 weeks
- 3% took prescription drugs not prescribed to them
- 24% of families affected by Alcoholism

Mental Health

- 28% of families have been affected by depression
- 10% reported they have felt sad or hopeless for 2 weeks in the past year
- 30% could not access mental health services

"I tried on more than one occasion to arrange for a therapist for my children. It never worked out."

-Charlestown Survey Respondent

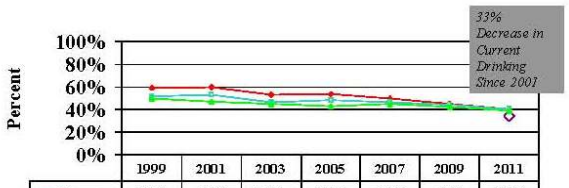
"I am very concerned about drug use in the community."

-Charlestown Survey Respondent

*Data based on 545 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more White, educated, and female perspective.

Revere and Chelsea High School Students Current Alcohol Consumption

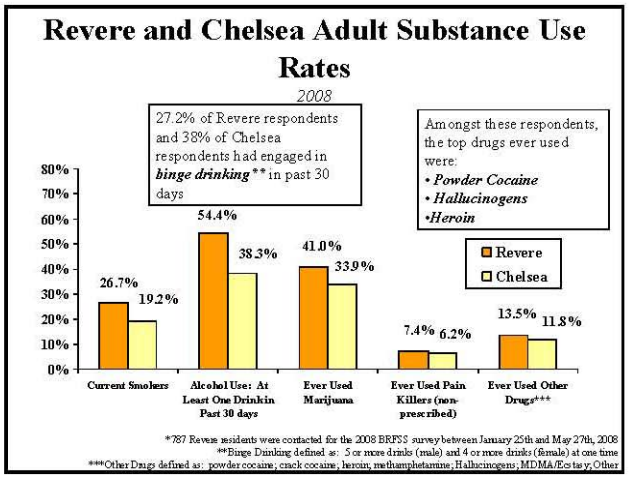
1999-2011

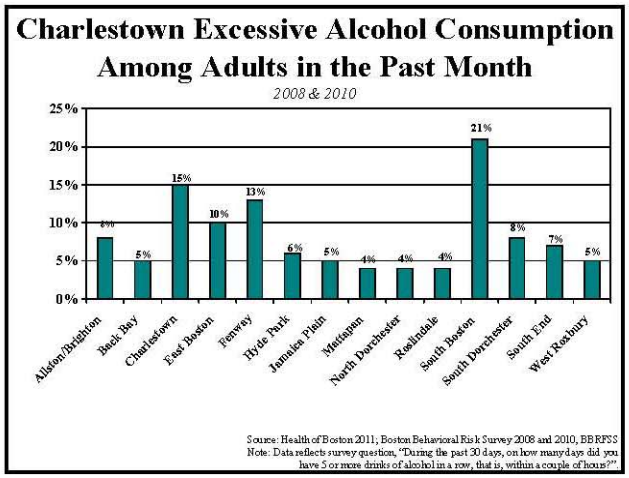


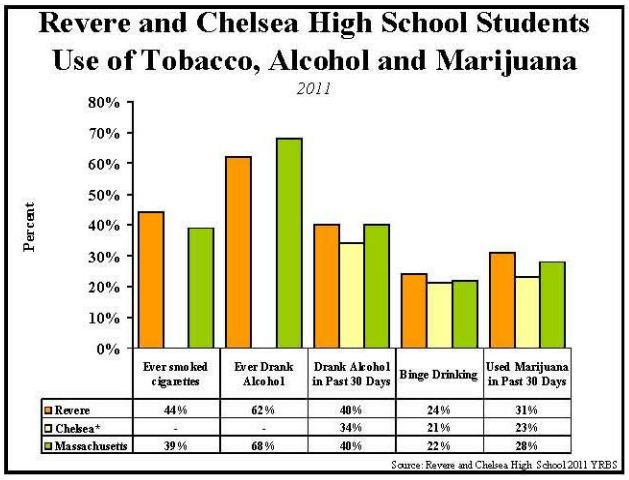
	1999	2001	2003	2005	2007	2009	2011
Revere	59%	60%	53%	54%	50%	45%	40%
Chelsea*	-	-	-	-	-	-	34%
Mass.	52%	53%	46%	48%	46%	44%	40%
Nation	50%	47%	45%	43%	45%	42%	39%

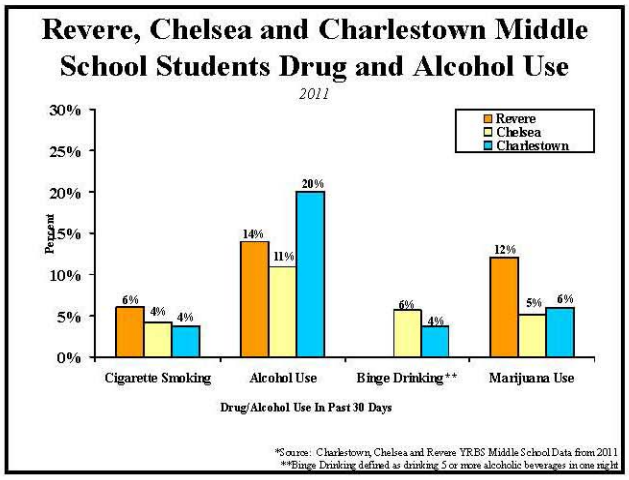
Source: 1999-2011 High School YRBS
*Methods of the Chelsea YRBS have changed, the most reliable data available is from 2011. **Drank alcohol in past 30 days

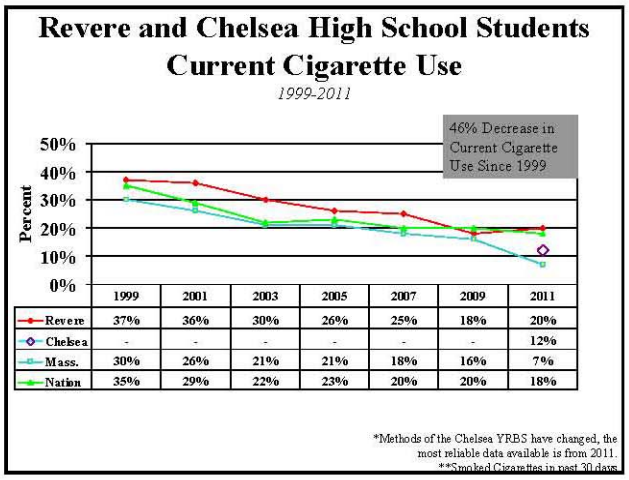
Appendix G

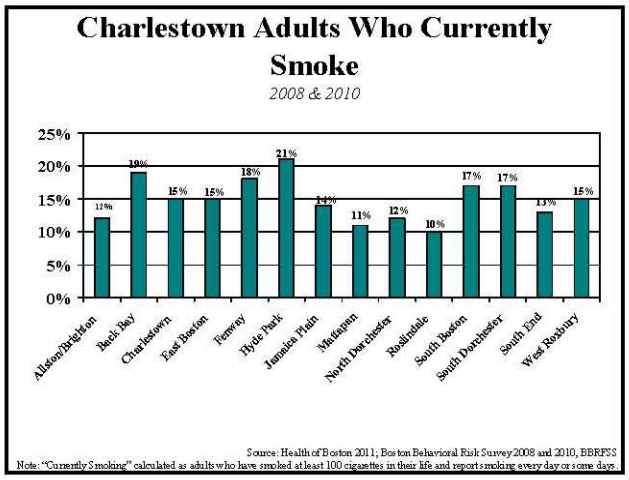

Revere and Chelsea Adult Substance Use Rates
2008
27.2% of Revere respondents and 38% of Chelsea respondents had engaged in binge drinking** in past 30 days
Amongst these respondents, the top drugs ever used were:
• Powder Cocaine
• Hallucinogens
•Heroin
Revere
Chelsea
80%
70%
60%
50%
40%
30%
20%
10%
0%
26.7%
19.2%
54.4%
38.3%
41.0%
33.9%
7.4%
6.2%
13.5%
11.8%
Current Smokers
Alcohol Use: At Least One Drinkin Past 30 days
Ever Used Marijuana
Ever Used Pain Killers (non-prescribed)
Ever Used Other Drugs***
*787 Revere residents were contacted for the 2008 BRFSS survey between January 25th and May 27th, 2008
**Binge Drinking defined as: 5 or more drinks (male) and 4 or more drinks (female) at one time
***Other Drugs defined as: powder cocaine, crack cocaine, heroin, methamphetamine, Hallucinogens, MDMA/Ecstasy, Other


Charlestown Excessive Alcohol Consumption Among Adults in the Past Month
2008 & 2010
25%
20%
15%
10%
5%
0%
8%
5%
15%
10%
13%
6%
5%
4%
4%
4%
21%
8%
7%
5%
Allston/Brighton
Back Bay
Charlestown
East Boston
Fenway
Hyde Park
Jamaica Plain
Mattapan
North Dorchester
Roslindale
South Boston
South Dorchester
South End
West Roxbury
Source: Health of Boston 2011; Boston Behavioral Risk Survey 2008 and 2010, BBRFSS
Note: Data reflects survey question, "During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?"


