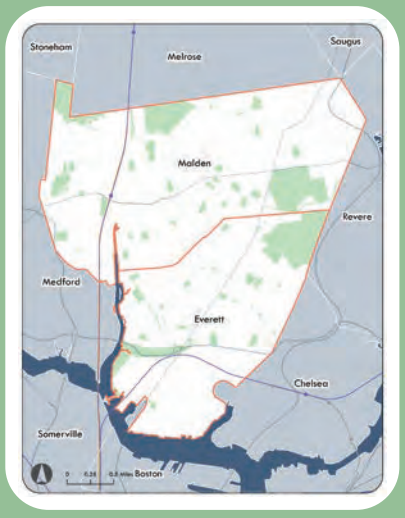
2019/2020

Everett-Malden Community Health Needs Assessment



CHA Cambridge Health Alliance

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Cambridge Health Alliance: https://www.challiance.org/community/health-improvement
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Table of Contents

A Note to Readers

Cambridge Health Alliance (CHA), Massachusetts General Hospital (MGH), and MelroseWakefield Healthcare (MWHC) came together to conduct the first Everett/Malden Collaborative Community Health Improvement (EMCCHI) assessment and report-back to the community. We wanted this information to be inclusive of community thoughts, knowledge and expertise. This process included the community at a variety of levels.

A new partnership

In the past, these three health care institutions would have organized three separate processes to complete a Community Health Needs Assessment (CHNA). Since CHA, MGH and MWHC have overlapping service areas, and in some cases collaborative programs serving this region, we decided to pilot a joint CHNA. We are also building upon a CHNA process and relationship from our work together in the North Suffolk region (Chelsea, Revere and Winthrop). Additionally, MWHC completed a 2019 CHNA as well. Most importantly, our missions are very similar - to improve the health of the communities that we serve - and collaborating on this assessment, report and subsequent implementation plan makes good sense.

Why is this important?

Each of these three health systems is required to conduct a Community Health Needs Assessment (CHNA) for various regulatory bodies. Rather than have three separate CHNAs, our goal was to create a full picture of the health needs and assets of the Everett and Malden communities by leveraging the data, knowledge, and partnerships that we collectively bring to the table. We committed to partnering with city leadership, residents, and other stakeholders to produce data and a report that reflects community priorities and interests and lays a foundation for action. We are grateful to the community members, patients, and partners who have joined with us as a part of this process.

The purpose of a community health assessment is to identify the strengths and needs of a community with regard to health, and to then channel that information into action toward achieving health equity. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Let us strive to build a community where health equity exists and where all people have the same chance to achieve their best health regardless of who they are, how much money they have, or what neighborhood they live in.

We thank you for participating in this process.

What is a Community Health Needs Assessment?

A community health needs assessment (CHNA) is a systematic process involving the community to identify and analyze community health needs and assets. In this context, needs are the gap between what currently exists and what could exist to help people be more healthy, such as improved access to grocery stores or more parks and open spaces. Assets, or resources, are something that enhances community life, and can include individuals, organizations, institutions, cultures and social structures. The process of identifying and analyzing these needs and assets is grounded in publicly reported data as well as input from the community through focus groups, surveys and interviews. It provides a way for communities to prioritize their health needs, and to develop a plan that further strengthens community assets through partnerships and a shared commitment to improving the health of everyone living or working there.

What you will find in this report:

- **Guiding Principles** describes the values and framework that guided this CHNA process, particularly a focus on health equity and the social, economic and environmental factors that contribute to it.
- **Listening and Learning: Data Collection and Findings** describes *how* data was collected (Data Collection: How we Listened and Learned) and *what* was found (Findings: What we Heard and Learned).
    - **Data Collection: How we Listened and Learned** describes the process of collecting and analyzing both *primary* (first-hand and new) and *secondary* (publicly reported and existing) data.
    - **Findings: What we Heard and Learned** describes data that was most compelling to community members during interviews, focus groups and community meetings, as well as during review of secondary data. This section is broken down into **Top Strengths of our Communities** and **Top Concerns Impacting Health**.
- **Summary and Conclusion** offers a summary of the data and an invitation for readers to translate this assessment into action for positive change in Everett and Malden.
- **Appendices** include all data sources and data collection tools, as well as individual Community Data Profiles and 1-page Community Snapshots.

Guiding Principles: What drove this work?

Using the THRIVE Framework: A different way to understand health and health equity

For this community health assessment of Everett and Malden, many factors were studied, including health behaviors and genetic factors. However, there was a strong focus on the impact that a community's environment and distribution of resources has upon its health. To better understand these

drivers of health, we piloted the use of a framework called ***A Tool for Health & Resilience In Vulnerable Environments*** **(THRIVE)**[1] - a tool for assessing community conditions, prioritizing them, and taking action to change them to improve both health outcomes and health equity. We chose to use this framework because we believe that expertise about community wellbeing exists in the community. The THRIVE tool allows us to formally recognize that expertise as an important part of the data collection process. It also reminds us that health outcomes do not exist in isolation, rather they are impacted by deeper systemic issues such as racism, class oppression, and gender inequity. The framework asks us to rethink the way we design plans to work towards lasting solutions that improve health. Based on years of research and dialogue, THRIVE identifies three main clusters of community conditions, which we also call determinants.

The first is **PEOPLE**, which refers to the conditions of the social and cultural environment -- things like social networks, civic participation, and typical behaviors and practices.

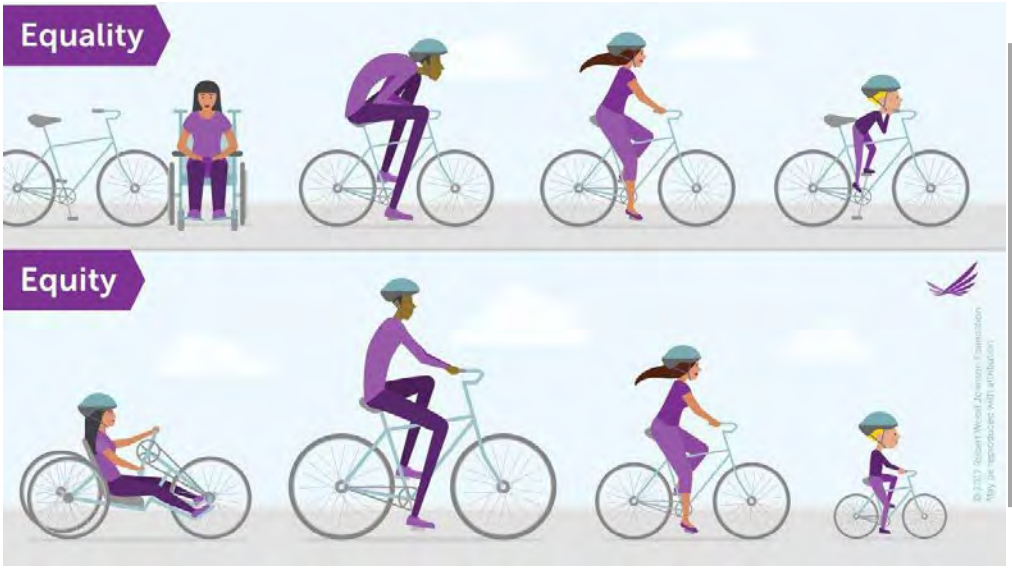
The second is **PLACE**, which refers to the conditions of the physical and built environment -- things like the products that are sold and marketed, parks and open spaces, housing options, health care services, and the air, water, and soil.

The third is **EQUITABLE OPPORTUNITY**, which refers to the economic and educational environment -- things like jobs, investment opportunities, schools, and adult learning opportunities.

If we understand what these determinants look like in Everett and Malden, we can begin to explore how the health outcomes that people experience might be explained by these underlying factors. Then, we can prioritize which underlying factors might be most impactful to address and develop plans of action to achieve ***health equity.***

[1] THRIVE – Prevention Institute: https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments

Health Equity: *Everyone* has a fair and just opportunity to be as healthy as possible.

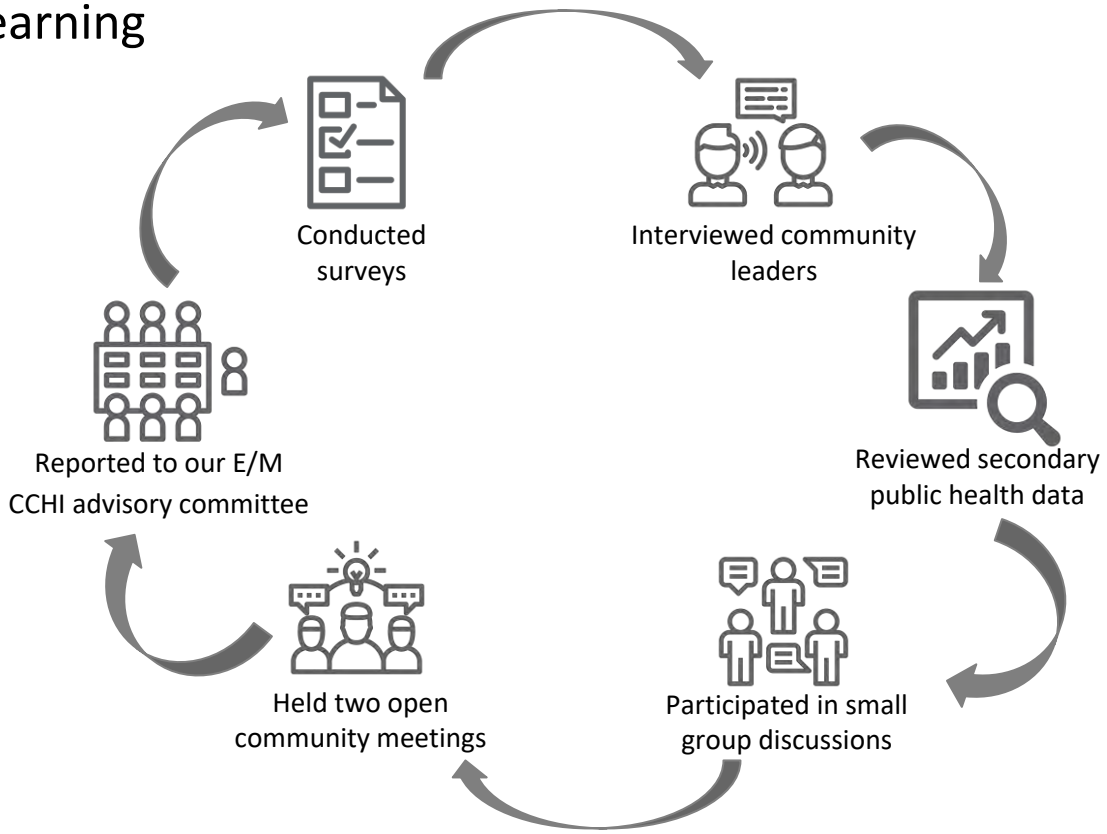


The difference between **equality** and **equity**:

As you can see on the graphic displayed, an **equality** approach gives everyone the same size and type of bike, with no regard for differences in lived experience and actual need. In comparison, an **equity** approach ensures that everyone gets the right bike for them.

This CHNA worked to understand the layers of community context that impact our patients' and residents' lives so we can work to bring them what they need (translation, screening and referral for particular services, specialized transportation, etc.) with the goal of providing better *health outcomes*.

Data Collection Process and Findings: Listening and Learning



The purpose of this assessment was to develop a full picture not only of health needs in Everett and Malden, but also of community strengths and assets. Over the course of several months, both ***secondary*** (publicly reported and existing) and ***primary*** (first-hand and new) data were collected and analyzed.

Secondary data is publicly reported data that includes local, regional, and state data on health outcomes as well as social, economic and environmental factors. This information comes from sources such as the Massachusetts Department of Public Health, the US Census Bureau, and local reports, such as the Everett Community Food Assessment and Plan and the Everett and Malden Youth Risk Behavior Survey reports. (For a complete list of data sources please see (Appendix A).

- ***A note on public health data*:** Much of the public health data in the *Health Outcomes* section is presented in "age adjusted rates" unless otherwise noted. Age-adjustment is a statistical process applied to rates of disease and death which allows populations or groups with different age structures to be compared. The occurrence of disease and death is often associated with age and the age distribution between populations may differ considerably. Thus, age-adjusted rates are helpful when comparing rates over time and between groups or populations (Health of Boston Report 2016-2017).
- ***Limitations on public health data:*** The MA Department of Public Health (DPH) data reporting system has changed since previous assessments in these communities, and the new system, the MA Population Health Information Tool (PHIT), was just released at the time this report was written, with more limited data available than the previous data system (known as MassCHIP.) Main limitations encountered through the secondary data review include:
    - Old data, due to reporting and analysis lags at the MA DPH and other agencies
    - Lack of sources for publicly available data for some important topic areas related to health such as cancer incidence and top causes of hospitalization
    - Available rates for some indicators included only one year of data, vs. the preferred presentation of multi-year rates
    - No ability to break MA DPH data down by age groups or by race
    - Data updates continue to occur while a CHNA process is ongoing, therefore, the data presented in this report represents the data that was available during the time of the process

To collect ***primary data*** we conducted interviews, surveys and focus groups to gain community thoughts about health, broadly defined, in Everett and Malden. We then held 2 open community meetings where we presented health data and asked for input and feedback to put the numbers in context. We wanted to hear from you -- the people who live, work and play here. The result is a collaborative report that tells a comprehensive story about the health and wellbeing of these two communities. (See the survey and focus group guides in Appendices B and C.)

Data Collection: How we listened and learned

Surveyed 67 individuals and interviewed various stakeholders

Individual perspectives were sought from community members at local events, and stakeholders who live and/or work in Everett and Malden were interviewed (including community leaders and staff at various health institutions). Sixty-seven surveys were administered at the following places between July and August 2019: Zion Baptist Church Block Party, Everett National Night Out, and the Malden Mobile Market. Stakeholder interviews were held with 10 community leaders in both Everett and Malden. Incentives to participate were provided. (See Appendix B for survey questions.)

Conducted 4 small group sessions

At these small group discussions, we focused on hearing from specific populations like youth and older adults to gain their unique perspectives on issues impacting their health and wellbeing. Focus groups were held at CHA Everett Care Center, the Northern Strand Community Farm, the Everett Connolly Center, and the Tri-City Hunger Network. Food and incentives to participate were provided. (See Appendix C for focus group questions.)

Held 2 open community meetings: "*What Keeps You Healthy? A Community Discussion in Everett and Malden.*"

At these two community meetings, over 45 people who live and/or work in Everett and Malden attended to hear about the health-related data that was collected and to share their perspectives on what it means in their lives. One session was held at Everett High School Crimson Cafe and the other was held at the Malden Senior Community Center. We presented and discussed public health data as well as data about social, environmental and economic concerns. Attendees broke out into small groups to explore what works well and what needs improvement in order for their communities to become healthier. Questions asked of each group included:

- What are the strengths or assets in your community that help to keep people healthy?
- What are the challenges or barriers in your community that make it difficult to be healthy?
- What do you see as the most significant priorities for improvement?

Materials to promote these events were distributed in the major languages of our communities (English, Spanish, Haitian Creole, Portuguese and Mandarin) and interpreters in each language were on site. We also provided transportation, childcare, elder care and healthy snacks.

English version of the flyer promoting community meetings

Participants from the Malden community meeting

Findings: What we heard and learned

Using the THRIVE framework of people, place and equitable opportunity, major themes that emerged from interviews, surveys, and discussions with residents and community leaders included resources and assets (listed below as "Top Strengths of Our Communities"), as well as challenges and priorities (listed below as "Top Concerns Impacting Health"). These themes were then analyzed against secondary/quantitative data and compiled below.

Top Strengths of Our Communities[2]

Diversity of our residents and businesses: Many participants saw cultural and linguistic diversity as a strength. One participant said, "As an immigrant moving here you feel like you are 'home' - safe and comfortable by hearing different languages and seeing/smelling/enjoying different food!"

• 41% of Everett and 43.3% of Malden residents are foreign-born
• 56.1% of Everett and 51.2% of Malden residents speak a language other than or in addition to English at home
• 78% of Everett and 71.6% of Malden students identify as a race/ethnicity other than white

[2] For all secondary data in this section, please see Appendix A for a list of sources.

Open space and recreation: Indoor and outdoor spaces and programming that promote physical activity was a strength mentioned by many community members. Focus group and community meeting participants said the Senior Centers in both Everett and Malden, as well as the Everett Health and Wellness Center and the Malden YMCA help them stay healthy. Youth mentioned that access to team sports helps them stay healthy; although Everett youth felt that sports and recreational activities other than football should be promoted more. The availability of parks, open spaces and bike paths/bike lanes in both Everett and Malden was also highlighted as a strength.

98.8% of Everett and 92.6% of Malden residents live within a 10-minute walk to a park

Access to free and low cost meals for students and seniors: Participants stated that having access to low-cost meals at Senior Centers, free meals at school, and free summer meals in the parks help them stay healthy. These meals help to decrease food insecurity in our communities, as more residents face rising housing costs, leaving less money to pay for food.

12.1% of Everett and 15.1% of Malden residents are food insecure, compared to 9.1% in MA

Produce markets and community gardens: Community members stated that mobile markets and pop-up markets (such as the YMCA market at the Malden Senior Center) have increased access to food, especially if it is difficult to travel to grocery stores. Participants noted the importance of ensuring that these services remain culturally relevant to build trust among customers, and one participant stated that *"It is important that food is familiar and authentic to clients, as well as healthy...language barriers may potentially prevent clients from accessing services - for example, if staff members do not speak the client's language, the client may not want to utilize services."* They also feel that community gardens are a strength, but there should be more - there is limited access due to low volume and long waitlists.

Social services, civic and community engagement: In community meetings many participants voiced appreciation of the various agencies and organizations in the area that offer services and opportunities for civic and community engagement, especially those who offer interpretation. Civic and community engagement (activities such as volunteering, voting, participating in group activities, advocacy, etc.) improves health by building social capital, which is defined as "features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit."[3] Particular organizations and agencies that were mentioned include Everett Family Resource Center, Mystic Valley Elder Services, Bread of Life, La Comunidad, Inc., MA Senior Action Council, ABCD Mystic Valley Opportunity Center, Senior PACE programs, school-based health centers, and faith-based organizations, to name a few.

