April 8, 2014

North Shore District Incentive Grant Partners

2014 Community Health Assessment

Submitted to:

North Shore District Incentive Grant Partners

Health Resources in Action
Advancing Public Health and Medical Research

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BACKGROUND

In the past five years, cross-jurisdictional partnerships among public health agencies have increased across the field. These partnerships have helped to align efforts among agencies working within a similar region as well as to utilize resources more effectively. To that end, the Massachusetts Department of Public Health (DPH) has funded several communities through its District Incentive Grant (DIG) program to consider regionalizing some public health efforts.

According to MA DPH, the DIG program is intended to address gaps in the capacities of Boards of Health and health departments across the Commonwealth to protect and promote public health through food protection, sanitary code enforcement, disease prevention and response, and policies and programs aimed at smoking, obesity, health disparities, underage drinking, and other health threats. Program funds aim to facilitate health departments to develop plans on how to share staff and services to improve the scope and quality of local public health services for their combined populations.

Health departments from the North Shore communities of Beverly, Danvers, Lynn, Marblehead, Nahant, Peabody, Salem, and Swampscott applied and received funding through the DIG initiative. One of the components of the DIG funding includes conducting a shared community health assessment (CHA) of the region to identify key areas of concern around community health, important assets and strengths, and potential opportunities for addressing community health needs.

In November 2013, the North Shore District Incentive Grant Partners contracted Health Resources in Action (HRiA), a non-profit public health organization in Boston, to conduct its community health assessment (CHA). The North Shore community health assessment focuses on the eight communities that are part of the DIG grant initiative: Beverly, Danvers, Lynn, Marblehead, Nahant, Peabody, Salem, and Swampscott.

METHODS

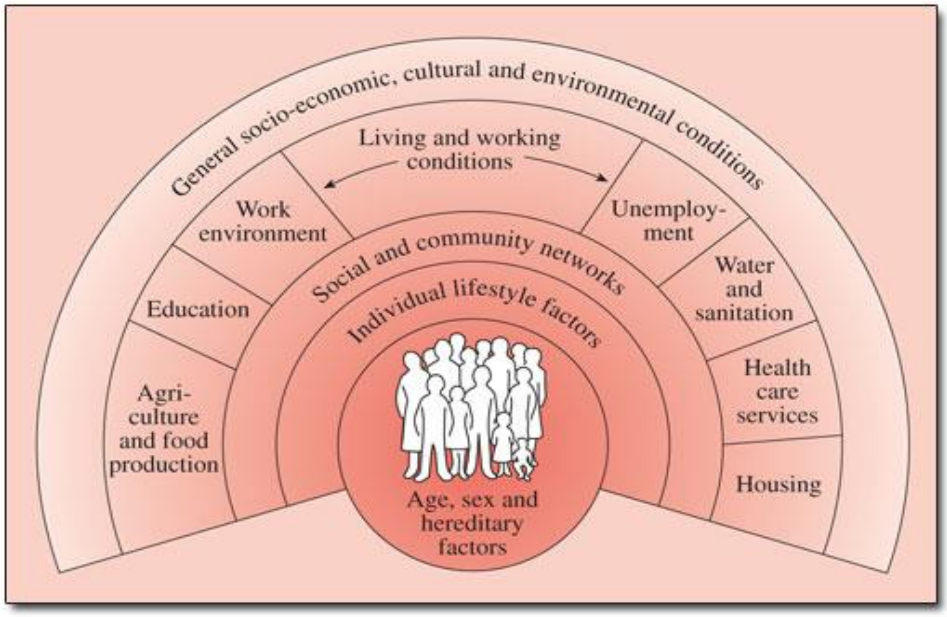
The following section describes how data for the community health assessment was compiled and analyzed, as well as the broader lens used to guide this process. Specifically, the CHA defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health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

Social Determinants of Health Framework

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

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

Figure 1: Social Determinants of Health Framework



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

Quantitative Data

In an effort to develop a social, economic, and health portrait of the North Shore DIG service area, HRiA reviewed existing data drawn from national, state, and local sources. Sources of data included the U.S. Census, Massachusetts Department of Public Health, and the Federal Bureau of Investigation, among others. Recognizing that a large amount of assessment-related work has already been conducted in the North Shore region, existing documents and data from the assessments conducted by area hospital (namely, North Shore Medical Center, Lahey Clinic Hospital, and Beverly Hospital) were reviewed and findings were integrated where appropriate. For key indicators, HRiA pulled updated data when needed.

Data analyses were generally conducted by the original data source (e.g., U.S. Census). Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS), as well as vital statistics. In some reports, data were available for the Department of Public Health's designated Community Health Network Area 14 (CHNA 14, which includes Danvers, Lynn, Marblehead, Nahant, Peabody, Salem, and Swampscott) or Essex County overall, rather than by specific community.

Qualitative Data

While existing quantitative data provide benchmarks on key indicators as well as insight on the magnitude and severity of specific risk factors and health outcomes, it may not tell the whole story. A review of existing qualitative data was conducted into attitudes, knowledge, and behaviors that have an impact on the health of residents in the North Shore as well as the context in which health-related decisions are being made. Among the existing community health assessment reports in the region, only North Shore Medical Center included explicit qualitative data findings from their 2012 assessment

process. In the North Shore Medical Center process, 28 key informant interviews and 4 community resident focus groups were conducted and reviewed for this report.

For the North Shore DIG community health assessment, two additional focus groups were conducted in March 2014 specifically with low-income community residents of Lynn, Peabody, and Salem to delve deeper into the experiences and concerns with more traditionally underserved populations. Specifically, 19 individuals participated in the two focus groups. Participants were specifically recruited to represent diverse racial and ethnic groups, low-income, and public housing tenants.

Focus group discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all discussions to ensure consistency in the topics covered. Each focus group was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, focus groups lasted 90 minutes and included 9-10 participants. As an incentive, focus group participants received a $25 stipend. A copy of the moderator's guide can be found in Appendix A.

Analyses

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

Limitations

As with all data collection efforts, there are several limitations related to this study's research methods that should be acknowledged. It should be noted that for the secondary data analyses, in several instances, current neighborhood level data were not available.

Data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHA benefit from large sample sizes and repeated administrations, enabling comparison over time.

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

FINDINGS

Social and Economic Context

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

Population Distribution

Quantitative data show that residents in the North Shore DIG service area comprise 4.4% of Massachusetts' total population (Table 1). Of the individual towns, Lynn is the largest community with a population of 90,392 in 2012, while Nahant is the smallest (n=3,438). However, since 2000, Peabody has seen the most population growth (+6.4%), while Swampscott's population has seen the largest decrease (-4.1%).

Table 1: Change in Population by State and Town, 2000 and 2012

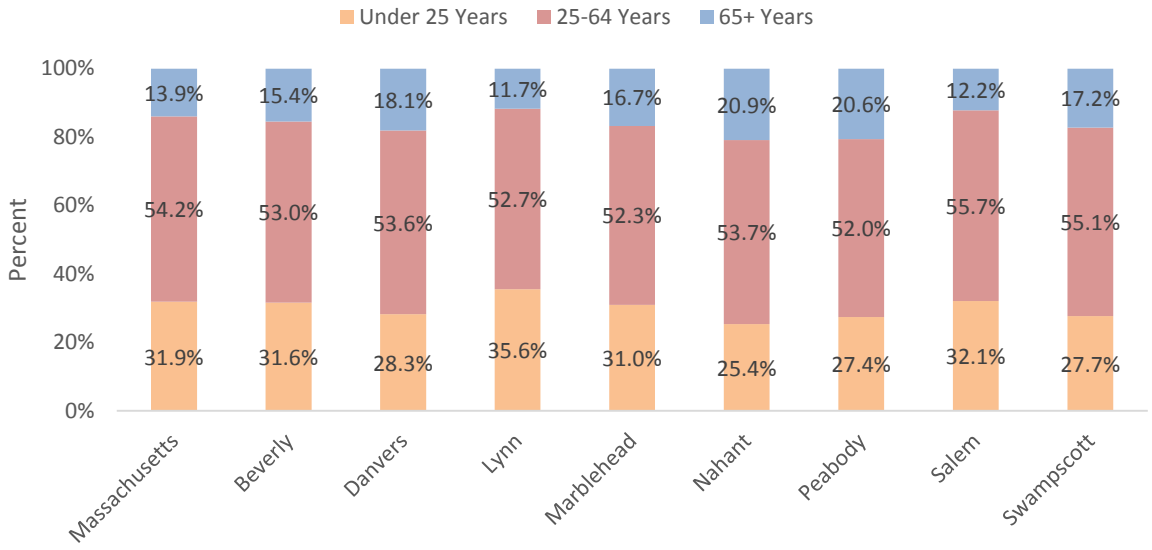
	2000	2012	% Change
Massachusetts	6,349,097	6,560,595	3.3%
Beverly	39,862	39,748	-0.3%
Danvers	25,212	26,568	5.4%
Lynn	89,050	90,392	1.5%
Marblehead	20,377	19,879	-2.4%
Nahant	3,632	3,438	-5.3%
Peabody	48,129	51,215	6.4%
Salem	40,407	41,641	3.1%
Swampscott	14,412	13,823	-4.1%

DATA SOURCE: US Census Bureau, US Census 2000, and American Community Survey 5-Year Estimates, 2008-2012

Age Distribution

Examining the age distribution of the North Shore area communities indicates that over half of the population in all cities and towns is between the ages of 25 and 64, which is similar to the state (Figure 2). Beverly, Lynn, Marblehead, and Salem tend to have younger populations (over 30% are under the age of 25), while the other communities have a higher proportion of senior residents (over 17% are 65 years and older) comparatively. In Nahant and Peabody, at least one in five residents are at least 65 years old or older.

