BOSTON COMMUNITY HEALTH ASSESSMENT

October 2014

Updated May 2016

Boston Alliance *for* Community Health

BOSTON PUBLIC HEALTH COMMISSION

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EXECUTIVE SUMMARY

In 2012, the Boston Public Health Commission (BPHC) partnered with the Boston Alliance for Community Health (BACH) to develop a Community Health Assessment and Community Health Improvement Plan.

Community Health Assessment as described by the Public Health Accreditation Board (PHAB) is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of the Community Health Assessment is to inform the development of strategies to address the community's health needs and identified issues.

This assessment included inputs from community members and over eighty different organizations using a process called Mobilizing for Action through Planning and Partnerships (MAPP). MAPP is a community-driven planning process for assessing and improving community health from many different perspectives.

The four different MAPP assessments included in this report are briefly described below:

COMMUNITY HEALTH STATUS ASSESSMENT

This assessment summarized the health status, quality of life, and risk/protective factors that contribute to health using a range of health and socio-economic indicators from multiple data sources including BPHC Health of Boston's report and the United States Census.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

This assessment identified themes that interest, concern, and engage the community, perceptions of quality of life, and community assets using a variety of methods including mapping, surveys, community meetings and focus groups

FORCES OF CHANGE ASSESSMENT

This assessment identified trends, factors and events that are occurring or will occur that will affect the community or local public health system.

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

In this assessment a broad range of stakeholders including local residents, public health and health care leaders, and elected officials participated in a structured process developed by the Centers for Disease Control and Prevention to evaluate the activities, capacities, and competencies of Boston's public health system based upon the ten essential public health service

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In this updated report, the summary of health indicators (Appendix A) was revised to include data from 2011-2013. A comprehensive analysis of these data, is reported in the BPHC's 2014/2015 Health of Boston which is available online. The Community Health Assessment, BPHC Health of Boston report and other data sources were used by BACH and other stakeholders in developing the Community Health Improvement Plan (Boston Alliance for Community Health MAPP Report 2014) which includes details of the five strategic priorities listed below:

1. How can we achieve racial and ethnic health equity?
2. How can we improve coordination and integration of healthcare and community-based prevention activities/services?
3. How can we build and increase resilience in communities impacted by trauma?
4. How can we improve health outcomes by focusing on education, employment, and transportation policies and practices?
5. How can we Increase the number of immigrants, people of color, and other under-represented residents in meaningful leadership roles and decision-making processes?

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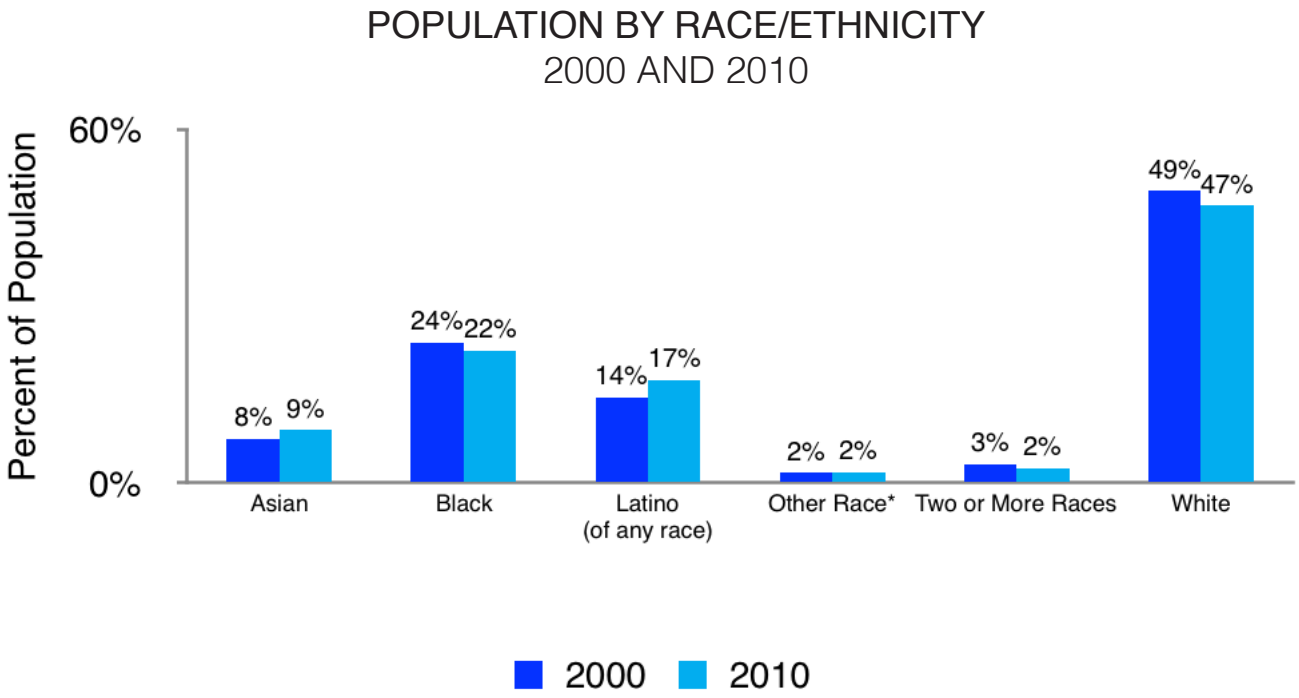
DEMOGRAPHIC PROFILE

In 2010, Boston had 617,594 residents making it the most populous city in Massachusetts. The overall population of Boston increased 5% between 2000 and 2010. During that time, the number of Latino residents and Asian residents increased by 27% and 24% respectively.

While English was the language most frequently reported being spoken at home, 35% of Boston residents ages 5 and over reported speaking a language other than English at home. Among the languages other than English spoken at home, Spanish (including Spanish Creole) was the most widely spoken language (15% of all homes), followed by French (including Patois, Cajun, and French Creole) (5%), Chinese (4%), Portuguese (including Portuguese Creole) (2%), and Vietnamese (2%).