More residents in Everett and Malden are registered to vote compared to the state (52.8% of Everett residents, 48.1% of Malden residents, 44.5% of MA)

[3] Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/civic-participation#4

Selected Community Demographics *(See Community Data Profiles in Appendix D for more demographic and community characteristics)*

	Everett	Malden	MA
Population	45,212	61,212	6,789,319
Population Density (Per Sq. Mile)	13,199.9	12,137.6	870.4
High School Graduate or higher	79.9%	86.5%	90.3%
Foreign born	41%	43%	16%
Racial Identity			
African American or Black	19.3%	16.3%	6.7%
Asian	6.5%	23.6%	6.3%
Hispanic	22.9%	9.3%	11.2%
Some other race	5.4%	4.1%	2.9%
White	45.9%	46.6%	72.9%
Languages Spoken			
Asian and Pacific Islander languages	3.9%	19.1%	4.2%
English only	43.9%	48.8%	76.8%
Other Indo-European languages[4]	29.9%	17.9%	8.8%
Spanish	19.7%	7.9%	8.8%
Other languages	2.6%	6.3%	1.4%
Data Source: US Census Bureau, American Community Survey (ACS) 2013-2017, 5-year estimates			

Top Concerns Impacting Health

The challenges and areas of highest priority that came up most often in primary (community and stakeholder engagement) and secondary (publicly available) data analyses were around the social, economic, and built environment, and include*:*

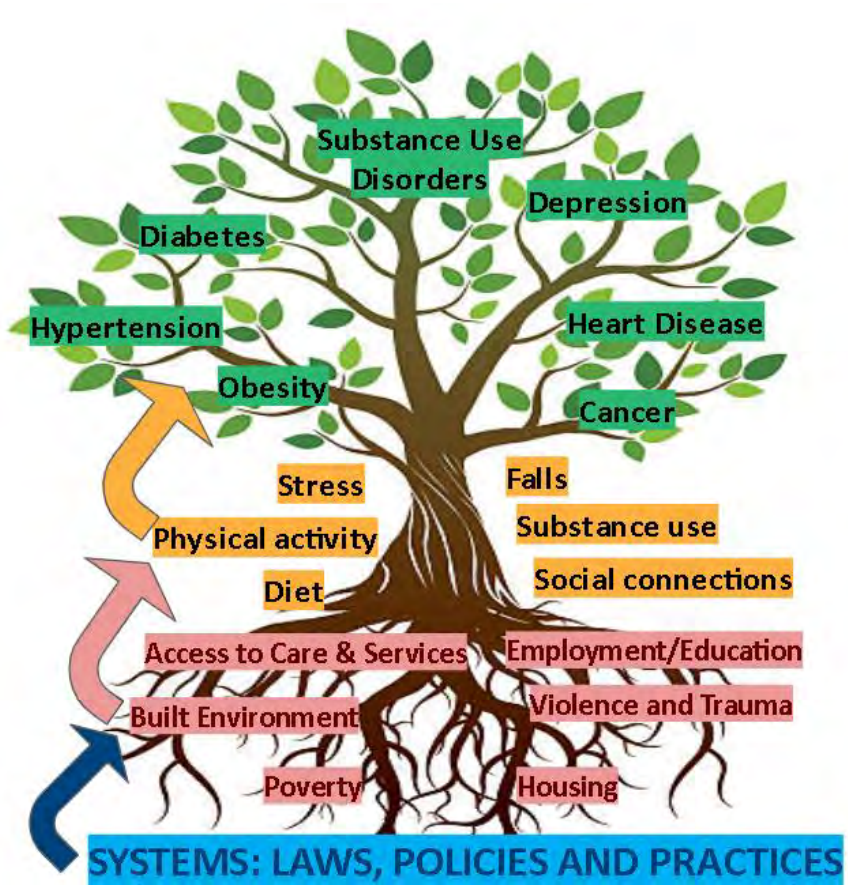
- **Housing affordability and stability (including homelessness)**
- **Access to healthy food**
- **Economic stability & mobility**
- **Access to care and services**

Other concerns voiced by the community and found in our secondary data analysis included health outcomes such as:

- **Behavioral health**
- **Chronic disease**
- **Infectious disease**

In the sections that follow, we look at various secondary data indicators for each area in each community, in comparison to the state of Massachusetts. Before the data is described, we would like to offer a diagram to illustrate the relationship between these factors.
This tree diagram is often used in public health work, and explains how health outcomes are influenced by multiple factors that build upon each other, from the groundwater up to the leaves.

[4] Other Indo-European languages: family of languages spoken in Europe and areas of European settlement and in much of Southwest and South Asia (Encyclopedia Britannica), and include (but are not limited to): French, Haitian, Italian, Portuguese, German, Greek, Persian, Hindi, and Indic languages



Health outcomes (green leaves) are influenced by genetic factors and ***lifestyle behaviors*** (orange trunk). These behaviors are shaped by access to and condition of the ***social, economic and built environment*** or the social determinants of health (red roots). These are the neighborhood or community conditions that shape where you live, work, play and pray, such as employment opportunities, quality and affordability of housing stock, transportation options, etc.

The availability and distribution of resources throughout the social determinants of health have been created and perpetuated by ***systems*** (the blue groundwater), laws, policies and practices, that have privileged some populations and disadvantaged other populations. These unjust systems make their way all the way up the tree, where we see health outcomes and health inequities.

So, while we most often see the leaves as the "problem" and look to the trunk (or the behavior) to make change, looking deeper into the roots and the groundwater is necessary to make lasting positive changes.

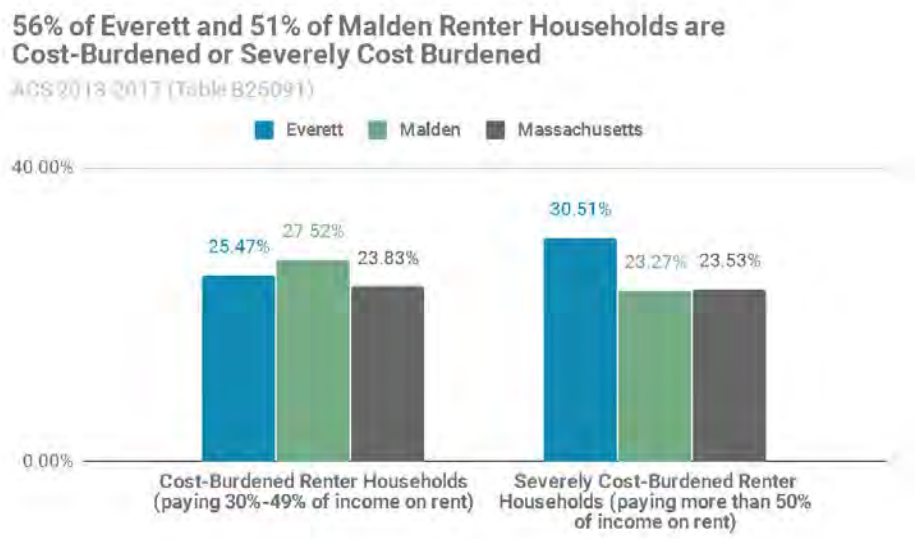
Social, Economic and Built Environment

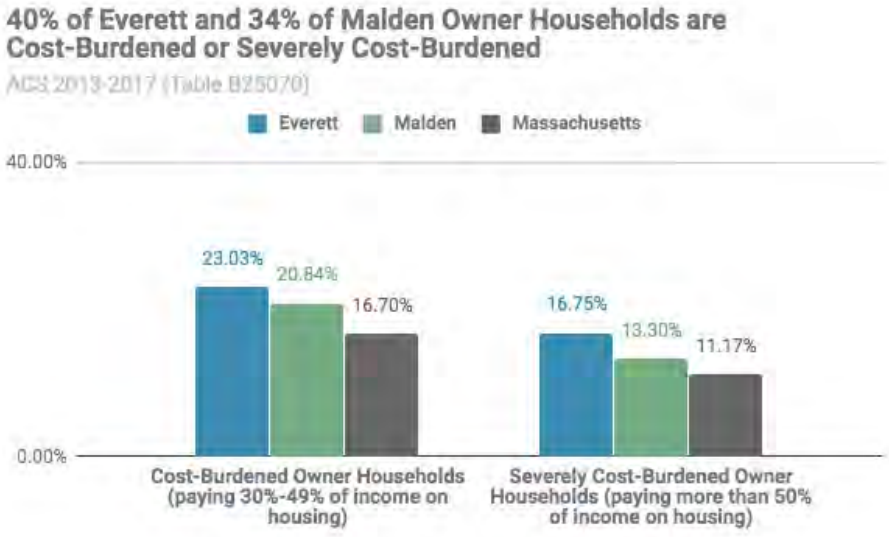
There are strong connections between social conditions, economic opportunities, and health - the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships all affect how healthy we can be.[5] The built environment includes the physical parts of where we live, work and play (e.g., homes, buildings, streets, open spaces, and infrastructure). Differing access to and condition of these factors explains in part why some Americans are healthier than others, and why Americans more generally are not as healthy as they could be.

[5] Social Determinants of Health: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Housing affordability, stability and safety

This was by far the biggest challenge and area of high priority voiced from participants through the community and stakeholder engagement process. Secondary data analysis supported this concern, as it was found that in comparison to the state, our communities have **high housing cost burden (especially among renters), high eviction rates, high churn rates in our schools and low Subsidized Housing Inventory (SHI).**





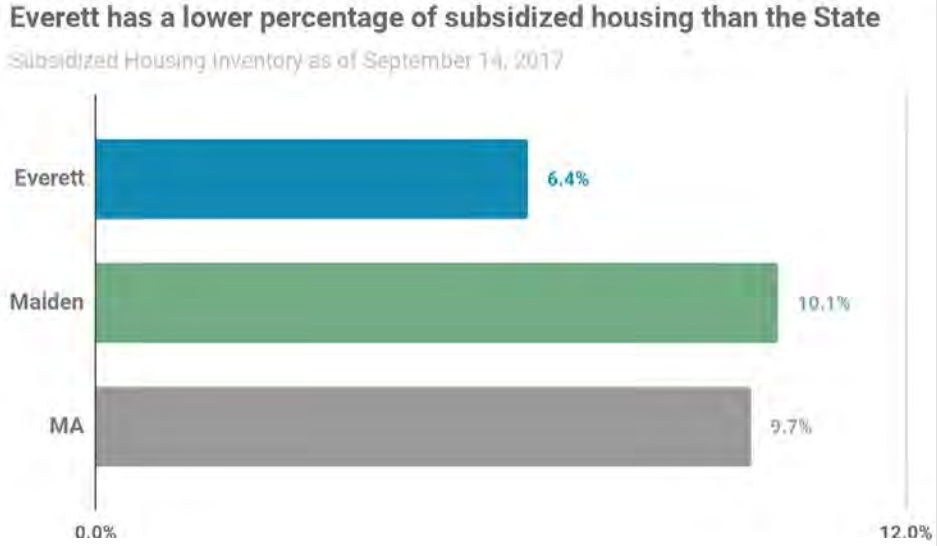
Housing cost-burden occurs when a household is paying between 30-49% of their monthly income on housing costs. ***Severely*** cost-burdened means they are paying 50% or more of their monthly income on housing. In Everett and Malden, renters carry this burden more than owners: 56% of Everett renters 51% of Malden renters are cost-burdened or severely cost-burdened, while 40% of Everett home owners and 34% of Malden home owners are cost-burdened or severely cost-burdened.

Eviction rates: According to the Eviction Lab at Princeton University[6], looking at evictions over time, both Everett and Malden have had higher eviction rates than the state. In 2016 (most recent data available), 2.17% of Everett renters and 1.71% of Malden renters were evicted from their households.

Churn rates: Unstable housing conditions can lead to **higher churn rates** within the schools. The churn rate measures the number of students transferring into or out of a public school district during the course of a school year, and is also referred to as "student mobility." The churn rate in 2018 was 19% in Everett and 18.5% in Malden, twice as high as the MA state rate of 8.6%. Research shows that each time students switch schools, they generally lose the equivalent of **3 months of reading and math learning in the classroom**, and that school districts with higher concentrations of mobile students had higher percentages of students with disabilities and fewer students in gifted education programs[7].

Focus group and community meeting participants also discussed the issue of housing affordability and stability:

- Participants in the community meetings mentioned that even poor quality, unsafe housing is being rented at high prices in Everett and Malden. Participants mentioned a lack of supportive policies to keep residents in their homes (such as tax incentives, rent stabilization, or just cause eviction statutes), emergency financial assistance or legal assistance, as well as truly affordable housing developments, and that these should be areas of high priority for advocates and policymakers.
- Also mentioned were the challenges faced when someone loses their home: *"It can be near impossible to find a new place that is affordable in today's market."* Residents have to come up with first and last month's rent, security deposit, and broker fees.



Data Source: Department of Housing and Community Development. Chapter 40B Subsidized Housing Inventory (SHI) as of September 14, 2017

The **Subsidized Housing Inventory (SHI)** is used to measure a community's stock of low- or moderate-income housing. Everett was lower than the state with 6.4% subsidized housing. Malden was slightly higher than the state, though it is projected that when this number is revised after the 2020 Census, both Everett and Malden will have significantly lower numbers. When the SHI is less than 10%, housing developers can bypass municipal Planning Boards and the municipality loses control of what type of housing is built in their community.

[6] Eviction Lab, Princeton University: https://evictionlab.org/#home-menu
[7] Student Mobility: How it Affects Learning, Education Week, 2016: https://www.edweek.org/ew/issues/student-mobility/index.html

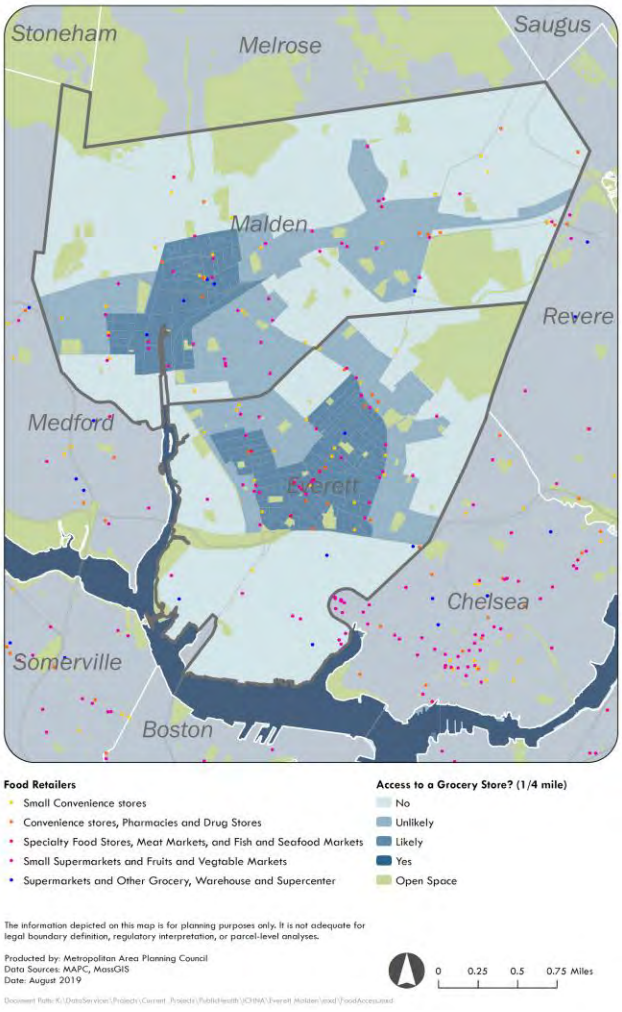
Focus groups also revealed community members' concerns regarding lead levels in homes and in the water supply. Lead can have short and long-term impacts on people. The threshold of the amount of lead that is "safe" in water is 15 parts per billion. As the table to the right shows, both Everett and Malden are lower than the threshold. However, recent reports about lead in aging water supply lines throughout Malden have led to community conversations about the safety of water.

2018 Water Lead Level		
Community	2018 Lead Level (parts per billion)	Threshold
Everett	**8.44 ppb**	**15 ppb**
Malden	**12.2 ppb**	**15 ppb**

Data Source: Massachusetts Environmental Public Health Tracking, 2013-2017 Five Year Average

Healthy food access

Another top concern voiced by community members was access to healthy food, particularly in relation to transportation, cost and availability. Secondary data to support this concern includes **low grocery store access; high rates of food insecurity; and high SNAP Gap.**



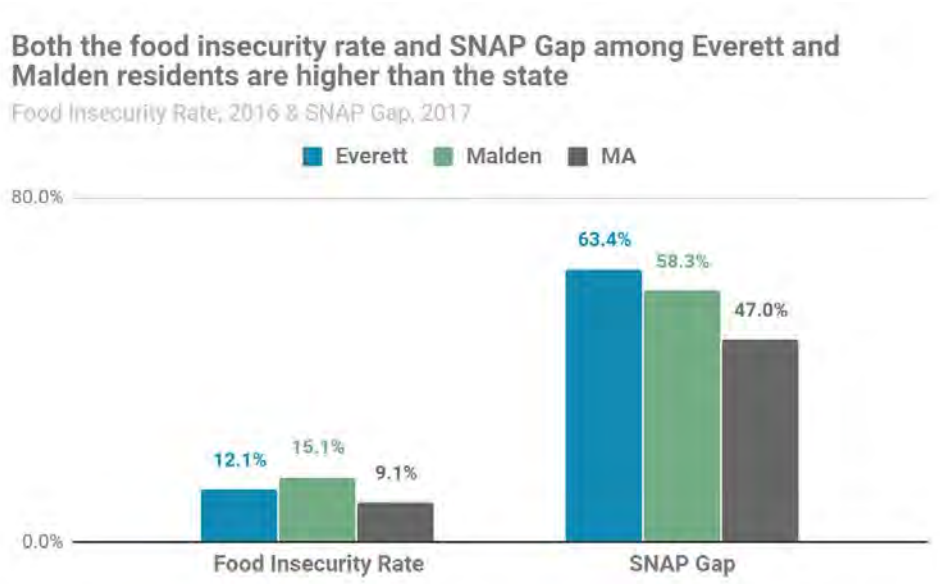
Access to a Food Retail Store within ¼ Mile

This map was developed by the Metropolitan Area Planning Council (MAPC) to show access to a food retail store within ¼ mile for residents. The colored dots represent different types of food retailers, including small convenience stores; convenience stores, pharmacies, and drug stores; specialty food stores, meat markets and seafood markets; small supermarkets and fruit and vegetable markets; and supermarkets and other grocery, warehouse, and supercenter stores. The lighter the blue shaded area, the less likely a resident living in that area has access to a food retail store within a short distance (¼ mile).