Figure 2: Age Distribution by State and Town, 2008-2012



DATA SOURCE: US Census Bureau, American Community Survey 5-Year Estimates, 2008-2012

Racial and Ethnic Distribution

Most of the communities in the North Shore area are predominantly White, non-Hispanic (over 90%), more so than the state overall (76.1%) (Table 2). Peabody, Salem, and Lynn have a greater percentage of racial/ethnic minorities, of whom the largest proportions identify as Hispanic/Latino. Most of the community residents noted that they have observed substantial increases in minorities and immigrant populations, particularly refugees, in Lynn and Salem; this growth in diversity presented both cultural richness and challenges to communities, particularly in terms of language, communication, and the provision of services.

Table 2: Racial and Ethnic Distribution by State and Town, 2010

	White, non-Hispanic	Black, non-Hispanic	Hispanic/Latino, any race	Asian, non-Hispanic	Other Race, non-Hispanic	Two or More Races, non-Hispanic
Massachusetts	76.1%	6.0%	9.6%	5.3%	1.1%	1.9%
Beverly	91.4%	1.5%	3.5%	1.7%	0.6%	1.3%
Danvers	93.8%	1.0%	2.3%	1.9%	0.2%	0.8%
Lynn	47.6%	10.5%	32.1%	6.9%	0.7%	2.2%
Marblehead	95.0%	0.7%	2.1%	1.0%	0.2%	1.0%
Nahant	95.5%	0.4%	1.5%	1.7%	0.3%	0.6%
Peabody	87.7%	1.9%	6.3%	1.8%	1.2%	1.1%
Salem	75.9%	3.5%	15.6%	2.6%	0.7%	1.7%
Swampscott	93.0%	1.1%	2.6%	1.9%	0.3%	1.1%

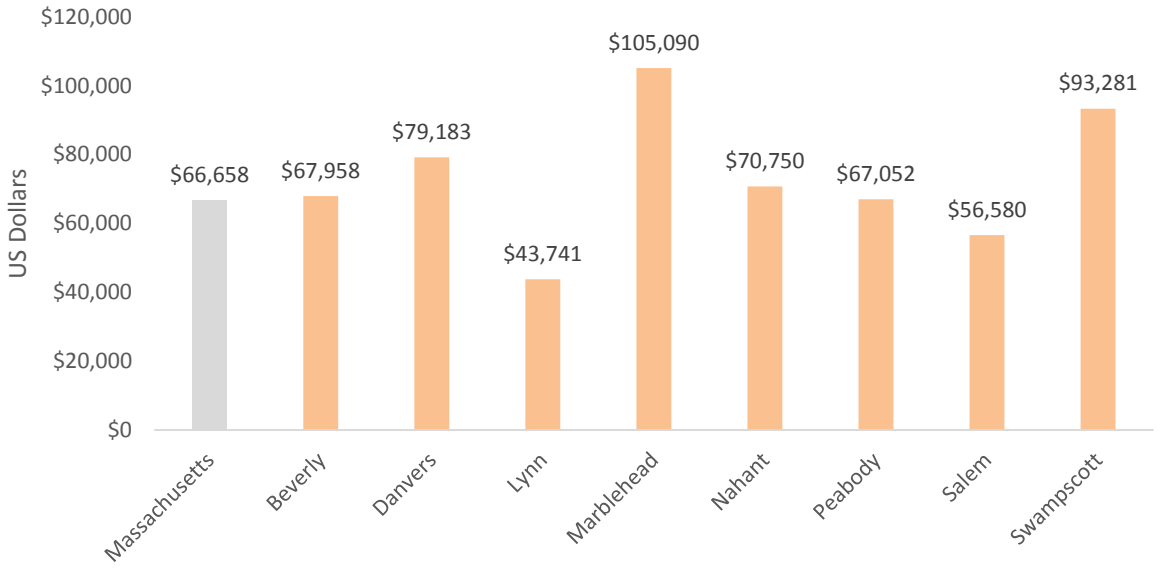
DATA SOURCE: US Census Bureau, US Census 2010

Income, Poverty, and Employment

Increasing concerns and financial challenges in this changing economy were predominant themes in recent focus group discussions, specifically in relation to residents' health as well as meeting day-to-day needs. Several focus group participants discussed the challenges of seeking services or engaging in preventive behaviors when a main focus is putting food on the table. Several participants mentioned how individuals and families with financial hardships seem to be increasing, especially as some services get cut. As one participant cited, "*With food stamps cut way back, we're happy to have a food pantry. But we don't have enough resources at the pantry… we can't keep up with all the new people coming.*"

Income, poverty, and unemployment levels demonstrate the wide range of socioeconomic conditions across the North Shore DIG service area communities. In 2008-2012, the majority of the communities had median incomes above the state ($66,658), ranging from $67,052 in Peabody to $105,090 in Marblehead (Figure 3). Median incomes in Lynn and Salem were lower than that of the state ($43,741 and $56,580, respectively).

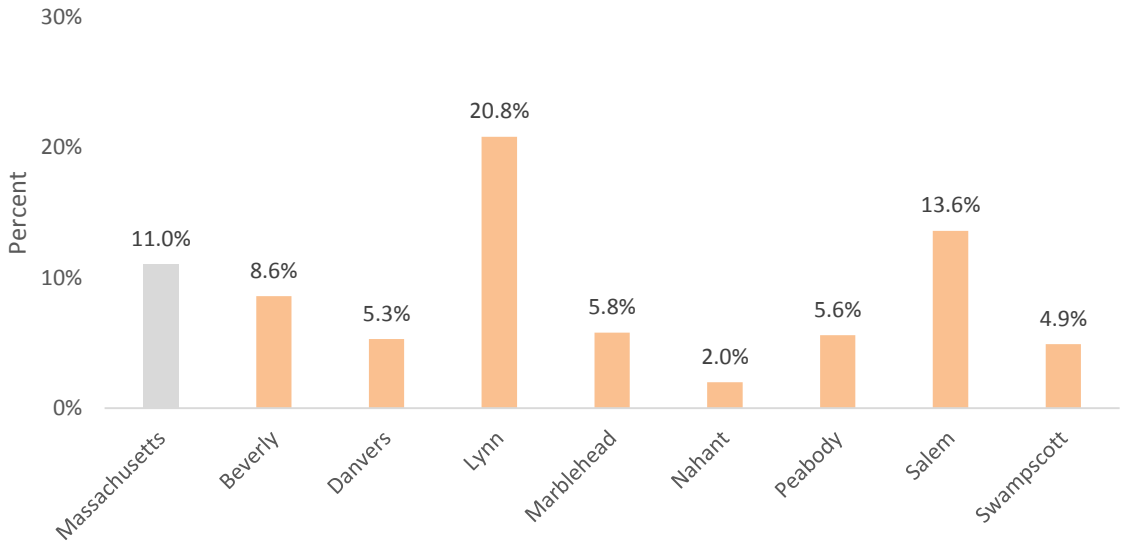
Figure 3: Median Household Income by State and Town, 2008-2012



DATA SOURCE: US Census Bureau, American Community Survey 5-Year Estimates, 2008-2012

Quantitative data show that the percentage of the population below poverty level in Lynn (20.8%) is nearly twice that reported for the state overall (11.0%) (Figure 4). Salem's reported 13.8% of the population in poverty also exceeded that of the state, but the remaining six service area communities were below the state average.