Revere and Chelsea High School Students Use of Tobacco, Alcohol and Marijuana
2011
Percent
80%
70%
60%
50%
40%
30%
20%
10%
0%
Ever smoked cigarettes
Ever Drank Alcohol
Drank Alcohol in Past 30 Days
Binge Drinking
Used Marijuana in Past 30 Days
Revere 44% 62% 40% 24% 31%
Chelsea* - - 34% 21% 23%
Massachusetts 39% 68% 40% 22% 28%
Source: Revere and Chelsea High School 2011 YRBS

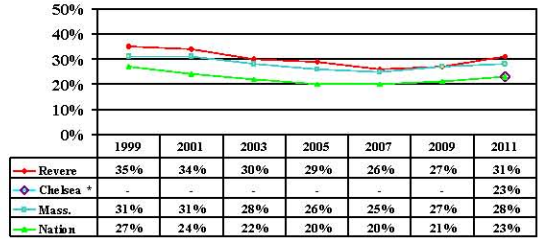

Revere, Chelsea and Charlestown Middle School Students Drug and Alcohol Use
2011
Percent
30%
25%
20%
15%
10%
5%
0%
Revere
Chelsea
Charlestown
6%
4%
4%
14%
11%
20%
6%
4%
12%
5%
6%
Cigarette Smoking
Alcohol Use
Binge Drinking**
Marijuana Use
Drug/Alcohol Use In Past 30 Days
*Source: Charlestown, Chelsea and Revere YRBS Middle School Data from 2011
**Binge Drinking defined as drinking 5 or more alcoholic beverages in one night


Revere and Chelsea High School Students Current Cigarette Use
1999-2011
46% Decrease in Current Cigarette Use Since 1999
Percent
50%
40%
30%
20%
10%
0%
1999 2001 2003 2005 2007 2009 2011
Revere 37% 36% 30% 26% 25% 18% 20%
Chelsea - - - - - - 12%
Mass. 30% 26% 21% 21% 18% 16% 7%
Nation 35% 29% 22% 23% 20% 20% 18%
*Methods of the Chelsea YRBS have changed, the most reliable data available is from 2011.
**Smoked Cigarettes in past 30 days


Charlestown Adults Who Currently Smoke
2008 & 2010
25%
20%
15%
10%
5%
0%
12%
19%
15%
15%
18%
21%
14%
11%
12%
10%
17%
17%
13%
15%
Allston/Brighton
Back Bay
Charlestown
East Boston
Fenway
Hyde Park
Jamaica Plain
Mattapan
North Dorchester
Roslindale
South Boston
South Dorchester
South End
West Roxbury
Source: Health of Boston 2011; Boston Behavioral Risk Survey 2008 and 2010, BBRFSS
Note: "Currently Smoking" calculated as adults who have smoked at least 100 cigarettes in their life and reports smoking every day or some days

Revere and Chelsea High School Students Current Marijuana Use

1999-2011

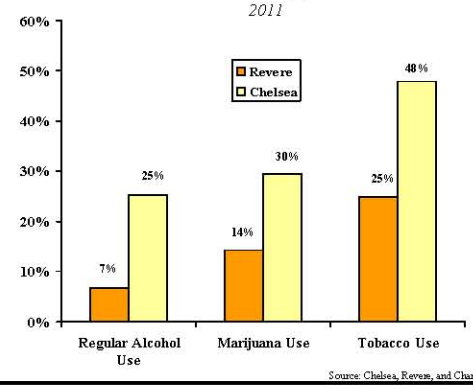


	1999	2001	2003	2005	2007	2009	2011
Revere	35%	34%	30%	29%	26%	27%	31%
Chelsea *	-	-	-	-	-	-	23%
Mass.	31%	31%	28%	26%	25%	27%	28%
Nation	27%	24%	22%	20%	20%	21%	23%

*Methods of the Chelsea YRBS have changed, the most reliable data available is from 2011. **Used marijuana in past 30 days

Perceived Great Risk of Substance Use in Chelsea and Revere High School Students

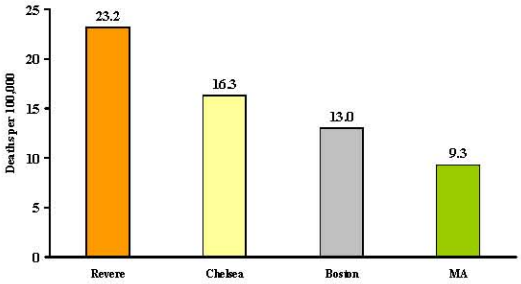
2011



Source: Chelsea, Revere, and Charlestown 2011 YRBS

Opioid Related Fatal Overdose Rates

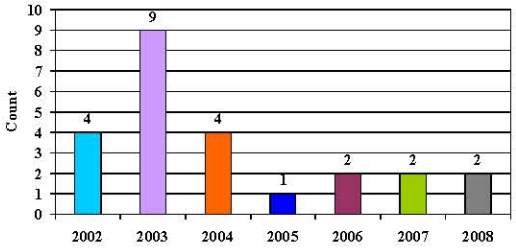
2007-2009



Source: MassCHIP, Vital Records 2007-2009
Age-adjusted to the 2000 US standard population.

Charlestown Opioid-Related Mortality

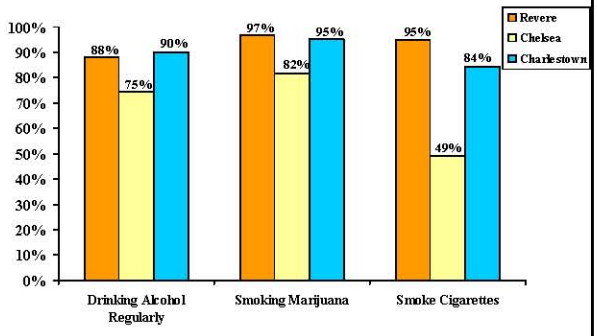
2003-2008



Source: Boston resident deaths, Massachusetts Department of Public Health
Data Analysis: Massachusetts Department of Public Health

Perceived Parental Disapproval Rate of Middle School Students Using Substances

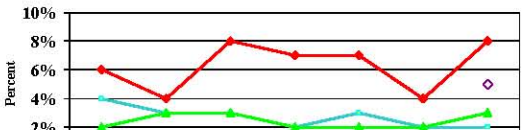
2011



Source: Chelsea, Revere, Charlestown 2011 Middle School YRBS

Revere and Chelsea High School Students Heroin Use

1999-2011



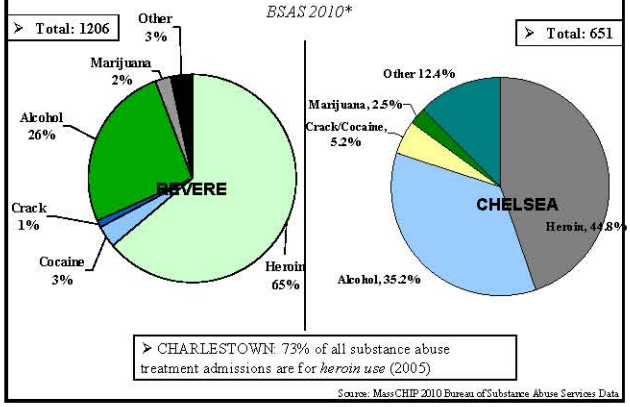
	1999	2001	2003	2005	2007	2009	2011
Revere	6%	4%	8%	7%	7%	4%	8%
Chelsea*	-	-	-	-	-	-	5%
Mass.	4%	3%	3%	2%	3%	2%	2%
Nation	2%	3%	3%	2%	2%	2%	3%

Source: 1999-2011 Revere High School YRBS
*Methods of the Chelsea YRBS have changed, the most reliable data available is from 2011