- Youth in Everett mentioned that Dunkin and Pizza Hut are right next to their school, and that it would be better to have healthier options closer to school. They also discussed that while having free lunch at school is helpful, youth participants stated that healthy options at school are difficult to access, since the lines are much longer for the healthier options, and they do not have enough time to wait in line.
- Malden participants noted that junk food is cheaper and often more available than healthy food; for example, a lot of the convenience stores in Malden do not carry fresh produce, which limits access to healthier foods.

Food Insecurity Rates

While there are local food resources beyond grocery stores, such as mobile markets, farmers markets, and food pantries, the food insecurity rate for both Everett and Malden are higher than the state. **Food insecure means lacking reliable access to a sufficient quantity of affordable, nutritious food**. Additionally, there are programs such as SNAP (Supplemental Nutrition Assistance Program, formerly known as Food Stamps) for which residents can apply. However, the **SNAP Gap** (households eligible for SNAP who are not accessing benefits) shows many residents are not utilizing this benefit in both Everett and Malden. Sixty-three percent of Everett residents and 58% of Malden residents who qualify for SNAP are not accessing those benefits, compared to 47% of MA residents overall.



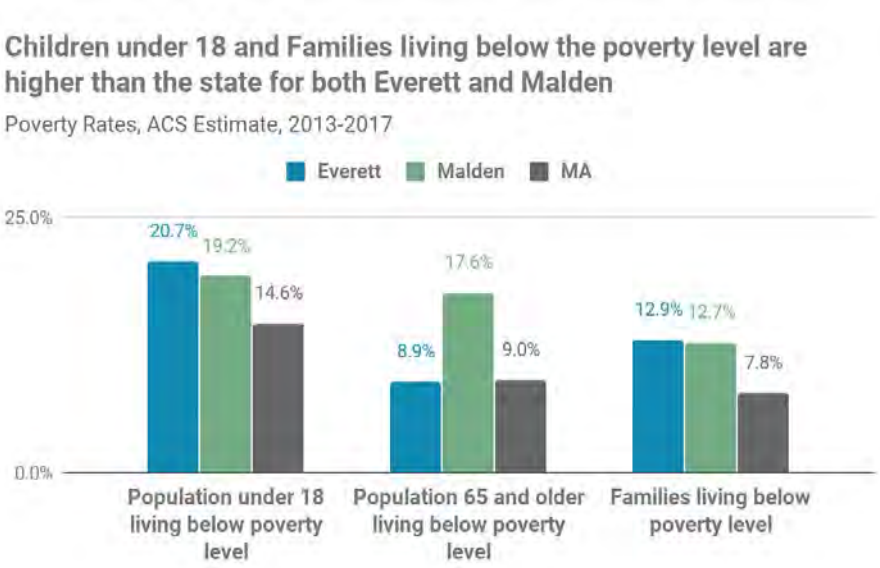
Data Sources: Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2016. Feeding America, 2018. Courtesy of The Greater Boston Food Bank. Food Bank of Western MA, 2017

Studies have shown that federal policy proposals continue to seek to discourage immigrants, including those with qualified documentation statuses, from participating in SNAP. Families eligible for benefits may be proactively disenrolling or choosing not to participate in nutrition assistance programs out of fear of deportation or future effects on their immigration status.[8]

[8] Lower SNAP Participation by Immigrant Mothers With Young Children, Children's HealthWatch, 2018, https://childrenshealthwatch.org/lower-snap-participation-by-immigrant-mothers-with-young-children/

Economic stability and mobility

Another top concern was economic stability & mobility, particularly around the lack of good jobs (jobs that pay a living wage and have benefits that meet the needs of individuals and families). While access to secondary data specifically around the number of good jobs in our communities wasn't available, the available data on income and employment show that our communities have **high rates of poverty (especially among youth and families); long commute times; and again, high housing cost burden** (which is discussed in "Housing" section above)**.**



Data Source: US Census Bureau, American Community Survey (ACS) 2013-2017, 5-year estimates

Poverty Rates

Both Everett and Malden have a higher percentage of residents under 18 living below poverty level than the state. For those 65 and older, almost 18% in Malden are living below poverty level compared to 9% in MA. Additionally, both communities have a higher percentage of families living below poverty level than the state. Although median household income has increased since 2000 in both Everett (by 41%) and Malden (by 37%), it has been at a lower rate of growth than the state (47%). Conversely, the percentage of families living below poverty level in Everett and Malden has increased at a much higher rate than the state (see chart below).

	Everett		Malden		MA	
	2000	2017	2000	2017	2000	2017
Median household income	$40,601	$57,254	$45,654	$62,361	$50,502	$74,167
% Families below poverty level	9.2%	12.9%	6.6%	12.7%	6.7%	7.8%

Data Source: US Census Bureau, American Community Survey (ACS) 2013-2017, 5-year estimates

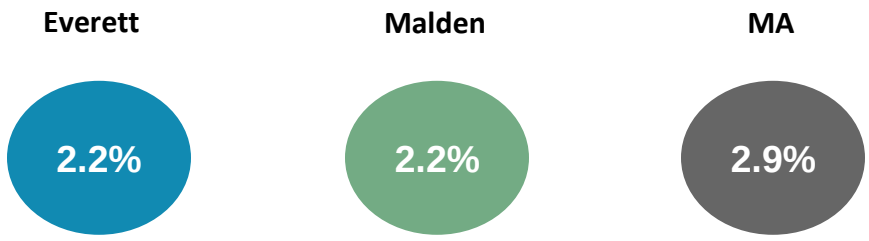
- Focus group and community meeting participants highlighted the challenge of having limited access to healthcare, including mental healthcare, because it is expensive; seniors noted that they have low income, creating a barrier to obtaining healthcare.
- They also noted that health insurance coverage is accessible, but it is not affordable, especially due to high deductibles.

Unemployment Rates

While the unemployment rate for both Everett and Malden are slightly lower than the state, this does not take into account those who have stopped seeking employment, those who are no longer eligible for unemployment benefits, or underemployment, which affects those who are working one or more

jobs with little to no health insurance or other employee benefits. Participants from the focus groups and community meetings also brought up the challenge of working for low wages and having to work many hours per week to keep up with increasing living costs.

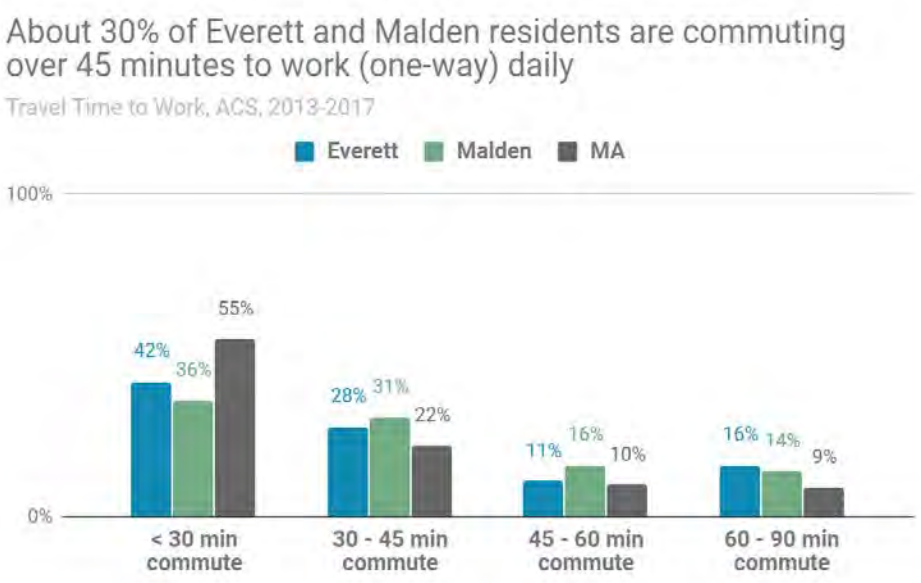
Unemployment Rate, April 2019



Data Source: US Bureau of Labor Statistics, BLS data finder 1.1, 2019 April

Commute Times

This chart shows that more Everett and Malden residents have long commute times (over 45 minutes) than the state. This means that at least 1.5 hours of their time is spent getting to and from work, taking time away from their other family/personal responsibilities. Long and unpredictable commutes can also have effects on psychological well-being, stemming from the sense of helplessness we experience in traffic. One recent study has found that aggressive behavior can carry over beyond a commute, as extreme traffic increases have been linked with the incidence of domestic violence, a crime shown to be affected by emotional cues. In extreme cases, responses to those cues can be quite large, leading to violence.[9]



Data Source: US Census Bureau, American Community Survey (ACS) 2013-2017, 5-year estimates

[9]Louis-Philippe Beland, Daniel A. Brent, Traffic and Crime, Journal of Public Economics, Volume 160, 2018 https://doi.org/10.1016/j.jpubeco.2018.03.002

Access to care and services

Access to care and services was another major area of concern for community members. Particular challenges to accessing needed care and services included lack of available services for substance use and mental health, affordability, and fear and distrust of institutions, particularly among immigrants. Focus group and community meeting participants discussed that due to fear, constantly changing information and lack of trust, many immigrants are not utilizing the services they need, such as healthcare or municipal resources. Insufficient efforts to reach multilingual and multicultural populations and lack of diverse leadership in local institutions (e.g. schools, municipal agencies, police departments, and elected officials) was also mentioned as contributing to fear and distrust of these systems, particularly among youth. Research conducted by the Blue Cross Blue Shield Foundation of Massachusetts[10] has indicated that this fear and mistrust often leads to high rates of uninsured residents, and both Everett and Malden have higher rates than the state of uninsured residents (Everett 7.1%, Malden 5.9%, MA 3.0%).

Health Outcomes

Health outcomes are the traditional "health issues" that are most often used to determine and measure the health of individuals. In this section, we discuss the top health outcome concerns voiced by the community and found in the review and analysis of public health data. These were: behavioral health, chronic disease and infectious disease.

Behavioral Health

What is it?

Behavioral health is a broad term that encompasses both mental health and substance use disorder. Behavioral health is shaped by various social, economic, environmental and biological factors, occurring at different stages of life. Each is an essential component to overall health and well-being including family and interpersonal relationships, and the ability to contribute to the community and society. Mental illnesses, such as depression and anxiety, affect people's ability to participate in healthy behaviors, including maintaining good physical health. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. A person with a diagnosis of a mental health or substance use disorder can experience relief of symptoms and live an active life with proper treatment, care and support.

What contributes to it?

There are a number of circumstances that can influence people to experience mental health or substance use disorders, many of which are commonly associated with genetics and family history, stressful life circumstances, chronic health conditions and/or social inequities. The combination of these factors may affect some individuals more deeply than others. Examples of contributing factors include:

[10] The Geography of Uninsurance in Massachusetts, https://www.bluecrossmafoundation.org/sites/default/files/download/publication/Geography_of_Uninsurance_REPORT_Aug2019_Final.pdf

trauma; social isolation; experiencing direct or generational discrimination and stigma; poverty or debt; chronic health conditions; loss of a valued and trusted relationship; unemployment or losing a job; housing quality or instability; substance misuse; domestic violence, and bullying or other physical or emotional abuse.

Why is it important?

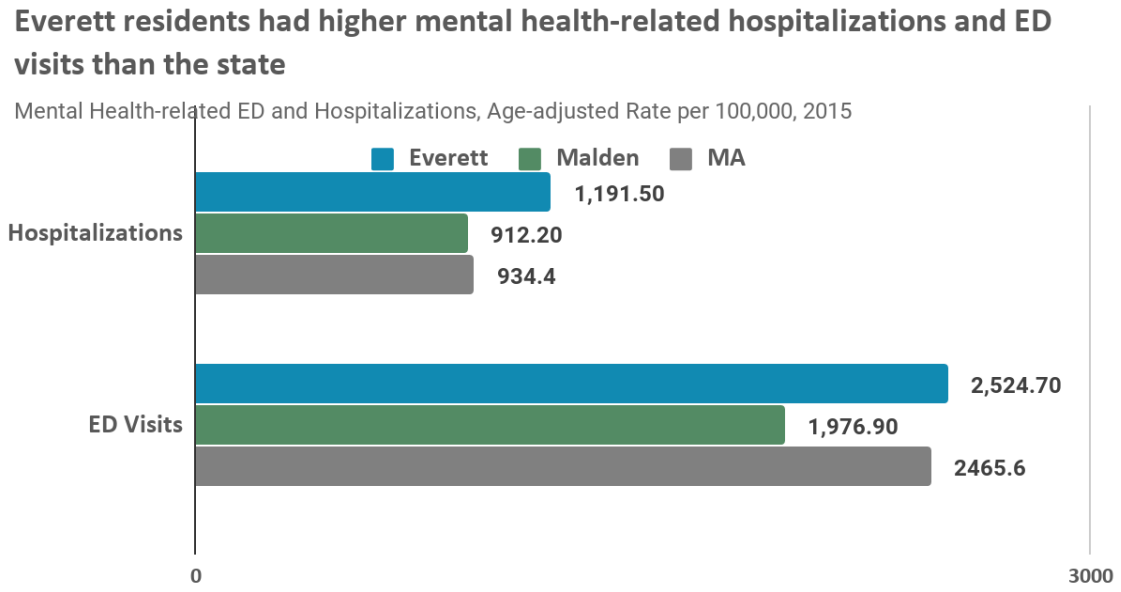
Areas of mental health (particularly youth depression and elder isolation) and substance use disorder (particularly the use of opioids, alcohol, youth vaping & marijuana) were issues that were voiced from participants through the community and stakeholder engagement process as the biggest health outcome concerns in our communities. Review and analysis of public health data (from MA Department of Public Health and the 2018/2019 Youth Risk Behavior Survey) on these areas indicate that these issues show up differently in each community. Below we look at various indicators for mental health and substance use in each community, in comparison to the state of Massachusetts. For more data on these issues, please see Community Data Profiles in Appendix D.

Key findings:

- What's similar in each community?
  - **Mental Health**: While age-adjusted suicide rates were lower than the state rate in both Everett and Malden, both communities see higher rates of youth depression and lack of a trusted adult to talk to compared to the state. This issue also came up in our focus groups, as some youth stated that the lack of adults who they can identify with (linguistically, culturally, etc.) causes them to feel distrustful.
  - **Substance use:** Both communities see higher age-adjusted rates of opioid-related mortality, substance-related mortality, opioid-related ED visits and hospitalizations, and total drug overdose hospitalizations than the state. For youth substance use, the data appears to contradict the perceptions of high youth rates of substance use, as most data indicators show Everett and Malden at lower rates than the state (see data charts below for more detail).

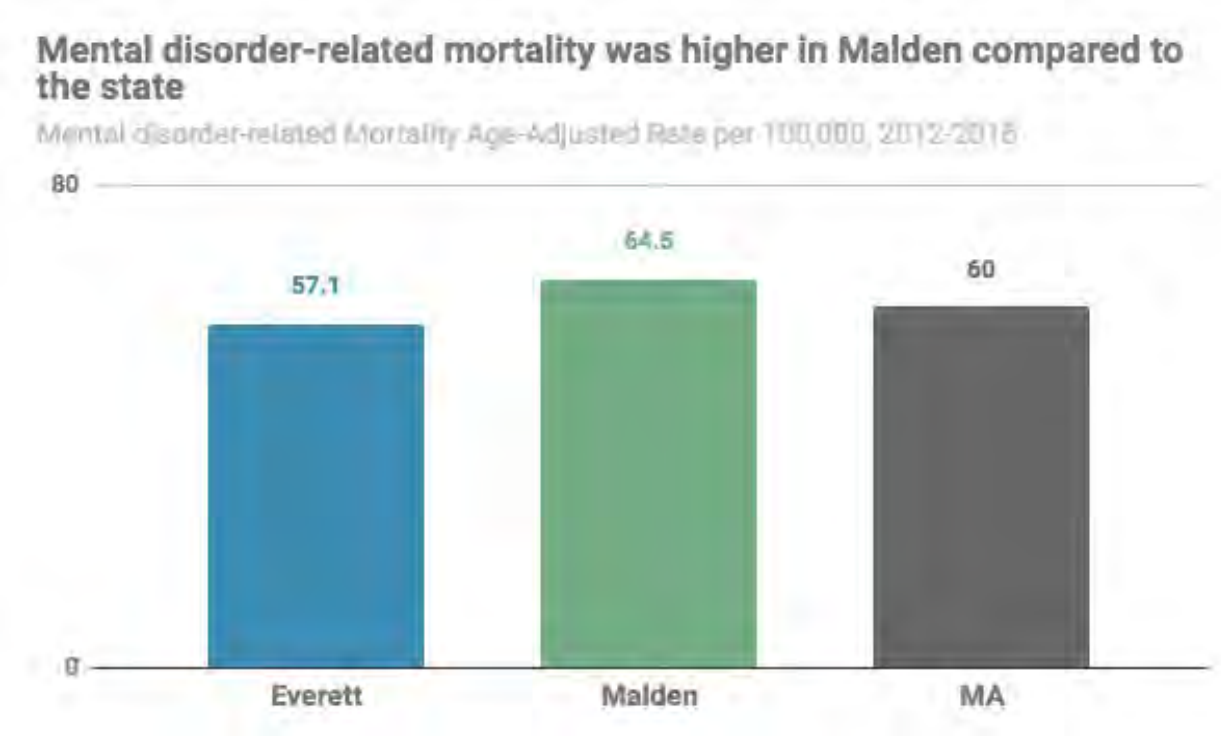
- What's unique?
  - **Mental Health:** Everett mental health-related hospitalizations, as well as middle and high school students who have attempted suicide in the past 12 months, are higher than the state. Malden's mental health-related mortality rates, as well as rates of elder isolation, (seniors over the age of 65 living alone), were higher than the state.
  - **Substance use:** Everett alcohol-related mortality, opioid overdose (heroin) ED visits and drug overdose ED visits were higher than the state. Malden middle school students who reported current (30 day) use of e-cigarettes and marijuana are higher than the state, while Malden high school students reported higher lifetime use of prescription drugs than the state.