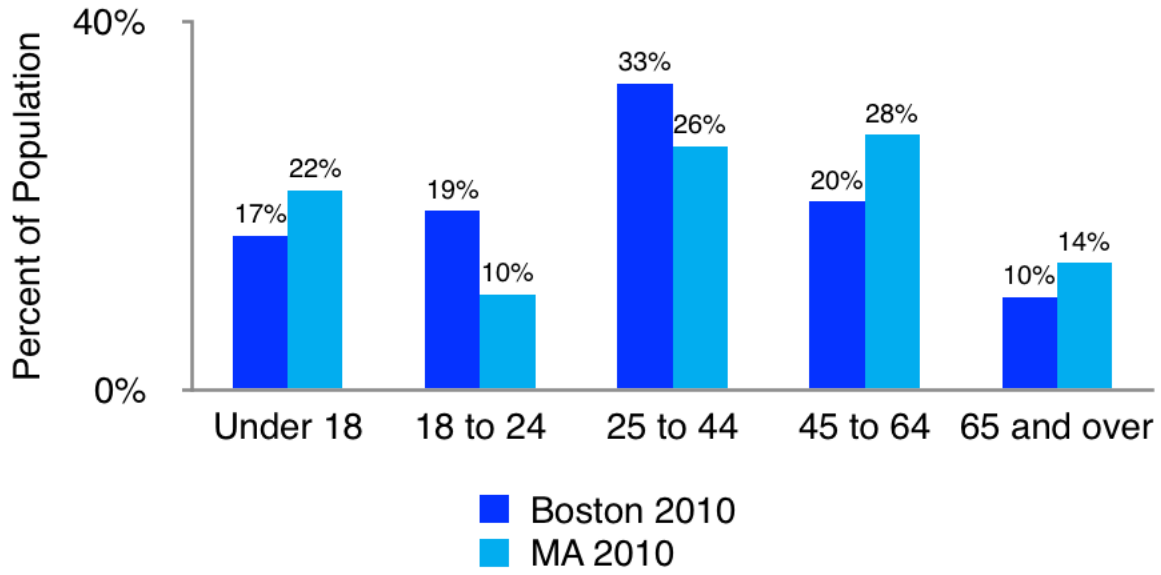
*Includes American Indians/Alaskan Natives, and Some Other Races
DATA SOURCES: Decennial Censuses 2000 and 2010, U.S. Census Bureau

The population of Boston has become increasingly diverse over time. While 50% of Boston residents were White in 2000, this percentage fell to slightly less than a majority (46%) by 2012. Much of the diversification in the population of Boston is due to an increase in the Latino population relative to the overall population of Boston, which increased from 14% in 2000 to 19% in 2012.

During the period 2010-2012, seventeen percent of Boston residents were less than 18 years of age. Children less than 5 years of age made up the greatest percentage of children (32%), while 15-17 year olds made up the smallest percentage of children (17%). Thirty-four percent of children in Boston were Black, 30% were Latino, 24% were White, and 7% were Asian.

In 2010, Boston had a higher percentage of adults ages 18-24 and 25-44 compared with Massachusetts. A higher percentage of Massachusetts residents were younger than 18 and older than 44 compared with Boston.

POPULATION BY AGE GROUP, BOSTON AND MASSACHUSETTS
2010



DATA SOURCES: Decennial Censuses 2000 and 2010

In 2012, 47% of all households in Boston consisted of families. The census defines a family household as one in which there is at least one person living in the household who is related by marriage, blood, or adoption to the householder (head of household). Of all households, an estimated 38% were individuals living alone, and an estimated 26% were married couple families, that is, the householder was living with a spouse.

In 2012, 13% of Boston households were linguistically isolated (defined as having no one within the household 14 years of age and over who speaks English only, or speaks English very well). Thirty-four percent of the linguistically isolated households spoke Spanish, 27% percent spoke Other Indo-European languages, 46% spoke Asian and Pacific Island languages, and 38% spoke other languages.

A comprehensive demographic profile of Boston can be found in the 2015 Health of Boston report, available online here.

MAPP ASSESSMENTS

BPHC and BACH completed the four MAPP assessments in spring 2013. The process for the completion of each the Community Health Status Assessment, Community Themes and Strengths Assessment, Forces of Change Assessment, and Local Public Health System Assessment are described below.

COMMUNITY HEALTH STATUS ASSESSMENTS

Process: *On April 5th, 2013, Boston Alliance for Community Health (BACH) and Boston Public Health Commission (BPHC) data committee reconvened to review and prioritize citywide data for the Community Health Status Assessment.*

BACH members and affiliates met to reexamine the list of indicators that had been previously collected. Data sources included the 2010 US Census, 2013 Health of Boston social determinants and health result, American Community Surveys, Boston Police Department Neighborhood Survey, Behavioral Risk Factor Surveillance Survey, and Vital Statistics. Using health equity and social determinants of health lenses, the group came up with the following key findings.

SOCIAL, ECONOMIC AND ENVIRONMENTAL DETERMINANTS

- In 2010, 54% of households in Boston were non-family households in which no one in the household was related by marriage, blood, or adoption.
- Boston currently has approximately 7.59 acres of green space per 1,000 residents.
- More than 3 in 10 people employed in Boston are in the industries of educational services, and health care and social assistance
- Almost three-quarters of Boston school-age children attended Boston public schools during 2012-2013. Most Latino and Asian children attended Boston public schools, 88% and 87%, respectively. Sixty-nine percent of Black children also did but only 53% of White children attended Boston public schools. This is comparable to the 2010-2011 school years.
- For the combined years of 2010-2012, the median household income for Latinos was $27,461 compared with $70,644 for White households, $36,419 for Asian households, and $37,385 for Black households.
- In 2010, 35% of Boston residents (ages 5 and older) reported speaking a language other than English at home. In 2000, 33% of residents spoke a language at home other than English
- During 2010-2012, 67% (CI 66.0-67.6) of occupied housing units in Boston were renter-occupied, while 34% were owner-occupied, compared to 68% renter-occupied and 32% owner-occupied in 2000.
- In 2013, Boston Public High schools had a 4-year graduation rate of 66% for students who entered grade 9 in the Fall of 2009 compared to 59% for students who entered grade 9 in the Fall of 2006.
- During 2010-2012, the percentage of Boston residents with less than a high school diploma was significantly higher among Latino adults, 34% (CI 31.5-36.3), Asian adults, 24% (21.0-27.2) and Black adults, 20% (17.9-21.7) than White adults, 6% (4.9-6.1). This indicates increased educational attainment compared to 2000 when 18% of Latino adults, 18% of Black adults, 14% of Asian adults, and 8% of White adults had less than a high school diploma.

Areas for Improvement

- In 2010, 60% of female-headed households with children under age 5 had income below the poverty level compared with 18% for all family households in Boston. This is an increase from 2000 when 45.6% of female-headed householders with children under age 5 had income below the poverty level compared to 15.3% of all family households.
- In 2013, 7,248 homeless individuals were counted in Boston ; 28% of these individuals were children. This is an increase from a homeless population of 6,484 in 2009, of which 25% were children.
- Black male residents had an unemployment rate of 32%, almost four times the rate of 9% for White male residents in 2010. In 2000, Black male residents had an unemployment rate of 12.8% while White male residents had an unemployment rate of 6.0%.
- Only 33% of Boston's employed residents took public transportation to work in 2010, with 29.0% of White residents, 38.0% of Black residents, 36.0% of Asian residents, and 39.1% of Hispanic residents utilizing public transportation to get to work.
- 75.1% of Boston's voting age population is registered to vote. 65.9% of these residents voted in the 2008 elections and 62.1% voted in the 2012 elections.
- Bostonians' trust in their neighbors decreased from 81% in 2007 to 75% in 2010.