Appendix G

Revere and Chelsea Primary Substance Treatment Admissions

*BSAS 2010**

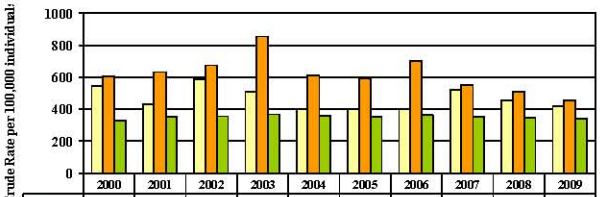


➢ CHARLESTOWN: 73% of all substance abuse treatment admissions are for *heroin use* (2005)

Source: MassCHIP 2010 Bureau of Substance Abuse Services Data

Revere and Chelsea Alcohol and Substance-Related Hospital Discharges

2000-2009

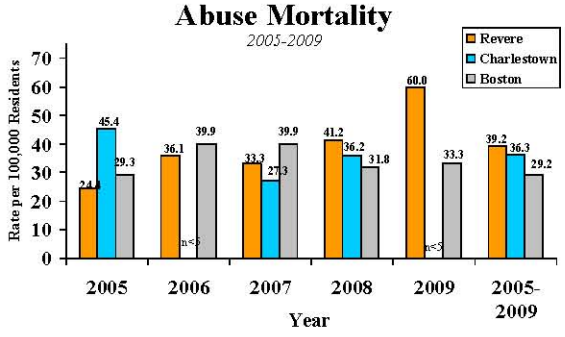


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Chelsea	543	432	585	512	398	402	396	519	455	417
Revere	604.08	631.11	673.73	853.16	610.69	588.35	700.31	551.03	511.51	456.63
MA	332.55	350.06	355.78	368.02	357.84	351.33	363.03	350.96	345.6	344.65

*Source: MassCHIP, 2000-2009 Uniform Hospital Discharge Data Set (UHDDS)

Revere and Charlestown Substance Abuse Mortality

2005-2009



Source: Registry of Vital Records and Statistics, MDPH (Prepared by the Injury Surveillance Program, MDPH)
Charlestown and Boston data from BPHC Data request.

Violence Prevention & Public Safety

Revere Quality of Life Survey: Violence

2012

- Low crime/safe neighborhood was #1 factor that defines a Healthy Community
- Crime and violence ranked second most important health problem
- Respondents ranked Revere a 3 on a scale of 1-3 as a safe place to live
- 2% have been affected by community violence and 3% reported physical abuse
- Respondents ranked feeling connected to neighbors and community a 3.2 on a scale of 1-5

"I think we need more police officers on Broadway especially during the summer months. I don't feel comfortable walking on Broadway and I grew up in this city my whole life" -Revere Survey Respondent

*Data based on 756 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more educated, older, female perspective.

Chelsea Quality of Life Survey: Violence

2012

- Crime and violence ranked as second most important problem in Chelsea
- Chelsea was rated a 2.5 on a scale of 1-5 as a safe place to live
- 3.6% report they or someone in their immediate family have been affected by community violence and 4.7% by physical abuse
- Respondents ranked feeling connected to neighbors and their community a 3.2 on a scale of 1-5

"Chelsea has the opportunity to be a great city. But violence, housing and lack of parental involvement are big issues..." -Chelsea Survey Respondent

"In general, Chelsea needs to become a safer place to live and do business..." -Chelsea Survey Respondent

*Data based on 959 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more White, educated, and female perspective.

Charlestown Quality of Life Survey: Violence

2012

- Low crime/safe neighborhood ranked as the most important factor that defines a healthy community (49%)
- 6% affected by community violence, 5% by physical abuse
- Lifelong residents ranked Charlestown a 3.6 on a scale of 1-5 as a safe place to live
- Respondents ranked feeling connected to neighbors and community a 3.8 on a scale of 1-5

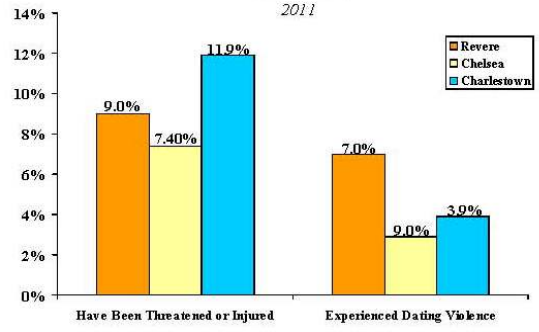
"A lot of people like to say crime is a problem down in the projects, but it is everywhere."
-Charlestown Survey Respondent

"I feel a sense of hopelessness and fear with the crime..."
-Charlestown Survey Respondent

*Data based on 545 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more educated, older, female perspective.

Middle School Students Who Have Experienced Violence

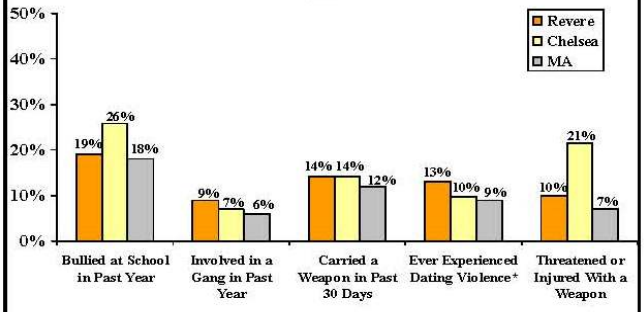
2011



Source: Chelsea, Revere, Charlestown 2011 YRBS

Revere and Chelsea High School Students Violence

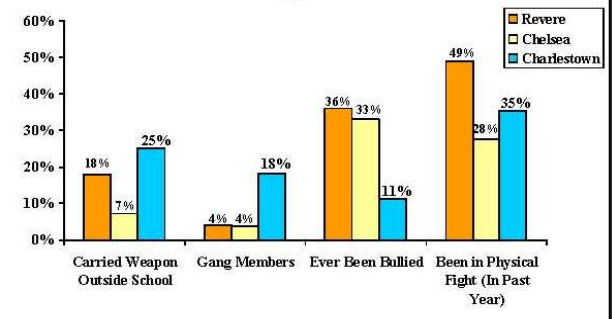
2011



Source: Chelsea 2011 YRBS High School 2011 (Grades 9-12, In 2011, 1,078 completed surveys of students with parental permission)
*Dating Violence is defined as having been hurt physically or sexually by a date or someone going out with

Revere, Chelsea and Charlestown Middle School Students Violence

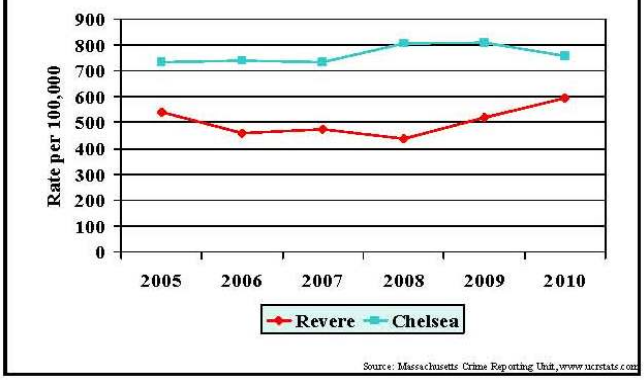
2011



Source: 2011 Revere, Chelsea, Charlestown Middle School YRBS

Revere and Chelsea Violent Crimes

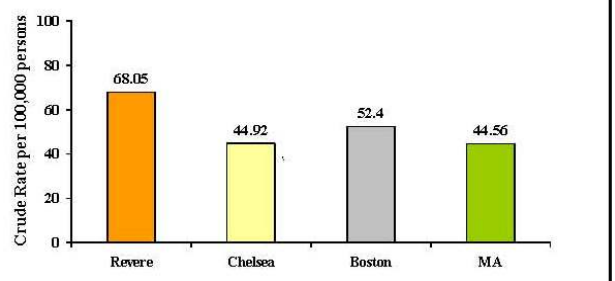
2005-2010



Source: Massachusetts Crime Reporting Unit, www.ucrstats.com

Mortality from Injury

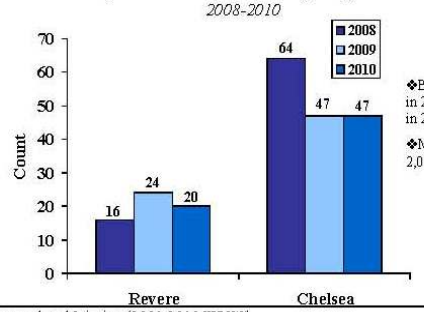
2007-2009



Source: MassCHIP, Vital Records (Mortality), 2007-2009

Weapon Related Injury Cases

2008-2010



- Boston had 386 cases in 2010 (down from 594 in 2008)
- Massachusetts had 2,039 cases in 2010