Mental Health Data



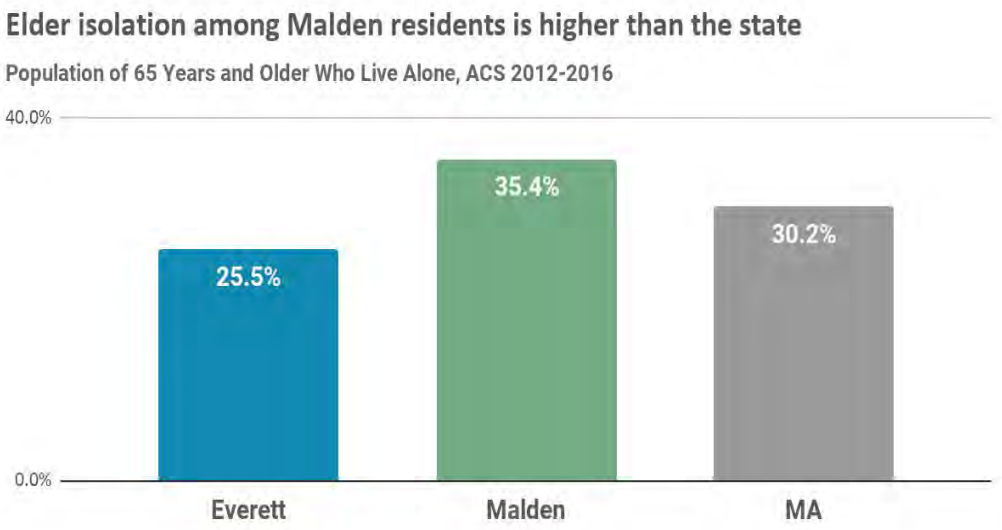
Note: These rates represent residents of the communities, not the location of the hospitalization or ED visit

Data Source: Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), 2015.



Note: These rates represent residents of the communities, not the location of the hospitalization or ED visit

Data Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Grouped for 2012-2016.

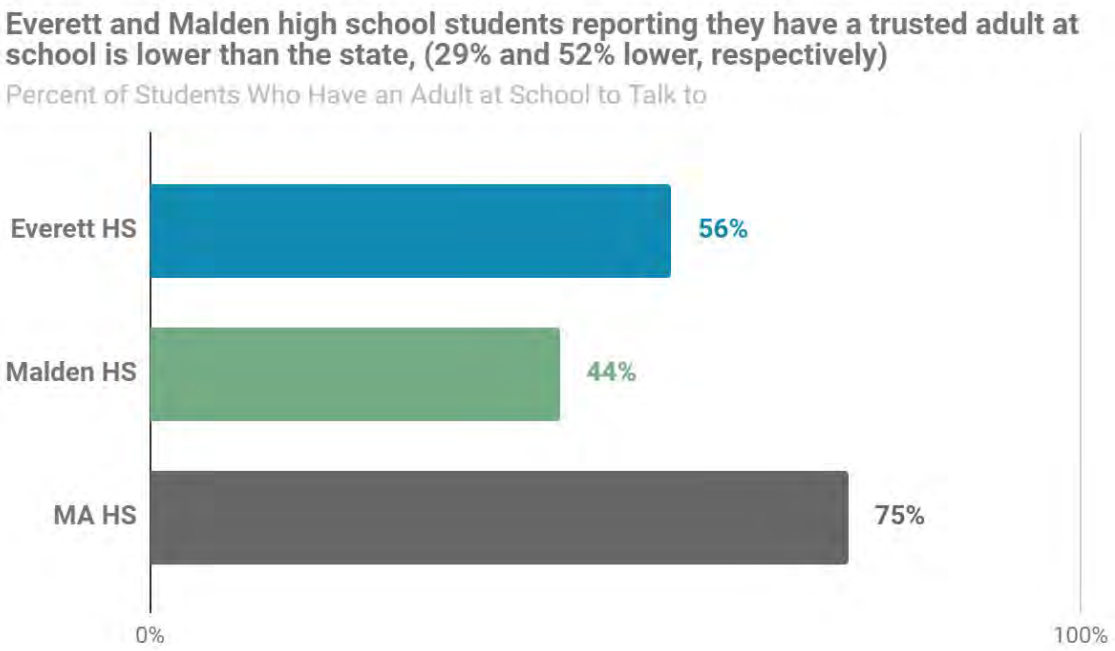


Data Source: ACS 2012-2016; found in Tufts 2018 Massachusetts Healthy Aging Community Profile report. Everett ACS 2013-2017 data was only available for population 60 years and older

	Everett MS (2019)	Everett HS (2019)	Malden MS (2018)	Malden HS (2018)	MA MS (2017)	MA HS (2017)
Depression	29%	40.4%	30%	28%	19%	27%
Attempted Suicide	6.6%	5.8%	3%	5%	4.2%	5.4%

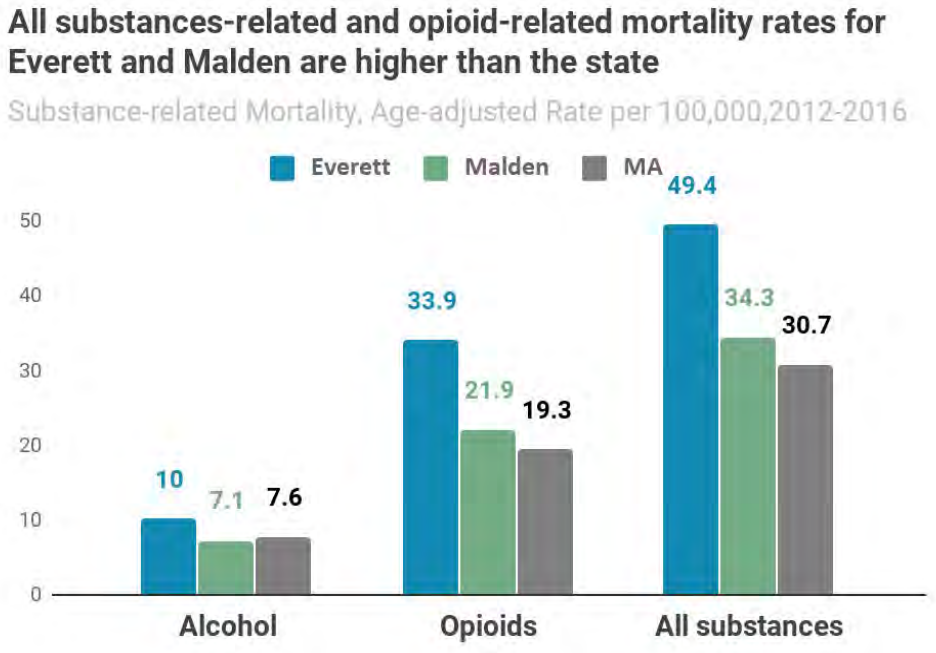
Data Source: 2018-2019 Everett YRBS, 2018 Malden YRBS, 2017 Massachusetts Youth Health Survey

As seen in the table above, rates of both Everett and Malden middle school (MS) students who experienced depression in the past 12 months were higher than the state (41.7% and 44.9% higher, respectively). Similarly, Everett and Malden high school (HS) students' rates of depression were also higher than the state, particularly in Everett, which was almost 40% higher than the state. Everett middle and high school students reported higher rates of attempted suicide in the past 12 months than the state - 44% higher for middle school students and 7% higher for high school students. Additionally, Everett high school students who had seriously considered suicide in the past 12 months was higher than the state - 14% of students compared to 12% of the state.

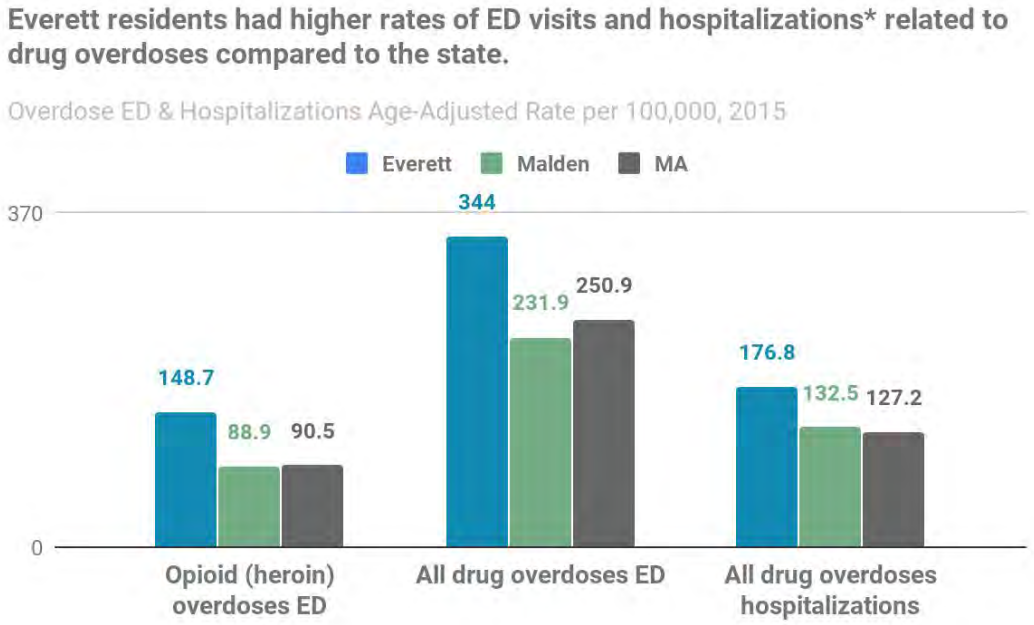


Data Source: 2018-2019 Everett YRBS, 2018 Malden YRBS, 2017 Massachusetts Youth Health Survey

Substance Use Data



Data Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Grouped for 2012-2016.



Note: these numbers represent residents of the communities, not location of overdose occurrence.

Past 30-Day Use	Everett MS (2019)	Everett HS (2019)	Malden MS (2018)	Malden HS (2018)	MA MS (2017)	MA HS (2017)
E-cigarettes/electronic vapor products	3.2%	13.8%	12%	14%	10%	20%
Marijuana	1.3%	16.1%	4%	10%	2%	24%
Alcohol	4%	17.1%	6%	13%	4.2%	31%
Prescription drug misuse	1%	1.3%	3%	3%	1.3%	4.1%

Data Source: 2018-2019 Everett YRBS, 2018 Malden YRBS, 2017 Massachusetts Youth Health Survey

Data shows that there have been a number of successes in youth substance use prevention in both Everett and Malden. We recognize that these successes require consistent and persistent effort to ensure that the behaviors continue to follow a downward trend. Youth substance use was voiced as a large concern by community members. However, publicly reported Youth Risk Behavior Survey (YRBS) data indicates that rates of youth substance use in both Everett and Malden were below state average. This data also shows that lifetime use for e-cigarettes, marijuana, alcohol, and prescription drug misuse among Everett and Malden middle and high school students were all lower compared to the state. The only exception to this was in Malden, which saw higher rates than the state in e-cigarette and marijuana use by middle school students and prescription drug misuse for Malden high school students.

Chronic disease

What is it?

Chronic diseases are health outcomes that are defined broadly as "conditions that last 1 year or more and require ongoing medical attention or limitation of activities of daily living, or both."[11]

What contributes to it?

Chronic diseases, like many health outcomes, are influenced by various factors (such as age, sex, and hereditary factors, as well as lifestyle behaviors), and these factors are shaped by access to and the condition of the social, economic and built environment (discussed above), which can either encourage or discourage healthy behaviors. For example, a family living in a safe, affordable (less than 30% of their monthly income) walkable neighborhood with access to reasonably-priced healthy food, and working a job that pays a living wage, offers good benefits and a reliable schedule, will have more opportunity to live a healthy lifestyle than a counterpart living without those assets.

Why is it important?

During community and stakeholder engagement, the chronic diseases of concern that came up most often were **cancer, diabetes, and obesity**. Review and analysis of public health data (from MA Department of Public Health) indicate that additional areas where our communities have rates higher than the state include **respiratory diseases** such as asthma and chronic obstructive pulmonary disease, or COPD (diseases that cause airflow blockage and breathing-related problems, including emphysema and chronic bronchitis[12]), and **major cardiovascular disease** (the group of disorders of heart and blood vessels, including hypertension/high blood pressure, heart attack and stroke[13]).

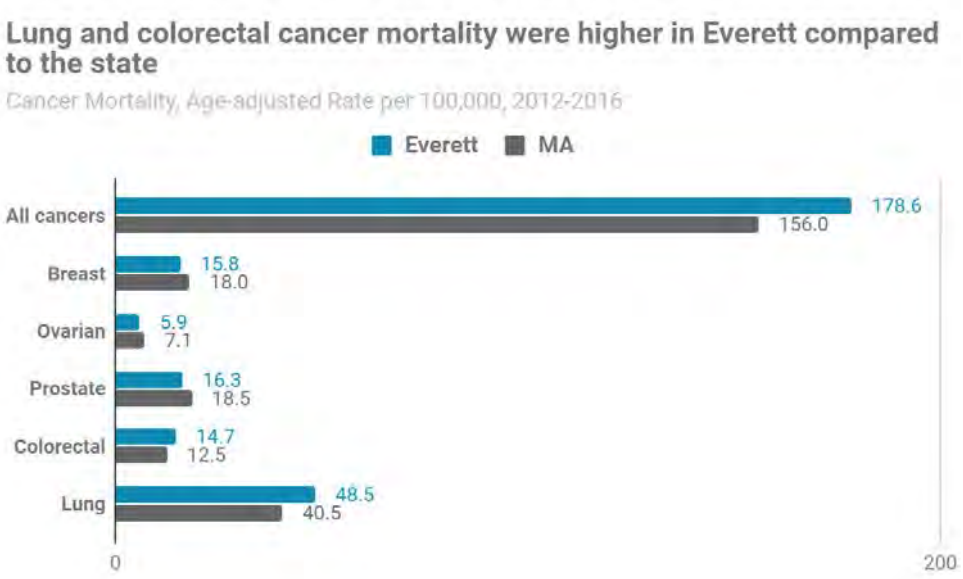
Key findings:

- What's similar in each community?
  - **Cancer:** When taken as a whole, cancer mortality rates are higher in both Everett and Malden than the state. When broken down by type, colorectal and lung cancer are higher than the state in both communities.
  - **Diabetes, obesity, and cardiovascular disease:** Everett and Malden rates of diabetes hospitalizations, emergency department (ED) visits, and mortality are higher than the state. Pediatric obesity (obesity rates for school aged children) rates in both communities are also higher than, or the same as, the state. Major cardiovascular disease ED visits are also higher in both communities.
  - **Respiratory disease:** Both Everett and Malden have lower childhood asthma prevalence than the state.

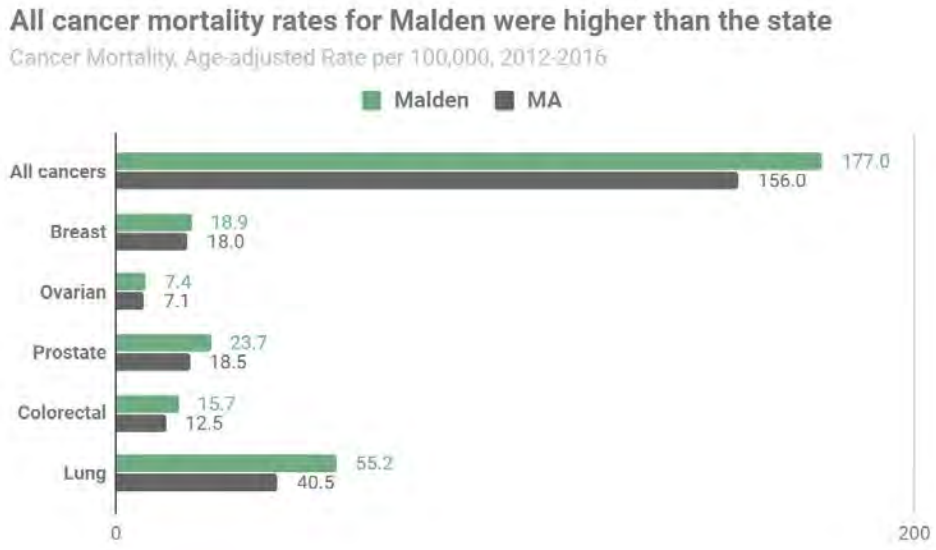
[11] Centers for Disease Control and Prevention: https://www.cdc.gov/chronicdisease/about/index.htm
[12] Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/copd/basics-about.html
[13] World Health Organization (WHO): https://www.who.int/cardiovascular_diseases/about_cvd/en/

- What's unique?
  - **Cancer:** When broken down by type, breast, ovarian and prostate cancer mortality are higher in Malden than the state.
  - **Respiratory diseases** appear to be more of a concern in Everett than Malden, as age-adjusted rates for COPD hospitalizations and asthma ED visits and hospitalizations are higher in Everett than the state.

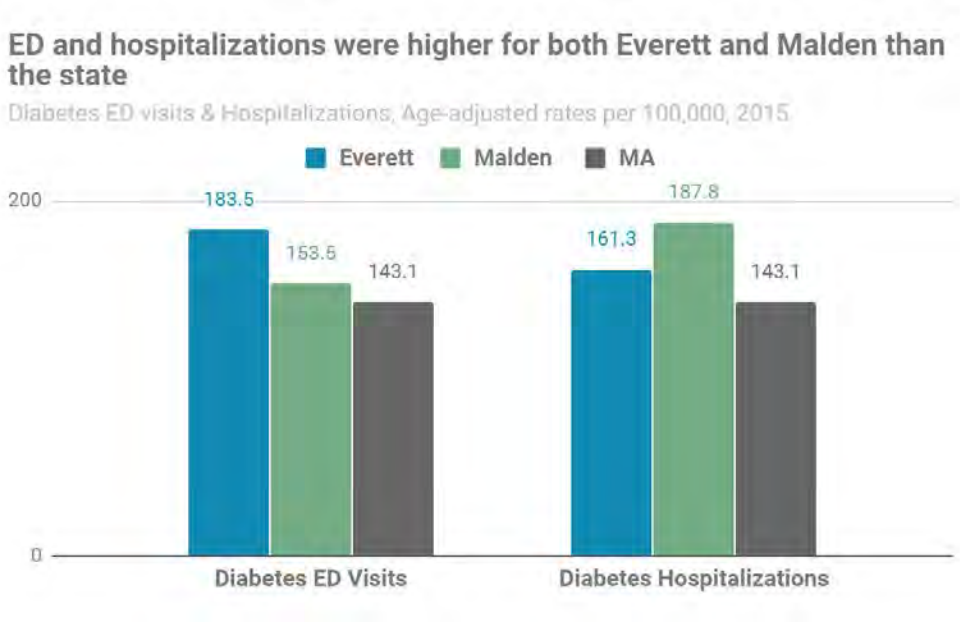
Cancer Data



Data Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Grouped for 2012-2016



Data Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Grouped for 2012-2016



Data Source: Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), 2015

Diabetes, Obesity and Cardiovascular disease data

Diabetes mortality rates in both Everett and Malden are higher than the state (39.6% and 43% higher, respectively).

