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DotHouse Health 2015 Community Health Needs Assessment FINAL Report

Submitted to:
DotHouse Health



Health Resources in Action
Advancing Public Health and Medical Research

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EXECUTIVE SUMMARY

Introduction

DotHouse Health is a federally qualified community health center serving the Fields Corner neighborhood of Dorchester within the city of Boston since 1972. In February 2015, DotHouse Health contracted Health Resources in Action (HRiA), a non-profit public health organization in Boston, to conduct its community health needs assessment (CHNA) to ensure that it is addressing the most pressing health concerns among its patient population and Dorchester residents. In addition to meeting the Health Resources and Services Administration (HRSA) health center program requirements (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act), the CHNA process was undertaken to:

- Provide a comprehensive portrait of the health status of DotHouse’s service area, using a social determinants of health framework and incorporating diverse perspectives
- Describe both overall trends and unique issues by sub-populations, and to compare these trends and issues to municipal data
- Generate action-oriented data that informs strategic planning and program development
- Identify health-related needs and describe the DotHouse service area’s assets and strengths

This report describes the process and findings of the community health needs assessment.

Methods

To identify the perceived health needs of the community, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in Dorchester; conducting a survey with 139 DotHouse staff and board members; conducting a survey (in English, Spanish and Vietnamese) of 129 DotHouse patients; and engaging over 60 individuals in focus group and interview discussions. Five focus groups were conducted with representatives of selected sectors or priority populations, including: Seniors, youth, men of color, and Spanish- and Vietnamese-speaking community members. Nine interviews were conducted with individuals representing a range of sectors, including community development, business, and health care, among others.

Findings

The following provides a brief overview of key findings that emerged from this assessment.

Community Social and Economic Context

- ❖ **Demographic Diversity:** Interview and focus group participants frequently noted that the neighborhood of Dorchester is quite large and has many distinct localities with unique assets and challenges. The most recent decennial census conducted in 2010 shows that while North Dorchester’s population has seen modest growth (1.0%), South Dorchester’s population has decreased by over 5.0%. While the data show that Boston overall is a predominantly White, non-Hispanic city (47%), Black, non-Hispanic residents comprise the majority of North and South Dorchester (44.0% and 45.8%, respectively). The Asian population makes up over one-third of the DotHouse patient population (35.5%), though it represents less than 10% of either of the population in North and South Dorchester.

“It’s diverse in its own way. There’s a significant Vietnamese population and Cape Verdean population, which seems to be growing; Caucasian and Latino on a smaller scale and African American. We’re pretty diverse.”

– Key informant interviewee

- ❖ **Income, Poverty, and Employment:** Residents and stakeholders described challenges and trade-offs in paying for housing, food, child care, medical care, and other basic necessities. While the percentage of South Dorchester residents living below poverty level (19.3%) is comparable to that of the city overall (21.2%), 29% of North Dorchester residents are living below poverty. DotHouse, by contrast, serves a population in which 80.3% of patients are below poverty level. Unemployment data aggregated over the years of 2008 through 2012 demonstrate that while 10.3% of the employment-eligible Boston residents are unemployed, this value rises to over 15% in South Dorchester, and nearly 18% in North Dorchester.
- ❖ **Education:** Interview and focus group participants described Dorchester’s residents as having various levels of education and working in a wide range of professions. In both North and South Dorchester, residents with a college degree or more comprise less than 25% of the population, compared to 44% for Boston overall.
- ❖ **Housing and Transportation:** A majority of interview and focus group participants expressed concerns about the lack of affordable housing in Dorchester, especially for seniors and families. Over half of North and South Dorchester renters (53.3% and 54.1%, respectively), have housing costs that comprise 30% or more of their household income. Many residents and stakeholders stated that Dorchester has access to adequate public transportation, but did note that certain parts of the neighborhood were further from the MBTA, which can also be unreliable at times.
- ❖ **Violence and Neighborhood Safety:** Issues related to violence and neighborhood safety were raised by almost all interview and focus group participants, and were especially prominent themes in the youth focus group discussion. While many residents described the neighborhood, particularly Field’s Corner, as becoming safer in recent years, others noted that violence is still a concern in certain areas of Dorchester. Rates of emergency department visits for nonfatal stabbing or gunshot wounds are higher in North and South Dorchester (1.6 and 2.1 visits per 1,000 residents, respectively) compared to Boston (0.9 visits per 1,000 residents).

Figure 1: Percent of Renter-Occupied Housing Units Paying at Least 30% of Household Income towards Rent, 2008-2012



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2008-2012 as reported by Health of Boston 2014-2015

Community Health Issues

The health issues and concerns that emerged as the most prominent in DotHouse’s community health needs assessment, included: chronic diseases – such as diabetes and asthma – and related behaviors, namely obesity, physical activity, and nutrition; mental and behavioral health; sexual health; and access to care.

- ❖ **Perceived Community Health Status:** Over 40% of DotHouse staff survey respondents described the community’s health as good on a scale of poor to excellent. Mental health, diabetes, obesity, and drug/alcohol abuse were viewed as the top health issues of concern for the community among staff survey respondents.

❖ **Mortality and Morbidity:** Cancer is the leading cause of death among city residents overall, followed by heart and cerebrovascular disease (including stroke). A similar pattern is seen in the neighborhoods of North and South Dorchester.

❖ **Chronic Diseases and Related Risk Factors:** Residents and stakeholders described issues related to overweight/obesity, diabetes, and asthma as affecting their community.

- Quantitative data show that in 2010, while 21.0% of adult Boston residents were obese, in South Dorchester, nearly one in four adults were obese (24.0%) compared to nearly one in three North Dorchester residents (31.0%).
- In 2010, North and South Dorchester also had a higher proportion of adult residents with diabetes (8.0% and 7.0%, respectively) compared to Boston (6.0%). However, in 2014, the proportion of DotHouse patients diagnosed with diabetes was 10.3%.
- The citywide disease burden of asthma in 2010 was 11.0% - an identical proportion to that which was observed in South Dorchester that same year. In contrast, North Dorchester reported a particularly high prevalence of asthma (18.0%). Asthma diagnoses among DotHouse patients in 2014 was comparatively lower at 8.6%.

❖ **Behavioral Health:**

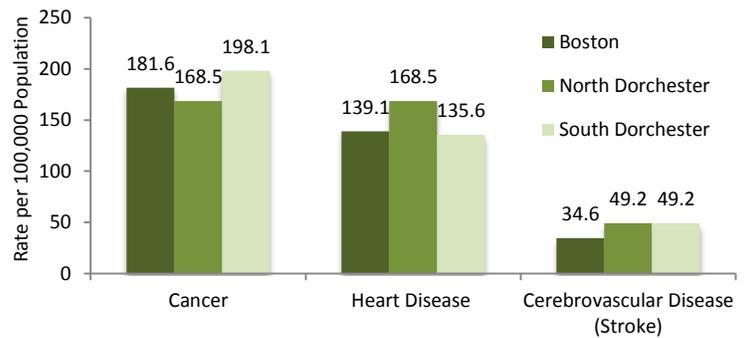
- Depression and stress were the most common mental health issues discussed, and participants frequently noted that these issues are directly connected with living in conditions of poverty and struggling to make ends meet.
- Participants stated that alcohol abuse has historically been and continues to be an issue for residents. Opiate abuse was also mentioned by many participants, as was marijuana use. Stakeholders discussed high rates of cigarette smoking among Vietnamese men in particular.