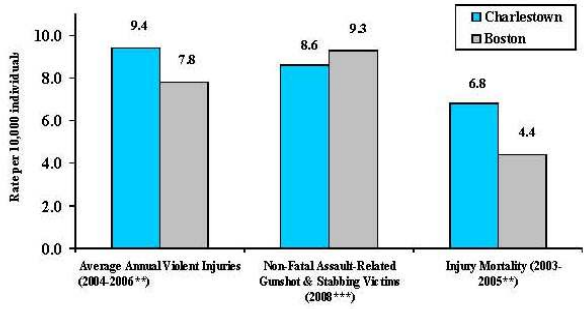
Weapon-related Injuries *(2008-2010 WRISS)*

- Highest amongst **ages 20-24** in Revere(24.6% of Injuries vs. 28.0% statewide)
- Very high amongst **males** in Revere (88.3% of Injuries vs. 88.1% statewide)
- Highest amongst **ages 20-24** in Chelsea (39 cases)

Source: MassCHIP WRISS Report 2008-2010

Violence and Injuries in Charlestown

2004-2008



*Violent injuries defined as injuries from guns or sharp instruments obtained during violent incidents & treated in an ER
**Source: Partners Community Benefit Report
***Source: Weapon Related Injuries, MA Department of Health, WRISS – from BPHC Health of Boston 2010 Report

Healthy Eating / Active Living

Revere Quality of Life Survey: Healthy Living

2012

- 56% of Revere residents exercise 30 minutes or more at least 3 days a week
- Main reason why people don't exercise is that they do not have enough time (47%)
- 52% rate their health as very good or excellent
- 49% of respondents had eaten vegetables and 42% had eaten fruit 1-3 times a day during the past week
- 11% did not eat fruit during the past week

"Revere really lacks access to healthy food. There are no supermarkets in the main area, you have to drive - no farmers markets, just a lot of junk food."
-Revere Survey Respondent

*Data based on 756 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more educated, older, female perspective.

Chelsea Quality of Life Survey: Healthy Living

2012

- 56% of respondents rated their health as very good or excellent
- 42% stated that the main reason they don't exercise is due to lack of time
- 36% consumed fruit a couple times in past 7 days, 38% for vegetables
- Chelsea was rated a 2.2 for being healthy (on a scale of 1-5)
- 59% of Chelsea residents exercise for 30 minutes or more at least 3 days/week

"I feel Chelsea is making strides toward becoming a healthy community attractive to newcomers."
-Chelsea Survey Respondent

*Data based on 959 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more White, educated, and female perspective.

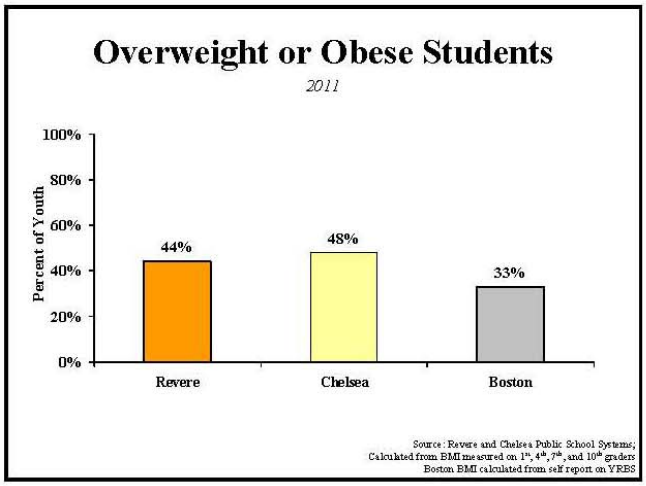
Charlestown Quality of Life Survey: Healthy Living

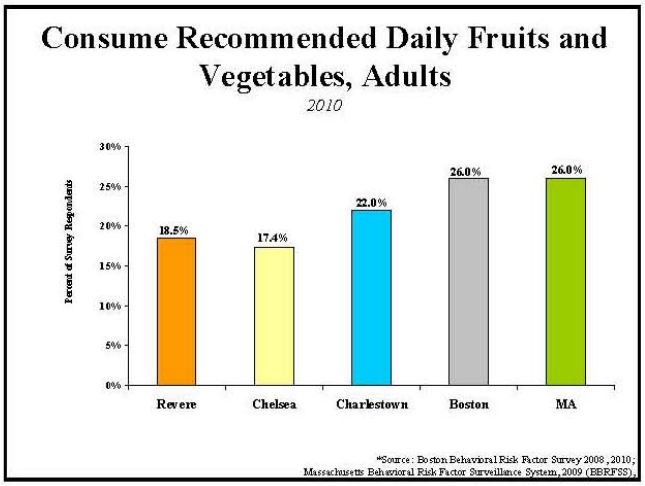
2012

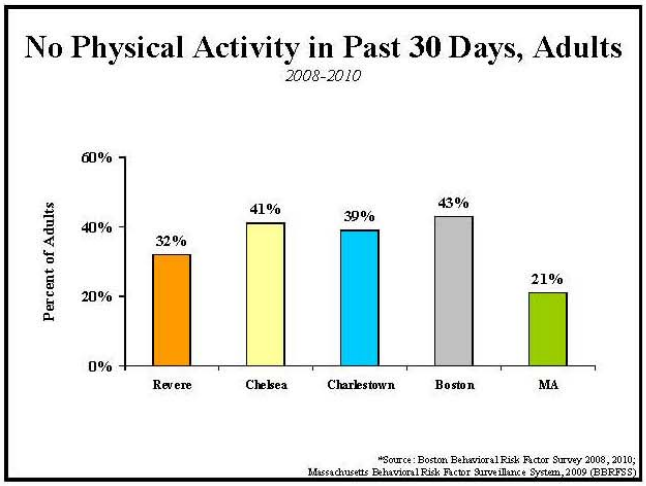
- 70% rated Charlestown as a healthy community, 2% rated it as very healthy
- 54% rated their health as very good or excellent
- 67% of Charlestown residents exercise at least 3 days a week
- 44% consume fruit and 50% consume veggies 1-3 times per day
- People are most active in the parks, fitness clubs, and fields. 42% stated the main reason they don't exercise is that they don't have enough time

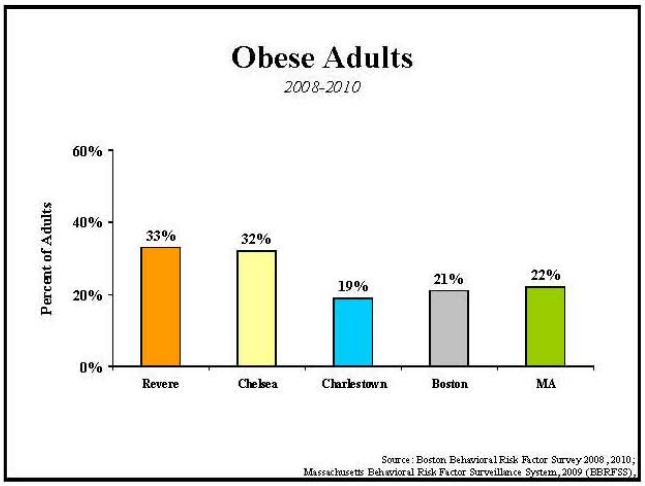
"I think the area of Charlestown is very unsafe and unhealthy, serious changes need to be made."
-Charlestown Survey Respondent

*Data based on 545 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more educated, older, female perspective.