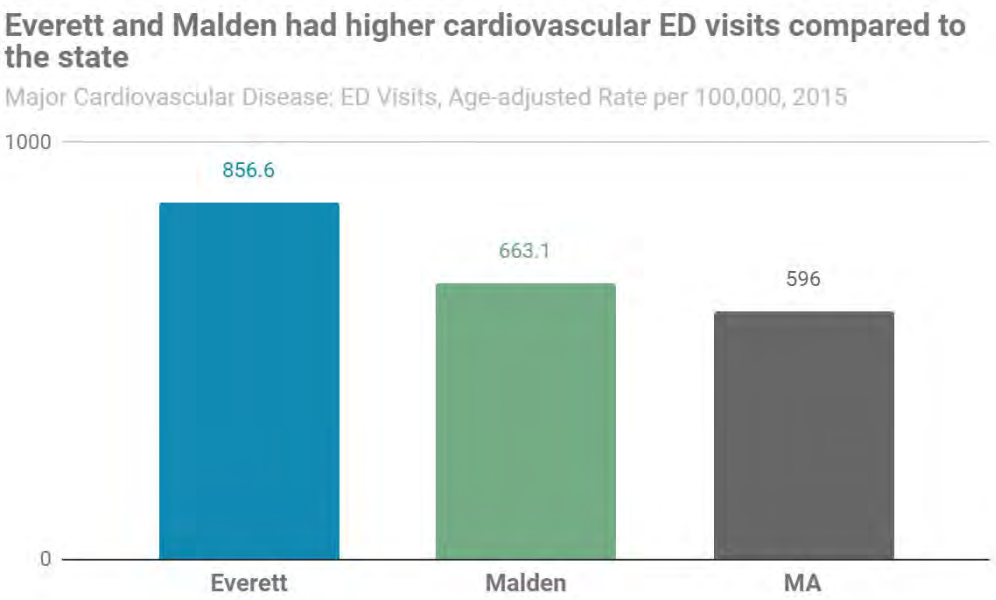
Diabetes Mortality	Everett	Malden	MA
Age-adjusted rate per 100,000, 2012-2016	22.1	22.9	14.8

Data Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Grouped for 2012-2016

Pediatric obesity rates in both Everett and Malden are higher than the state (with the exception of Malden Grade 10, which is the same as the state).

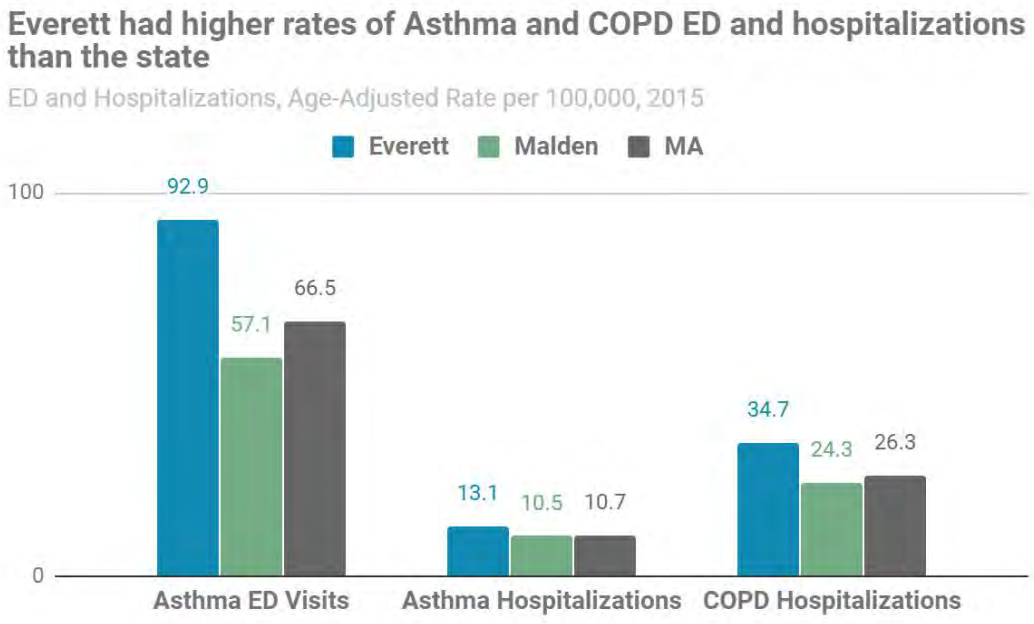
Percent of Overweight or Obese Public School Students	Everett (2016-2017)	Malden (2016-2017)	MA (2014-2015)
Grade 1	43%	34%	28%
Grade 4	56%	40%	34%
Grade 7	48%	46%	34%
Grade 10	36%	33%	33%

Data Source: Percentage of obese children per grade in Massachusetts. Massachusetts department of Public Health. Results from the Body Mass Index Screening in Massachusetts Public School Districts, 2014 - 2015, b) Percentage of obese children per grade in communities. Local Health Measures year 2016 – 2017.



Data Source: Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), 2015.

Respiratory Disease Data



Data Source: Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), 2015.

Infectious disease

What is it?

The World Health Organization defines infectious disease as caused by "organisms such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another."[14] It can also be spread between insects or other animals to humans, by consuming contaminated food or water, or being exposed to organisms in the environment. For the purposes of this report, we'll focus on top areas of concern in Everett and Malden, specifically sexually transmitted diseases (STDs) also known as sexually transmitted infections (STIs).

What contributes to it?

Sexually transmitted infections can be transmitted from person to person through skin-to-skin contact, vaginal sex, anal sex, oral sex, contact with bodily fluids, such as blood or semen, and through shared use of needles. STIs are either bacterial (chlamydia, gonorrhea, and syphilis) or viral (HPV, HIV, herpes, and hepatitis C).

According to the CDC, there are multiple factors that drive the continued increase in STIs, including:

- Drug use, poverty, stigma, and unstable housing, which can reduce access to STI prevention and care
- Decreased condom use among vulnerable groups, including young people and gay and bisexual men
- Cuts to STI programs at the state and local level – in recent years, more than half of local programs have experienced budget cuts, resulting in clinic closures, reduced screening, staff loss, and reduced patient follow-up and linkage to care services.[15]

Why is it important?

Transmission of sexually transmitted infection is preventable. What is key is preventing the microbes from entering the body.

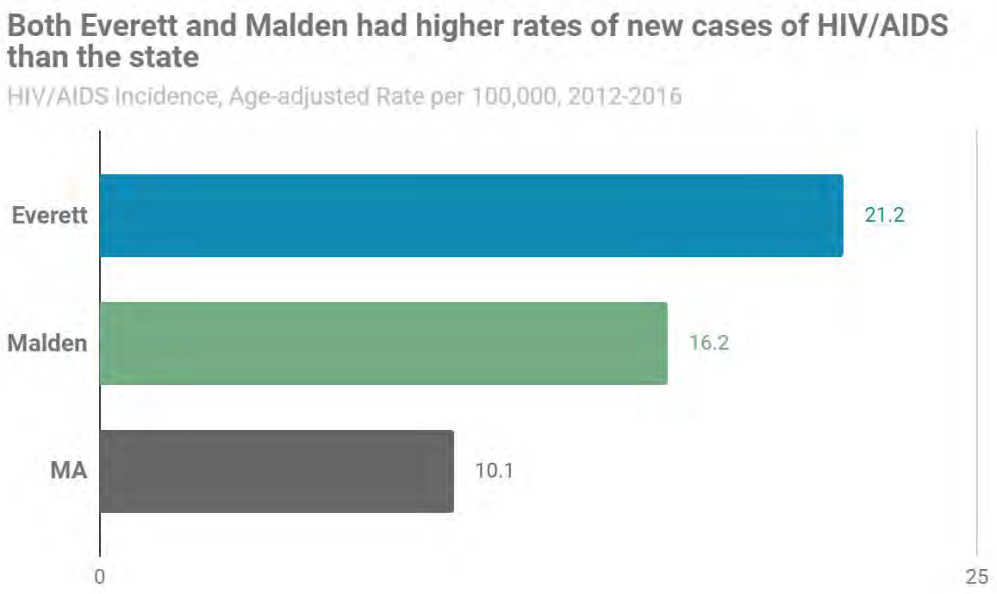
Key findings:

- What's similar in each community?
  - Both Everett and Malden had higher rates of chlamydia, gonorrhea and syphilis than the state
  - Both Everett and Malden had higher rates of new cases of HIV/AIDS than the state
  - Both Everett and Malden had higher rates of new cases of tuberculosis than the state
- What is unique?
  - Everett had higher rates of new cases of Hepatitis C than the state

[14] World Health Organization (WHO): https://www.who.int/topics/infectious_diseases/en/

[15] New CDC Report: STDs Continue to Rise in the U.S.: https://www.cdc.gov/nchhstp/newsroom/2019/2018-STD-surveillance-report-press-release.html

Infectious disease data

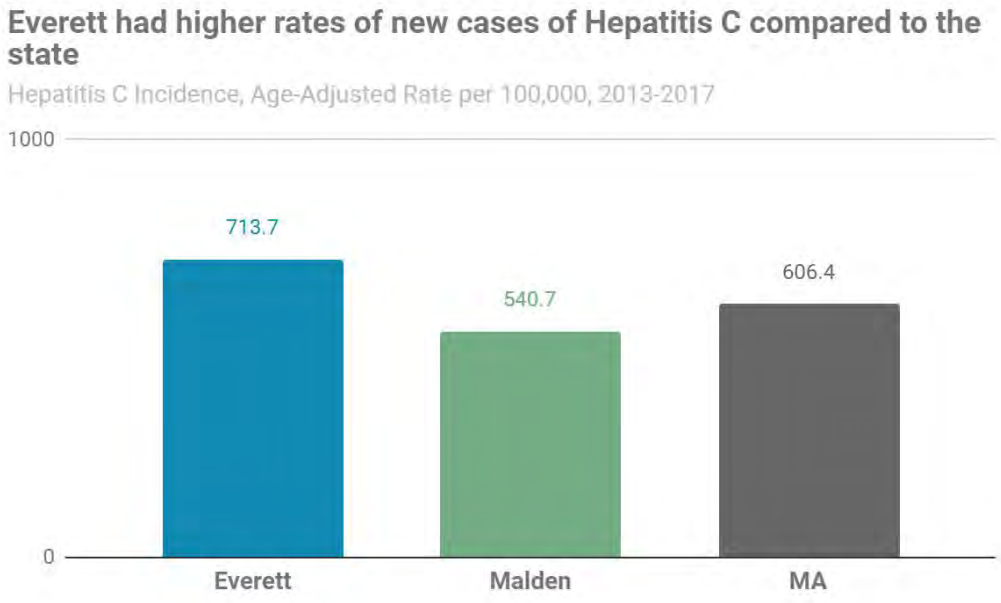


Data Source: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, HIV/AIDS Surveillance Program, 2012 -2016

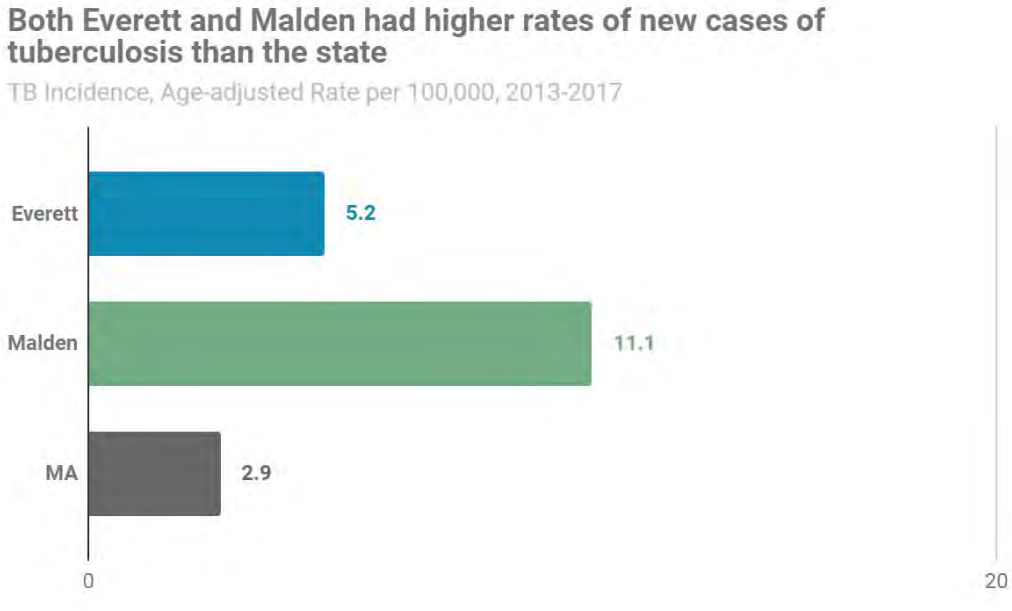
Both Everett and Malden had higher rates of chlamydia, gonorrhea and syphilis incidence than the state

Age-adjusted Rate per 100,000, 2013-2017	**Everett**	**Malden**	**MA**
Chlamydia incidence	**613.1**	**439.6**	**383.0**
Gonorrhea incidence	**102.8**	**76.7**	**68.0**
Syphilis incidence	**26.5**	**21**	**12.9**

Data Source: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, grouped by 2013 – 2017



Data Source: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, grouped by 2013 – 2017



Data Source: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, grouped by 2013 – 2017

Data Summary and Conclusion

The Everett/Malden Collaborative for Community Health Improvement CHNA report is a result of strong collaboration between municipalities, residents, healthcare institutions and social service providers. In coming together, these entities recognized the challenges of meaningfully improving the health of all community members and the strength that we could collectively bring toward meeting that goal. We are grateful to everyone who was a part of this process and enhanced the results through their time, expertise and perspective.

A consistent finding in both Everett and Malden primary data collection was that **economic stability and mobility** and **housing affordability** are among our communities' highest areas of concern. This is also supported by the secondary, publicly available, data for the communities. Despite frequent national news reports of record stock market highs and low unemployment rates, many residents are working but still not able to keep up with the costs of living. A third major area of concern that emerged was **behavioral health**, particularly substance use disorders and mental health. These concerns are almost identical with those found through similar Community Health Needs Assessments being conducted in 2019 within the City of Boston, North Suffolk region, and the MWHC region.

As we establish priority areas for continued collaboration, we will develop working groups with leaders and subject matter experts to develop a Community Health Improvement Plan (CHIP). The CHIP will benefit from a new motivation for continuing regional collaboration over the coming years. The CHIP will create opportunities to identify 'low hanging fruit' initiatives that can be implemented immediately with few resources, as well as initiatives needing more funding and other resources to move forward. We anticipate that our CHIP working groups will produce well thought-out proposals to address our region's needs, which will stand a good chance of receiving funding to enable their implementation. This funding could be from federal and state resources, foundations, as well as new funding available to our communities for community health improvement via the Determination of Need funding mechanism administered by the Massachusetts Department of Public Health.

The transition from the issuing of this report to the formation of working groups that are designing strategies to address priority concerns requires that we create a structure and processes that can support our efforts over the next several years. To that end, throughout 2020 we will work together to create a sustainable foundation for meeting, decision-making and tracking our work. Based on the work of all partners throughout 2019, we look forward to a plan that emerges in 2020 that will have measurable, positive impacts on the health and quality of life of all residents of our two communities.

Authors

Cambridge Health Alliance, Department of Community Health Improvement: Renée Cammarata Hamilton, MSW, MPA; Jean Granick, MS; and Kathleen O'Brien, MA

Mass General Hospital, Center for Community Health Improvement: Danelle Marable, MA and Kelly Washburn, MPH

MelroseWakefield Health Care, Community Services: Eileen Dern, RN, CES and Barbara Kaufman, MPH

Thank you to Partners & Reviewers

Like many Community Health Needs Assessments, the Everett/Malden Collaborative for Community Health Improvement (EMCCHI) has been a labor of love and collective action. Cambridge Health Alliance, Mass General Hospital and MelroseWakefield Healthcare would like to thank those whose work informed our process, as well as the dedicated guidance and support of our partner organizations, including:

Institute for Community Health (ICH)
Metropolitan Area Planning Council (MAPC)
Everett High School and Malden Senior Community Center for hosting the community meetings

Interns and volunteers conducted interviews, gathered surveys and administered focus groups, and we are indebted to their generous donation of time. We thank each interviewee, focus group participant, and survey respondent, whose invaluable feedback and individual perspectives will contribute to the shaping of community health improvement in Everett and Malden.

We thank the dedicated interns, researchers, and volunteers who conducted focus groups, compiled data, and provided informative reports, including:

Laura McNulty, Washington University in St. Louis
Amanda Bank, Tufts University
Peter Joo, Harvard T.H. Chan School of Public Health

Appendices:

A. Secondary Data Sources
B. Survey Instrument
C. Focus Group Instrument
D. Community Data Profiles
E. 1-Page Community Snapshots
F. Resources: Links to CHNAs previously done in and around Everett and Malden
    a. Everett Well-Being Report 2014
    b. Malden Well-Being Report 2016
    c. MelroseWakefield Healthcare Community Health Needs Assessment 2019
    d. North Suffolk Integrated Community Health Needs Assessment 2019

Appendix A: Secondary Data Sources
(In alphabetical order)

- The Commonwealth of Massachusetts, Registered Voters and Party Enrollment as of February 1, 2019, accessed at: https://www.sec.state.ma.us/ele/elepdf/enrollment_count_20190201.pdf
- Everett Student Health Survey, Social Science Research and Evaluation, Inc. (SSRE), 2019
- Eviction Lab, 2016, accessed at: https://evictionlab.org/
- Executive Office of Labor and Workforce Development (EOLWD), 2017, accessed at: http://lmi2.detma.org/lmi/lmi_es_a.asp
- Food Bank of Western MA, 2017, accessed at: https://public.tableau.com/profile/food.bank.of.western.ma#!/vizhome/MHandSNAP/Story1
- The Greater Boston Housing Report Card 2017: Ideas from the Urban Core, Responsive Development as a Model for Regional Growth
- Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2016. Feeding America, 2018. Courtesy of The Greater Boston Food Bank
- Malden Housing Needs Assessment, Metropolitan Area Planning Council, 2019, accessed at: http://www.mapc.org/wp-content/uploads/2019/07/MaldenHousingNeedsAssessment_June2019.pdf
- Malden Middle School and High School Health Surveys, Institute for Community Health (ICH), 2018
- Massachusetts Bay Transportation Authority (MBTA), 2018
- Massachusetts Department of Elementary and Secondary Education (DESE) 2017-2018, 2018-2019
- Massachusetts Department of Elementary and Secondary Education (DESE), Office of Student and Family Support, McKinney-Vento Homeless Education Data, 2018
- Massachusetts Department of Housing and Community Development (DHCD), Chapter 40B Subsidized Housing Inventory (SHI), as of September 14, 2017
- Massachusetts Department of Public Health (MDPH):
    - Body Mass Index Screening in Massachusetts Public School Districts, 2014 - 2015
    - Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, 2013 - 2017
    - Bureau of Infectious Disease and Laboratory Sciences, HIV/AIDS Surveillance Program, 2012 - 2016

  - Center for Health Information and Analysis (CHIA), 2014
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Appendix B: Survey Instrument

Everett and Malden Community Health Survey

Thank you for sharing your opinions about factors that shape **opportunities for good health** in your community. This survey is for people who live or work in **Everett or Malden.** The information we collect will be used by Cambridge Health Alliance, Massachusetts General Hospital, and MelroseWakefield Healthcare to create a report about community health in Everett and Malden. We will share the report with the community in late September, and identify ways that we can work together to improve health and wellbeing.