HEALTH BEHAVIORS AND OUTCOMES

- The adolescent birth rate for female residents' ages 15-17 significantly decreased from 19.7 births per 1,000 females in 2008 to 10.1 in 2012, and the overall percentage of preterm births among all Boston residents did not significantly change from 9.7% in 2008 to 9.6% in 2012.

- From 2008 to 2012 there was a significant decrease in the Boston and the Black infant death rate. In 2008, the Boston infant death rate was 7.2 infant deaths per 1,000 live births and the Black infant death rate 14.6 infant deaths per 1,000 live births. In 2012, the Boston infant death rate was 4.7 and the Black infant death rate was 6.6 . However, the rate for Black infants was based on a count of less than 20 infant deaths and should be interpreted with caution.

- Boston's heart disease hospitalization rate decreased from 11.3 in 2008 to 9.8 in 2012 while the heart disease death rate decreased from 152.6 in 2008 to 131.1 in 2012.

- Between 2005 and 2013, the percentage of Boston public high school students who reported smoking cigarettes decreased. However, there was no significant change in the percentage of Boston adult residents who reported smoking cigarettes during the same period.

- Between 2005 and 2013, the percentage of Boston public high school students who reported persistent sadness (feeling sad, blue, or depressed every day for two weeks straight during the past year) did not significantly change.

Areas for Improvement

- From 2007 to 2013, the percentage of public high school students getting regular physical activity during the past week remained statistically similar as did the percentage reporting excessive alcohol consumption (binge drinking) during the past month from 2005-2013.

- In 2013, 17% (CI 13.8-19.8) of Boston public high school students consumed one or more sodas a day. The percent of Boston public high school students who consumed one or more sodas a day was lower in 2013 than in 2011, 24% (CI 19.9-28.2).

- In 2007, 14.5% (CI 12.5-16.5) of Boston public school students were obese. In 2013, 13.8% (CI 11.4-16.2) of Boston public school students were obese.

- In 2005, 19.4% (CI 17.1-21.7) of Boston adults were obese while in 2013 21.7% (CI 20.0-23.4) of Boston adults were obese. From 2005 to 2013, there was no significant change in the percentage of Boston adults who were obese.

- The percentage of Boston adults who reported having asthma or diabetes during the past month) remained statistically similar from 2008 to 2013.

- From 2008 to 2012, asthma emergency department (ED) visits decreased significantly in Boston, from 13.0 per 1,000 residents in 2008 to 10.3 in 2012, despite the prevalence of asthma remaining unchanged for Boston public high school students and for adults from 2005 to 2013.

- The percentage of Boston adults who reported having persistent sadness (being sad, blue or depressed 15 or more days) from 2005 to 2013 significantly increased from 8.4% (CI 6.8-10.1) in 2005 to 12.2% (CI 10.7-13.7) in 2013.

- Compared to residents of color, Boston's White residents have higher rates of:
    - Suicide
    - Substance Abuse

- Compared to Boston's White residents, Black and Latino residents have higher rates of:
    - Births to adolescent females
    - Low birth weight births
    - Infant deaths
    - Asthma emergency department visits among children less than 5 years old
    - Heart disease hospitalizations
    - Cerebrovascular disease (including stroke)-related hospitalizations
    - Diabetes hospitalizations
    - Nonfatal gunshot and stabbing injuries resulting in emergency department visits
    - Homicide
    - Adult obesity (based on self-reported height and weight)
    - Adults who self-reported having persistent sadness (feeling sad, blue or depressed 15 or more of the past 30 days)

- Compared to Boston's adult residents whose annual household income was $50,000 or more in 2013 than, adult residents with income of less than $25,000 had higher rates of:
    - Smoking 28.5% (CI 25.6-32.4)
    - Asthma 15.5% (CI 12.3-18.8)
    - Diabetes 13.5% (CI 11.1-15.9)
    - High blood pressure 32.8% (CI 29.2-36.3)
    - Obesity 29.3% (CI 25.6-33.0)
    - Persistent Sadness 22.2% (CI 18.6-25.8)

- Compared to Boston's adult residents whose annual household income was less than $25,000 in 2013, adult residents with annual household incomes of $50,000 or more had higher rates of:
    - Heavy drinking 31.4% (CI 28.0-34.8)
    - Physical activity 67.6% (CI 64.3-70.8)

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

Process: *On April 5th, 2013, Boston Alliance for Community Health (BACH) and Boston Public Health Commission (BPHC) data committee reconvened to review and prioritize citywide data for the Community Health Status Assessment.*

BACH members and affiliates met to reexamine the list of indicators that had been previously collected. Data sources included the 2010 US Census, 2013 Health of Boston social determinants and health result, American Community Surveys, Boston Police Department Neighborhood Survey, Behavioral Risk Factor Surveillance Survey, and Vital Statistics. Using health equity and social determinants of health lenses, the group came up with the following key findings.

ACROSS ALL NEIGHBORHOODS

Themes:

- Behavioral health concerns
- Language/cultural issues
- Health food access/affordability
- Education/job readiness
- Economy – need to strengthen, more opportunities, address poverty, affordability
- Public safety
- Community cohesion/coordination
- Quality/diverse housing stock
- Education and schools in neighborhoods-school assignment

Strengths (Assets):

- Active civic engagement
- Community engagement
- Partnerships
- High rate of satisfaction w/quality of life – people know each other
- Diversity is embraced/values
- Many, high quality hospitals and community health centers
- Institutions of higher education
- Research funds

SUBSETS OF NEIGHBORHOODS

Themes (Assets):

- Increasing green space (Hyde Park, Mattapan, South Boston, Dorchester)
- Transportation (Roxbury, Dorchester, Hyde Park, Mattapan)
- Need to engage newcomers and people of color in community leadership (East Boston, Roslindale, Roxbury, Hyde Park, Charlestown)
- Trash (Mattapan, Chinatown)
- Jobs
- Youth Development (Charlestown, Codman, Jamaica Plain, Roslindale)
- Brownfield cleanup (Hyde Park, East Boston, Dorchester)
- Access to quality care

High Impact Issues of Note:

- Violence and crime
- Gentrification (South Boston, South End, Charlestown)
- Lack of community cohesion (Allston/Brighton, Mission Hill, Fenway)
- Substance Abuse (Charlestown, South Boston, South End, Codman Square)
- Poverty and Racism (all neighborhoods)- need equity in jobs and employment
- Housing- affordable, accessible, stable
- Educational quality and access (East Boston, Jamaica Plain, South Boston)
- Access to transportation (Hyde Park, Mattapan, Franklin Field, Jamaica Plain, Roslindale)
- Obesity/diabetes (Codman Square, East Boston, Mission Hill, Jamaica Plain)
- Immigration and immigrants (+/-) (Charlestown/East Boston)

Correlations/Systems Approach:

- Mental health- substance abuse- public safety
- Youth development- jobs
- Obesity/diabetes- fresh food- exercise- public safety
- Open space- public safety
- Education- community cohesion
- Behavioral health (substance abuse, mental health)- access to care- economy
- Early education and care
- Violence- individual and community trauma- mental health- public safety

FORCES OF CHANGE ASSESSMENT

Process: *In addition to engaging in the Community Themes and Strengths Assessment, the April 22nd, 2013, retreat participants conducted the citywide Forces of Change Assessment. Participants engaged in structured conversations to determine the forces that affect the context in which Boston's local public health system operates. The group came up with the following overarching forces.*

INEQUITABLE PUBLIC TRANSPORTATION SYSTEM

Fairmont Indigo Line
- Creation of 5 new stations on commuter rail line increases access to Downtown and jobs for Dorchester and Roxbury residents but has infrequent trains.

Transportation for seniors and people with disabilities
- Not all busses are accessible and "The Ride" is underfunded and difficult to use

MBTA budget process and rising cost of public transportation
- City of Boston has minimal input on MBTA budget; fares keep increasing.

COMMUNITY ENGAGEMENT

MAPP process
- Multi-stakeholder involvement in many neighborhoods and cross-sector involvement of many organizations

Community-based best practices
- There are many successful and evidence-based programs in Boston

Lack of community capacity to engage residents
- It is very difficult to engage residents due to time and money when there is not a perceived crisis
- Student population is transient, not as cohesive with neighborhood

CONSIDERATION OF THE ENTIRE LIFE SPECTRUM

Focus on early childhood and family
- Increased call for increasing early childhood education and health care funding

Increasing senior population
- Presents major challenges for chronic disease management as well as socio-economic issues associated with aging

Dynamic flux of community demographics
- Ethnic and racial diversity in some neighborhoods presents opportunities and challenges for increased inclusion in decision making and community cohesion

HOW PREVENTION MONEY GETS SPENT

Affordable Care Act
- There is significant funding for multi-sector "community transformation" in the ACA and payment reform incentivizes providers to engage in prevention

Prevention Trust
- Massachusetts has a 5 year, $15 million per year funded trust that cannot be "raided" by the legislature in lean times.

Shift to wellness and disease management

Providers and employers are moving in this direction

Primary care providers
- Increasing understanding of social determinants of health and need to link primary care prevention.

MA Dept of Public Health Determination of Need process
- Requirement that 5% of the capital outlay for clinical space and equipment must be directed to community health and prevention

IRS requirement of non-profit hospitals to conduct community health assessments
- Hospitals are required to engage the community in their assessment process which gives more opportunities for neighborhood coalitions to connect to hospital prevention and community benefits programs

POLICY DRIVERS

City planning- licensing, zoning

State lab scandal
- Decreased public confidence in public health and large numbers of incarcerated people with substance abuse and violent backgrounds released into the community suddenly.

Dynamic flux of community demographics
- Ethnic and racial diversity in some neighborhoods presents opportunities and challenges for increased inclusion in decision making and community cohesion

Affordable housing and homelessness policies; rising housing demand squeezing out middle income population
- Subsidized "affordable" housing and greater gentrification in many neighborhoods

Medical marijuana regulations and implementation
- Unknown impact, particularly on youth

Place-based strategies create funding inequity
- Double-edged sword - Some neighborhoods in need improve while others get left out

Institutional barriers in public benefits
- System is difficult to navigate and results in people not getting benefits for which they are entitled

VIOLENCE AND TRAUMA

Effects of trauma, violence, natural disasters
- Homicide, suicide and the effects of substance abuse and untreated mental illness means some neighborhoods are traumatized on the community level

National Rifle Association
- Their increased radical opposition to gun control results in increased accidental and purposeful gun deaths and injuries

Emergency response system
- Flu response and marathon bombing response shows an effective system in Boston that includes public health and public safety.

POLITICAL CHANGES

Mayoral and city council election
- We have had a mayor who is highly committed to public health. Many unknowns about the future. Existing relationships may not be able to continue and energy and time will need to be invested in building new personal and institutional relationships

Federal sequestration

BOSTON PUBLIC SCHOOLS

Relationships with neighborhoods
- Since many children do not attend school in their neighborhood, it is difficult for community groups and schools to partner effectively.

School assignment plans
- Unclear how the new plan will change relationships and affect health

HIGHER EDUCATION ACCESSIBILITY

Employment trends
- Many of the available and new jobs require high skills and education