Youth Development / Education

Quality of Life Survey: Youth

2012

On a scale of 1-5, survey respondents rated their communities as a good place to raise children…

- **Revere** was rated a 3.2
- **Chelsea** was rated a 2.5
- **Charlestown** was rated a 3.7

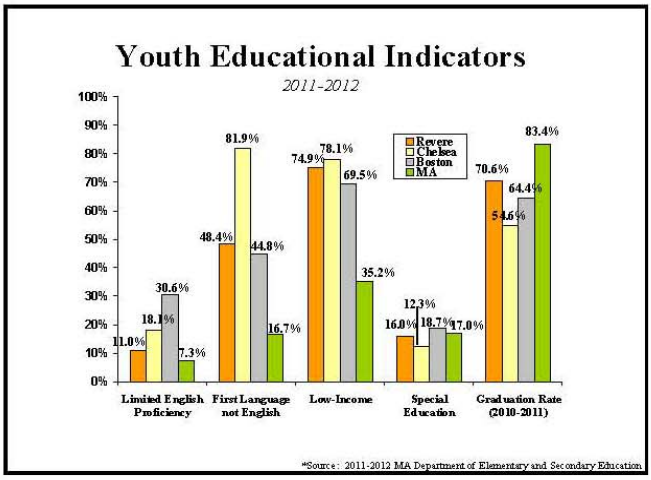
"I don't think the involvement of schools with children and their families is increasing, and there should be more input between both." -Revere Survey Respondent

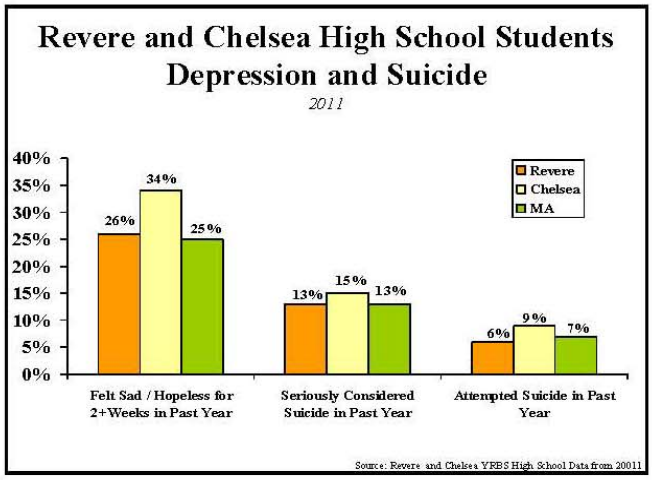
"There are after school clubs etc for younger children but nothing much to keep the slightly older age groups involved and out of trouble." -Charlestown Survey Respondent

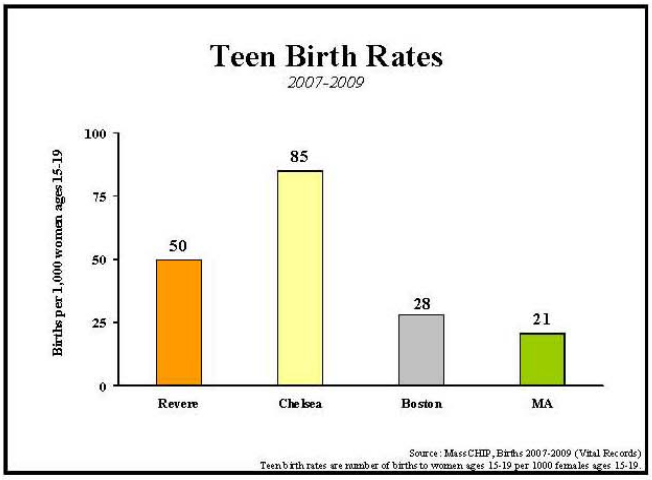
"I am worry of my younger child growing to be a teen in Chelsea." -Chelsea Survey Respondent

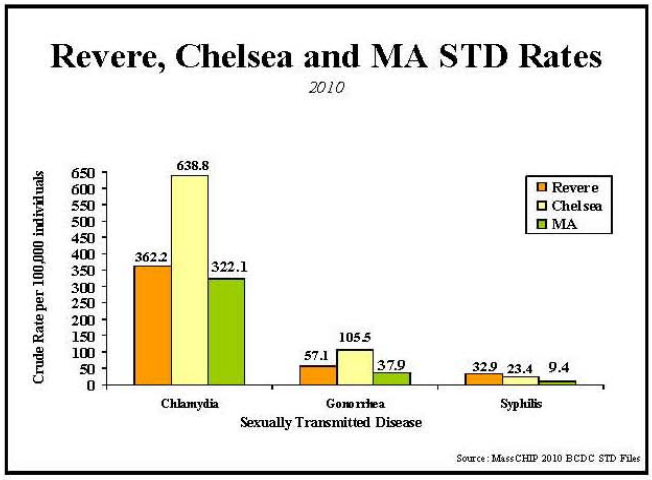
*Data based on 959 completed surveys that were distributed in February and March in print, online, and in multiple languages through the

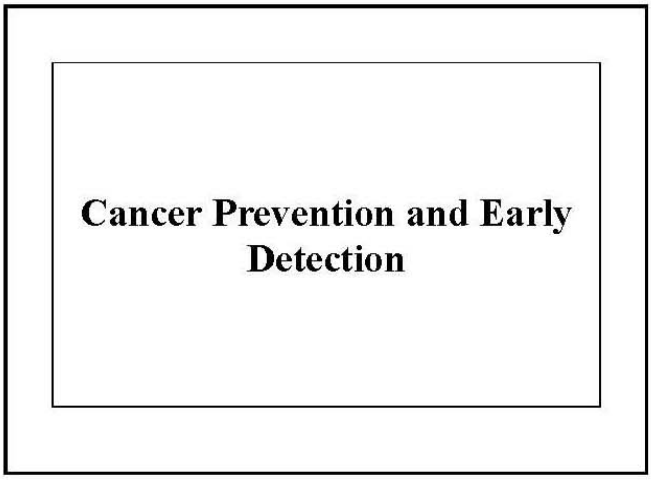
Appendix G

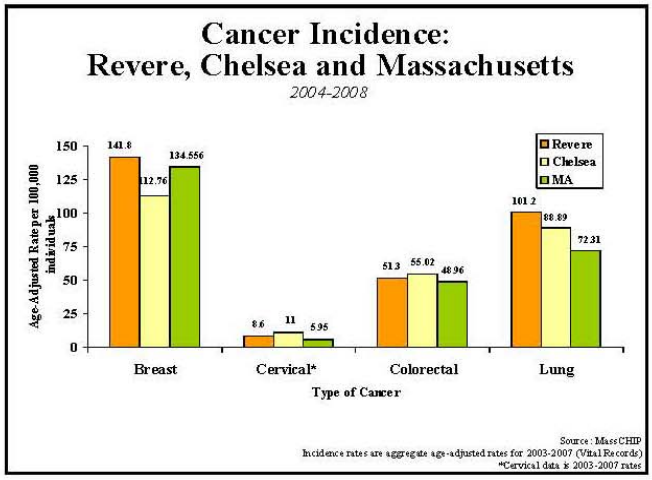

Youth Educational Indicators
2011-2012
Revere
Chelsea
Boston
MA
11.0%
18.1%
30.6%
7.3%
48.4%
81.9%
44.8%
16.7%
74.9%
78.1%
69.5%
35.2%
16.0%
12.3%
18.7%
17.0%
70.6%
54.6%
64.4%
83.4%
Limited English Proficiency
First Language not English
Low-Income
Special Education
Graduation Rate (2010-2011)
*Source: 2011-2012 MA Department of Elementary and Secondary Education


Revere and Chelsea High School Students
Depression and Suicide
2011
Revere
Chelsea
MA
26%
34%
25%
13%
15%
13%
6%
9%
7%
Felt Sad / Hopeless for 2+Weeks in Past Year
Seriously Considered Suicide in Past Year
Attempted Suicide in Past Year
Source: Revere and Chelsea YRBS High School Data from 20011


Teen Birth Rates
2007-2009
Births per 1,000 women ages 15-19
50
85
28
21
Revere
Chelsea
Boston
MA
Source: MassCHIP, Births 2007-2009 (Vital Records)
Teen birth rates are number of births to women ages 15-19 per 1000 females ages 15-19


Revere, Chelsea and MA STD Rates
2010
Crude Rate per 100,000 individuals
Revere
Chelsea
MA
362.2
638.8
322.1
57.1
105.5
37.9
32.9
23.4
9.4
Chlamydia
Gonorrhea
Syphilis
Sexually Transmitted Disease
Source: MassCHIP 2010 BCDC STD Files