The survey should take **10 to 15 minutes** to complete. In appreciation of your participation, you will be **entered into a raffle for one of two $50 Visa gift cards**. You will need to provide your name and contact information on a raffle ticket so we can notify you if you win, but this information will not be connected to your survey answers. We will draw two winners and notify them in mid-August.

Your participation in this survey is voluntary. For your privacy, the survey **will not ask for your name** and is completely **anonymous**. If you do not feel comfortable answering a question, you may skip it. Taking this survey will not affect any services or benefits that you receive.

Thank you again for completing this survey and sharing your opinions and experiences!

For more information about this survey or participating in future community meetings, please contact Renee Cammarata Hamilton at (781) 338-0505 or rcammaratahamilton@challiance.org

Part 1: Your Community

1. We are interested in your experiences in the community where you spend the most time. In which community do you spend the most time? (If you spend equal amounts of time in both communities, please feel free to complete a separate survey for each one.)
   - ❑ Everett
   - ❑ Malden

2. Do you live or work in the community selected above? Please check only one response.
   - ❑ I live and work here
   - ❑ I live here
   - ❑ I work here

3. How many years have you lived in the community selected above?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years but not all my life
   - ❑ I have lived here all my life
   - ❑ I do not live here, but I work here

4. How many years have you worked in the community selected above?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years
   - ❑ I do not work here, but I live here

Part 2: Health and Wellbeing Factors

The following statements describe people, places, and opportunities that promote health and wellbeing. Please tell us how true you believe each statement is in your community, and how much of a priority it should be for improvement. Check the response that matches your opinion.

5. In my community, people help and look out for each other.

How true?	Priority for improvement?
❑ True	❑ Low Priority
❑ Somewhat true	❑ Medium Priority
❑ Not at all true	❑ High Priority
❑ I don't know	❑ I don't know

6. People work together to improve our community.

How true?	Priority for improvement?
❑ True	❑ Low Priority
❑ Somewhat true	❑ Medium Priority
❑ Not at all true	❑ High Priority
❑ I don't know	❑ I don't know

7. In my community, we generally promote health and safety.

How true?	Priority for improvement?
❑ True	❑ Low Priority
❑ Somewhat true	❑ Medium Priority
❑ Not at all true	❑ High Priority
❑ I don't know	❑ I don't know

8. Products that are sold and marketed in my community are safe and healthy.

How true?	Priority for improvement?
❑ True	❑ Low Priority
❑ Somewhat true	❑ Medium Priority
❑ Not at all true	❑ High Priority
❑ I don't know	❑ I don't know

9. My community looks and feels inviting and safe.

How true?	Priority for improvement?
❑ True	❑ Low Priority
❑ Somewhat true	❑ Medium Priority
❑ Not at all true	❑ High Priority
❑ I don't know	❑ I don't know

10. People have access to safe, clean parks and open spaces.

How true?	Priority for improvement?
❑ True	❑ Low Priority
❑ Somewhat true	❑ Medium Priority
❑ Not at all true	❑ High Priority
❑ I don't know	❑ I don't know

11. People have access to reliable transportation.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

12. Housing in my community is affordable for people with different income levels.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

13. Housing in my community is safe and good quality.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

14. Health care in my community meets people's physical health needs.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

15. Health care in my community meets people's mental health needs.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

16. The air, water, and soil in my community are safe.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

17. People in my community have opportunities to participate in arts and cultural expression.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

18. People have access to good local jobs with living wages and benefits.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority
- ❑ I don't know

19. People have access to local investment opportunities, such as owning homes or businesses.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority

20. Education in my community serves learners of all ages.

How true?

- ❑ True
- ❑ Somewhat true
- ❑ Not at all true
- ❑ I don't know

Priority for improvement?

- ❑ Low Priority
- ❑ Medium Priority
- ❑ High Priority

Part 3: Strengths and Challenges

21. What do you see as the most important strengths of your community?

_____

_____

_____

22. What do you see as the most significant challenges facing your community?

_____

_____

_____

23. Is there anything else you would like to share about your community?

_____

_____

_____

Part 4 (Optional): About You

Please tell us about yourself. You may skip any items you prefer not to answer.

24. How old are you?
- ❑ 19 years old or under
- ❑ 20 - 34 years old
- ❑ 35 - 64 years old
- ❑ 65 years old or over

25. How do you describe your gender? (check all that apply)
- ❑ Female
- ❑ Male
- ❑ Non-binary
- ❑ Other gender identity

26. How do you describe your race and ethnicity? (check all that apply)
- ❑ Asian
- ❑ Black / African
- ❑ Hispanic / Latinx
- ❑ Native American
- ❑ Pacific Islander
- ❑ White
- ❑ Other

27. How long have you lived in the United States?
- ❑ Less than 1 year
- ❑ 1-5 years
- ❑ 6-10 years
- ❑ Over 10 years but not all my life
- ❑ I have lived here all my

Thank you again for completing this survey! Your voice is important and we appreciate your sharing your opinions with us. Please remember to fill out a raffle ticket if you would like to be entered to win a $50 Visa gift card.

Appendix C: Focus Group Questions

Everett and Malden Community Health Assessment
Focus Group Discussion Guide

Please complete this section for each focus group:

Date:	Start Time:	End time:
Group Name and Location:		
Number of participants:		
Facilitator Name:	Note-taker Name:	
Were gift cards distributed? If yes, how many?		
Did all participants agree to audio recording?	Was the sign-in sheet completed?	
Did anything unusual occur during this focus group? (Interruptions, etc.)		

General Instructions

- The concepts that this focus group aims to explore are based on the THRIVE model (Tool for Health and Resilience in Vulnerable Environments). THRIVE is a framework for understanding how the inequitable distribution of power, money, and resources in society (structural drivers) plays out at the community level, in part by shaping the circumstances and conditions (community determinants) in which people are born, live, work, learn, play, and age. These structural drivers and community determinants, in turn, influence health outcomes and health equity. THRIVE is a tool for engaging community members in assessing community determinants, prioritizing them, and taking action to change them to improve health equity.
- THRIVE identifies 12 determinants of health, grouped into three clusters: 1) social-cultural environment (people), 2) physical / built environment (place), and 3) economic / educational environment (equitable opportunity). Please be familiar with the factors before facilitating. Note that the collaborative has added *access to health care services* as an additional factor in the "place" cluster, and separated jobs from investment in the "equitable opportunity" cluster.
- This discussion guide is intended for focus group facilitators and note-takers. It should not be distributed to participants.

- As a facilitator, your role is to guide the conversation so that everyone's voice is heard and all topics of interest are discussed. This requires you to manage time carefully, to create a space where people feel safe speaking up, and to manage group dynamics. Here are some key instructions and tips:
    - It is not necessary to ask people to introduce themselves by name. If participants want to introduce themselves, ask them to use their first name only.
    - You will need to get group consensus on which topics will be discussed in detail. As you listen to the possible topics elicited through Section 1 of the script, jot them down in the three THRIVE clusters. This will help you reflect back the top topics of interest to get group consensus, and to find the relevant questions in the guide.
    - Based on the topics the group agrees to, find the relevant section of the guide. The guide is organized by cluster, then by factor. Read the introductory statement followed by relevant questions and sub-questions as written in the guide, and probe for the concepts noted. The questions will allow participants the chance to share both strengths and challenges, or positives and negatives, about the topic.
    - Use pauses and prompts ("Can you give an example?" "Could you say more about that?" "Why do you think this is?") to encourage participants to reflect and share their experiences and opinions in greater depth.
- As a note-taker, your role is to document the main concepts, themes, and narratives mentioned during the focus group. This requires you to listen carefully, to document exact words and phrases, and to paraphrase appropriately. Here are some key instructions and tips:
    - Use paper and pen/pencil, not a computer, if possible.
    - Do not associate people's names with their comments. Instead, use numbers (Participant #1, #2, etc.) to track remarks in your notes.
    - Responses such as "I don't know" are still important to document.
- After the focus group, the note-taker should type up their notes under each question. The notes should be shared with the facilitator to review, edit, and verify. The facilitator and note-taker should come to a consensus on what goes in the notes.

Materials and Set-up

- Audio recorder
- Chairs in a circle, around a table or in open space
- Sign-in sheet
- Gift cards
- Clipboard, extra paper, and pens for facilitator and note-taker
- Copies of this discussion guide; copies of flyers for listening sessions

As participants arrive, ask them to complete the sign in sheet. On their way out, they will indicate whether they received a gift card in the last column of the sign in sheet.

Opening Script

Thank you for participating in tonight's discussion on health in your community. [If applicable: We are grateful to _____ for hosting us in this space.] I'm going to review some information about the purpose and ground rules for the discussion, then we'll begin.

We are interested in hearing your opinions about factors that shape opportunities for good health in your community. The information we collect will be used by Cambridge Health Alliance, Massachusetts General Hospital, and MelroseWakefield Healthcare to create a report about community health in Everett and Malden. We will share the report with the community in late September, and identify ways that we can work together to improve health and wellbeing.

We want everyone to have the chance to explain their personal experiences. Please allow those speaking to finish before sharing your own comments. The discussion will last no more than 90 minutes. To keep the conversation moving, I may steer the group to specific topics. I may try to involve people who are not speaking up as much to share their opinions, especially if one or more people seem to be dominating the conversation. If I do this, it's to make sure everyone's perspective is included. We are here to ask questions, to listen, and to make sure you all have the chance to share your comments.

We will keep your identity, participation, and remarks private. We would like you all to agree as a group to keep today's conversation confidential as well. We will be taking notes during the focus group, but your names will not be associated with your responses. When we report the results of this assessment, no one will be able to identify what you have said. We hope you'll feel free to speak openly and honestly.

With your permission, we would like to audio record the focus group to help ensure we accurately capture your thoughts and obtain exact quotes to emphasize particular themes in our final report. No one besides our project staff would have access to these recordings, and we would destroy them after our report is written. Does everyone agree to the audio recording?

If and only if all participants agree, take out the audio recorder. If one or more person does not agree or is hesitant, do not record the focus group.

Does anyone have any questions before we begin?

Finally, to help avoid distractions, please turn your cell phones off or place them on vibrate.

Thank you again for participating in this discussion.

Turn on the audio recorder if all consented.

Section 1 Script: Community Perceptions

1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?

   Take note of key factors that are mentioned to choose the direction of Section 2. Try to capture at least one in each cluster (People, Place, Equitable Opportunity)

2. What are some of the things that make it hard for you to be healthy?

   Take note of key factors that are mentioned to choose the direction of Section 2. Try to capture at least one in each cluster (People, Place, Equitable Opportunity)

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] significantly impact health for you. Did I capture that correctly?

   If yes, move on to Section 2. If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation) Let's talk more deeply about these concepts.

Section 2 Script: Exploring Key Factors

If factor is in the Social-Cultural Environment (People) cluster:

People tend to be healthier in neighborhoods where people feel connected and are able to take action to meet goals for their own lives and communities. Communities with strong social networks even tend to have longer life expectancies, and better physical and mental health. You mentioned [X] as something that significantly impacts health. Let's explore that.

1. ***Social Networks and Trust*.** In what ways do you see people helping each other and looking out for each other in your community?
   a. In what ways do you see people not looking out for each other?
   b. *Probe for trust, shared history, mutual obligation, sharing information, fostering new connections*
2. ***Participation and Common Good*.** How would you describe people's desire and ability to work to improve the community?
   a. In what ways do you see this play out?
   b. *Probe for participation in community and social organizations, political process*
3. ***Norms and culture*.** Social norms can have a role in affecting health. In what ways do you see people in your community promoting health and safety in general?
   a. In what ways do you see people not promoting health and safety in general?
   b. *Probe for what behaviors are rewarded, what behaviors are discouraged, what values are reflected, inclusivity and tolerance*

If factor is in the Physical / Built Environment (Place) cluster

The places people live, work, play, and learn directly affect our health and shape our behaviors. You mentioned [X] as something that significantly impacts health. Let's explore that.
In this section, only ask those questions that are relevant to the factor of interest.

1. ***What's sold and promoted.*** How would you describe the products and services that are sold and marketed in your community?
    a. In what ways do the availability and marketing of products affect people's health?
    b. *Probe for availability, safety, affordability, cultural appropriateness, harmfulness*
2. ***Look, Feel, and Safety.*** How does the appearance of your community make people feel?
    a. How does the look and feel of your community affect people's health?
    b. *Probe for neighborhood maintenance, perception of safety, sense of being inviting to people of different cultures*
3. ***Parks & Open Space.*** How would you describe the parks, green spaces, and open areas in your community?
    a. How do these spaces affect people's health in your community?
    b. *Probe for availability, accessibility, applicability to different ages and cultures*
4. ***Getting Around.*** How would you describe the ways that people get around?
    a. How do these options affect people's health in your community?
    b. *Probe for safety, reliability, accessibility, and affordability, including for public transit, walking, biking, mobility aid devices*
5. ***Housing.*** How would you describe the housing options in your community?
    a. How does housing affect people's health in your community?
    b. *Probe for quality, safety, affordability to residents of mixed income levels*
6. ***Health care access.*** How would you describe the health care options in your community?
    a. What are the most significant mental or physical health care access needs in your community, in your opinion?
    b. *Probe for quality, accessibility, affordability, relevance to priorities*
7. ***Natural environment.*** How would you describe the air, water, and soil in your community?
    a. How do the air, water, and/or soil affect people's health in your community?
    b. *Probe for safety, toxicity.*
8. ***Arts and culture.*** What kinds of opportunities do people have to participate in the arts and cultural expression?
    a. How do the arts affect people's health in your community?
    b. *Probe for arts that reflect and value diverse backgrounds, accessibility, participation*

If factor is in the Economic / Educational Environment (Equitable Opportunity) cluster

Differences in access to resources and opportunities can impact health and safety over a lifetime. You mentioned [X] as something that significantly impacts health. Let's explore that. *In this section, only ask those questions that are relevant to the factor of interest.*

1. ***Living Wages:*** How would you describe the job opportunities in your community?
    a. How do jobs affect people's health in your community?
    b. *Probe for living wages, benefits*
2. ***Local Wealth:*** How would you describe the investment opportunities in your community?
    a. How do investment opportunities affect people's health in your community?
    b. *Probe for homeownership, business ownership*
3. ***Education*****:** How would you describe the schools and adult education programs in your community?
    a. How do education opportunities affect people's health in your community?
    b. *Probe for quality, accessibility, applicability to learners of all ages, including literacy*

Section 3 Script: Final Remarks and Closing

1. Are there other factors that influence your health that we have not discussed tonight that you feel are important?
2. We would like to thank all of you for participating in this focus group and hope all of you had the chance to voice your opinions. Once we have completed focus groups, surveys, and data collection, we will be writing a report on the findings. Our plan is to share the report back with the community in late September. From there, we will identify ways that we can work together to improve health and wellbeing, in partnership with community members and leaders. Your opinions and participation play a key role in this process and we really appreciate your assistance.
3. To help show our appreciation for your involvement in tonight's discussion, please see me before you leave so that we may provide you with a gift card [$15 Target, Amazon, or Market Basket]. Please remember to fill out the last column on the sign-in sheet to indicate that you received a gift card.

Wrapping Up

Shut off the audio recorder and make sure the audio file is saved. Make sure the space is cleaned up and secured. Answer any lingering questions that participants may have, and ensure everyone departs safely. Save the audio file in Drive; after finalizing notes, save the file in Drive.

Appendix D: Community Data Profile

EVERETT COMMUNITY DATA PROFILE 2019-2020

Please note that some of this data has been updated and differs from the data in the body of the report

Table 1. Community Demographics[1]	Everett		Massachusetts	
	#	%/Rate	#	%/Rate
Total population	45,856	---	6,830,193	---
Population density (per sq. mile)	13,398.6	---	875.5	-----
Female	23,412	51.06%	3,516,214	51.48%
Male	22,444	48.94%	3,313,979	48.52%
Age				
Under 5	3,445	7.51%	362,855	5.3%
5 - 19 years	8,569	18.69%	1,226,228	17.95%
20 - 34 years	11,405	24.87%	1,456,131	21.32%
35 - 64 years	17,644	38.48%	2,706,929	39.63%
65 years and over	4,793	10.45%	1,078,224	15.79%
Race and Ethnicity				
American Indian and Alaska Native	10	0.02%	8,890	0.13%
Asian	3,161	6.89%	440,336	6.45%
Black or African American	8,178	17.83%	463,796	6.79%
Hispanic or Latino	12,143	26.48%	789,127	11.55%
Native Hawaiian and Other Pacific Islander	3	0.01%	1,698	0.02%
White	20,436	44.57%	4,930,412	72.19%
Some other race	484	1.06%	53,268	0.78%
Two or more races	1,441	3.14%	142,666	2.09%
Foreign-Born Residents and Continent of Origin				
Foreign-born residents	*18,498*	*40.34%*	*1,129,732*	*16.54%*
Africa	1,091	5.90%	105,168	9.31%
Asia	2,256	12.20%	343,718	30.42%
Europe	1,530	8.27%	234,648	20.77%
Latin America	13,552	73.26%	411,277	36.40%
North America	69	0.37%	30,761	2.72%
Oceania	0	0.00%	4,160	0.37%
Top 5 Languages Spoken at Home for Residents Over 5 Years Old				
Population 5 years and older=42,411 in Everett; 6,467,512 in MA				
English only	18,565	43.77%	4,941,922	76.41%
Language other than English	23,846	56.23%	1,525,590	23.59%
Asian and Pacific Islander languages	1,589	3.75%	275,078	4.25%
Spanish	9,134	21.54%	581,553	8.99%
Other Indo-European languages*	12,139	28.62%	576,664	8.92%
Other languages	984	2.32%	92,295	1.43%

*This category includes any language other than English or Spanish that was originated in Europe or India.