❖ **Sexual Health, Teenage Pregnancy, and Birth Outcomes:**

- Sexually transmitted infections (STIs) were mentioned by some stakeholders and residents, and was discussed most prominently during the youth focus group. Rates of STIs are higher in North and South Dorchester compared to Boston overall. While Boston reported a rate of 766.7 cases of Chlamydia per 100,000 population, North and South Dorchester (1,543.7 and 1,279.8 per 100,000 population, respectively) had substantially higher rates. The incidence rates for Chlamydia and Gonorrhea in North Dorchester more than double those of Boston.
- Some interviewees and participants in the men and youth focus group participants cited teenage pregnancy as a key health issue. The rate of teen pregnancy in North Dorchester (26 births per 1,000 females ages 15-17) exceeded that of Boston (20.1 births per 1,000 females ages 15-17) in 2010. In contrast, the rate of teen pregnancy in South Dorchester (16.4 births per 1,000 females ages 15-17) was lower

❖ **Health Care Access and Utilization:** Interview and focus group participants noted a lack of primary care providers and dentists in the community, which leads to long wait times for appointments. In general, participants praised DotHouse for providing services and materials in

Figure 2: Rate of the Leading Causes of Death per 100,000 Population by City and Neighborhood, 2010



DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health
 DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office as reported by Health of Boston 2012-2013

many languages; however, some participants in the Spanish-language and Vietnamese-language focus groups described challenges finding interpreters, especially during dental care and at pharmacies.

- Overall, most DotHouse patient survey respondents reported being very satisfied with the availability of health or medical providers who take their insurance (74.6%) and overall health or medical services in the area (71.4%). They were least likely to report being very satisfied with the availability of alcohol or drug treatment services (26.5%).
 - Among patient survey respondents, case management services were found to be most useful DotHouse community service, followed by food pantry and WIC services (62.4%, 58.4%, and 54.1%, respectively).
 - According to patient survey respondents, the most frequently identified challenges in accessing care included long wait to schedule an appointment (30.9%), long wait at appointment time to see doctor (21.1%), and health care information is not kept confidential (20.2%).
- ❖ **Other Community Health Issues:** A few other health issues were mentioned by some interview and focus group participants, although they did not emerge as prominent concerns; these included: domestic violence; the needs of caretakers in the community, especially among seniors; and chronic pain particularly its overlap with behavioral health and depression.

Community Assets and Programs

Residents and stakeholders identified many assets and strengths of their community:

- ❖ **Diversity, Energy and Local Amenities:** Dorchester was described as “diverse” and “energetic,” with many local amenities including public transportation, churches and historical sites.
- ❖ **Sense of Community and Civic Pride:** Many participants also described a strong sense of community and civic pride. Stakeholders noted that a number of formal civic associations exist in Dorchester, and also shared that informally many residents are actively involved in developing their communities.
- ❖ **Available Social Services and Other Resources:** Stakeholders stated that numerous local non-profits and social service providers are present in the community, and either provide direct services to residents or are working on issues of broader community and economic development.

“Dorchester has a lot of people really committed to being involved in their community. [There are a] large number of civic associations.”

– Key informant interviewee

Community Suggestion for Future Programs, Services, and Initiatives

Assessment participants were asked about their vision for the future of their community, and ideas for programs, services and initiatives. Among DotHouse staff survey respondents, ‘more chronic disease prevention services’, ‘more programs or services focusing on obesity/weight control’, and ‘providing more counseling or mental health services’ emerged as high priority areas for addressing in the future.

Prominent themes for future programs, services and initiatives that emerged from interviews and focus groups included:

- ❖ *Intervening at the socioeconomic level to improve mental and physical health:* During focus groups and interviews, poverty was viewed as a root cause for both physical and mental health issues.
- ❖ *Supporting employment opportunities through education and provision of child care:* When asked about their vision for the future of the community, many participants stated that they hope to see increased career opportunities for local residents. Stakeholders and residents noted

that education (ranging from vocation schooling to college preparation) and affordable child care will be two key facilitators for expanding job opportunities.

- ❖ *Addressing safety and built environment issues:* Many stakeholders and residents described safety issues as being a concern for the neighborhood and having a direct impact on health. While specific suggestions for improving safety were not frequently discussed, when asked about the future of their community participants did point to improved safety as a priority. A few stakeholders also noted that substandard housing and air quality can have an impact on health in general and specifically on asthma prevention and control.
- ❖ *Provide Health Education Focused on Prevention:* Many stakeholders and residents described the provision of health education focused on prevention as a high priority, and stated that education is needed around sexual health (especially as it relates to teenage pregnancy and sexually transmitted infections), chronic disease prevention (particularly diabetes and asthma), and substance abuse prevention.
- ❖ *Coordinating communication and referrals among local agencies:* Health care and social service stakeholders frequently noted that, while many local services exist, there are opportunities to improve communication and referrals amongst them to maximize reach and avoid duplication of effort.

Key Themes and Conclusions

Several overarching themes emerged from this synthesis:

- ❖ ***Dorchester, and Field's Corner specifically, is a vibrant, diverse neighborhood with a strong sense of community and many local amenities and services.*** Community assets frequently discussed included diversity, the strong sense of community and ownership among residents, and the availability of health and social services.
- ❖ ***Safety, housing and employment are key concerns for many residents.*** While some participants described Field's Corner as safer compared to previous years, others still consider parts of Dorchester to be dangerous. Residents expressed concerns about housing affordability and gentrification, and stated that there is a need for increased employment opportunities.
- ❖ ***Chronic diseases, such as obesity and asthma, and sexual health emerged as prominent health issues among Dorchester residents.*** Quantitative data show that Dorchester is disproportionately affected by obesity, asthma, and STIs. Risk factors for chronic diseases, including healthy eating and physical activity, and a need for increased sexual health education were described by participants as pressing issues.
- ❖ ***Behavioral health concerns were frequently noted, especially the need for additional services and insurance coverage.*** Participants emphasized the stress and depression among residents that is connected to living in poverty, and noted that insurance coverage and availability of treatment beds limits access to mental health services. Substance abuse also emerged as a concern – specifically the use of alcohol, marijuana, tobacco, and opiates.
- ❖ ***Opportunities exist to improve access to care, particularly mental health, dental health, and interpreter services.*** While health care is available, long wait times for appointments - especially for dentists - were described as impeding access to care. Lack of health insurance coverage was noted as a barrier to receiving mental health and dental services. While interpreter services were considered to be strong, gaps were identified in the areas of dental and pharmacy services. Transportation was also identified by some as a barrier to care.