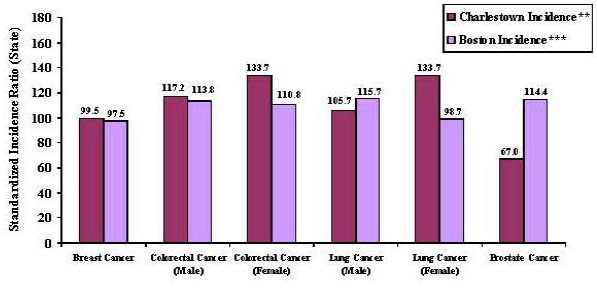

Cancer Prevention and Early Detection


Cancer Incidence:
Revere, Chelsea and Massachusetts
2004-2008
Age-Adjusted Rate per 100,000 individuals
Revere
Chelsea
MA
141.8
112.76
134.556
8.6
11
5.95
51.3
55.02
48.96
101.2
88.89
72.31
Breast
Cervical*
Colorectal
Lung
Type of Cancer
Source: MassCHIP
Incidence rates are aggregate age-adjusted rates for 2003-2007 (Vital Records)
*Cervical data is 2003-2007 rates

Appendix G

Charlestown Cancer Incidence

*Standard Incidence Ratios 2003-2007**



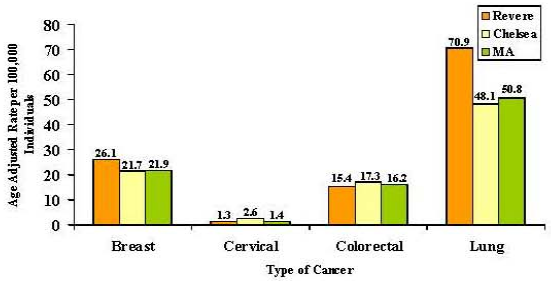
*Standard Incidence Ratios describe how a community's cancer incidence and mortality compare with the state as a whole. Ex: An incidence ratio of 100 indicates an incidence equal to that of the state; a ratio of 105 indicates incidence 5% higher than the state while a ratio of 95 indicated incidence 5% lower than the state. Data Source: MA Cancer Registry, Bureau of Health Information, Statistics, Research, and Evaluation, MA Department of Health,

**Charlestown data from the BPHC Cancer Incidence and Mortality in Boston Neighborhoods 2003-2007 Report

***Boston Data from MassCHIP, Massachusetts DPH

Cancer Mortality: Revere, Chelsea and Massachusetts

2005-2009

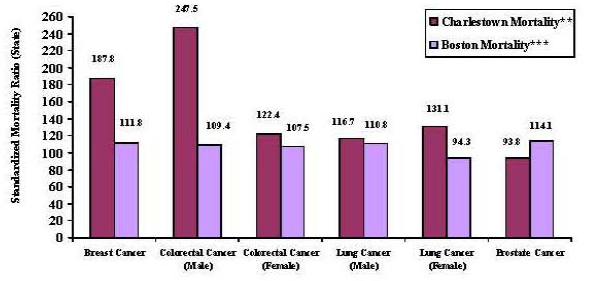


Source: MassCHIP

Mortality rates are aggregate age-adjusted rates for 2005-2009 (Vital Records)

Charlestown Cancer Mortality

Standard Mortality Ratios 2003-2007 (not incidence rates)*



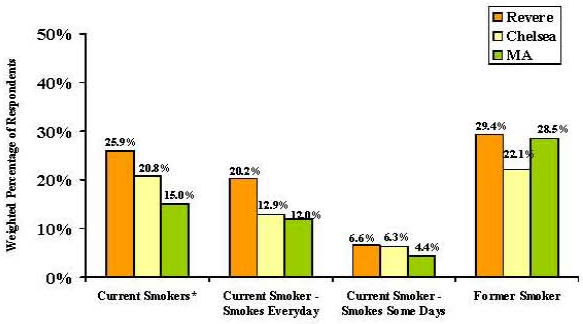
*Standard Mortality Ratios describe how a community's cancer incidence and mortality compare with the state as a whole. Ex: An incidence ratio of 100 indicates an incidence equal to that of the state; a ratio of 105 indicates incidence 5% higher than the state while a ratio of 95 indicated incidence 5% lower than the state. Data Source: MA Cancer Registry, Bureau of Health Information, Statistics, Research, and Evaluation, MA Department of Health,

**Charlestown data from the BPHC Cancer Incidence and Mortality in Boston Neighborhoods 2003-2007 Report

***Boston Data from MassCHIP, Massachusetts DPH

Revere and Chelsea Smoking Rates

2008 & 2009



Source: 2008 BRFSS survey (self-reported)-787 Revere residents were contacted between January 25th and May 27th, 2008

*2009 BRFSS from MA DPH

Access to Care For Vulnerable Populations

Revere Quality of Life Survey: Access to Care

2012

- Access to care ranked #3 (23%) when asked what defines a Healthy Community
- 62% were always able to get needed care, 12% were sometimes able, and 3% were never able
- 46% receive routine health care in a practice outside of Revere
- 39% believe there are no barriers to accessing care, 7% stated insurance was a barrier, 9.5% stated that there are no doctors available
- 21% of respondents receive care at the MGH Revere HealthCare Center

"People of color and immigrant don't have equal access to resources." -Revere Survey Respondent

*Data based on 756 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more educated, older, female perspective.

Chelsea Quality of Life Survey: Access to Care

2012

- Access to care ranked #3 (27%) when asked what defines a Healthy Community
- 54% were always able to get needed care, 16.7% were sometimes able, and 6% were never able
- 34.5% receive routine health care in a practice outside of Chelsea
- 31.2% believe there are no barriers to accessing care, 7.7% stated insurance was a barrier, 6.7% stated that there are no doctors available
- 18% of respondents receive care at the MGH Chelsea HealthCare Center

"For young people in Chelsea, there is a large need for culturally appropriate and easily accessible services..."
-Chelsea Survey Respondent

*Data based on 959 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more White, educated, and female perspective

Charlestown Quality of Life Survey: Access to Care

2012

- Access to health care ranked as second most important factor that defines a Healthy Community
- 58% were always able to get needed care, 10% were sometimes able, and 2% were never able
- 43% receive routine health care in a practice outside of Revere
- 47% believe there are no barriers to accessing care, 11% stated insurance was a barrier, 7% stated that there are no doctors available, 7.5% stated the hours of operation made it difficult
- 48% of respondents receive care at the MGH Charlestown HealthCare Center

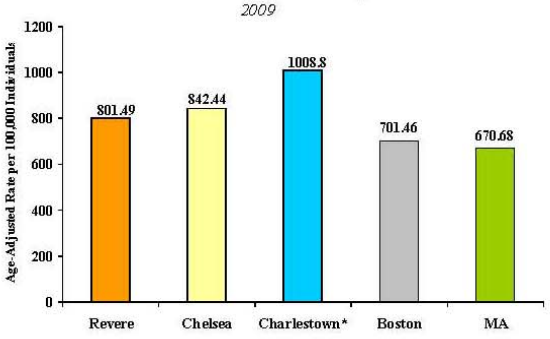
"Please help us make Charlestown a healthier place for kids and families, especially families of older kids who have committed to staying in the community long term"
-Charlestown Survey Respondent

*Data based on 545 completed surveys that were distributed in February and March in print, online, and in multiple languages through the Assessment Committee and in public locations. Sample represents a more educated, older, female perspective

Mortality

Overall Mortality

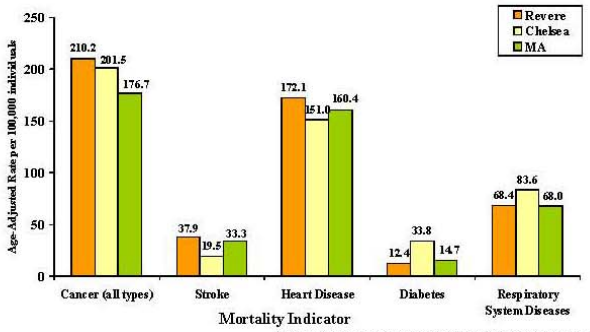
2009



Source: Mass Dept. of Public Health MassCHIP database 2009 (Vital Records) *Charlestown: 2008 Boston Resident Deaths, Department of Public Health – 2010 Health of Boston Report

Revere and Chelsea Chronic Disease Mortality

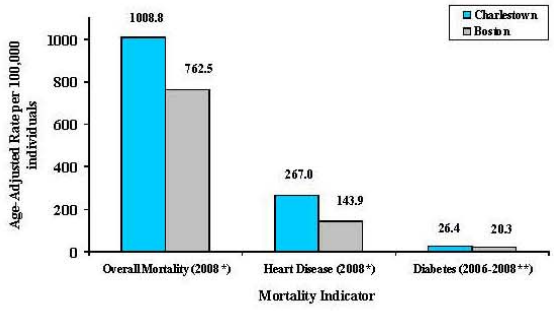
2007-2009



*Data Source: Mass Dept. of Public Health MassCHIP database 2007-2009 aggregate age-adjusted (Vital Records)

Charlestown Chronic Disease Mortality

2008



*Source: Boston Resident Deaths, as reported by BPHC in The Health of Boston 2010Report

SUBSTANCE ABUSE PREVENTION

GOAL: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children (HP 2020)

NATIONAL DATA
Adolescent abuse of prescription drugs has continued to rise over the past 5 years (Vicodin and OxyContin). Substances seen as available & safe. (HP 2020)

The Local Problem

Substance abuse was identified as the #1 problem in all three communities.