Rising cost of college
- Increases wealth gap and potential for success

Access for local youth

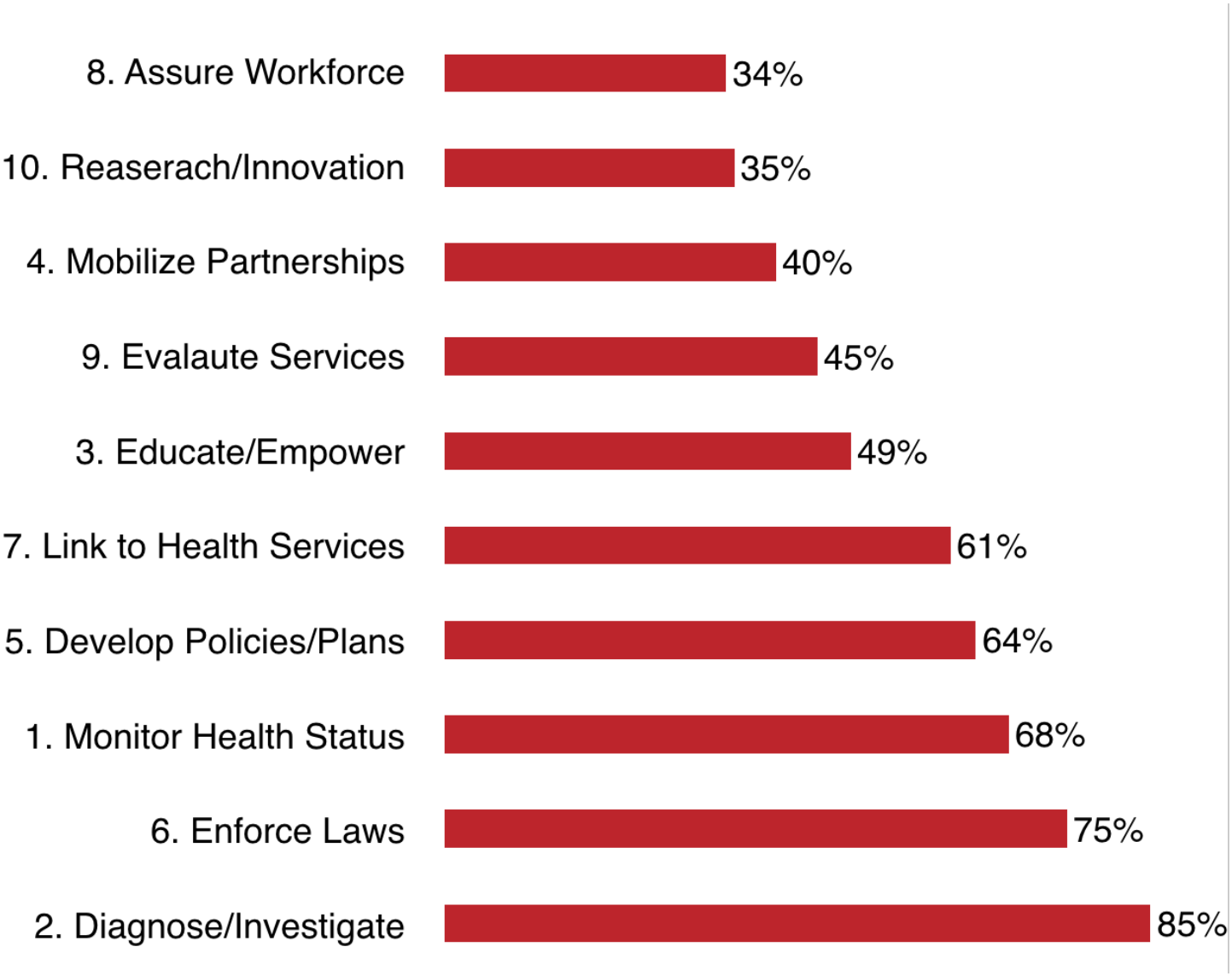
COMMUNICATION ACROSS ALL AGES

Social media fragmented by age
- Need to develop different modes of communication with different age groups
- Digital divide in communities So much communication happens digitally and poorer communities have less access

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

Process: *On February 2nd, 2013, 118 local residents and public health leaders and dozens of volunteers came together to conduct the Local Public Health System Assessment. Using the National Public Health Performance Standards Program, the group determined the activities, capacities, and competencies of Boston's public health system related to the 10 essential public health services. The results of the Local Public Health System Assessment are presented below.*

Key Findings: *Rank Ordered Performance Score of 10 Essential Public Health Services*



STRENGTHS AND WEAKNESS OF EACH ESSENTIAL PUBLIC HEALTH SERVICE

Assure a Competent Public and Personal Health Care Workforce- 34%

- Strengths
  - Strong emergency preparedness plans in place
  - Workforce standards, e.g. job descriptions
- Weaknesses
  - Lack of collaborative leadership
  - Applying health equity/racial justice lens to professional development, e.g. training, hiring, practice, etc.

Research for New Insights and Innovative Solutions to Health Problems- 35%

- Strengths
  - Large amounts of research dollars
  - Some community-based organizations propose and conduct their own studies
  - More research over the past year on health inequities
  - Strong partnership between LPHS and institutions of higher learning and/or research organizations
- Weaknesses
  - Sectors not working together
    - E.g. Community based organizations often do not know about research projects and therefore cannot participate or give input as to what hypothesis should be tested
  - History- racial victimization and communities not benefiting from research; cultural disconnect between research institutions and communities
  - Challenge of moving best practice from literature to actual practice
  - Organizations don't have resources or the capacity to do annual reviews

Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services- 45%

- Strengths
  - Provision of health services
  - Collective achievement has lead to high rates of insured residents
  - LPHS recognizes that disparities are real, that they relate to determinants other than economic status, and they are ready to help correct these disparities
- Weaknesses
  - Lack of assessment of community satisfaction
  - Redundancies
  - Lots of gaps for how information is used and disseminated

  Lack of system wide partnerships or system wide evaluations

Mobilize Community Partnerships to Identify and Solve Health Problems- 40%

- Strengths
  - Lots of citywide and neighborhood level activity– outreach, surveys, goal setting, engagement, i.e. Yearly Neighborhood Health Status report, Health of Boston is neighborhood specific, hospitals and CHCs conduct community based assessment
  - Flu response
  - Messaging penetrating throughout city
  - Cross-sector alliances
- Weaknesses
  - Residents not accessing information
  - Language and literacy barriers
  - Haphazard mechanism in city to identify and engage constituents
  - Activity silo-ed by topic and/or neighborhood – challenge crossing lines
  - Few large scale efforts
  - Funding/resources; consistency; sustainability

Inform, Educate, and Empower Individuals and Communities about Health- 49%

- Strengths
  - Information going out and consistency in messaging, e.g. flu response
  - Emergency preparedness- trainings, evaluation, data
  - City Council/policy makers
- Weaknesses
  - Information not reaching citizens– barriers to engaging and communicating, i.e. distrust, literacy, language, cultural
  - Resources available but segmented
  - Turf issues
  - Difficult to evaluate health messaging
  - System is a maze- not everyone can navigate

Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable- 61%

- Strengths
  - Identifying gaps
  - RIch array of organizations and perspectives
  - High visibility of healthy food and healthy activity promotion at the city level
  - Agency capability to conduct assessments
  - Many avenues for disseminating and receiving info
- Weaknesses
  - Racial, financial barriers
  - Many redundancies and shortage of services: social services not widely offered (disability), mental health and substance use not fully identified in community health systems

Develop Policies and Plans that Support Individual and Community Health Efforts- 64%

- Strengths
  - Strong level of youth engagement
  - Flu mobilization and emergency response
  - Good relationships/communication between city and state
  - Robust Boston Public Health Commission, organizational structure, and coordination with stakeholders, significant involvement in health equity issues
  - Increased knowledge about laws and regulations
  - Public meetings and hearings that allow for greater citizen representation
  - Huge effort to coordinate and support coalitions
  - Cross-sector support from BACH
  - Strategic, multi-year plan is reviewed annually
- Weaknesses
  - No community health improvement process or plan
  - Policies that lead to unfair distribution of resources
    - Programs driven by funding, not by need – i.e. lacking resources for harm reduction, losing direct service workers. History racial victimization and communities not benefiting from research; cultural disconnect between research institutions and communities
  - Need more coordination between larger hospitals and community health centers, provide more resources
  - Lack of outreach to and representation of Asian and Pacific Islander residents