BACKGROUND

Overview of DotHouse Health

DotHouse Health is a federally qualified community health center serving the Fields Corner neighborhood of Dorchester within the city of Boston since 1972. We serve over 22,000 patients and provide the following programs and services: primary care across the life span; a walk-in urgent care clinic; nutrition; clinical and social services case management; women's health; behavioral health; dental and eye clinics; radiology; a 340(b) pharmacy and an onsite laboratory. The health center removes barriers to access by hosting essential services on-site; creates programs that address the social determinants of health; and our over 300 staff provide care in multiple languages. As such, we offer case management, translation, financial counseling for insurance enrollment, youth development at our Teen Center, family-centered recreation and wellness including a swimming pool and gymnasium, free tax preparation, a farmer's market and a food pantry. These programs work in concert with our clinical teams to insure residents have access to resources to help them improve their health. The health center is affiliated with Boston Medical Center.

Purpose and Scope of the Assessment

In February 2015, DotHouse Health contracted Health Resources in Action (HRiA), a non-profit public health organization in Boston, to conduct its community health needs assessment (CHNA). This report describes the process and findings from this effort. In addition to meeting the Health Resources and Services Administration (HRSA) health center program requirements (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act), the CHNA process was undertaken to achieve the following overarching goals:

- To provide a comprehensive portrait of the health status of DotHouse's service area, using a social determinants of health framework and incorporating diverse perspectives
- To describe both overall trends and unique issues by sub-populations, and to compare these trends and issues to municipal data
- To generate action-oriented data that informs strategic planning and program development
- To not only identify health-related needs, but to also describe the DotHouse service area's assets and strengths which may be leveraged and expanded

Definition of the Community Served by DotHouse Health

DotHouse Health undertook a community health needs assessment to ensure that it is addressing the most pressing health concerns among residents in Dorchester, which is in closest proximity to the health center, as well as its general patient population. Per the Boston Public Health Commission, the neighborhood of Dorchester is comprised of North (zip codes 02121 and 02125) and South Dorchester (zip codes 02122 and 02124). DotHouse is located in zip code 02122.

METHODS

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

quality). The beginning discussion of this section discusses the larger social determinants of health framework which helped guide this overarching process.

Study Approach and Community Engagement Process

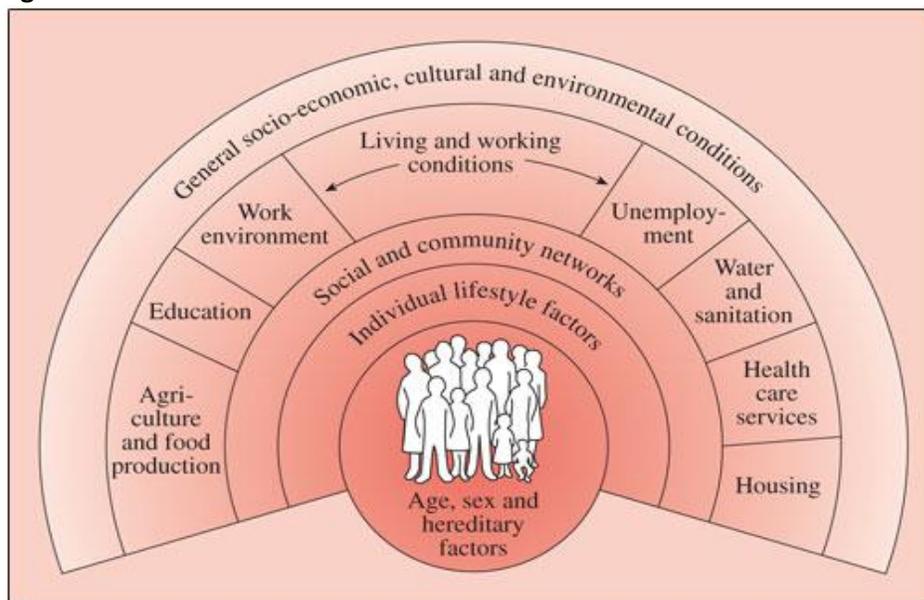
So that the process was informed by diverse perspectives, the community health needs assessment employed a participatory approach, when possible. This type of approach helps guide the research methods and questions so that they are salient to the community as well as aids in building support and buy-in at the community level for both the assessment study and subsequent planning processes. As part of this effort, DotHouse Health sought input from its Board of Directors at several stages of the assessment study. The Board participated in a formal meeting to brainstorm a list of potential stakeholders. A CHNA subcommittee of board members was engaged in bi-weekly conference calls and e-mails throughout assessment planning and implementation, finalized the list of potential stakeholders for interviews, provided suggestions on who to engage, and gave feedback on the stakeholder and focus group guides.

Social Determinants of Health Framework

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

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

Figure 3: Social Determinants of Health Framework



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

Quantitative Data

The following section describes the quantitative data sources included in this report.

Review of Secondary Data

In an effort to develop a social, economic, and health portrait of Dorchester and DotHouse's patient population, HRiA reviewed existing data drawn from national, state, and local sources. Health center specific data – such as patient demographics, services provided, and clinical indicators – were obtained from the Bureau of Primary Health Care Uniform Data System (UDS). Additional sources of data included the U.S. Census, Massachusetts Department of Public Health, Boston Redevelopment Authority, Boston Public Health Commission, and Boston Police Department, among others. Data analyses were generally conducted by the original data source (e.g., U.S. Census, Boston Public Health Commission). Types of data included self-report of health behaviors from large, population-based surveys such as the Boston Behavioral Risk Factor Surveillance System (BBRFSS), as well as vital statistics.

DotHouse Health Staff and Board Member Survey

In order to understand staff perceptions around key community health concerns as well as their primary priorities for services and programming, a brief survey was developed and administered online to DotHouse staff and board members. The survey included an automatic skip pattern where non-clinical staff were taken to one section of the survey to answer questions about their perceptions of community health needs and priorities, while clinical staff were taken to a different section to answer similar questions about their patients. DotHouse reviewed and provided feedback on the survey and also disseminated the survey link to their staff networks within health center. The survey was administered during the month of April 2015.

A total of 139 DotHouse staff and board members completed the survey (response rate of 44.1%). Among these, 56.1% of respondents represented clinical staff and 43.9% represented non-clinical staff. Table 1 presents the distribution of characteristics among all survey respondents.