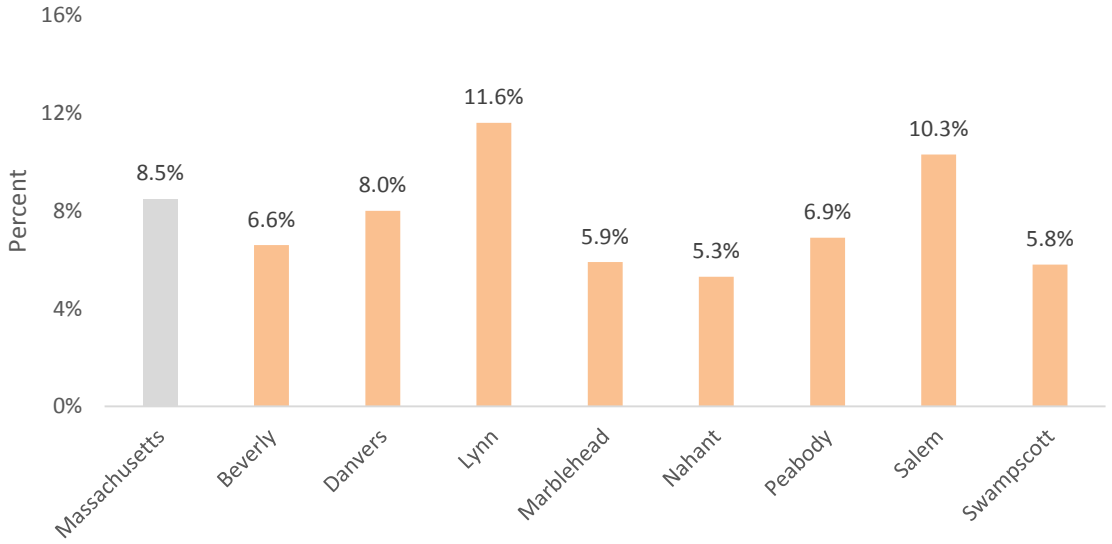
Figure 4: Percentage of the Population below Poverty by State and Town, 2008-2012



DATA SOURCE: US Census Bureau, American Community Survey 5-Year Estimates, 2008-2012

As illustrated in Figure 5, unemployment data mirror trends noted in the poverty data. Lynn and Salem (11.6% and 10.3%, respectively) have a higher percentage of unemployed population as compared to the state (8.5%). The other six service area communities have lower proportions of unemployed residents than the state, with Nahant reporting the lowest at 5.3%.

Figure 5: Percentage of Population Unemployed by State and Town, 2008-2012



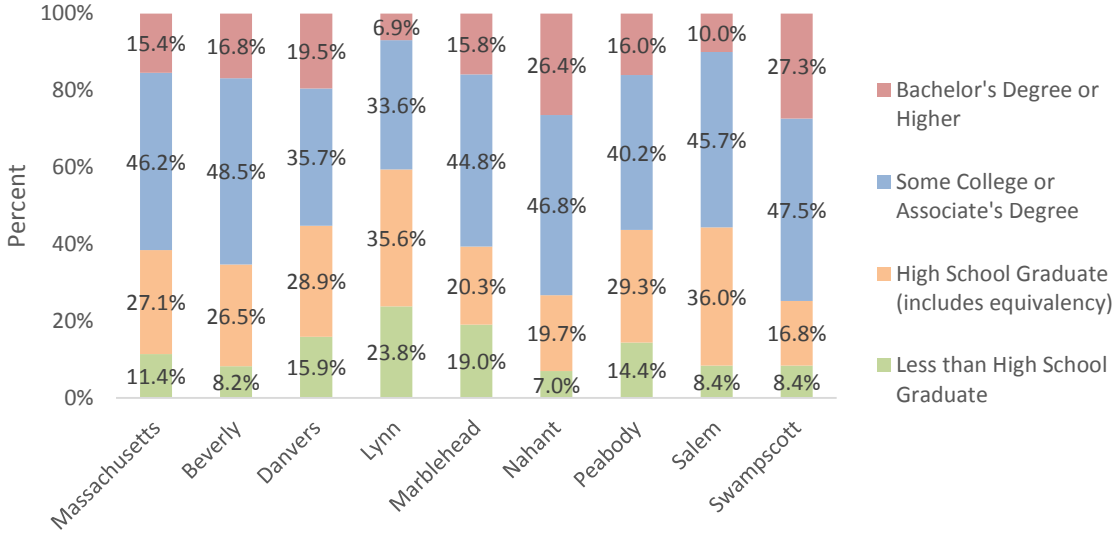
DATA SOURCE: US Census Bureau, American Community Survey 5-Year Estimates, 2008-2012

Educational Attainment

Educational attainment varies across the region. Figure 6 depicts educational attainment of adults 25 years and older in the region. Results of the 2008-2012 American Community Survey demonstrate that among the North Shore communities, Swampscott and Nahant demonstrate the highest levels of educational attainment, with more adults holding a bachelor's degree or higher (27.3% and 26.4%, respectively) than the state overall (15.4%) (Figure 6). Educational attainment for high school in the

region was generally higher than the state average (88.7%) for the 2010-2011 academic year, although the communities of r, Lynn (68.5%), Peabody (77.6%), and Salem (79.1%) had lower graduation rates compared to the state (82.1%).

Figure 6: Distribution of Educational Attainment by State and Town, 2008-2012

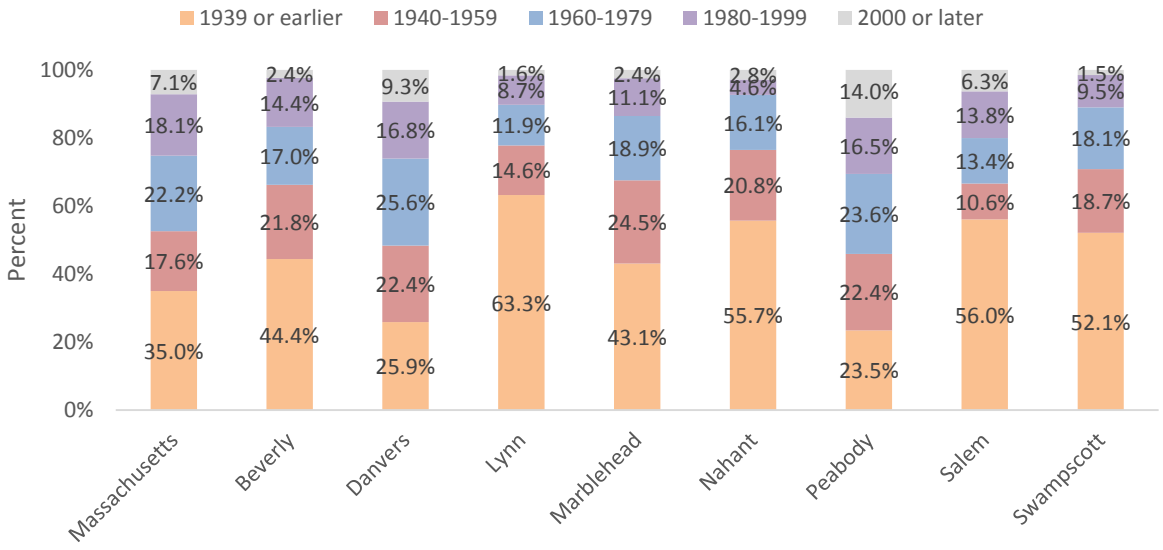


DATA SOURCE: US Census Bureau, American Community Survey 5-Year Estimates, 2008-2012

Housing and Homelessness

Housing was a key issue raised among focus group participants in the recent community health assessment focus groups. Some residents identified housing quality as a community issue that is often overlooked. Several participants also expressed concern that when substandard housing is demolished, it is not replaced with newer low-income housing. Rental costs were identified as prohibitively expensive by recent focus group participants, the existing supply of low-income housing was described as not meeting the demand. As one focus group participant stated, *"There is a long waiting list for Section 8 housing. People spend 20 years on that waiting list. And then what use is it? By then your kids are all grown."* Further exacerbating these issues, the housing stock is aging and may be falling into disrepair. For example, quantitative data show that the majority of the housing stock in Lynn, (63.3%), Nahant (55.7%), and Salem (56.0%) was built in 1939 or earlier (Figure 7).

Figure 7: Housing Stock by Distribution of Year Built by State and Town, 2008-2012



DATA SOURCE: US Census Bureau, American Community Survey 5-Year Estimates, 2008-2012

Related to housing, homelessness was of foremost concern across recent focus group participants as well as community members engaged in prior assessments in the region (i.e., North Shore Medical Center assessment process). Peabody residents discussed the need for a shelter, similar to that available in Salem, for their homeless population who is otherwise, *"shuffled around with no place to go when it is cold."* In the meantime, participants suggested vans be used to pick up and transport homeless individuals to shelters in neighboring towns during the cold season. Focus group participants also commented on youth homeless as a growing concern, with one participant noting, *"There are 14 homeless kids at my school."*

Other issues noted as disproportionately affecting the homeless population included a dearth of resources to aid in maintaining personal hygiene, which then further limits their food access options. As one participant clarified, *"when hygiene is an extreme issue, [the homeless] are not allowed to go into the pantries, but they still need food."* CORI checks were also discussed in relation to the homeless population as impacting access to existing homeless services, shelter, and medications among other services. One recent focus group participant stated, *"A criminal record shouldn't mean you have to freeze to death."* Further, several participants noted how homelessness adds a layer of complication to successful treatment and management of both acute and chronic illness. Quantitative data show that while Lynn has begun to report a recent decrease in homelessness, other Essex county cities and towns are showing an increase. Overall, the North Shore area accounts for approximately 9% of the statewide homeless shelter count.

Crime and Safety

Though crime and safety were not largely discussed among focus group participants, a few participants across the multiple assessments did note that community and interpersonal violence have a significant impact on stress, mental health, injury, and opportunities for engagement in the community. For example, several Lynn participants in previous assessments attributed residents' low levels of outdoor physical activity to their concern over safety in public parks; they identified gang activity as the primary issue. As depicted in Table 3, Lynn reported higher violent and property crime rates than did other North Shore DIG service area communities, though the crime rates have been steadily decreasing over time.