Monitor Health Status to Identify Community Health Problems- 68%

- Strengths
  - Amount and organizations collecting/reporting, e.g. The Indicators Project, Health of BostonFlu response
  - Use of registries, e.g. Boston Police Department, healthcare
- Weaknesses
  - Combining neighborhoods, i.e. combining neighborhoods, defining neighborhoods differently
  - Data collected by many organizations- not shared, no “community health profile,” overlaps/gaps
  - Limited communication with residents, i.e. do not address multiple languages in the community in data collection and sharing
  - Need more effective enforcement of regulations and protocols

Enforce Laws and Regulations that Protect Health and Ensure Safety- 75%

- Strengths
  - Widespread knowledge about laws and regulations
  - Systematic approach, e.g. tobacco
  - Many initiatives to promote health and safety, i.e. inspections of nail salons
  - Most individual organizations have an emergency response plan
  - Flu response – lots of coordination
- Weaknesses
  - No regular review
  - Emergency response plans often aren’t shared or known
  - Public health system needs to understand that non-health laws (social justice issues) also impact equity
  - Uneven enforcement of existing regulations (tobacco advertising, store window signage)

Diagnose and Investigate Health Problems and Health Hazards in the Community- 85%

- Strengths
  - City-wide emergency preparedness and response (i.e. Shots fire program – sensors around city that recognize fire arm shooting), risk communication, emergency preparedness, and response
  - Excellence in flu response
  - Coordinated effort with agencies, i.e. EMS existing in BPHC creates great link
  - Laboratories
  - Interconnectedness of health centers
  - Providers - mandated to ask demographic questions, trainings
  - Grants to community organizations to improve emergency preparedness

- Weaknesses
  - State lab situation
  - Communication with community
  - Many providers still use paper- not current standard/best practice, late submission of data and currently no consequence, questionable quality of data - no standard collection system around ethnicity, cultural values, etc.
  - Serious issues around resources

At a follow-up meeting on April 1st, 2013, a group of community stakeholders prioritized the following Essential Public Health Services (bolded above):

- Mobilize Community Partnerships to Identify and Solve Health Problems
- Inform, Educate, and Empower Individuals and Communities about Health
- Develop Policies and Plans that Support Individual and Community Health Efforts

HEALTH INEQUITIES

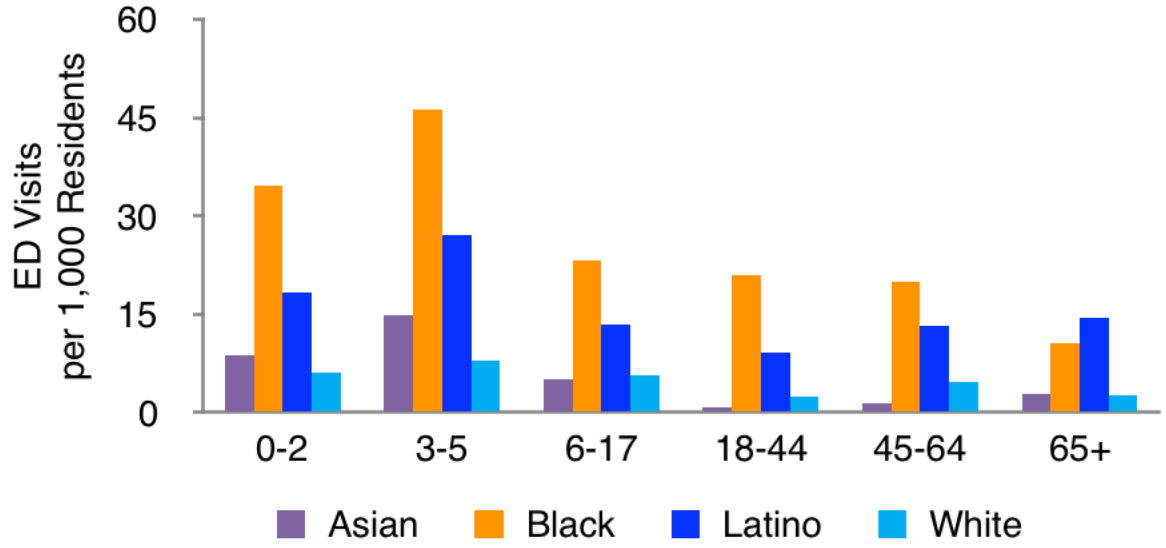
There are persistently different outcomes between racial and ethnic groups in comparisons with White residents

- Black residents experience a disproportionate burden of morbidity and mortality from common conditions. Black residents experience higher rates of preterm births, asthma emergency room visits, obesity, hypertension, hepatitis B, tuberculosis, influenza, HIV infection, diabetes hospitalizations and deaths, heart disease hospitalizations, nonfatal gunshot/stabbing emergency department visits, and cancer deaths compared to White residents.

- Latino residents experience higher rates of the following conditions compared to White residents: heart disease hospitalizations, HIV infection, influenza, asthma emergency department visits, diabetes hospitalizations, and nonfatal gunshot/stabbing emergency department visits.

- Asian residents experience higher rates of tuberculosis and Hepatitis B compared to White residents.

FIGURE 6.8 ASTHMA EMERGENCY DEPARTMENT VISITS BY AGE AND RACE/ETHNICITY
2012



Unfortunately opportunities to access the financial and community resources necessary to meet basic needs, make positive health choices, and avoid the adverse health impacts of chronic stress are not equally available to all Boston residents.