Between 34 and 40% of high school youth report current drinking

Between 20 and 24% of high school and 15 and 21% of adults engage in current binge drinking

Current marijuana use has increased since 2007 by 11% statewide.

7% of Revere and 25% of Chelsea high school students believe that people are at great risk of harming themselves if they use alcohol regularly (1-2 a day).

14% of Revere and 30% of Chelsea high school students believe that people are at great risk of harming themselves if they smoke marijuana regularly.

Approximately 2-10 people die a year from opioid overdoses in each of the three communities.

CCHI Objectives

By 2015 a 5% change for the following:

- Decrease current use of alcohol, & tobacco among youth and adults. (YRBS, BRFSS)
- Decrease the percent of youth and adults engaged in binge drinking.* (YRBS, BRFSS)
- Decrease the percent of current marijuana usage among youth. *(YRBS)
- Increase the percent of youth who perceive great risk associated with substance abuse.* (YRBS)
- Decrease opioid overdoses and deaths.* (BSAS)

Community & Hospital Strategies

Primarily through community coalitions and with patients provide...

- **Education:** *Evidenced- based prevention curricula in schools; Youth Asset Development Model
- **Early childhood home visiting:** * To build resiliency, increase protective and decrease risk factors for children and families
- **Parent engagement**: Parent Coffees & on-line parent conversations.
- **Social Marketing/ Communication**
- **Policies:** * To address alcohol, tobacco, prescription drug and Narcan availability and distribution
- **Safety / Law Enforcement:** Underage drinking / alcohol sales, public usage, disturbances. *Explore Broken Window Approach:* Collaborate with community organizations / police to reduce drug activity in neighborhoods and increase perception of safety.
- **Community-based Interventions:** Comprehensive models to coordinate community based services to youth, track progress and measure results. (ex. Harlem Children's Zone)
- **Community Health Workers** to connect persons with addiction and their families to treatment and other services.

Clinical interventions:

- **Universal evidence based screening** and brief intervention (SBI) in primary and specialty care (OB)*
- Embed substance abuse services within adult med

New for CCHI

Expand substance abuse to Chelsea

** HP 2020 Recommendation*

VIOLENCE PREVENTION & PUBLIC SAFETY

GOAL: Prevent unintentional injuries and violence, and reduce their consequences (HP 2020) and help individuals to be and feel safe and secure in their homes and communities.

NATIONAL DATA

- The social environment has a notable influence on the risk for injury and violence through individual social experiences (social norms, victimization), social relationships, (parental monitoring, family interactions), the community environment, and societal level factors (cultural beliefs, attitudes). Interventions that address these social and physical factors have the potential to prevent unintentional injuries and violence. (HP 2020)

The Local Problem

Violence/Public Safety identified as the #2 problem in all three communities, particularly as it relates to substance abuse.

Community residents report feeling unsafe on the streets and in parks due to drug activity and paraphernalia.

About 1 in 4 Chelsea and Revere residents do not feel connected to their neighbors or their community, a key contributor to perceptions of safety.

21.5% of Chelsea high school students (7% State) report having been threatened or injured with a weapon in the past year.

More than 10% of Chelsea & Revere high school students have experienced dating violence in their lifetime.

22% of Charlestown middle school children have witnessed violence in their neighborhood, including shootings.

CCHI Objectives

By 2015 a 5% change for the following:

- Increase the feelings of safety in one's community. (Community Survey/Focus Groups)
- Increase connectedness to neighbors and the community. (Community Survey, BRFSS)
- Decrease percent of youth who have been threatened or injured or experienced dating violence.* (YRBS)
- Increase identification of victims and referrals to services.(Program Data)

Community & Hospital Strategies

Primarily through community coalitions and with patients provide...

- **Early childhood home visiting:*** To build resiliency, increase protective and decrease risk factors for children and families.
- **Education & School Based Programming:*** Evidence based curricula; community resource guide.
- **Parent engagement:** Parent coffees to build connectedness and skills.
- **Social Marketing/Communication***
- **Physical Environment:** Improve the built environment to increase safety and physical activity (lighting, sidewalk & park improvements, etc.).
- **Safety / Law Enforcement:** Police enforcement/presence around underage drinking / alcohol and drug sales, public usage, disturbances, etc. "Broken Window" approach with "drug houses" in Chelsea.

Clinical interventions:

- **Navigation:** Through HAVEN, MGH's domestic violence program & Violence Intervention Advocacy Program (VIAP), a program for victims of community violence in the MGH Emergency Dept.
- **Universal evidence based violence/domestic violence screening** and brief intervention (SBI) in primary and specialty care and within the worksite.*

New for CCHI

Improve the built environment as a safety strategy.

"Broken Windows" Approach

Expand early childhood home visiting

HP 2020 Recommendation

OBESITY /HUNGER PARADOX - HEALTHY EATING / ACTIVE LIVING

GOAL: Promote and improve health, fitness and quality of life and reduce chronic disease risk through the consumption of healthful diets and daily physical activity and achievement and maintenance of healthy body weights (HP 2020)

NATIONAL DATA
- More than 80% of adults and youth do not meet the guidelines for aerobic physical activity.
- In order to change diet and weight, individual behaviors must change as well as the policies and environment that support these behaviors. (HP2020)

The Local Problem

Identified by communities as a concern and associated with diabetes, heart disease and hunger in all communities.

Healthy Eating

18% of Boston high school students reported consuming recommended serving of 5 or more daily servings of fruits and vegetables a day. (Chelsea & Revere Data TBD)

About 1 in 5 adults consume the recommended daily amount of fruits and vegetables.

Active Living

22% of Revere and 27% of Boston high school youth report engaging in regular physical activity (43% State); 32% Revere, 41% Chelsea, 39% Charlestown adults report **not** getting any physical activity in past 30 days (21% state)

Obesity & Hunger

44% Revere, 48% Chelsea youth are overweight or obese (34% State); 33% Revere, 32% Chelsea, 19% Charlestown adults are obese (22% state).

Approx. 20% of Chelsea patients and 9% of Revere pediatric patients screened positive for hunger in 2011.

CCHI Objectives

By 2015 a 5% change for the following:

Healthy Eating
- Increase the amount of nutritious food and decrease access to sweetened beverages inside of school.* (School Data)
- Increase consumption of fruits and vegetables by adults and youth.* (YRBS/ BRFSS)

Active Living
- Increase the percent of youth and adults who meet federal physical activity guidelines (Youth: 1 hour per day 5+ days a week/Adults: 30 minutes a day 5+ days a week adults).* (YRBS/BRFSS)

Obesity & Hunger
- Decrease the percent of youth and adults who are considered overweight and obese.* (DPH, BRFSS)
- Increase access to food resources, especially for those that screen positive for hunger. (MGH)
- Change the built environment to enhance access to physical activity.* (Community Data)

Community & Hospital Strategies

Primarily through community coalitions and with patients provide...
- **Education:** Evidence based curricula in schools, sports, and youth orgs.
- **Policies:*** Healthier food options at schools, stores & restaurants; increase physical activity time in schools; trans fat ban; health impact assessments.
- **Alternative Activities** with healthy food and physical activity for youth after school.
- **Social Marketing/Communication:*** "Making the Healthy Choice the Easy Choice" – *First Lady Michelle Obama*
- **Physical Environment:*** Farmers markets / mobile food pantries. Improve the built environment to increase safety and physical activity (ex. lighting, sidewalks, bike lanes, clean parks, walking trails).

Clinical interventions:
- **Universal evidence based screening** and brief intervention (SBI) in primary and specialty care (OB) for nutrition, physical activity and hunger.*
- Routine collection of **BMI** in Primary Care.*
- **Prescriptions** for healthy eating and physical activity from physicians.