Table 3: Rate of Offenses Known to Law Enforcement per 100,000 Population by State and Town, 2010*

	Violent Crime	Property Crime
Massachusetts	466.6	2350.5
Beverly	288.6	1663.2
Danvers	173.6	3638.7
Lynn	845.8	2763.2
Marblehead	131.3	939.0
Nahant	205.3	1114.4
Peabody	216.6	2372.6
Salem	454.8	2455.2
Swampscott	137.8	1951.1

DATA SOURCE: US Department of Justice, Federal Bureau of Investigation, Offenses Known to Law Enforcement, 2010

* Total Counts standardized to US Census 2010 Population data

Community Strengths and Assets

Community focus group residents cited a number of organizational assets and resources in their community. Several cited specific organizations such as the Haven for Hunger food pantry, YMCA, Catholic Charities, and senior centers. Additionally recreational programs and facilities—such as parks and school-based programs emphasizing physical activity—were also mentioned as important resources in the community. The region was also viewed as providing high quality health care both in the hospital and in community health centers. Several focus group participants also cited residents themselves as assets. They noted that some neighborhoods have strong community cohesion and that people look out for each other. Certain spots in the neighborhood served *"as a place where friends and family get to hang out and chit chat,"* which was considered important to promote a sense of community.

Community Health Issues

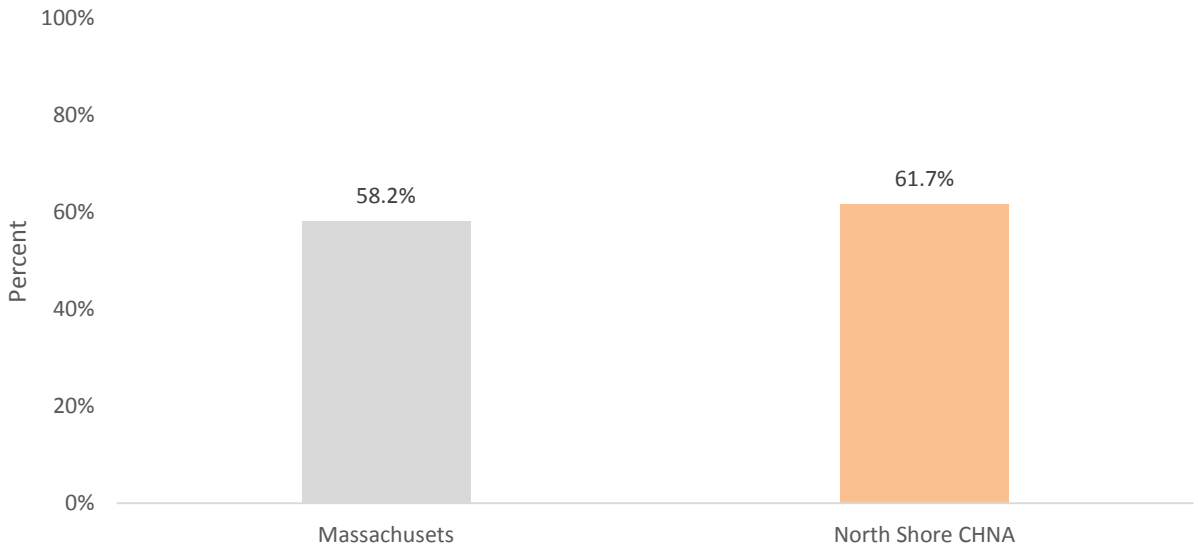
This section focuses on the health issues and concerns that emerged as the most prominent in the North Shore DIG community health assessment process. Specifically, areas that rose to the top as far as severity and magnitude from the quantitative data, as well as issues of greatest concern and opportunity among focus group participants included: chronic diseases – such as diabetes and asthma – and related behaviors, namely obesity, substance abuse, and access to care.

> ***"We need more places for recreation so that teenagers and young kids are not causing trouble and that they have something to do."*—Focus group participant**
>
> ***"We need more places around the city to exercise, and to make sure those exercise places are cheaper."—Focus group participant***

Obesity, Physical Activity, and Healthy Eating

Obesity and its related behaviors of physical inactivity and unhealthy eating were cited among some residents as pressing concerns in the community. Although residents listed several resources working to address these and associated issues (e.g., churches subsidizing grocery purchases, YMCA programming, Community Life Center health screenings), they believed there were numerous reasons for the rates of obesity in the North Shore. Specifically the prevalence of fast food restaurants, affordability of healthy foods, safety concerns resulting in limited use of public parks, public spaces littered with used drug paraphernalia, limited physical activity options for adults and youth, and unhealthy food options for school lunch were cited as challenges for low-income residents. As one focus group participant summarized, *"Salem has opened a lot of new healthy places to eat, like Life Alive. And Red line café sells a lot of healthy stuff too, but then you have three times as many fast food places. And it's expensive. You can get a salad for like $7 dollars but a double cheeseburger for a buck."* Quantitative data support observations made by residents in that slightly more adults in the North Shore region (61.7%) are overweight or obese than statewide (58.2%) (Figure 8).

Figure 8: Percentage of Adults Who Reported Being Overweight or Obese by State and CHNA 14, 2007-2009

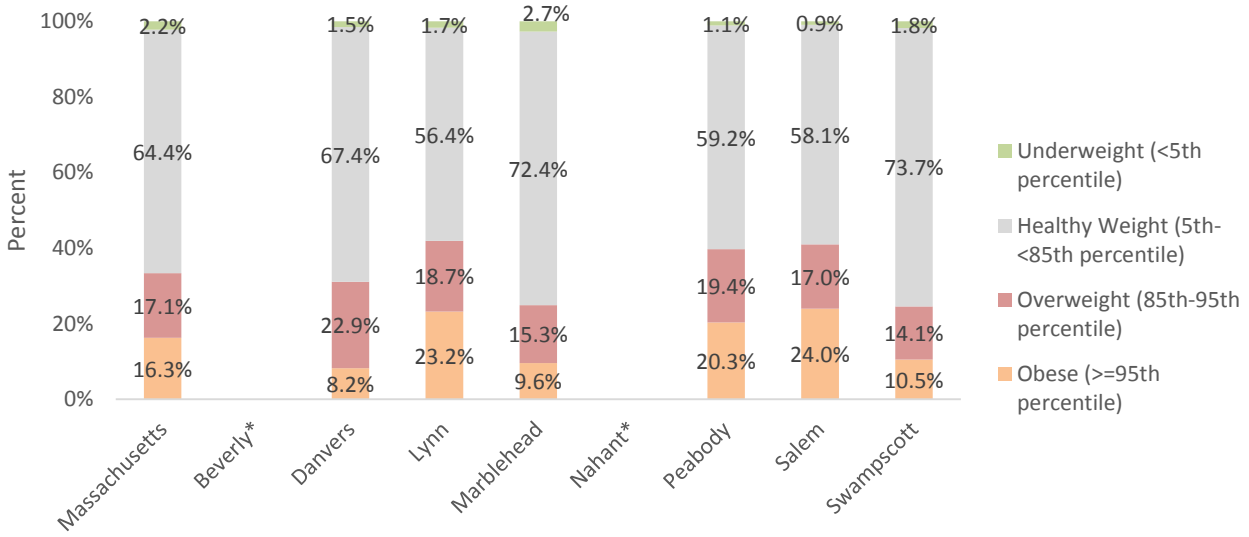


DATA SOURCE: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System, 2007-2009

As illustrated in Figure 9, the percentages of overweight and obese school-aged children in the service area communities were lower than those of adults but did vary by town. In Marblehead, which had the

highest percentage of children in the healthy weight range, nearly 1 of every 4 children was either overweight or obese. Lynn, Salem, and Peabody had the highest proportions of overweight and obese children.

Figure 9: Weight Distribution among School-Age Children by State and City, 2010



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Essential School Health Services (ESHS) Data Report, 2010

Chronic Disease: Diabetes and Asthma

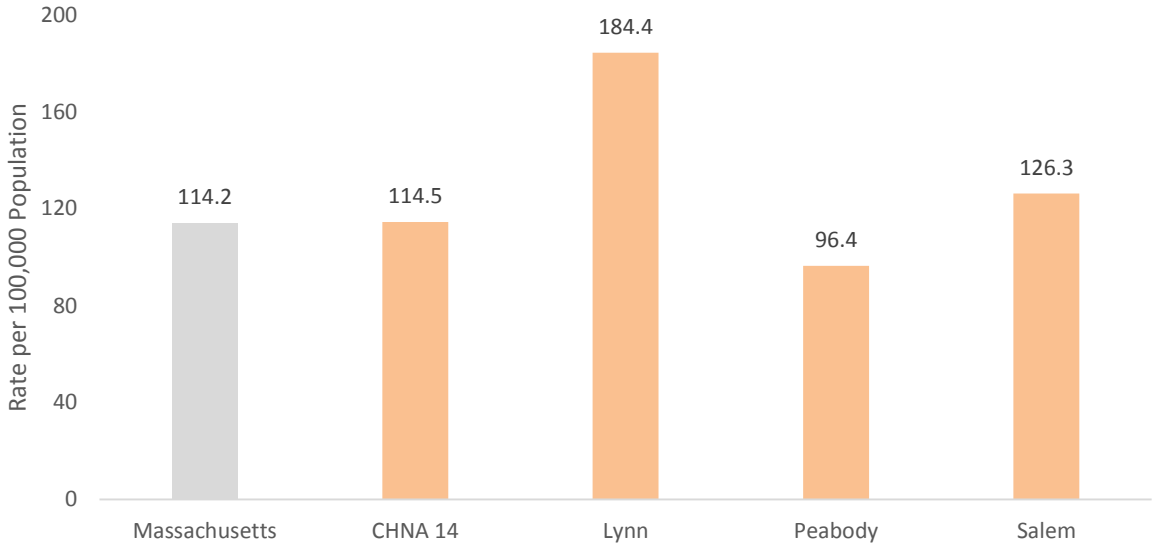
In addition to obesity, other chronic conditions that were of concern for residents included diabetes and asthma. They emphasized the important role of lifestyle behaviors – such as healthy eating and active living – in preventing and reducing these conditions.