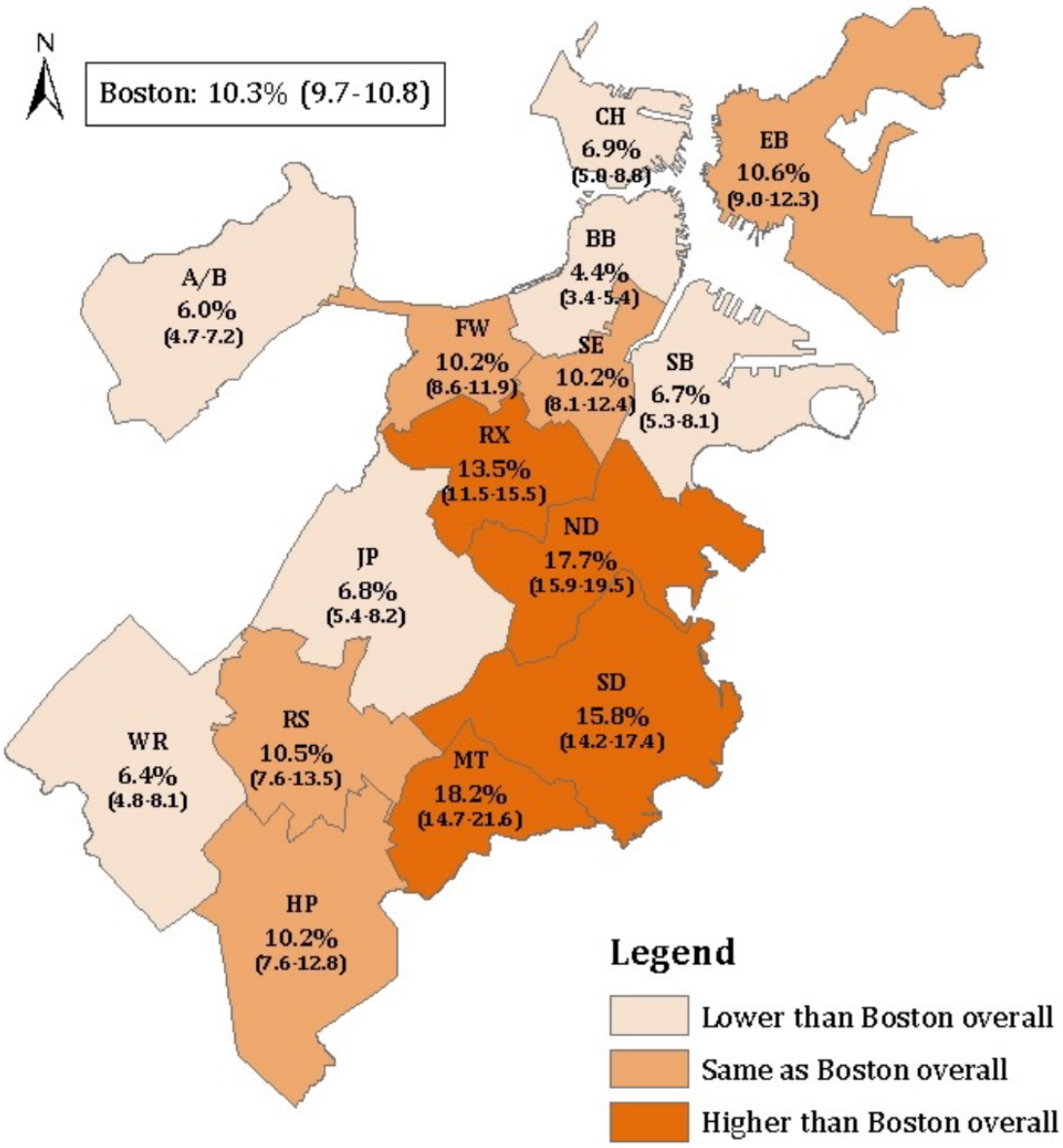
APPENDIX A: UPDATED HEALTH INDICATORS (2015/2016 BPHC Health of Boston)

Unless otherwise indicated by a note underneath a graphic, all data in this section of the report was analyzed by the Research and Evaluation Office of the Boston Public Health Commission

Indicator	Year(s)	Race/Ethnicity			
Maternal and Child Health					
Infant Deaths (per 1,000 live births)	2012	n<5	6.6	6.5	3.0
Low Birth Weight (Percent of Births)	2012	6.3%	10.5%	9.1%	7.3%
Preterm Births (Percent of Births)	2012	5.6%	10.5%	10.7%	9.3%
Chronic Disease					
Asthma (Percent of Adults)	2013	2.8% (0.2-5.3)	11.9% (9.4-14.4)	11.9% (8.8-15.1)	11.8% (9.5-14.2)
Asthma Emergency Department Visits (per 1,000 residents)	2012	2.8	21.8	12.7	4.1
Diabetes Hospitalizations (per 1,000 residents)	2012	0.6	3.9	2.3	1.4
Diabetes Deaths (per 100,000 residents)	2012	n<5	39.5	23.9	14.3
Heart Disease Hospitalizations (per 1,000 residents)	2012	4.1	13.6	9.9	9.0
Heart Disease Deaths (per 100,000 residents)	2012	44.6	155.9	80.2	144.9
Hypertension (Percent of adults)	2013	16.2% (9.9-22.4)	36.7% (33.0-40.5)	26.2% (22.0-30.3)	18.6% (16.7-20.6)
Obesity (Percent of adults)	2013	15.3% (8.9-21.6)	33.0% (29.3-36.8)	27.3% (23.1-31.6)	16.2% (13.9-18.4)
Sexual Health					
Ever Sex (Percent of High School Students)	2013	22.0 (12.8-31.2)	50.4 (43.3-57.4)	57.4 (50.8-64.0)	35.0 (25.4-44.6)
Newly Diagnosed Cases of HIV (per 100,000 residents)	2011	n<5	66.9	34.6	18.2
People Living with HIV (per 100,000 residents)	2011	140.7	1541.3	854.2	742.0
Infectious Disease					
Influenza (per 100,000 residents)	2012-2013	125.6	405.6	269.5	174.7
Hepatitis B (per 100,000 residents)	2012	325.4	59.7	18.7	16.8
Hepatitis C (per 100,000 residents)	2012	46.0	150.0	157.9	178.9
Salmonella (per 100,000 residents)	2012	24.8	20.4	9.8	17.9
Tuberculosis (per 100,000 residents)	2012	17.7	15.3	n<5	2.1
Mental Health					
Mental Health Hospitalizations† (per 100,000 residents)	2012	1.7	8.3	5.3	9.9