New for CCHI

Expand healthy eating/active living initiatives to Charlestown

** HP 2020 Recommendation*

YOUTH DEVELOPMENT / EDUCATION

GOAL: Improve the healthy development, health, safety and well-being of adolescents and young adults. (HP 2020)

NATIONAL DATA

- The adolescent population is becoming more ethnically diverse, with rapid increases in the numbers of Hispanic and Asian American youth, requiring cultural responsiveness to health care needs and sharpened attention to disparate health and academic outcomes, which are correlated with poverty, especially among adolescents from minority racial and ethnic groups.
- There is growing empirical evidence that well-designed youth development interventions preventing adolescent health risk behaviors can lead to positive outcomes. (HP 2020)

The Local Problem

Students entering school with limited English proficiency. (First language not English: 82% Chelsea, 48% Revere, 45% Boston.)

70% or more are considered low-income in all three communities compared to 35% of students across the state. (78% Chelsea, 75% Revere, 70% Boston)

Graduation rates are low: 57% Chelsea, 71% Revere, 64% Boston, 83% State)

34% of Chelsea and 26% of Revere high school students report feeling depressed (25% State)

69% of Chelsea and 77% of Revere high school students want to complete college or purse a graduate degree.

Only 42% of the Boston high school graduating class of 2000 who entered college had graduated seven years later.

CCHI Objectives

By 2015 a 5% change for the following:

- Increase leadership opportunities for youth. (CCHI Program Data)
- Increase youth assets. (CCHI & School Data)
- Increase the percent of youth who participate in extracurricular and out of school activities.* (YRBS & CCHI Program Data)
- Increase youth participation in MGH CCHI programming and interventions. (CCHI Program Data)
- Increase educational achievement for youth participating in CCHI programs.* (CCHI Program & DOE Data)

Community & Hospital Strategies

- **Peer Leadership Groups in schools:** Empower students to engage in efforts that positively impact their schools and communities.
- **Youth Asset Development:** With schools, help build youth internal and external assets helping youth develop resilience and strengths that are necessary to prevent problems.
- **Mental Health/Social Support:** Continue to provide medical and mental health services at the Revere & Chelsea school-based health clinics.
- **STEM – Youth Scholars Program:** Expose youth to topics and careers in Science, Technology, Engineering and Math as pathway out of poverty.
- **Bicentennial Scholars:** Intense college coaching and SAT preparation for STEM participants as well as continued support in postsecondary education.
- **Strengthening Families Program:*** An evidence-based family skills training program to reduce problem behaviors in children and improve social competencies and school performance.

Clinical interventions:

- **Youth Mentoring by MGH Employees**

New for CCHI

Expand STEM & the Bicentennial Scholars Program.

Youth Asset Development

**HP 2020 Recommendation*

CANCER PREVENTION AND EARLY DETECTION

GOAL: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer (HP 2020) with a focus on prevention and early detection.

NATIONAL TRENDS / DATA

- Cancer remains a leading cause of death in the US, second only to heart disease. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers (colorectal, breast, uterine, & kidney).
- Socio economic status, more than race or ethnicity predicts the likelihood of an individual's or group's access to education, health insurance and safe and healthy living/working conditions all of which play a major role in the prevalence of behavioral risk factors for cancer and rates of cancer screenings. (HP 2020)

The Local Problem

Cancer was identified as a concern, particularly in the community of Charlestown.

8,000 MGH vulnerable patients (as defined by TopCare) are in need of breast, cervical, and/or colorectal screening.

The incidence and mortality from breast, cervical, colorectal and lung are high in all three communities

Lung cancer incidence and mortality are particularly high in all three communities.

All three communities have higher smoking rates than the state.

CCHI Objectives

By 2015:

- Navigate 60% of MGH vulnerable patients (as defined by TopCare) to breast, colon or cervical cancer screening appointments. (MGH Patient Data)
- Navigate 3900 patients for breast cancer screening and follow-up at Mattapan, Geiger, Neponset and Mid-Upper Cape Health Centers.
- Navigate 1800 MGH patients to breast and cervical follow-up appointments.
- Launch smoking prevention for youth and smoking cessation in all three communities.
- Increase the number of smoke free housing units in Chelsea & Revere.
- Healthy Living Objectives for Charlestown, Chelsea & Revere – See Healthy Living Logic Model

Community & Hospital Strategies

- **Patient Navigation:** For breast, cervical and colorectal screening and abnormal follow-up to reduce barriers to screening*
- **Social Marketing:*** Healthy living campaign with a focus on smoking
- **Policies:** Healthier food options at schools, stores & restaurants; increase physical activity time in schools; smoke free housing in Chelsea & Revere.
- **Physical Environment:** To promote healthy living - farmers markets; increase physical activity by improving lighting, sidewalks, bike lanes, walking trails, etc.

Clinical interventions:

- **TopCare Screening:** Reminders, education, letters, phone calls and navigation to encourage individual screening*
- **Smoking prevention / cessation**

New for CCHI

Expand cancer navigation/ to more vulnerable MGH patients

Smoking Prevention and Cessation

***HP 2020 Recommendation**

ACCESS TO CARE FOR VULNERABLE POPULATIONS

GOAL: Improve access to comprehensive, quality health care services (HP 2020)

NATIONAL DATA
- Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life.
- Access to health services encompasses four components: health insurance coverage, a usual and ongoing source of care (PCP), timeliness of care and sufficient providers available to address demand. (HP 2020)

The Local Problem	*CCHI Objectives*	*Community & Hospital Strategies*
Despite coverage, vulnerable patients experience cultural, socio-economic, linguistic and other barriers to care. MGH has addressed barriers by forming partnerships or creating programs that outreach to homeless, seniors and refugees and others. Some vulnerable patients, especially those with mental health and substance abuse disorders, are high utilizers of care. *Contextual Factors* Communities identified barriers to care at MGH health centers including: hours of operation, shortage of primary care, limited linguistic capacity (Charlestown), and no urgent care (Revere & Charlestown). MGH health center market share ranges from 15 to 35% of respective communities. Residents finding care at Cambridge Health Alliance & East Boston Neighborhood Health Center.	▪ Decrease barriers to care and increase cultural competence by expanding language capacity, navigation and outreach. (MGH Data; CCHI program data) ▪ Increase number of health care providers interested in community health to increase cultural competence. (COPC Elective)	▪ Community health workers / interpreters & navigators ▪ Continue support for Senior HealthWISE, Boston Health Care for the Homeless Program at MGH & the MGH Chelsea Refugee and Immigrant Health Program *Possible Clinical Strategies:* ▪ Promote Community Oriented Primary Care course for medical, pediatric and med/peds residents. ▪ Work with Primary Care and the health centers to implement the medical home and adapt to the needs of vulnerable patients. ▪ Create a quality indicator for primary care physicians around community health improvement/social determinants of health. ▪ Work with Partners Population Health Management to incorporate needs of vulnerable patients and populations in care redesign and high risk patient management. ▪ Expand primary care access (HP 2020)

New for CCHI

Expand the CHW / Navigation model

Collaborate with Primary Care and Population Health Management

Building Healthier Communities

Massachusetts General Hospital ◊ Center for Community Health Improvement

Substance Abuse Prevention / Intervention

- ▲ Increase the percent of youth who perceive great risk associated with substance abuse
- ▼ Decrease current use of alcohol, tobacco & marijuana & binge drinking
- ▼ Decrease opioid overdoses and deaths

Violence Prevention/Public Safety

- ▲ Increase the feeling of safety in the community
- ▲ Increase connectedness to neighbors and the community
- ▲ Increase identification of victims and referrals to services
- ▼ Decrease the percent of youth who have been threatened or experienced violence

Obesity/ Hunger Paradox

- ▲ Increase consumption of fruits and vegetables by adults and youth
- ▲ Increase physical activity in adults and youth
- ▲ Change the built environment to support health
- ▼ Decrease the percent of youth and adults who are considered overweight & obese

Healthy Eating /Active Living

Youth Development / Education

- ▲ Increase participation in MGH CCHI youth programming and interventions
- ▲ Increase the percent of youth who participate in extracurricular and out of school activities
- ▲ Increase educational achievement for youth participating in CCHI programs
- ▲ Increase youth assets and leadership opportunities

Cancer Prevention / Early Detection

- ▲ Navigate 60% of MGH vulnerable patients to cancer screening

- ▲ Increase smoking cessation services and prevention efforts
- ▲ Increase the number of smoke free housing units
- ▲ Increase healthy eating and active living

Access to Care for Vulnerable Populations

- ▲ Increase the number of health care providers interested in community health
- ▲ Improve responsiveness to vulnerable populations and patients through care redesign
- ▼ Decrease barriers to care for vulnerable populations