Table 1: DotHouse Health CHNA Staff and Board Member Survey Respondent Characteristics by All Respondents

Survey Respondent Characteristics	Percent
Age (N=91)	
Under 18 years old	0.0%
18-24 years old	8.8%
25-34 years old	16.5%
35-44 years old	26.4%
45-54 years old	15.4%
55-64 years old	19.8%
65-74 years old	13.2%
75 years old or more	0.0%
Gender (N=91)	
Male	18.7%
Female	81.3%
Race/Ethnicity (N=87)	
White, non-Hispanic	50.6%
Black, non-Hispanic	17.2%
Hispanic, any race	10.3%
Asian, non-Hispanic	12.6%
Native Hawaiian or Other Pacific Islander, non-Hispanic	0.0%
American Indian or Alaskan Native, non-Hispanic	0.0%
2 or more races, non-Hispanic	1.1%
Other, non-Hispanic	8.0%
Educational Attainment (N=92)	
HS Diploma or Less	7.6%
Some College or Associate's Degree	23.9%
College graduate or more	68.5%
Job Description Among Employees (N=86)*	
Staff	89.3%
Management	16.7%
Tenure at DotHouse Among Employees (N=84)	
Less than 1 year	20.2%
At least 1 but less than 4 years	21.4%
At least 4 but less than 7 years	16.7%
At least 7 but less than 10 years	10.7%
10 years or more	31.0%
Primary Department Among Employees (N=84)	
Health Care Services	59.5%
Community Services	15.5%
Finance	7.1%
Executive	3.6%
Administration	14.3%
Tenure at DotHouse Among Board Members (N=10)	
Less than 1 year	40.0%
At least 1 but less than 4 years	20.0%
At least 4 but less than 7 years	20.0%
At least 7 but less than 10 years	10.0%
10 years or more	10.0%

DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff and Board Survey, 2015

*Check all the apply question therefore will not sum to 100%

DotHouse Health Patient Survey

In order to inform the assessment as well as meet patient centered medical home requirements, a survey was also conducted to obtain feedback from patients on their experiences with the practice and their care. A survey instrument was developed – adapting questions from the CAHPS PCMH Survey Tool – to assess access, communication, and coordination. Demographic questions were also included to determine representation of the patient population. The survey was translated into Spanish and Vietnamese by DotHouse.

During May-July 2015, DotHouse staff and volunteers (e.g., AmeriCorps students) administered the hard-copy survey to a convenience sample of patients in the DotHouse waiting room. Depending on patient literacy level, the survey was self-administered or interviewer-administered. Survey participation was voluntary and participants received a \$10 gift card to a local supermarket as an incentive.

A total of 129 DotHouse patients completed the survey. It is important to note that after data collection had begun, additional edits were made to the survey. Prior to revisions, 19 respondents had completed the survey, with an additional 110 respondents completing the survey after revisions were made. Throughout this report results corresponding to the original versus revised survey questions are indicated. Table 2 presents the distribution of characteristics among total patient survey respondents. This survey was conducted in English, Spanish, and Vietnamese. Notable differences by language of administration are discussed throughout.

Table 2: DotHouse Health CHNA Patient Survey Respondent Characteristics by All Respondents, N=129

Survey Respondent Characteristics	Percent
Age	
18-24 years old	8.7%
25-34 years old	13.4%
35-44 years old	18.9%
45-54 years old	21.3%
55-64 years old	15.0%
65-74 years old	12.6%
75 years old or more	10.2%
Sex/Gender*	
Male	22.2%
Female	77.8%
Transgender	0.0%
Genderqueer	0.0%
Other	0.0%
Sexual Orientation (revised survey only, n=110)	
Straight, heterosexual	81.2%
Lesbian, Gay, Homosexual	2.0%
Bisexual	3.0%
Don't know/other	1.0%
Decline	12.9%
Race/Ethnicity	
White, non-Hispanic	12.8%
Black or African American, non-Hispanic	20.0%
Hispanic or Latino, any race	24%
Asian, non-Hispanic	40%
Native Hawaiian or Other Pacific Islander, non-Hispanic	0%
American Indian or Alaskan Native, non-Hispanic	0%

Survey Respondent Characteristics	Percent
2 or more races, non-Hispanic	0.8%
Other, non-Hispanic	2.4%
Education	
Less than high school (revised survey only, n=110)*	3.5%
Some High School	35.1%
High school graduate/GED	36.0%
Some college/2 year degree	18.4%
4 year college graduate	5.3%
More than 4 year college degree	1.8%
Patient Tenure	
Less than 6 months	8.7%
6 months to less than 1 year	3.2%
1 year to less than 3 years	15.1%
3 years to less than 5 years	15.1%
5 years or more	57.9%
Visits to DotHouse Health by you/family for care over last 12 months	
1	5.6%
2	7.1%
3	7.9%
4	11.1%
5 to 9	31.0%
10 +	37.3%
Insurance Coverage**	
Yes, private health insurance	10.9%
Yes, Medicare	18.6%
Yes, other govt. plan	64.3%
No health insurance	1.6%
Other	7.0%
Survey Administration Language	
English	52.7%
Spanish	11.6%
Vietnamese	35.7%

DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

*Note: the original survey (19 respondents) only included “Male” and “Female” response options. Additional response options were added to the revised survey (110 respondents).

** This is a 'check all that apply' question thus responses exceed n=129 but proportions are calculated as a percentage of total respondents (n=129)

Qualitative Data

From May – August 2015, focus groups and interviews were conducted with community stakeholders and residents to gauge their perceptions of the community, their health concerns, and what programming, services, or initiatives are most needed to address these concerns. Priority sectors and representative participants were identified based on a brainstorming session with DotHouse board members. Over 60 individuals were engaged in qualitative research to discuss the health issues they deemed critical in their community.

A total of five focus groups and nine key informant interviews were conducted with individuals from across Dorchester. Focus groups were conducted with representatives of selected sectors or priority populations, including: Seniors, youth, men of color, and Spanish- and Vietnamese-speaking community members. A total of 54 individuals participated in the focus groups. Interviews were conducted by

phone with nine individuals representing a range of sectors, including community development, business, and health care, among others.

Discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all discussions to ensure consistency in the topics covered. Each focus group and interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, focus groups lasted 90 minutes and included 8-14 participants, while interviews lasted approximately 30-45 minutes. As an incentive, focus group participants received \$30 in cash.

Analyses

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

Limitations

As with all research efforts, there are several limitations related to this study's research methods that should be acknowledged. It should be noted that for the secondary data analyses, in several instances, current neighborhood level data were not available. In regard to the Boston Behavioral Risk Factor Survey (BBRFS), neighborhood-level data generally do not include homeless people or people whose neighborhood of residence was not reported in the survey (except in the Boston overall numbers).

Data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. However, it is important to note that the DotHouse CHNA Staff and Board Member Survey and Patient Survey, also self-reported data, may be prone to selection bias – that is, individuals who had more positive experiences may have been more likely than other individuals to complete the survey, so that survey respondents are not representative of the larger staff or patient population. Therefore, the survey findings represent a sub-set of health center staff and patients and may be limited in their generalizability.

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

FINDINGS

COMMUNITY SOCIAL AND ECONOMIC CONTEXT

The health of a community is associated with numerous factors including what resources and services are available (e.g., safe green space, access to healthy foods) as well as who lives in the community. The section below provides an overview of the population of Dorchester, including the DotHouse patient population.

Demographic Diversity

“[Dorchester is the] largest neighborhood in Boston – like a yard having microclimates.” – Key informant interviewee

“Some parts are dirty, some are clean. Some parts are good, some are bad.” – Youth focus group participant

Interview and focus group participants frequently noted that the neighborhood of Dorchester is quite large and has many distinct localities with unique assets and challenges.