Persistent Sadness (Percent of Public High School Students)	2013	19.8% (11.4-28.3)	29.6% (24.1-35.1)	32.9% (27.3-38.4)	30.3% (20.9-39.7)
Persistent Sadness (Percent of Adults)	2013	9.1% (4.6-13.7)	13.1% (10.3-16.0)	16.7% (12.8-20.6)	10.8% (8.5-13.0)
Persistent Anxiety (Percent of Public High School Students)	2013	10.1% (0.7-19.6)	14.9% (11.5-18.4)	16.9% (12.2-21.6)	18.9% (16.5-21.2)
Persistent Anxiety (Percent of Adults)	2013	10.7% (5.7-15.7)	19.2% (16.0-22.5)	17.7% (13.6-21.8)	23.1% (20.0-26.1)
Suicide (per 100,000 residents)†	2012	n<5	3.1	n<5	7.6
Substance Abuse					
Unique-Person Treatment† Admissions (per 1,000 residents)	2013	1.2	14.2	13.3	15.9
Unintentional Overdose Deaths† (per 100,000 residents)	2012	n<5	6.6	9.9	22.3
Violence					
Bullied in the Past 12 Months (Percent of Public High School Students)	2013	6.8% (3.1-10.6)	12.4% (8.1-16.7)	12.2% (8.9-15.5)	18.4% (10.2-27.5)
Nonfatal Gunshot/Stabbing Emergency Department Visits† (per 1,000 residents)	2012	n<5	2.3	0.7	0.3
Homicide† (per 100,000 residents)	2012	n<5	19.9	7.7	2.0
Cancer					
Mammograms within the Past 2 Years (Percent of Females Ages 50-74)	2013	*	90.8% (86.7-95.0)	96.3% (92.7-99.9)	88.2% (84.8-91.5)
Pap Test within the Past 3 Year (Percent of Females Ages 21-65)	2013	61.8% (49.2-74.3)	85.8% (81.6-90.1)	84.4% (78.8-90.1)	92.3% (89.7-94.8)
Overall Cancer Deaths† (per 100,00 residents)	2012	131.9	209.5	132.6	200.0
Death					
Life Expectancy	2012	87.2	77.0	86.4	79.5
All-Cause Mortality† (per 100,000 residents)	2012	380.5	772.8	496.1	749.3

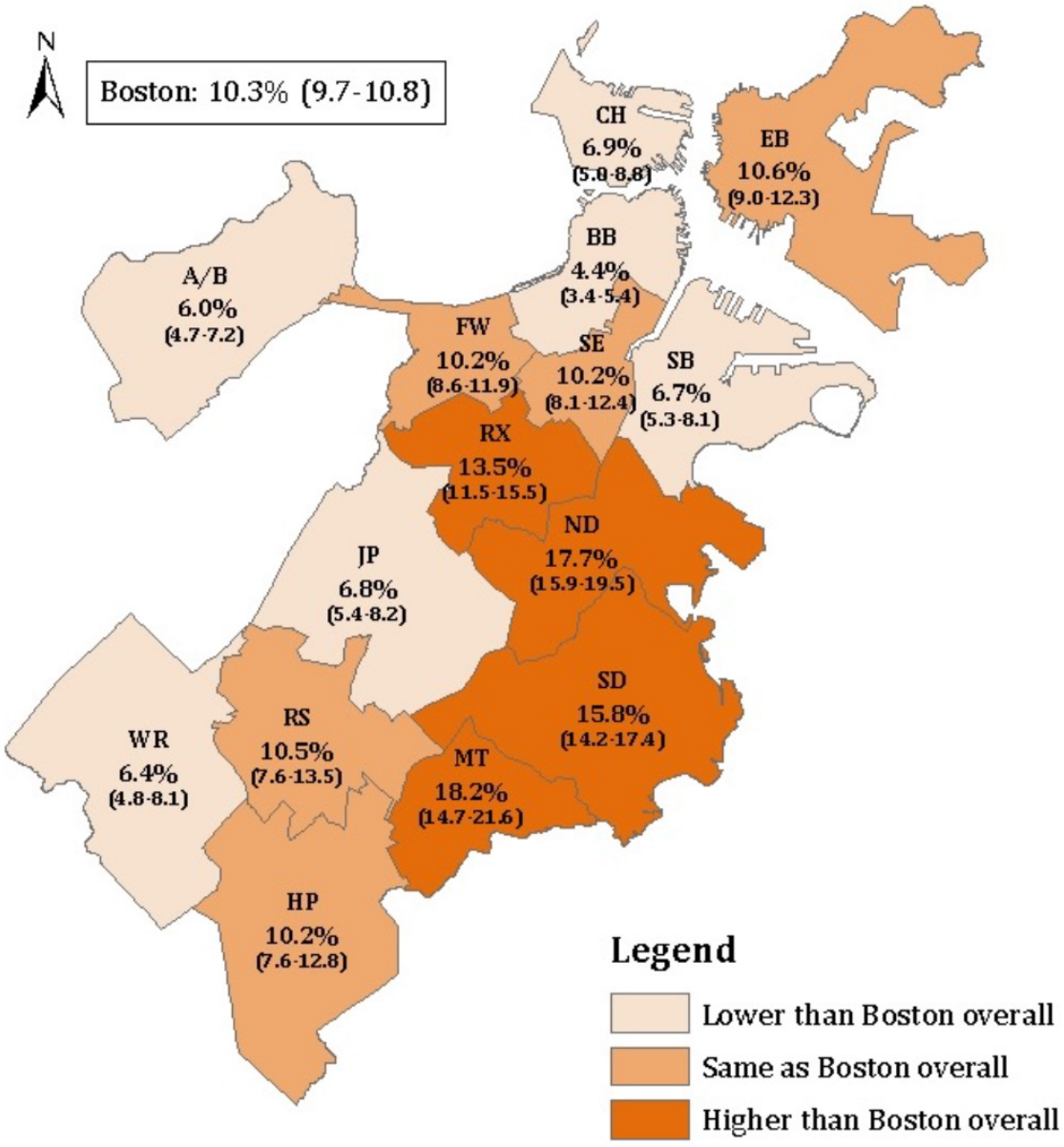
APPENDIX B: PERCENT OF POPULATION WITH LESS THAN A HIGH SCHOOL EDUCATION BY NEIGHBORHOOD, 2008-2012 COMBINED



NOTE: Back Bay includes Beacon Hill, Downtown, the North End, and the West End. The South End includes Chinatown.

DATA SOURCE: American Community Survey, 2008-2012, U.S. Census Bureau

APPENDIX C: UNEMPLOYMENT RATE BY NEIGHBORHOOD, 2008-2012 COMBINED



NOTE: Back Bay includes Beacon Hill, Downtown, the North End, and the West End.
The South End includes Chinatown.

APPENDIX D: LIST OF DATA SOURCES

Boston Survey of Children's Health 2012, Boston Public Health Commission
Boston Resident Live Births, Registry of Vital Records and Statistics, Bureau of Health Information Research Statistics and Evaluation, Massachusetts Department of Public Health
Boston Resident Deaths, Registry of Vital Records and Statistics, Bureau of Health Information Research Statistics and Evaluation, Massachusetts Department of Public Health
Acute Hospital Case Mix Databases (Hospital Inpatient Discharge Database; Outpatient Hospital Observation Discharge Database; Outpatient Emergency Department Database), Massachusetts Center for Health Information and Analysis
Census 2000 and 2010, Bureau of the Census, U.S. Department of Commerce
City of Boston (January 2015). Open Space and Recreation Plan 2015-2021. Retrieved from http://www.cityofboston.gov/parks/openspace/2015-2021.asp
Community focus groups and town halls

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