<u>Diabetes</u>

Although not extensively discussed by focus group participants, the prevalence of diabetes in the population was noted as a particular challenge for dietary-based public services, such as food pantries. One focus group participant commented on how *"many diabetics visiting the food pantries find that there is little that can be offered to them. I wish there was a sugar-free section."*

In 2008, the North Shore region (CHNA 14) had a similar rate of diabetes-related emergency room visits to the state overall (114.5 and 114.2 per 100,000 respectively). However, Lynn residents experienced a higher rate of diabetes-related emergency visits (184.4 per 100,000) compared to others in the region as well as statewide (Figure 10). Salem's diabetes-related emergency room visit rate (126.3 per 100,000) was also above that of the region; whereas Peabody's rate (96.3 per 100,000) was below the region's rate.

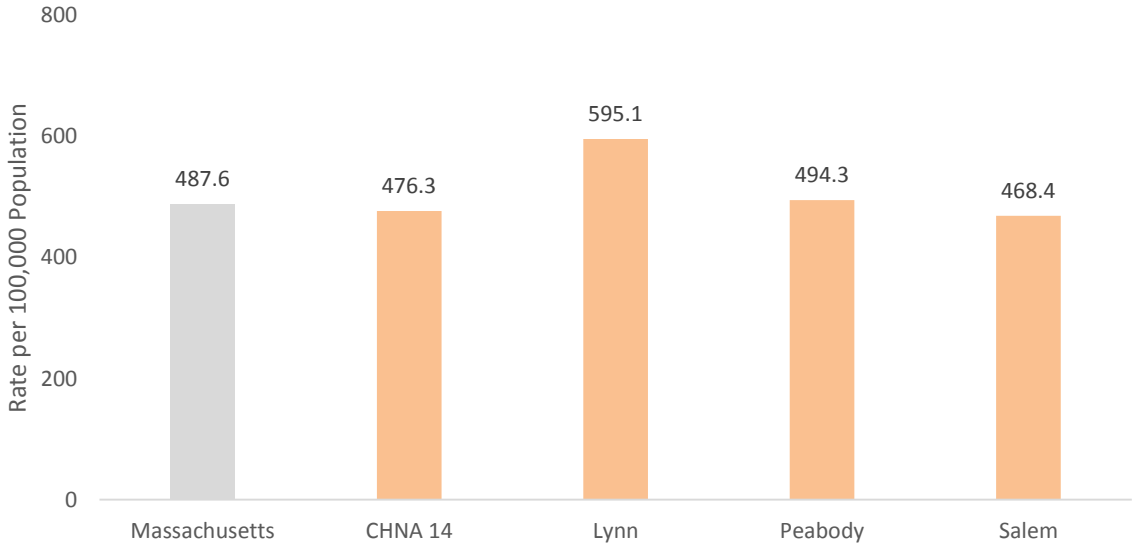
Figure 10: Age-Adjusted Rate of Diabetes-Related Emergency Room Visits per 100,000 Population by State, CHNA 14, and Select Towns, 2008



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Hospital Data, 2008

While the diabetes inpatient hospitalization rate in the North Shore region (476.3 per 100,000 is below that of the state (487.6 per 100,000), the rate in Lynn is nearly 1.25 times higher than that of the region (Figure 11).

Figure 11: Age-Adjusted Rate of Diabetes Inpatient Hospitalization per 100,000 Population by State, CHNA 14, and Select Towns, 2008



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Hospital Data, 2008

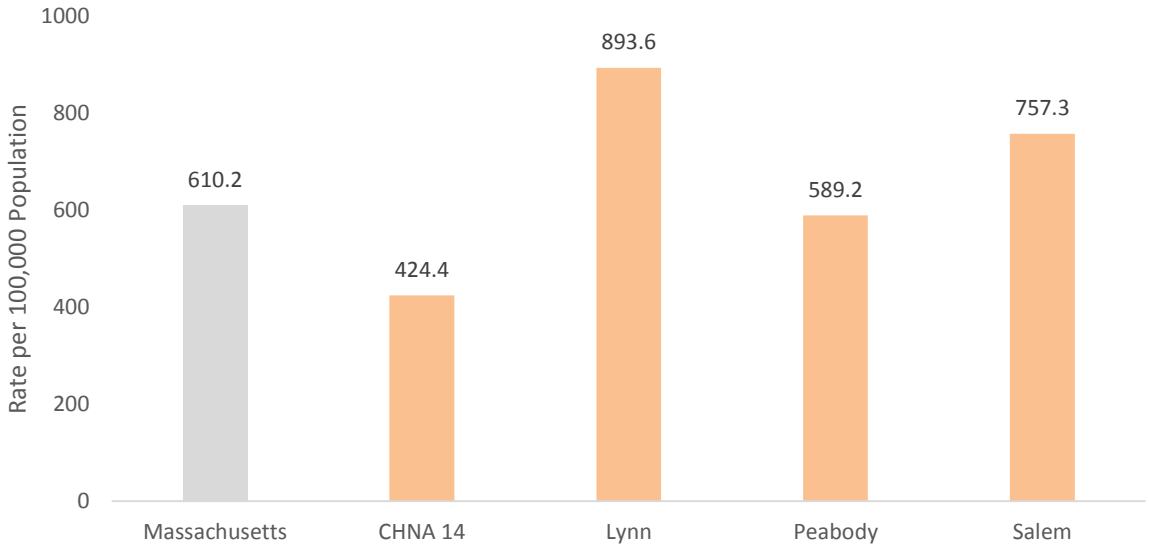
Asthma and Respiratory Illnesses

Focus group participants discussed asthma as a particular challenge for many North Shore residents, and saw this as being affiliated with elevated rates of cigarette smoking in the region. As one participant said, *"I have asthma, but I smoke. I can't say much about it, I am at risk of getting COPD if I don't quit. It*

runs in my family. My cousins have it; my grandmother too." Several participants agreed that they either know people with asthma, or have been diagnosed with asthma themselves. Further, participants expressed concern over the burden of costs associated with trying to manage the disease.

Quantitative data largely confirm these observations. In 2008, the rate of asthma emergency room visits in Lynn (893.6 per 100,000) was more than double that of the North Shore region (424.4 per 100,000); this rate was similarly elevated in Salem (757.3 per 100,000), as compared to the state overall (610.2 per 100,000).

Figure 12: Age-Adjusted Asthma Rate of Emergency Room Visits per 100,000 Population by State, CHNA 14, and Select Towns, 2008

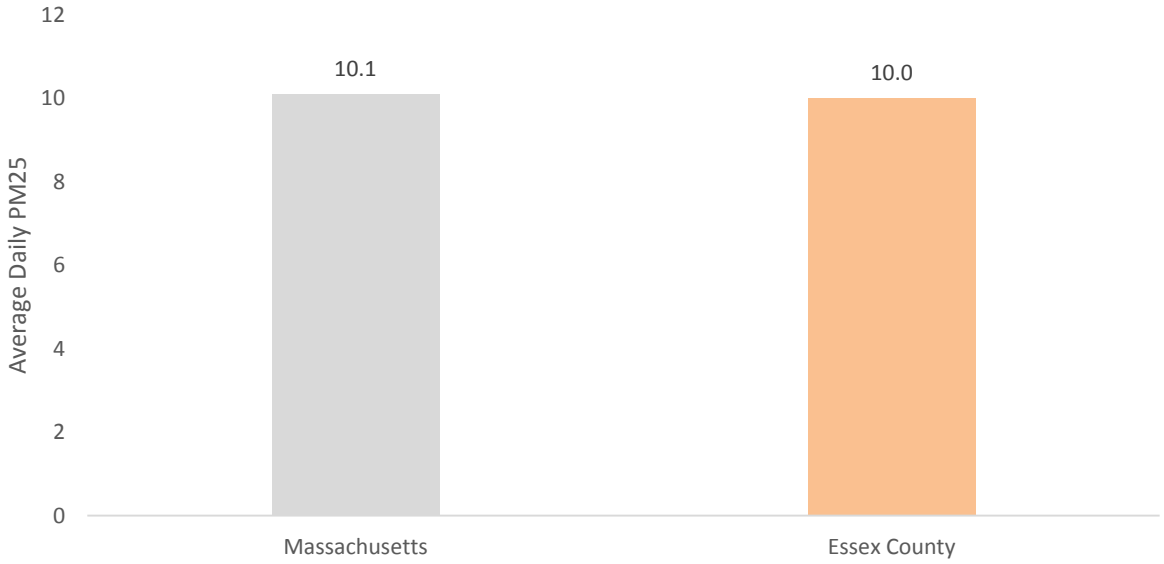


DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Hospital Data, 2008

The County Health Ranking & Roadmaps database collects data on average daily fine particulate matter as a measure of air pollution which can have negative health consequences including decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.[i] Essex County's average daily fine particular matter measurement is similar to that of the state, and towards the lower end of the spectrum among Massachusetts counties which range from 9.9 to 10.3.