Sources

1. All data in Table 1 comes from the U.S. Census Bureau, American Community Survey (ACS),2014-2018, 5-year estimates

Table 2. Social Determinants of Health	Everett		Massachusetts	
	#	%/Rate	#	%/Rate
Access to Health Services				
Population with no health insurance coverage[1]	2,933	6.42%	189,470	2.80%
Built Environment				
Number of bus routes in community[2]	9	---	---	---
Number of subway routes in community[2]	0	---	---	---
Number of commuter rail stops in community[2]	0	---	---	---
Lead parts per billion detected in drinking water[3]*	8.4	---	---	---
*Massachusetts State limit: 15 ppb				
Education				
Highest educational attainment for residents ages 25 years and older[1]				
(Population 25 years and older= 30,402 in Everett; 4,748,795 in MA)				
Less than 9th grade	3,306	10.87%	214,205	4.51%
9th to 12th grade, no diploma	2,475	8.14%	240,155	5.06%
High school graduate (includes equivalency)	10,640	35.00%	1,150,846	24.23%
Some college, no degree	5,795	19.06%	740,784	15.60%
Associate's degree	2,009	6.61%	365,103	7.69%
Bachelor's degree	3,995	13.14%	1,128,877	23.77%
Graduate or professional degree	2,182	7.18%	908,825	19.14%
Public school district data[4]				
Total 2018-19 enrollment in district	7,107	---	951,631	---
High school graduation rate	---	74.90%	---	88.00%
High school dropout rate	---	3.70%	---	1.80%
% of students who experienced disciplinary action	---	5.63%	---	4.25%
Churn rate *	---	22.30%	---	8.50%
*Churn rate is used to assess student mobility. It represents the percentage of all students transferring into or out of a school within a school year. It is calculated as the number of students enrolled in public schools that are not reported as enrolled in the same school throughout the year.				
Public school district student race/ethnicity[4]				
Asian	362	5.10%	66,614	7.00%
Black or African American	1,166	16.40%	87,550	9.20%
Hispanic	3,866	54.40%	197,939	20.80%
Native American	28	0.40%	1,903	0.20%
Native Hawaiian/Pacific Islander	7	0.10%	952	0.10%
Multi-race non-Hispanic	121	1.70%	36,162	3.80%
White	1,564	22.00%	561,462	59.00%
Public school district selected student characteristics [4]**				
English language learner	1,777	25.00%	102,776	10.80%
First language not English	4,627	65.10%	208,407	21.90%
Students with economic disadvantages	3,418	48.10%	296,909	31.20%
Students with disabilities	1,265	17.80%	172,245	18.10%
Students with high needs	5,046	71.00%	452,976	47.60%
**Individual students can be in included in more than one of the above populations; therefore, the percentages add up to more than 100%.				

	Everett		Massachusetts	
	#	%/Rate	#	%/Rate
Employment				
Unemployment rate (October 2019)[5]	---	2.0%	---	2.9%
Commuting characteristics				
Commuting methods to work of workers 16 years and older[1] *(Working population 16 years and older= 23,527 in Everett; 3,500,223 in MA)*				
Bicycle	165	0.70%	28,002	0.80%
Carpooled	3,176	13.50%	262,517	7.50%
Drove alone	12,705	54.00%	2,457,157	70.20%
Public transportation (excluding taxicab)	5,623	23.90%	357,023	10.20%
Taxicab, motorcycle, or other means	329	1.40%	45,503	1.30%
Walked	800	3.40%	171,511	4.90%
Worked at home	729	3.10%	175,011	5.00%
Commuting time[1] *(Working population 16 years and older who did not work at home= 22,786 in Everett, 3,324,189 in MA)*				
Mean travel time to work (in minutes)	*36.2*	---	*29.7*	---
Less than 10 minutes	1,732	7.60%	352,364	10.60%
10 to 14 minutes	1,686	7.40%	392,254	11.80%
15 to 19 minutes	1,800	7.90%	435,469	13.10%
20 to 24 minutes	2,347	10.30%	422,172	12.70%
25 to 29 minutes	1,117	4.90%	192,803	5.80%
30 to 34 minutes	4,124	18.10%	468,711	14.10%
35 to 44 minutes	2,233	9.80%	275,908	8.30%
45 to 59 minutes	2,985	13.10%	355,688	10.70%
60 or more minutes	4,762	20.90%	425,496	12.80%
Food Access				
Food insecurity rate 2018[6]	5,400	12.10%	463,250	9.10%
Households with children under 18 utilizing SNAP[1]	1,583	10.01%	126,821	4.87%
SNAP gap 2017 (households eligible for SNAP who are not accessing benefits)[7]	11,660	63.40%	680,789	47.00%
Housing				
Total housing units[1]	16,871	---	2,882,739	---
Occupied housing units[1]	15,816	93.75%	2,601,914	90.26%
Owner occupied	5,999	37.93%	1,621,053	62.30%
Renter occupied	9,817	62.07%	980,861	37.70%
Housing units classified as Subsidized Housing Inventory (SHI) 2017[8]	1,061	6.4%	262,223	9.7%
Renters who are paying 30 to 49 percent of income in rent (cost burdened)[1]	2,495	25.42%	233,880	23.84%
Renters who are paying 50 percent or more of income in rent (severely cost burdened)[1]	2,643	26.92%	228,020	23.25%
Homeowners who are paying 30 to 49 percent of income for ownership costs (cost burdened)[1]	1,404	23.40%	264,376	16.31%
Homeowners who are paying 50 percent or more of income for ownership costs (severely cost burdened)[1]	1,182	19.70%	178,683	11.02%
Median single-family home sale price (in 2017 inflation adjusted USD)[9]	$410,000.0	---	$379,000.00	---

	Everett		Massachusetts	
	#	%/Rate	#	%/Rate
Income & Poverty[1]				
Median household income (in 2018 inflation adjusted USD)	$60,482	---	$77,378	---
Per capita income (in 2018 inflation adjusted USD)	$26,591	---	$41,794	---
Population under 18 years old living below poverty level	2,365	21.17%	188,810	13.89%
Population 65 years old and over living below poverty level	396	8.43%	93,961	9.02%
Families living in the community	10,773	---	1,651,808	---
Families living below poverty level	1,325	12.30%	123,886	7.50%
Families with female householder, no husband present	3,147	29.21%	317,946	19.25%
Families with female householder, no husband present living below poverty level	812	25.80%	74,081	23.30%
Social Environment				
Crime[10] *(per 100,000 residents)*				
Violent crime rate	173	368.0	23,337	338.1
Property crime rate	685	1,457.3	87,196	1,263.3
Social support				
Elder isolation rate (seniors over 65 living alone)[11]	1,233	25.50%	307,037	30.20%
High school students reporting they have a trusted adult to talk with at school [12,13]	---	56.00%	---	75.00%
Voter enrollment[14]				
Residents who are registered to vote	10,264	52.70%	1,975,106	44.50%
Youth Violence and Trauma[12,13]				
High school students reporting being bullied on school property in last 12 months	---	15.00%	---	15.00%
High school students reporting being cyber bullied in last 12 months	---	11.00%	---	13.60%
High school students reporting ever being physically hurt by a date	---	4.00%	---	5.60%
High school students reporting ever having sexual contact against will	---	7.00%	---	10.40%

Sources

1. U.S. Census Bureau, American Community Survey (ACS). 2014-2018. Data presented as minutes for commuting time, and 5-year estimates and percentage of estimates for all other data.
2. Massachusetts Bay Transportation Authority. 2018. Number of buses, subway stops, and commuter rail stops presented in total number.
3. Massachusetts Water Resources Authority, Everett Water report. 2018. Lead parts in water presented as parts per billion.
4. Massachusetts Department of Elementary and Secondary Education. 2019. Public school district data presented as percentage of total numbers.
5. United States Bureau of Labor Statistics (BLS). 2019. Unemployment rate presented as not seasonally adjusted percentage.
6. The Greater Boston Food Bank, Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2016. 2018. Food insecurity rate presented as total number and percentage rate.
7. The Food Bank of Western Massachusetts, Massachusetts SNAP GAP. 2017. Data presented as total numbers and percentage of total numbers.
8. Massachusetts Housing and Community Development department. 2017. Housing units classified as Subsidized Housing Inventory presented as total number and percentage.
9. The Boston Foundation, the Greater Boston Housing Report Card. 2017. Median single-family home sale price presented as 2017 inflation adjusted USD.
10. United States Federal Bureau of Investigation, Uniform Crime Reporting (UCR) Program. 2018. Data presented as total number and rate per 100.000 residents.
11. Massachusetts Healthy Aging Collaborative, Massachusetts healthy aging community profile. 2018. Data presented as total numbers, and percentage of total numbers.

12. Everett Public Schools, Everett Student Health Survey/Youth Risk Behavior Survey (YRBS). 2019. Data presented as percentage of total numbers.
13. Massachusetts Department of Public Health, Youth Risk Behavior Survey (YRBS). 2017. Data presented as percentage of total numbers.
14. Secretary of the Commonwealth of Massachusetts, Massachusetts Voter Enrollment Breakdown. 2019. Presented as total numbers and percentage of total numbers.

Table 3. Health Outcomes

Emergency department, hospitalization and mortality data reflect Everett residents who received care anywhere, not just those people who received care in Everett.

	Everett		Massachusetts	
	#	%/Rate	#	%/Rate
Behavioral Health				
All ages mental health/mental illness *(age-adjusted rate per 100,000)*				
Suicide mortality[1]	14	6.7	3,110	8.7
Mental health related emergency department visits[2]	1,198	2,524.7	168,735	2,465.6
Mental health related hospitalizations[2]	548	1,191.5	65,671	934.4
Mental disorder-related mortality[1]	123	57.1	26,566	60.0
Youth mental health[3,4] *in past 12 months*				
High school students who experienced depression	---	40.40%	---	27.40%
High school students who seriously considered suicide	---	14.10%	---	12.40%
High school students who attempted suicide	---	5.80%	---	5.40%
All ages substance use visits *(age-adjusted rates per 100,000)*				
Total drug overdose emergency department visits [2] *	167	344.0	16,699	250.9
Total drug overdose hospitalizations[2]	85	176.8	8,920	127.2
Total substance-related mortality[1]*	108	49.4	10,710	30.7
Alcohol-related mortality	21	10.0	2,952	7.6
Opioid-related mortality	75	33.9	6,429	19.3
*Total drug overdose emergency department visits includes visits for heroin, non-heroin opioids and all other types of drug overdoses; total substance-related mortality includes mortality due to alcohol, opioids, and all other types of substances				
Youth substance use[3,4]				
High school students who have ever used alcohol	---	44.20%	---	56.20%
High school students who have used alcohol in the last 30 days	---	17.10%	---	31.40%
High school students who have ever used cigarettes	---	12.80%	---	19.60%
High school students who have used cigarettes in the last 30 days	---	2.60%	---	6.40%
High school students who have ever used e-cigarettes	---	36.00%	---	41.10%
High school students who have used e-cigarettes in the last 30 days	---	13.80%	---	20.10%
High school students who have ever used marijuana	---	28.60%	---	37.90%
High school students who have used marijuana in the last 30 days	---	16.10%	---	24.10%
Chronic Disease				
Cancer[1] *(age-adjusted rate per 100,000)*				
All cancer mortality*	363	178.6	63,929	156.0
Breast cancer mortality	18	15.8	4,100	18.0
Colorectal cancer mortality	30	14.7	5,143	12.5
Lung cancer mortality	96	48.5	16,503	40.5
Ovarian cancer mortality	7	5.9	1,635	7.1
Prostate cancer mortality	12	16.3	3,046	18.5
*All cancer mortality includes the five types of cancer listed above as well as deaths from all other types of cancer				
Cardiovascular disease *(age-adjusted rate per 100,000)*				
Major cardiovascular disease hospitalizations[2]	683	1576.9	126,640	1,563.1
Major cardiovascular disease mortality[1]	409	195.9	77,337	179.7
Cerebrovascular disease (stroke) hospitalizations[2]	90	206.6	20,789	255.1
Cerebrovascular disease (stroke) mortality[1]	60	28.6	12,117	28.2

	Everett		Massachusetts	
Diabetes *(age-adjusted rate per 100,000)*	*#*	*%/Rate*	*#*	*%/Rate*
Diabetes related hospitalizations [2]	84	183.5	11,896	158.9
Diabetes mortality [1]	45	22.1	6,131	14.8
Obesity[5]				
Youth who are overweight or obese (children in grade 1)	233	43.0%	17,698	28.3%
Youth who are overweight or obese (children in grade 4)	252	57.80%	21,129	33.6%
Youth who are overweight or obese (children in grade 7)	236	55.50%	20,220	34.0%
Youth who are overweight or obese (children in grade 10)	117	35.0%	18,933	33.2%
Respiratory disease				
Children living with asthma (prevalence rate per 100 students)[6]	515	9.8	82,279	12.1
Asthma emergency department visits (age-adjusted rate per 100,000)[2]	432	92.9	42,887	66.5
Chronic obstructive pulmonary disease (COPD) related hospitalizations (age-adjusted rate per 100,000)[2]	98	34.7	14,319	26.3
Infectious Disease[7]* *(age-adjusted rate per 100,000)*				
Chlamydia incidence	---	613.1	---	383.0
Gonorrhea incidence	---	102.8	---	68.0
Hepatitis C incidence	---	713.7	---	606.4
HIV/AIDS prevalence	---	575.7	---	293.2
HIV/AIDS incidence	---	21.2	---	10.1
Syphilis incidence	---	26.5	---	12.9
Tuberculosis incidence	---	5.2	---	2.9
*Incidence is the number of new cases of a disease, prevalence is number of people living with a disease				
Injuries *(age-adjusted rate per 100,000)*				
All injury and poisoning emergency department visits[2]	90	185.1	11,352	173.0
All injury and poisoning mortality[1]	145	66.9	19,189	53.0
Maternal & Child Health				
Teen birth rate (per 1,000 females ages 15-19 per city/town)[8]	23	17.5	2,104	9.4
Percent of live births receiving adequate prenatal care[2]	2,463	81.0%	249,304	69.49%
Percent of live births with low birthweight[2]	260	8.1%	26,915	7.50%
Sexual & Reproductive Health[3,4]				
High school students who have ever had sexual intercourse	---	39.30%	---	35.30%
High school students who used condom at last intercourse	---	58.50%	---	57.80%

Sources

1. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Mortality and birth data. 2012-2016. Data presented as total number of cases and age-adjusted rate per 100,000.
2. Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), Emergency department visits and hospitalization. 2014. Data presented as total number of cases and age-adjusted rate per 100,000.
3. Everett Public Schools, Student Health Survey/Youth Risk Behavior Survey (YRBS). 2019. Data presented as percentage of total numbers.
4. Massachusetts Department of Public Health, Youth Risk Behavior Survey (YRBS). 2017. Data presented as percentage of total numbers.
5. Massachusetts Department of Public Health, Body Mass Index Screening in Massachusetts Public School Districts, 2015. 2017. Data presented as total numbers and percentages of total numbers.
6. Massachusetts Department of Public Health Bureau of Environmental Health. 2016-2017. Data presented as number of cases of asthma per 100 K-8th grade students.

7. Massachusetts Department of Public Health Bureau of Infectious Disease and Laboratory Sciences (BIDLS). New cases of Chlamydia, Gonorrhea, Hepatitis C, Syphilis and Tuberculosis, presented as total number of cases and age-adjusted rate per 100,000 2018; New cases HIV and presented total number as age-adjusted rate per 100,000; 2017. People living with HIV presented as age-adjusted rate per 100,000 2017.
8. Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Massachusetts Births 2016. Data presented as total numbers and rate per 1,000 females ages 15-19 per city/town, and total numbers and percentage of total numbers.

MALDEN COMMUNITY DATA PROFILE 2019-2020

Please note that some of this data has been updated and differs from the data in the body of the report

Table 1. Community Demographics[1]	Malden		Massachusetts	
	#	%/Rate	#	%/Rate
Total population	61,094	---	6,830,193	---
Population density (per sq. mile)	12,111.1	---	875.5	-----
Female	31,751	51.97%	3,516,214	51.48%
Male	29,343	48.03%	3,313,979	48.52%
Age				
Under 5	3,126	5.12%	362,855	5.3%
5 - 19 years	9,222	15.09%	1,226,228	17.95%
20 - 34 years	17,806	29.15%	1,456,131	21.32%
35 - 64 years	23,456	38.39%	2,706,929	39.63%
65 years and over	7,484	12.25%	1,078,224	15.79%
Race and Ethnicity				
American Indian and Alaska Native	15	0.02%	8,890	0.13%
Asian	14,277	23.37%	440,336	6.45%
Black or African American	9,821	16.08%	463,796	6.79%
Hispanic or Latino	5,684	9.30%	789,127	11.55%
Native Hawaiian and Other Pacific Islander	17	0.03%	1,698	0.02%
White	28,757	47.07%	4,930,412	72.19%
Some other race	704	1.15%	53,268	0.78%
Two or more races	1,819	2.98%	142,666	2.09%
Foreign-Born Residents and Continent of Origin				
Foreign-born residents	*26,668*	*43.65%*	*1,129,732*	*16.54%*
Africa	3,027	11.35%	105,168	9.31%
Asia	12,574	47.15%	343,718	30.42%
Europe	2,256	8.46%	234,648	20.77%
Latin America	8,538	32.02%	411,277	36.40%
North America	241	0.90%	30,761	2.72%
Oceania	32	0.12%	4,160	0.37%
Top 5 Languages Spoken at Home for Residents Over 5 Years Old				
Population 5 years and older=57,968 in Malden; 6,467,512 in MA				
English only	27,697	47.78%	4,941,922	76.41%
Language other than English	30,271	52.22%	1,525,590	23.59%
Asian and Pacific Islander languages	11,158	19.25%	275,078	4.25%
Spanish	4,588	7.91%	581,553	8.99%
Other Indo-European languages*	10,865	18.74%	576,664	8.92%
Other languages	3,660	6.31%	92,295	1.43%

*This category includes any language other than English or Spanish that was originated in Europe or India.