Population

The most recent decennial census conducted in 2010 shows that overall the City of Boston has experienced a growth of almost 5% since 2000 (Table 3). While North Dorchester’s population has seen similar, though modest growth (1.0%), South Dorchester’s population has decreased by over 5.0%. As illustrated in Figure 4 the census blocks that comprise North and South Dorchester are comparably dense and tend to fall in the mid-range compared with other Boston neighborhoods.

According to Uniform Data Reporting System (UDS) data, DotHouse’s patient population has been steadily increasing from 20,758 in 2011 to 23,834 patients in 2014.ⁱ

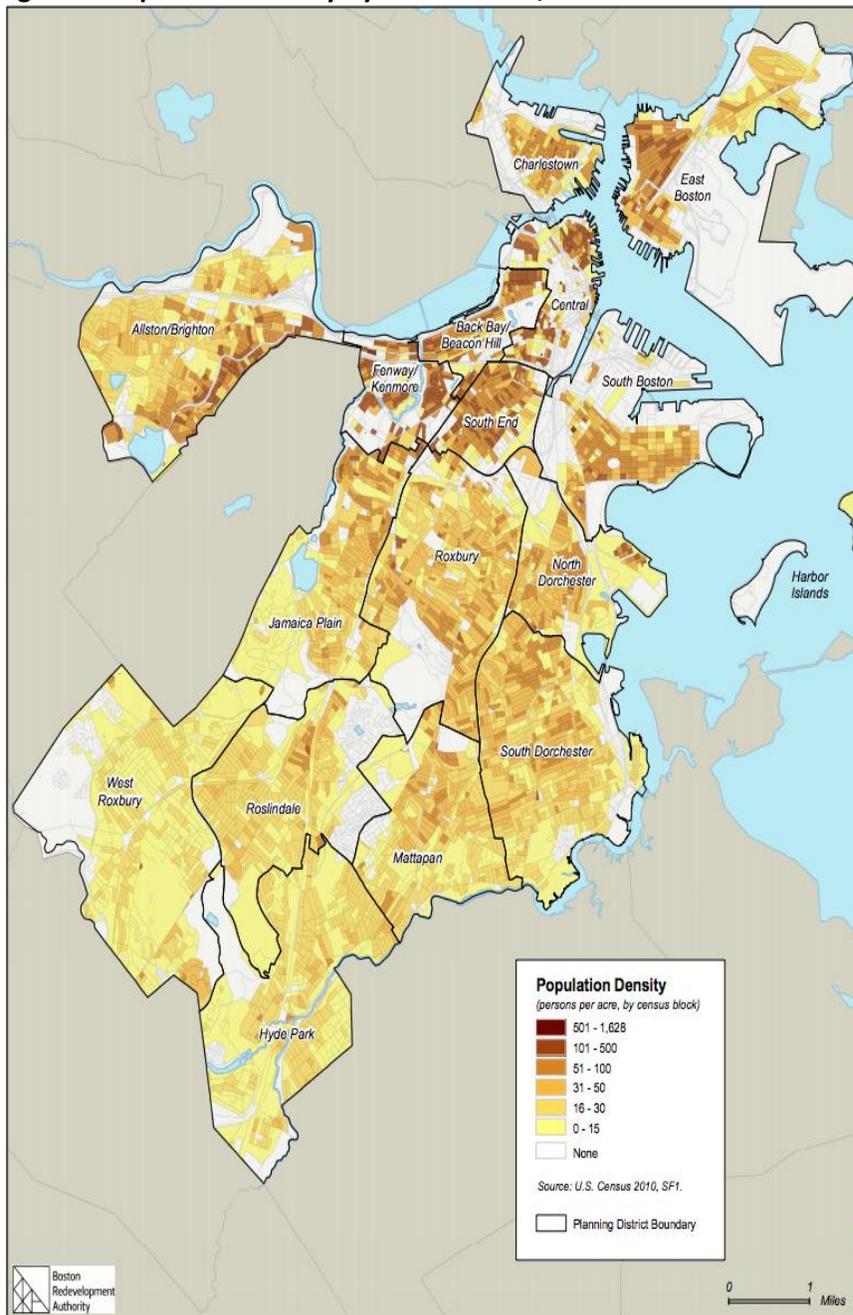
Table 3: Total Population by City and Neighborhood, 2010

Geography	2000 Population	2010 Population	% Change
Boston	589,141	617,591	4.8%
North Dorchester	58,675	59,273	1.0%
South Dorchester	75,329	71,262	-5.4%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2000 and 2010 Census as reported by Health of Boston 2012-2013

ⁱ DotHouse Health, UDS Summary Report, 2015

Figure 4. Population Density by Census Block, 2010

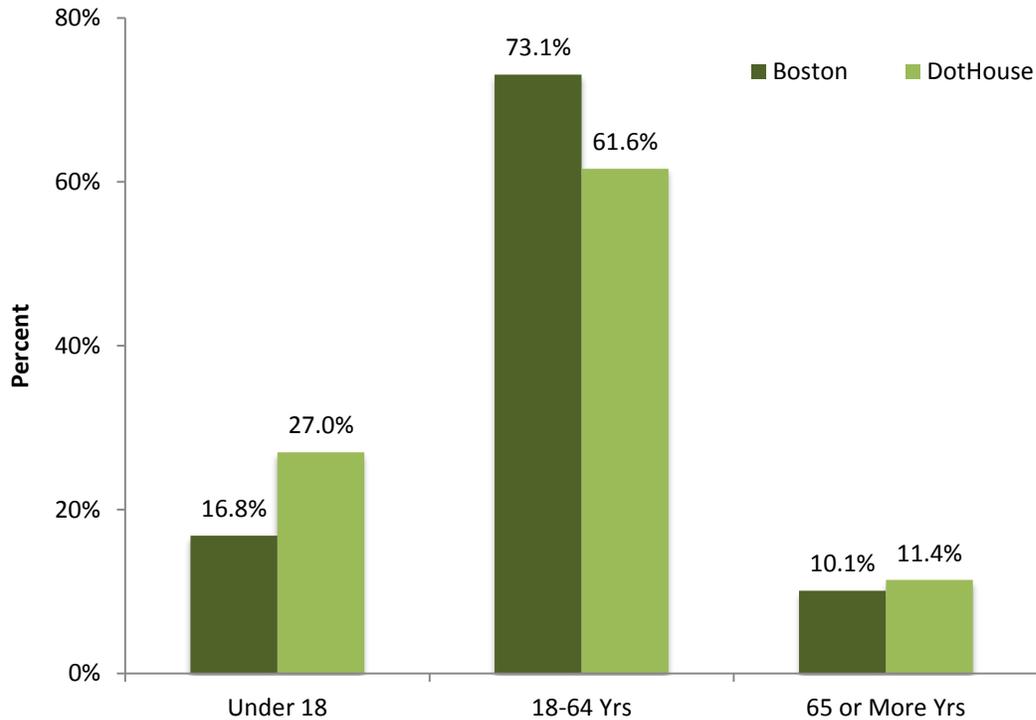


DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Boston Redevelopment Authority

Age Distribution

Nearly three-fourths of Boston's population was between the ages of 18 and 64 years (73.1%) in 2010 (Figure 5). Boston youth comprise the next most populous group (16.8%) followed by seniors (10.1%). This distribution was largely mirrored among the 2013 DotHouse patient population; however, there was a substantially larger proportion of youth represented among the patients (27.9%) than among overall Boston residents.