[i] Centers for Disease Control and Prevention, CDC WONDER Environmental data, as cited by County Health Rankings & Roadmaps, 2013

Figure 13: Average Daily Fine Particulate Matter by State and County, 2008



DATA SOURCE: Centers for Disease Control and Prevention, CDC Wonder, Outdoor Air Quality, as reported by County Health Rankings & Roadmaps, 2013

Substance Use and Abuse: Tobacco, Alcohol, and Illicit Drug Use

When discussing substance use, participants focused primarily on cigarette smoking, excessive alcohol consumption, and illicit drug use (e.g., prescription drug abuse and injection drug use). Several participants noted that substance abuse is not just an individual issue, but one that affects entire families and the larger community. For example, one focus group participant discussing cigarette smoking as a *"big issue"* in the region noted, *"my mom is a smoker, so I have had second-hand smoke all my life."* Other effects of substance use noted by residents included emotional and financial strain on loved ones, increased violence in the community, a segment of the young adult population unemployed, and youth skipping school.

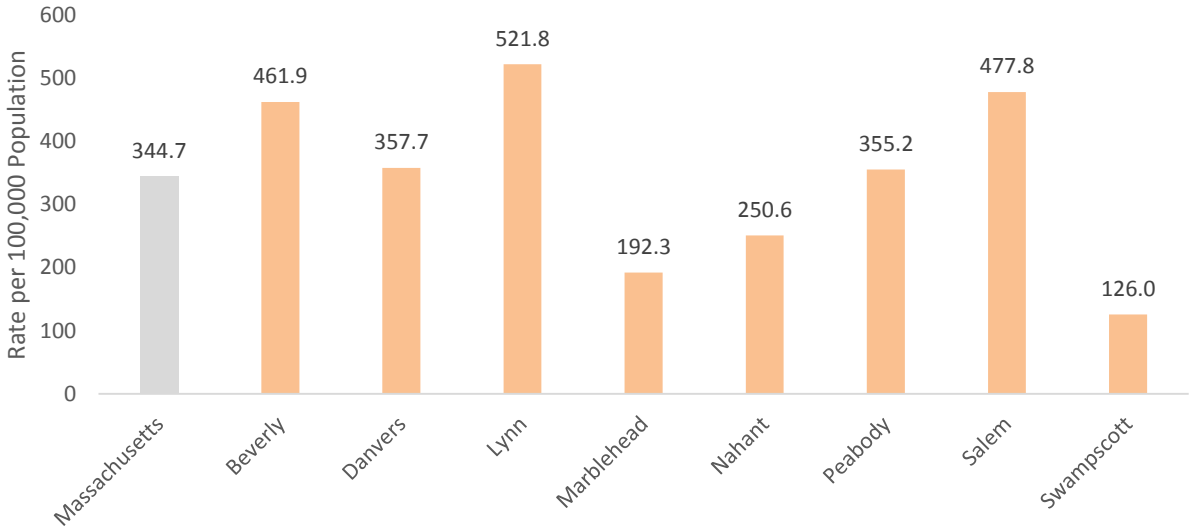
***"Cigarettes are probably the most pressing health concern in my community. Like I saw a 12 year old walking around smoking."*—Focus group participant**

"I don't think you should just cut smoking off with some new ban. People need help quitting. Bans should come with plans for helping people quit."—Focus group participant

One focus group participant from a previous assessment process cited the prevalence of injection drug use in the region and noted that *"Heroin has been a big issue lately, you cannot stop it from coming around because someone is going to sneak it around. At my school they are having Narcan classes to teach people how to reverse the effects of an overdose."* During previous assessment discussions, several low-income focus group participants identified themselves as former addicts or as having family members who were addicted. Those who identified themselves as former drug users described experiencing discrimination when accessing health services and noted a stigma associated with patients having a history of drug addiction.

Figure 14 illustrates the rate of alcohol and other drug-related hospital discharges for the state of Massachusetts as well as the North Shore DIG service area. Of the eight communities that comprise the service area, five had hospital discharge rates that exceeded the statewide rate. Among those, Lynn (521.8 per 100,000 population), Salem (477.8 per 100,000 population) and Beverly (461.9 per 100,000 population) had the highest rates of alcohol and other drug-related hospital discharges.

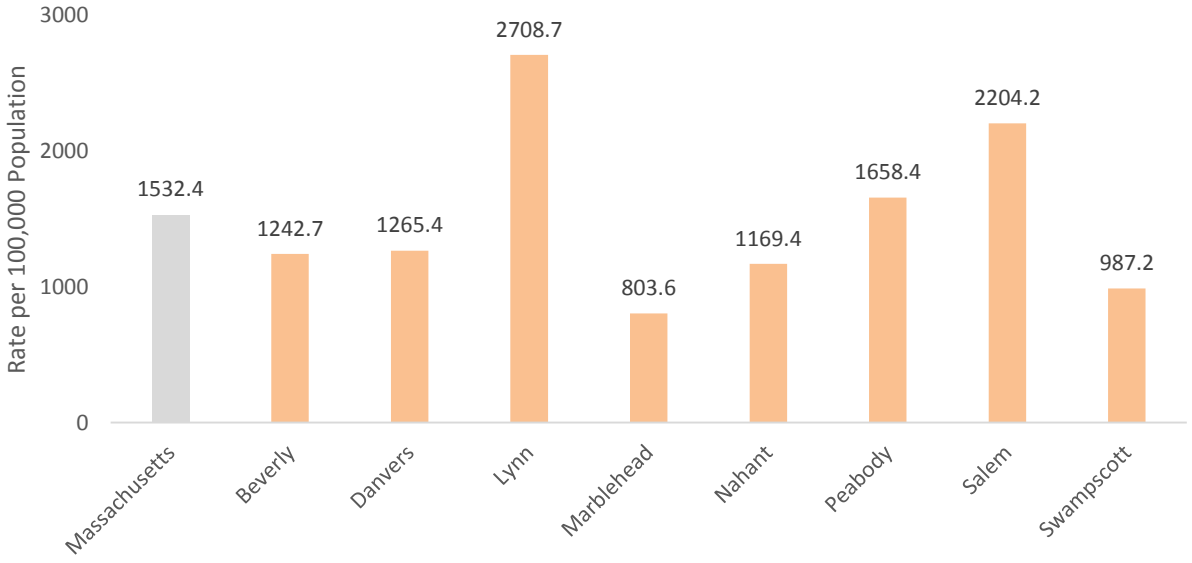
Figure 15: Rate of Alcohol and other Drug-Related Hospital Discharges per 100,000 Population by State and Town, 2011



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Health Status Indicators Report, 2011

Focus group participants discussed difficulty accessing substance abuse treatment services in certain North Shore towns, such as Peabody. With a dearth of rehabilitation centers within Peabody proper, transportation to out-of-own clinics was discussed as a limitation as well. Quantitative data show that Lynn had the highest rate of admissions to Department of Public Health (DPH)-funded treatment programs among the service area communities, exceeding the statewide rate by almost two times (Figure 16). Salem and Peabody also had rates that exceeded the statewide reporting.