Sources

1. All data in Table 1 comes from the U.S. Census Bureau, American Community Survey (ACS),2014-2018, 5-year estimates

Table 2. Social Determinants of Health	Malden		Massachusetts	
	#	%/Rate	#	%/Rate
Access to Health Services				
Population with no health insurance coverage[1]	2,945	4.83%	189,470	2.80%
Built Environment				
Number of bus routes in community[2]	17	---	---	---
Number of subway routes in community[2]	1	---	---	---
Number of commuter rail stops in community[2]	1	---	---	---
Lead parts per billion detected in drinking water[3]*	12.2	---	---	---
* Massachusetts State limit: 15 ppb				
Education				
Highest educational attainment for residents ages 25 years and older[1]				
(Population 25 years and older = 43,719 in Malden; 4,748,795 in MA)				
Less than 9th grade	3,563	8.15%	214,205	4.51%
9th to 12th grade, no diploma	2,344	5.36%	240,155	5.06%
High school graduate (includes equivalency)	12,508	28.61%	1,150,846	24.23%
Some college, no degree	6,560	15.00%	740,784	15.60%
Associate's degree	2,855	6.53%	365,103	7.69%
Bachelor's degree	9,409	21.52%	1,128,877	23.77%
Graduate or professional degree	6,480	14.82%	908,825	19.14%
Public school district data[4]				
Total 2018-19 enrollment in district	6,564	---	951,631	---
High school graduation rate	---	79.50%	---	88.0%
High school dropout rate	---	3.20%	---	1.80%
% of students who experienced disciplinary action	---	5.96%	---	4.25%
Churn rate *	---	19.00%	---	8.50%
*Churn rate is used to assess student mobility. It represents the percentage of all students transferring into or out of a school within a school year. It is calculated as the number of students enrolled in public schools that are not reported as enrolled in the same school throughout the year.				
Public school district student race/ethnicity[4]				
Asian	1,523	23.20%	66,614	7.00%
Black or African American	1,267	19.30%	87,550	9.20%
Hispanic	1,621	24.70%	197,939	20.80%
Native American	7	0.10%	1,903	0.20%
Native Hawaiian/Pacific Islander	0	0.00%	952	0.10%
Multi-race non-Hispanic	276	4.20%	36,162	3.80%
White	1,864	28.40%	561,462	59.00%
Public school district selected student characteristics [4]**				
English language learner	1,313	20.00%	102,776	10.80%
First language not English	3,623	55.20%	208,407	21.90%
Students with economic disadvantages	2,855	43.50%	296,909	31.20%
Students with disabilities	1,103	16.80%	172,245	18.10%
Students with high needs	4,450	67.80%	452,976	47.60%
**Individual students can be in included in more than one of the above populations; therefore, the percentages add up to more than 100%.				

	Malden		Massachusetts	
	#	%/Rate	#	%/Rate
Employment				
Unemployment rate (October 2019)[5]	---	2.2%	---	2.9%
Commuting characteristics				
Commuting methods to work of workers 16 years and older[1] *(Working population 16 years and older= 31,632 in Malden; 3,500,223 in MA)*				
Bicycle	95	0.30%	28,002	0.80%
Carpooled	2,531	8.00%	262,517	7.50%
Drove alone	16,733	52.90%	2,457,157	70.20%
Public transportation (excluding taxicab)	9,838	31.10%	357,023	10.20%
Taxicab, motorcycle, or other means	443	1.40%	45,503	1.30%
Walked	1,044	3.30%	171,511	4.90%
Worked at home	949	3.00%	175,011	5.00%
Commuting time[1] *(Working population 16 years and older who did not work at home= 30,697 in Malden, 3,324,189 in MA)*				
Mean travel time to work (in minutes)	*35.1*	---	*29.7*	---
Less than 10 minutes	1,320	4.30%	352,364	10.60%
10 to 14 minutes	2,210	7.20%	392,254	11.80%
15 to 19 minutes	2,609	8.50%	435,469	13.10%
20 to 24 minutes	3,223	10.50%	422,172	12.70%
25 to 29 minutes	1,351	4.40%	192,803	5.80%
30 to 34 minutes	6,078	19.80%	468,711	14.10%
35 to 44 minutes	3,315	10.80%	275,908	8.30%
45 to 59 minutes	5,372	17.50%	355,688	10.70%
60 or more minutes	5,188	16.90%	425,496	12.80%
Food Access				
Food insecurity rate 2018[6]	9,170	15.10%	463,250	9.1%
Households with children under 18 utilizing SNAP[1]	3,130	13.61%	126,821	4.87%
SNAP gap 2017 (households eligible for SNAP who are not accessing benefits)[7]	11,566	58.00%	680,789	47.00%
Housing				
Total housing units[1]	24,273	---	2,882,739	---
Occupied housing units[1]	22,996	94.74%	2,601,914	90.26%
Owner occupied	9,392	40.84%	1,621,053	62.30%
Renter occupied	13,604	59.16%	980,861	37.70%
Housing units classified as Subsidized Housing Inventory (SHI) 2017[8]	2,542	10.1%	262,223	9.7%
Renters who are paying 30 to 49 percent of income in rent (cost burdened)[1]	3,578	26.30%	233,880	23.84%
Renters who are paying 50 percent or more of income in rent (severely cost burdened)[1]	3,230	23.74%	228,020	23.25%
Homeowners who are paying 30 to 49 percent of income for ownership costs (cost burdened)[1]	1,843	19.62%	264,376	16.31%
Homeowners who are paying 50 percent or more of income for ownership costs (severely cost burdened)[1]	1,394	14.84%	178,683	11.02%
Median single-family home sale price (in 2017 inflation adjusted USD)[9]	$430,000.0	---	$379,000.00	---

	Malden		Massachusetts	
	#	%/Rate	#	%/Rate
Income & Poverty[1]				
Median household income (in 2018 inflation adjusted USD)	$64,178	---	$77,378	---
Per capita income (in 2018 inflation adjusted USD)	$31,086	---	$41,794	---
Population under 18 years old living below poverty level	2,329	20.06%	188,810	13.89%
Population 65 years old and over living below poverty level	1,338	18.12%	93,961	9.02%
Families living in the community	14,345	---	1,651,808	---
Families living below poverty level	1,908	13.30%	123,886	7.50%
Families with female householder, no husband present	2,986	20.82%	317,946	19.25%
Families with female householder, no husband present living below poverty level	875	29.30%	74,081	23.30%
Social Environment				
Crime[10] *(per 100,000 residents)*				
Violent crime rate	180	292.8	23,337	338.1
Property crime rate	588	956.6	87,196	1,263.3
Social support				
Elder isolation rate(seniors over 65 living alone)[11]	2,590	35.40%	307,037	30.20%
High school students reporting they have a trusted adult to talk with at school [12,13]	---	54.00%	---	75.00%
Voter enrollment[14]				
Residents who are registered to vote	14,949	48.10%	1,975,106	44.50%
Youth Violence and Trauma[12,13]				
High school students reporting being bullied on school property in last 12 months	---	9.00%	---	15.00%
High school students reporting being cyber bullied in last 12 months	---	7.00%	---	13.60%
High school students reporting ever being physically hurt by a date	---	3.00%	---	5.60%
High school students reporting ever having sexual contact against will	---	2.00%	---	10.40%

Sources

1. U.S. Census Bureau, American Community Survey (ACS). 2014-2018. Data presented as minutes for commuting time, and 5-year estimates and percentage of estimates for all other data.
2. Massachusetts Bay Transportation Authority. 2018. Number of buses, subway stops, and commuter rail stops presented in total number.
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	#	%/Rate	#	%/Rate
Behavioral Health				
All ages mental health/mental illness *(age-adjusted rate per 100,000)*				
Suicide mortality[1]	20	6.4	3,110	8.7
Mental health related emergency department visits[2]	1,326	1,976.9	168,735	2,465.6
Mental health related hospitalizations[2]	600	912.2	65,671	934.4
Mental disorder-related mortality[1]	200	64.5	26,566	60.0
Youth mental health[3,4] *in past 12 months*				
High school students who experienced depression	---	28.0%	---	27.4%
High school students who seriously considered suicide	---	10.0%	---	12.4%
High school students who attempted suicide	---	5.0%	---	5.4%
All ages substance use visits *(age-adjusted rates per 100,000)*				
Total drug overdose emergency department visits [2] *	157	231.9	16,699	250.9
Total drug overdose hospitalizations[2]	88	132.5	8,920	127.2
Total substance-related mortality[1]*	112	34.3	10,710	30.7
Alcohol-related mortality	23	7.1	2,952	7.6
Opioid-related mortality	72	21.9	6,429	19.3
*Total drug overdose emergency department visits includes visits for heroin, non-heroin opioids and all other types of drug overdoses; total substance-related mortality includes mortality due to alcohol, opioids, and all other types of substances				
Youth substance use[3,4]				
High school students who have ever used alcohol	---	40.00%	---	56.20%
High school students who have used alcohol in the last 30 days	---	13.00%	---	31.40%
High school students who have ever used cigarettes	---	8.00%	---	19.60%
High school students who have used cigarettes in the last 30 days	---	2.00%	---	6.40%
High school students who have ever used e-cigarettes	---	27.00%	---	41.10%
High school students who have used e-cigarettes in the last 30 days	---	14.00%	---	20.10%
High school students who have ever used marijuana	---	22.00%	---	37.90%
High school students who have used marijuana in the last 30 days	---	10.00%	---	24.10%
Chronic Disease				
Cancer[1] *(age-adjusted rate per 100,000)*				
All cancer mortality*	532	177.0	63,929	156.0
Breast cancer mortality	33	18.9	4,100	18.0
Colorectal cancer mortality	47	15.7	5,143	12.5
Lung cancer mortality	163	55.2	16,503	40.5
Ovarian cancer mortality	13	7.4	1,635	7.1
Prostate cancer mortality	25	23.7	3,046	18.5
*All cancer mortality includes the five types of cancer listed above as well as deaths from all other types of cancer				
Cardiovascular disease *(age-adjusted rate per 100,000)*				
Major cardiovascular disease hospitalizations[2]	990	1,563.2	126,640	1,563.1
Major cardiovascular disease mortality[1]	501	165.4	77,337	179.7
Cerebrovascular disease (stroke) hospitalizations[2]	151	239.9	20,789	255.1
Cerebrovascular disease (stroke) mortality[1]	74	24.7	12,117	28.2

	Malden		Massachusetts	
Diabetes *(age-adjusted rate per 100,000)*	#	%/Rate	#	%/Rate
Diabetes related hospitalizations [2]	126	187.8	11,896	158.9
Diabetes mortality [1]	68	22.9	6,131	14.8
Obesity[5]				
Youth who are overweight or obese (children in grade 1)	129	28.40%	17,698	28.30%
Youth who are overweight or obese (children in grade 4)	176	40.00%	21,129	33.60%
Youth who are overweight or obese (children in grade 7)	182	45.20%	20,220	34.00%
Youth who are overweight or obese (children in grade 10)	120	34.20%	18,933	33.20%
Respiratory disease				
Children living with asthma (prevalence rate per 100 students)[6]	587	10.9	82,279	12.1
Asthma emergency department visits (age-adjusted rate per 100,000)[2]	348	57.1	42,887	66.5
Chronic obstructive pulmonary disease (COPD) related hospitalizations (age-adjusted rate per 100,000)[2]	105	24.3	14,319	26.3
Infectious Disease[7]* *(age adjusted rate per 100,000)*				
Chlamydia incidence	---	439.6	---	383.0
Gonorrhea incidence	---	76.7	---	68.0
Hepatitis C incidence	---	540.7	---	606.4
HIV/AIDS prevalence	---	518.3	---	293.2
HIV/AIDS incidence	---	16.2	---	10.1
Syphilis incidence	---	21.0	---	12.9
Tuberculosis incidence	---	11.1	---	2.9
*Incidence is the number of new cases of a disease, prevalence is number of people living with a disease				
Injuries *(age-adjusted rate per 100,000)*				
All injury and poisoning emergency department visits[2]	104	156.8	11,352	173.0
All injury and poisoning mortality[1]	164	51.5	19,189	53.0
Maternal & Child Health				
Teen birth rate (per 1,000 females ages 15-19 per city/town)[8]	11	7.1	2,104	9.4
Percent of live births receiving adequate prenatal care[2]	3,301	81.80%	249,304	69.49%
Percent of live births with low birthweight[2]	340	7.80%	26,915	7.50%
Sexual & Reproductive Health[3,4]				
High school students who have ever had sexual intercourse	---	27.00%	---	35.30%
High school students who used condom at last intercourse	---	63.00%	---	57.80%

Sources

1. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Mortality and birth data. 2012-2016. Data presented as total number of cases and age-adjusted rate per 100,000.
2. Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), Emergency department visits and hospitalization. 2014. Data presented as total number of cases and age-adjusted rate per 100,000.
3. Malden Public Schools, Student Health Survey/Youth Risk Behavior Survey (YRBS). 2019. Data presented as percentage of total numbers.
4. Massachusetts Department of Public Health, Youth Risk Behavior Survey (YRBS). 2017. Data presented as percentage of total numbers.
5. Massachusetts Department of Public Health, Body Mass Index Screening in Massachusetts Public School Districts, 2015. 2017. Data presented as total numbers and percentages of total numbers.
6. Massachusetts Department of Public Health Bureau of Environmental Health. 2016-2017. Data presented as number of cases of asthma per 100 K-8th grade students.

7. Massachusetts Department of Public Health Bureau of Infectious Disease and Laboratory Sciences (BIDLS). New cases of Chlamydia, Gonorrhea, Hepatitis C, Syphilis and Tuberculosis, presented as total number of cases and age-adjusted rate per 100,000 2018; New cases HIV and presented total number as age-adjusted rate per 100,000; 2017. People living with HIV presented as age-adjusted rate per 100,000 2017.
8. Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Massachusetts Births 2016. Data presented as total numbers and rate per 1,000 females ages 15-19 per city/town, and total numbers and percentage of total numbers.

Appendix E: 1-Page Community Snapshots

2019 Community Health Needs Assessment (CHNA) Highlights

Everett

Demographics at a Glance

- **45,212** Total Population
- **41%** Born Outside the US
- **13%** Families Live in Poverty
- **39%** Of population are 35-64 years old

Data Source: U.S. Census Bureau, American Community Survey (ACS) 2013-2017, 5-year estimate

What is a CHNA?

If we know the root causes of poor health, we can work to change them. This will lead to better health for people and their community. A CHNA involves reviewing data to uncover these root causes.

Data Approach & Collection Process

THRIVE* Framework

THRIVE looks at data by the root causes that can impact health.

People + Place + Equitable Opportunity = Health Outcomes

As part of the Everett/Malden CHNA, we asked members in Everett about the quality of life in their community. We wanted to hear their thoughts on:

- Community strengths
- Health concerns
- What helps them to be healthy

- **303 community surveys collected**
- **Review of publicly reported data**
- **3 small group discussions**
- **2 open community meetings**
- **Development of community advisory board**

Strengths of Community

- **Open space & recreation**
- **Diversity of residents & businesses**
- **Community gardens**
- **Access to free and low cost meals for students & seniors**
- **Social services, civic/community engagement**

Top Concerns Impacting Health

Behavioral Health Outcomes
- Mental health
- Substance use disorders

Chronic Diseases
- Cancer
- Obesity
- Diabetes
- Respiratory disease

Access to Care and Services
- Affordability
- Fear and distrust of government agencies

Infectious Diseases
- HIV
- Hepatitis C

Neighborhood Conditions
- Healthy food access
- Housing stability, affordability, safety & homelessness
- Economic stability and mobility

Next Steps

- Publish full assessment report
- Prioritize areas of focus
- Develop community health implementation plan (CHIP)

*For more information on THRIVE: https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments

If you have questions or want to get involved with Everett/Malden Collaborative for Community Health Improvement

- Renee Cammarata Hamilton, rcammaratahamilton@challiance.org
- Barbara Kaufman, bkaufman@melrosewakefield.org
- Danelle Marable, dmarable@partners.org

CHA Cambridge Health Alliance
MGH 1811 Massachusetts General Hospital
MW Melrose Wakefield Healthcare
Proudly wellforce

2019 Community Health Needs Assessment (CHNA) Highlights

Malden

Demographics at a Glance

61,212 Total Population

43% Born Outside the US

13% Families Live in Poverty

39% Of population are 35-64 years old

Data Source: U.S. Census Bureau, American Community Survey (ACS) 2013-2017, 5-year estimate

What is a CHNA?

If we know the root causes of poor health, we can work to change them. This will lead to better health for people and their community. A CHNA involves reviewing data to uncover these root causes.

Data Approach & Collection Process

THRIVE* Framework

THRIVE looks at data by the root causes that can impact health.

People + Place + Equitable Opportunity = Health Outcomes

As part of the Everett/Malden CHNA, we asked members in Malden about the quality of life in their community. We wanted to hear their thoughts on:

- Community strengths
- Health concerns
- What helps them to be healthy

303 community surveys collected

Review of publicly reported data

3 small group discussions

2 open community meetings

Development of community advisory board

Strengths of Community

Open space & recreation

Diversity of residents & businesses

Produce markets & community gardens

Access to free and low cost meals for students & seniors

Social services, civic/community engagement

Top Concerns Impacting Health

Behavioral Health Outcomes
- Mental health
- Substance use disorders

Chronic Diseases
- Cancer
- Obesity
- Diabetes
- Respiratory disease

Access to Care and Services
- Affordability
- Fear and distrust of government agencies

Infectious Diseases
- HIV
- Hepatitis C

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Next Steps

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CHA Cambridge Health Alliance

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

MW Melrose Wakefield Healthcare

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Appendix F: Resources

Links to Community Health Needs Assessments (CHNAs) previously done in and around Everett and Malden:

- Cambridge Health Alliance Wellbeing of Everett 2014: http://www.challiance.org/Resource.ashx?sn=Everett_Wellbeing_Report_2014
- Cambridge Health Alliance Wellbeing of Malden 2015: http://www.challiance.org/Resource.ashx?sn=WellBeingofMaldenReport2015
- MelroseWakefield Healthcare Community Health Needs Assessment 2019: https://www.melrosewakefield.org/wp-content/uploads/2017/07/2019-MWHC-CHNA-report_updated.pdf
- North Suffolk Integrated Community Health Needs Assessment 2019: https://www.northsuffolkassessment.org/