Figure 5: Age Distribution by City and DotHouse Health Patients, 2010* and 2014**



*DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

**DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

NOTE: Boston data is from 2010 while DotHouse patient data is from 2014

NOTE: Data not available by neighborhood

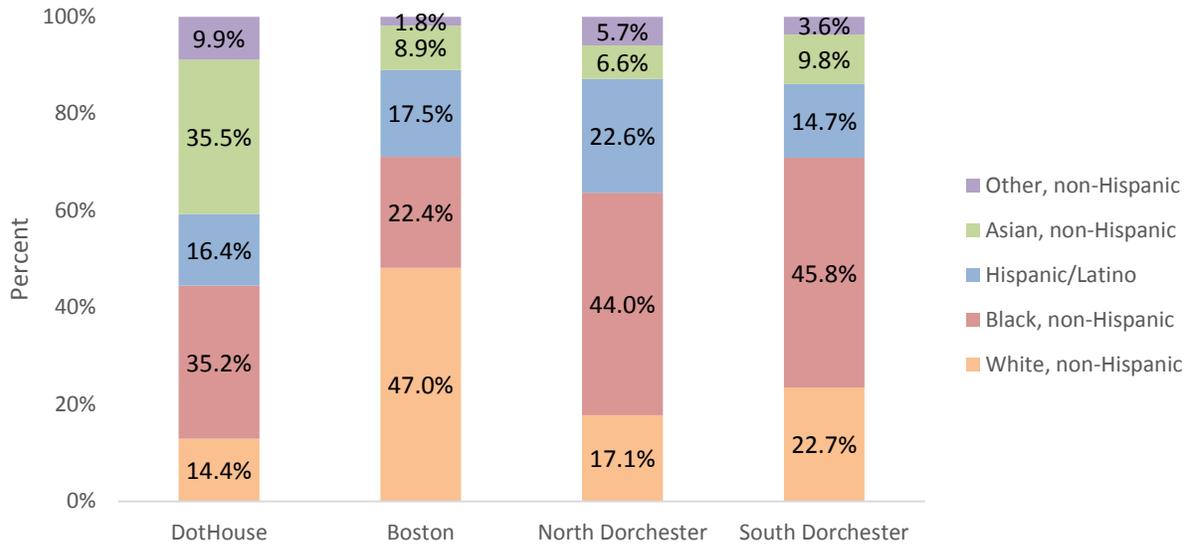
Racial and Ethnic Composition

“It’s diverse in its own way. There’s a significant Vietnamese population and Cape Verdean population, which seems to be growing; Caucasian and Latino on a smaller scale and African American. We’re pretty diverse. For years the most significant population is Vietnamese but it’s becoming more diverse.” – Key informant interviewee

A majority of key informant interviewees and focus group participants described Dorchester’s racial and ethnic diversity, and cited this diversity as a strength of the neighborhood.

Figure 6 details the 2010 racial and ethnic composition of Boston overall and the neighborhoods of North and South Dorchester specifically, as well as DotHouse’s patient population. While the data show that Boston is a predominantly White, non-Hispanic city (47%), there is substantial variation in the racial and ethnic diversity when stratified by neighborhood. For example, the White, non-Hispanic population in North and South Dorchester is 17.1% and 22.7%, respectively. Conversely, Black, non-Hispanic residents comprise the majority of these neighborhoods, followed by those who identify as Hispanic/Latino of any race. Notably, the Asian population makes up over one-third of the DotHouse patient population (35.5%), though it represents less than 10% of either of the neighborhoods that comprise the DotHouse catchment area.

Figure 6: Racial/Ethnic Composition by City, Neighborhood, and DotHouse Patients, 2010* and 2014**



*DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

**DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

NOTE: Boston data is from 2010 while DotHouse patient data is from 2014

NOTE: 'Other Race' consists of American Indians/Alaskan Natives and Some Other Races

Language Composition

A linguistically isolated household is defined by the census bureau as one in which members aged 14 year or older have at least some difficulty speaking English.ⁱⁱ As detailed in Table 4, South Dorchester’s linguistically isolated households are proportionate to that of Boston overall. North Dorchester, by contrast, has a slightly higher proportion of linguistically isolated households (15.9%). According to 2014 UDS data, 41.5% of DotHouse Health patients are served in a language other than English.

Table 4: Linguistically Isolated Households by City and Neighborhoods, 2008-2012

Geography	Percent
Boston	11.8%
North Dorchester	15.9%
South Dorchester	11.4%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2008-2012 as reported by Health of Boston 2014-2015

ⁱⁱ The Census defined ‘linguistically isolated households’ as those in which no members aged 14 years or older (1) speaks only English or (2) speaks a non-English language and speaks English “very well.”

Income, Poverty, and Employment

“Financial support ties in with housing – because of high rent they only have enough for that and not for utilities, food.” – Key informant interviewee

“WIC is for women and children. What about men who have custody?” – Focus group participant

“Child care is always a big issue for people trying to get jobs, it’s extremely expensive. There are vouchers if you’re very low income. But if you cross that mark you can’t get any help and it’s still too expensive.” – Key informant interviewee

Residents and stakeholders described challenges and trade-offs in paying for housing, food, child care, medical care, and other basic necessities. Participants in the men’s focus group noted that some social services, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), are primarily targeted to women. Many residents and stakeholders discussed employment specifically. Participants described a lack of employment opportunities in the neighborhood, including “different avenues for career opportunities.” Stakeholders noted that many immigrants live in the community, and that it can be particularly difficult for them to find work due to language barriers and/or immigration status. Stakeholders also noted that the high cost of child care, especially for those who earn just enough to disqualify them for child care subsidies, is a key barrier to employment. Finally, stakeholders noted that the work that is available is often inconsistent or requires employees to frequently change their schedules, making it difficult to schedule non-work appointments such as doctor’s visits.