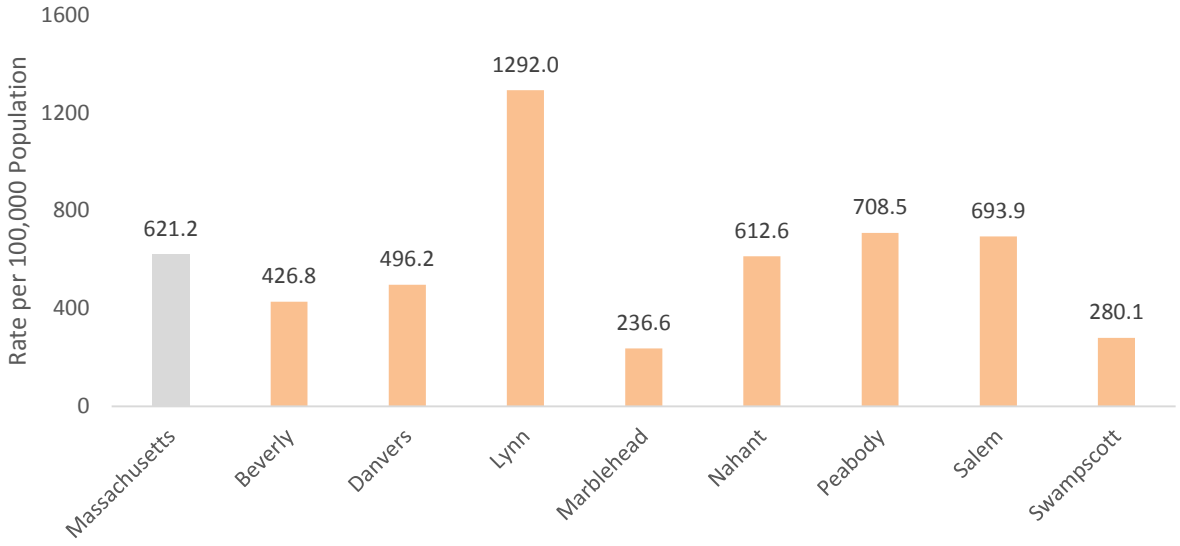
Figure 16: Rate of Admissions to DPH Funded Treatment Programs per 100,000 Population by State and Town, 2011



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Health Status Indicators Report, 2011

Injection drug use admissions rates to DPH funded treatment programs were over two-times higher in Lynn compared to statewide (1292.0 per 100,000 population and 621.2 per 100,000 population, respectively) (Figure 17). All other North Shore DIG service area communities were either slightly greater than the statewide rate, or below it.

Figure 17: Rate of Injection Drug User Admissions to DPH Funded Treatment Programs per 100,000 Population by State and Town, 2011



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Health Status Indicators Report, 2011

While focus group participants were concerned about illicit drugs, alcohol and tobacco is a much more common issue. Table 4 indicates the percentage of adults in the region who report being a current smoker, exposed to environmental tobacco smoke, and engage in binge drinking. Data indicate that smoking rates are higher in the North Shore region than in Massachusetts overall, with nearly 1 in 5 North Shore area adults identifying as a current smoker.

Table 4: Adults Reporting in Engaging in Tobacco and Alcohol Behaviors, 2007-2009

	CHNA 14	Massachusetts
% adults considered current smokers*	19.7%	15.8%
% adults reported that they were exposed to environmental tobacco smoke at home, work or other places	38.6%	37.5%
% adults reported binge drinking**	17.5%	17.6%

DATA SOURCE: Massachusetts Department of Public Health, A Summary of Health Risks and Preventive Behaviors in Community Health Network Areas (CHNAs), 2007-2009

*A current smoker was defined as someone who has smoked at least 100 cigarettes in his/her lifetime and who currently smokes either some days or everyday.

**Binge drinking defined as consumption of five or more drinks for men or four or more drinks for women on any one occasion in the past month.

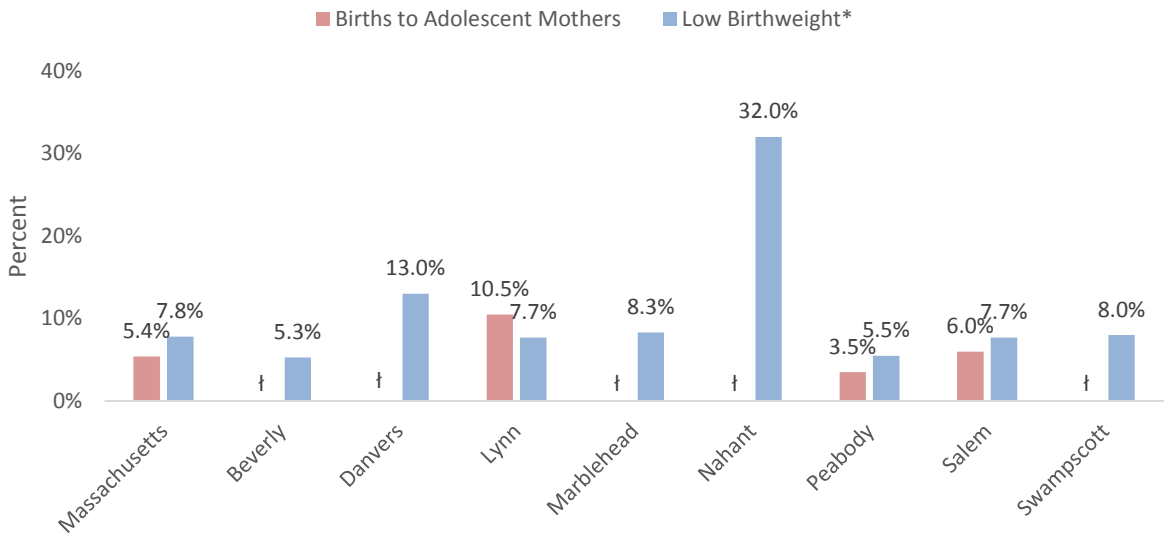
Recent focus group participants emphasized the need to make tobacco-related treatment options more accessible to accompany any potential changes in policy targeted towards reducing smoking rates in the region. As one resident stated, *"My doctor told me to quit smoking. She prescribed the patch which costs $30.00 and is not covered by MassHealth. The alternative costs $3.00 with MassHealth, but it has bad side effects that mess with you. I don't want to take that."* Public housing residents also discussed a notable increase in the housing regulations around smoking, stating that *"Section 8 is stern about*

substance use" and *"has smoking rules that are in better shape"* but also pointed out that such rules are often difficult to enforce. Focus group participants also discussed that smoke can permeate into their apartments from other housing units. As one participant noted, *"when a lot of people smoke, it smells. Where my mother lives here in Salem when you open the cabinet behind the sink, you can smell the smoke coming from the second floor, because someone is smoking."* Participants did not believe that residents were always abiding by the rules of the housing complex, and even smoking designated areas could smell up the building.

Sexual, Maternal, and Child Health

Although sexual health was not a topic raised among focus group participants, quantitative data were reviewed for the purposes of the assessment to provide an overall portrait of health. Birth outcomes data indicate that Nahant (32.0%) had the highest percentage of low birth weight babies (less than 2500 grams), which was over four-times that reported statewide (7.8%). However, it should be noted that since Nahant is such a small community, one lowbirthweight baby skews the proportion because of the small denominator. Of those towns for which teen pregnancy data were available, Lynn had the highest percentage of births to adolescent mothers (10.5%), nearly twice that reported statewide (5.4%).

Figure 18: Teenage Pregnancy and Low Birth Weight by State and Town, 2010



DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Health Status Indicators Report, 2010
* Low birth weight is defined as less than 2500 grams
'ł' indicate data were not available

Table 5 presents data on the rates of select infectious diseases per 100,000 population across the state and in the service area communities. Lynn and Salem (621.6 and 369.8 per 100,000 population, respectively) had rates of Chlamydia that exceeded the statewide rate (322.1 per 100,000 population). Gonorrhea rates were most elevated in Lynn as well (79.2 per 100,000 population), as was Syphilis (18.4 per 100,000 population).

Table 5: Rates of Select Infectious Disease Indicators per 100,000 Population by State and Town, 2010

	Chlamydia	Gonorrhea	Syphilis
Massachusetts	322.1	37.9	9.4
Beverly	195.8	12.6	ł
Danvers	119.2	0.0	0.0
Lynn	621.6	79.2	18.4
Marblehead	69.0	0.0	ł
Nahant	222.8	0.0	0.0
Peabody	164.9	15.7	ł
Salem	369.8	28.8	12.0
Swampscott	84.0	0.0	0.0

DATA SOURCE: Massachusetts Department of Public Health, MassCHIP, Health Status Indicators Report, 2010

'ł' indicate data were not available

Health Information Sources and Access to Health Services

Issues related to healthcare access were also explored in the focus groups. Barriers discussed included: information about what services are available, transportation to and from services, and health insurance coverage and cost. The following section describes the use and availability of services in the community, as well as the challenges to accessing them.

Health Information Sources

According to focus group participants, residents of the North Shore region receive health information from a variety of sources. These sources include the media (e.g., newspapers, television, radio, and internet), health care providers (e.g., doctor, nurse), insurance companies, by word-of-mouth (e.g., family members and friends), school, and community health centers or clinics. When probed on which of the aforementioned were trusted sources for health information, focus group participants identified the North Shore Medical Clinic in Salem, certain websites (e.g., ".gov" URLs, WebMD), and health classes at the local hospitals and schools. Challenges with existing methods of information dissemination identified by focus group participants included frustration with automated phone resources and services (e.g., endless menu options and long wait times to speak to a human representative), and difficulty accessing web-based resources for elderly and homeless. As one participant put it, *"I don't know many homeless people with an email address*." Focus group participants recommended disseminating health information through pamphlets and a toll-free number to speak with a health expert.

> ***"In terms of health sources that I trust most, you can take classes at the hospitals. There's a health clinic in Beverly that you can go to for health information."*—Focus group participant**
>
> ***"There should be more access to information. I think every City Hall should be a place that houses this information."—Focus group participant***

Challenges to Accessing Health Care Services

Recent focus group participants were also asked about challenges to accessing care. The primary challenges identified by residents included insurance coverage, cost of care, a general lack of local medical specialists, and limited public transportation leading to congestion. Populations discussed as facing particular challenges with accessing health care included the homeless and individuals either currently or formerly abusing substances. Specifically, certain medications were described as difficult to access for past substance users. As one participant put it, "*If you had an early-life drug problem, it's hard*

to access certain meds. My brother has to go to the hospital ER for morphine shots for his pancreatitis." Focus group participants generally agreed that the stigma associated with substance use exacerbated these access challenges.