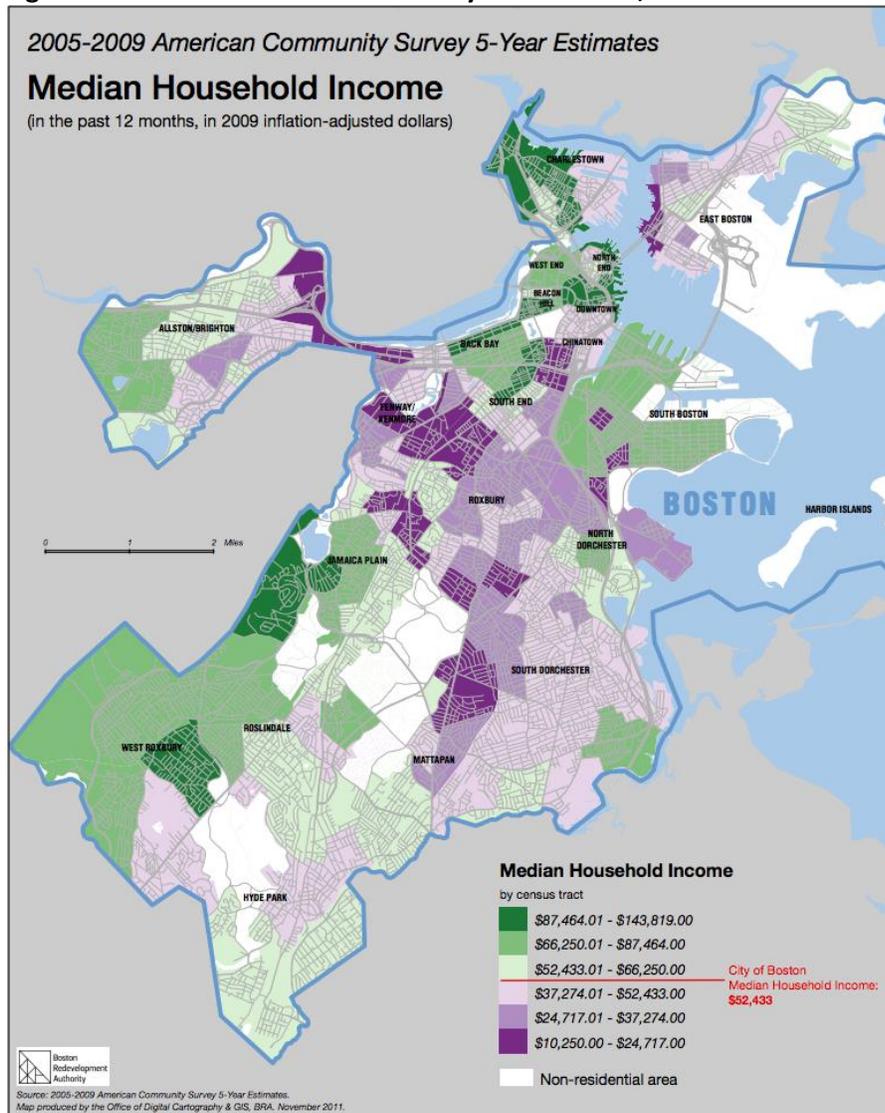
Aggregate data from 2008 to 2012 indicate that the median household income in Boston was \$53,136; however, substantial variation is observed when stratified by neighborhood. As illustrated in Table 5, the zip codes that comprise South Dorchester have median household incomes that are more comparable, though slightly lower than that of Boston overall. By contrast, North Dorchester’s median household incomes by zip code are approximately \$23,000 lower than the citywide value. Figure 7 provides a visual illustration of the 2005-2008 median household income by census tract, thus showing more granular variation than available at the zip code level.

Table 5: Median Household Income by City, Neighborhood, and Zip Code, 2008-2012

Geography	Income
Boston	\$53,136.00
North Dorchester	
02121	\$30,419.00
02215	\$30,823.00
South Dorchester	
02122	\$51,798.00
02124	\$48,329.00

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2008-2012 as reported by Health of Boston 2014-2015

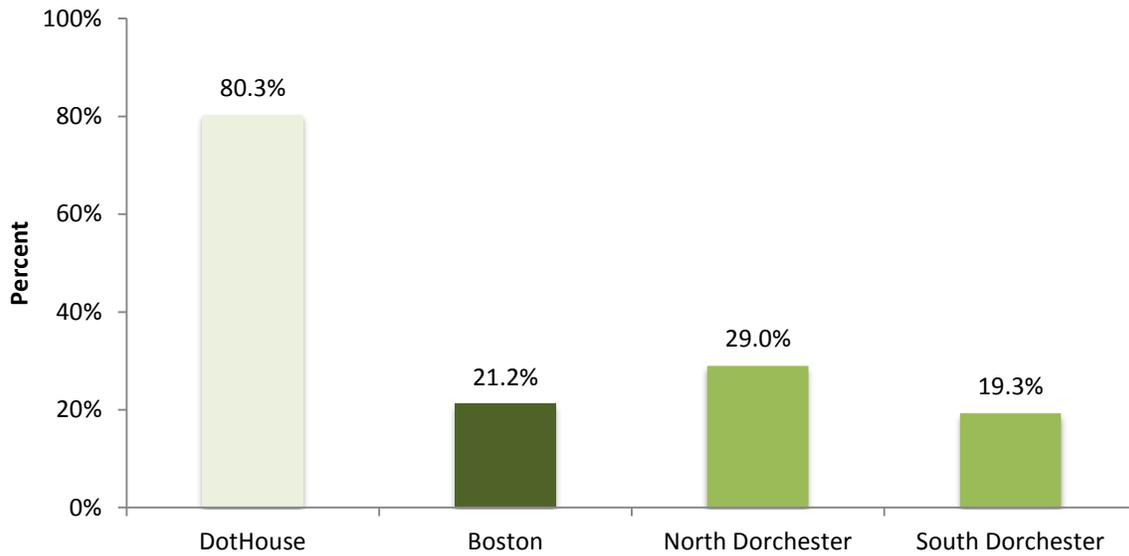
Figure 7: Median Household Income by Census Tract, 2005-2009



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Boston Redevelopment Authority

Just over 21% of Boston families are below poverty level, with this percentage varying by neighborhood (Figure 8). While the percentage of South Dorchester residents living below poverty level (19.3%) is comparable to that of the city overall (21.2%), 29% of North Dorchester residents are living below poverty. DotHouse, by contrast, serves a population in which 80.3% of patients are below poverty level.

Figure 8: Percent of Families below Poverty by DotHouse, City, and Neighborhood, 2008-2012* and 2014**



*DATA SOURCE: American Community Survey, 2008-2012, U.S. Census Bureau as reported by Health of Boston 2014-2015

**DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

NOTE: Boston data is from 2008-2012 while DotHouse Health patient data is from 2014

Unemployment data aggregated over the years of 2008 through 2012 demonstrate that while 10.3% of the employment-eligible Boston residents are unemployed, this value rises to over 15% in South Dorchester, and nearly 18% in North Dorchester (Figure 9).