The challenges to accessing care faced by the under- and uninsured was a common theme raised by participants. Challenges ranged from the inability to afford prescription medications to insufficient coverage for substance abuse treatment. In addition, long wait times after applying for insurance often led to costly out-of-pocket payments for necessary medications –several participants shared similar experiences pertaining to the MassHealth application process. One participant described his experience saying, *"it took seven months to get insurance. While waiting, I had to pay full price for prescriptions, which went as high as $500 for a single medication. I also had to pay for a $1500 ambulance ride."*

Vision for the Future

When asked about suggested approaches for addressing community health needs and overcoming barriers to access and utilization, recent North Shore focus group participants' recommendations clustered around several health topic areas: obesity and associated behavioral risk factors, homelessness, and substance use.

Obesity and Related Behavioral Risk Factors

Around obesity, focus group participants suggested expanding opportunities for youth to exercise by offering more alternatives to team sports through collaborations with local physical activity organizations, periodically opening school exercising facilities to the community, and striving towards the implementation of a public bike share program. Overall, participants were interested in more low-cost or free recreational opportunities throughout their community, so that being active would be easy to do and close to them. Equally important was the need for nutrition programs to provide information on healthy eating (e.g., portion size, caloric intake) and improving the school lunch options. A more robust health curriculum taught by positive adult role models demonstrating healthy behaviors was also described as beneficial.

Substance Use, including Smoking

Expanding services related to substance abuse was supported and suggested by focus group participants. They noted that a helpful first step in this process would be to enhance training opportunities regarding several facets of behavioral health, including: recognition of signs and symptoms, addressing overdoses, de-stigmatizing behavioral health care, and understanding community resources and referral processes. The de-stigmatization piece was particularly important to focus group participants who described public perception of addiction as a particularly challenging barrier to accessing social and health care services. As one focus group participant noted, "*I'm already labeled because I got in trouble when on drugs and alcohol and now I can't get into affordable housing."* In addition to training, interview participants also strongly emphasized the need for expanded substance abuse treatment options.

When asked about smoking-related programs and services, several focus group participants discussed changing the infrastructure of housing complexes so that those who do smoke could smoke in an area that was confined to them and away from the building. As one participant mentioned, *"we need more ashtrays and benches away from the apartments so we can go there and still be social, but not bother the people with asthma."* Other participants discussed the importance of making cessation services more enticing and accessible to smokers.

Homelessness

An increase in services targeted towards the homeless population was a priority concern for all recent focus group participants. Participants stressed the need for more shelters to house the homeless population, particularly during the winter months, as well as transportation services to and from existing shelters. As one participant noted, *"We need more places for those on the street, the homeless. When you walk by the shop entrances at night you see people huddled there."* Other suggested services included re-opening organizations that used to allow for the homeless to use their showering facilities, as well as adjusting regulations around CORI checks that limit services available to homeless individuals with prior criminal records. Another focus group participant summarized this by saying, *"the homeless should be taken care of. First housing, then job, then self-esteem. Treat them as humans."*

Outreach and Community Engagement

Greater collaboration, outreach, and engagement of residents as well as people involved in the health, health care, and social service communities was viewed as an important step in moving forward on future initiatives. This was suggested by focus group participants as a way to ensure that future policy and program implementation was informed by the community members for which it was created. Participants expressed that deliberate efforts are needed to create a collaborative process that urges people to come together, exchange ideas, and learn from each other. As one focus group participant put it, *"people who are dealing with these issues every day should be involved in these decisions."*

KEY THEMES AND CONCLUSIONS

Key Themes

Through a review of the secondary data and discussions with community residents, this assessment report provides an overview of the social and economic environment of the North Shore DIG service area communities, health conditions and behaviors that most affect the population, and perceptions of strengths and gaps in the current environment. Several overarching themes emerged from this synthesis:

- *The social, economic, and physical context of the community underscores all aspects of daily life for residents.* Limited employment and housing opportunities, as well as homelessness among community members have a significant impact on the social and economic context of the area. Despite considerable socioeconomic challenges, community cohesion and activism were considered important neighborhood assets, as well as existing organizations and resources.

- *Chronic diseases and related lifestyle behaviors were viewed as important community health issues which disproportionately affect low-income residents.* Chronic diseases such as diabetes and asthma were concerning health issues among participants and are also conditions that consistently follow social and economic patterns. Obesity was one of the most concerning health issues cited by stakeholders and residents engaged in this assessment, particularly regarding limited access to affordable healthy food and safe spaces for physical activity

- *Substance abuse emerged as a pressing issue for the community, for which there is a lack of services.* Specifically, cigarette smoking among adults and youth, prescription drug abuse, injection drug use, and excessive alcohol consumption were perceived as pressing health concerns. Participants indicated the stigma associated with substance use create barriers to care.

- *Despite the expansion of healthcare coverage, insurance status, a complex healthcare system, and cultural and linguistic differences prevent residents from receiving care.* While healthcare coverage is less of a challenge than it once was, financial barriers related to insurance status and the cost of care (e.g., co-pays) remain.

Conclusions

The community served by the North Shore District Incentive Grant Partners faces several social and economic challenges that have a significant impact on population health. However, residents are resilient and there are numerous assets and strengths such as organizational programs and services.

Health issues such as chronic diseases and their risk factors—especially diabetes, asthma, obesity, and limited physical activity and healthy nutrition—as well as substance abuse were seen as significant concerns that impact many residents. Furthermore, low income and homeless residents are disproportionately affected by these health conditions. Potential partnerships with health care services, social service organizations, schools, and organizations focused on specific populations (e.g., immigrant communities, homeless population) can help in further reaching specific underserved groups.

Appendix: Focus Group Moderator's Guide

Goals of the focus group:

- To determine perceptions of the health strengths and needs of the community, overall and specifically related to asthma and tobacco use
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

I. BACKGROUND

- Hi, my name is _____ and I am with Health Resources in Action, a non-profit public health organization. I'd also like to introduce my colleague _____. He/She is involved with me on this project and is here to observe and take notes during our discussion, so that I can have my hands and attention free as we talk. Thank you for taking the time to speak with us today.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- The health departments in the greater North Shore area—specifically Beverly, Danvers, Lynn, Marblehead, Nahant, Peabody, Salem, Swampscott—is undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of residents and how health needs are currently being addressed. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.

- We will be conducting several of these discussion groups around the area. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.

- Lastly, please turn off your cell phones, beepers, or pagers or at least put them on vibrate mode. The group will last only about 90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS

Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share– such as how many children you have or what activities you like to do in your spare time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ISSUES

1. Tonight, we're going to be talking a lot about the community that you live in. How would you describe your community?

2. If someone was thinking about moving into your community, what would you say are some of its biggest strengths or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

    a. What are some of the biggest problems or concerns in your community? [PROBE ON ISSUES IF NEEDED – HEALTH, ECONOMIC, SOCIAL, SAFETY, ETC.]

3. What do you think are the most pressing *health* concerns in your community?

    a. How have these health issues affected your community? In what way?

        i. What specific population groups are most at-risk for these issues?

4. [PROBE ON SPECIFIC ISSUES] There were several issues you [MENTIONED/DID NOT MENTION].

    a. For example, **asthma** – how much of concern is asthma in your community? How do you see it impacting the lives of families and residents in your community?

    b. How about smoking – how much of an issue is **smoking** in your community? How do you see it impacting the lives of families and residents in your community?

    c. How about obesity – how much of an issue is **obesity** in your community? How do you see it impacting the lives of families and residents in your community?

IV. PERCEPTIONS OF PUBLIC HEALTH/PREVENTION SERVICES AND HEALTH INFORMATION

5. Let's talk about a few of the health issues you mentioned. [SELECT TOP HEALTH CONCERNS] What programs, services, and policies are you aware of in the community that currently focus on these health issues? [IF NOT MENTIONED, PROBE SPECIFCIALLY ABOUT **ASTHMA** AND **SMOKING**]

    a. What's missing? What programs, services, or policies are currently not available that you think should be?

6. What do you think the community should do to address these issues? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

    a. What do you think needs to happen within your housing complex around these issues? What could be done in the housing complex to help with asthma? Decrease smoking rates? Or promote an overall healthy environment?

7. Where do you hear most of your information about health?

    a. What sources of health information do you trust the most?

b. Where or who in your community would you want to receive information from about these issues?

V. VISION OF COMMUNITY AND PROGRAM/SERVICE ENVIRONMENT

8. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?

    a. What is your vision specifically related to people's health in the community?

        i. What do you think needs to happen in the community to make this vision a reality?

        ii. Who should be involved in this effort?

VI. CLOSING

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon.

[TALK ABOUT HOW PARTICIPANTS CAN GET A COPY OF THE REPORT, IF POSSIBLE]