Figure 9: Unemployment Rate by City and Neighborhoods, 2008-2012

Geography	Percent
Boston	10.3%
North Dorchester	17.7%
South Dorchester	15.8%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2008-2012 as reported by Health of Boston 2014-2015

NOTE: Unemployment rate ranges by Boston neighborhood from 4.4% in Back Bay to 18.2% in Mattapan

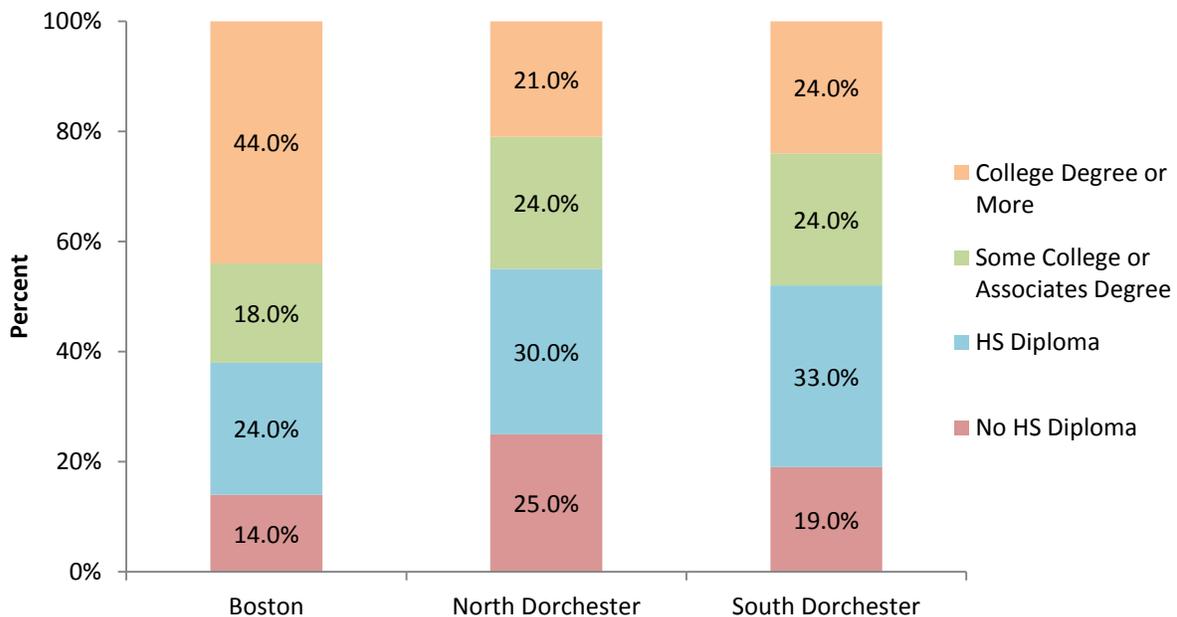
Education

“We have different levels of education and professions. We have doctors and nurses to secretaries – all different types of work populations.” – Key informant interviewee

Interview and focus group participants described Dorchester’s residents as having various levels of education and working in a wide range of professions. Residents and stakeholders also praised local schools, and service providers described successful collaborations with public schools in the area.

Quantitative data show high educational attainment among Boston’s adult residents aged 25 years and older, with 44% having earned a college degree or more (Figure 10). When stratified by neighborhood however, the data show that in both North and South Dorchester, residents with a college degree or more comprise less than 25% of the population. Further, one in four adult residents in North Dorchester had no high school diploma.

Figure 10: Educational Attainment of Adults 25 Years and Older by City and Neighborhood, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census

Housing and Transportation

“Housing is a big issue – at least what I see with the kids. A lot are homeless [and] live with someone else because their parents don’t have a place to live, because they lost their job.” – Key informant interviewee

“I live with my daughter. She bought a house. Otherwise I’d have to try and find a low income senior place to live. I thank God every day I get up.” – Focus group participant

“The threat of gentrification is growing because of [Dorchester’s] proximity to downtown and interest of developers – it’s inevitable.” – Key informant interviewee

A majority of interview and focus group participants expressed concerns about the lack of affordable housing in Dorchester, especially for seniors and families. Residents described issues of homelessness, which they stated includes not only individuals sleeping on the street or in shelters, but also families living with other relatives or friends in crowded situations. Participants noted that they see new developments and buildings being built in Dorchester, but that this just leads to rent increases. Stakeholders and residents also described feeling worried about gentrification and displacement of long-time residents. While they welcomed the addition of new restaurants and shops to Dorchester, they feared that current residents would soon be unable to afford to live in the neighborhood.

In 2010, a majority (66.0%) of housing units in Boston were renter-occupied (Figure 11). This distribution was similar across North and South Dorchester, although South Dorchester had a greater proportion of homeowners (42.0%) compared to Boston and North Dorchester (34.0% and 31.0%, respectively).

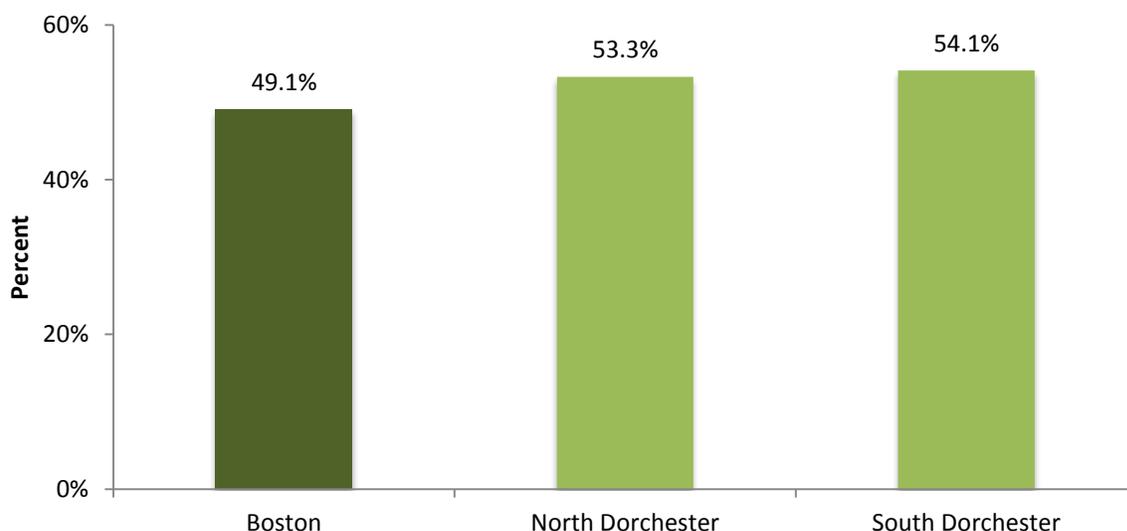
Figure 11: Housing Tenure by City and Neighborhood, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as reported by Health of Boston 2012-2013

Figure 12 illustrates the proportion of Boston renters whose housing costs comprise 30% or more of their household income aggregated from 2008 to 2012. Hovering around half of city residents overall, this percentage increases to 53.3% and 54.1% among North and South Dorchester residents, respectively. Further, among DotHouse patients, 0.2% were experiencing homelessness in 2014.

Figure 12: Percent of Renter-Occupied Housing Units Paying at Least 30% of Household Income Towards Rent, 2008-2012



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, American Community Survey, 2008-2012 as reported by Health of Boston 2014-2015

NOTE: Ranges from 30.5% in Back Bay to 57.3% in Fenway

Table 6 tracks the change overtime, from 2008 to 2013, in the number of foreclosure petitions across Boston and within the neighborhoods of North and South Dorchester. Since the height of the financial crisis in 2008, there has been a substantial decrease in the number of foreclosures observed. Among the geography considered, this decrease has been highest in North Dorchester (91.0%) compared with South Dorchester and the city overall (both 88.0%).

Table 6: Number of Foreclosure Petitions by City and Neighborhoods, 2008-2013

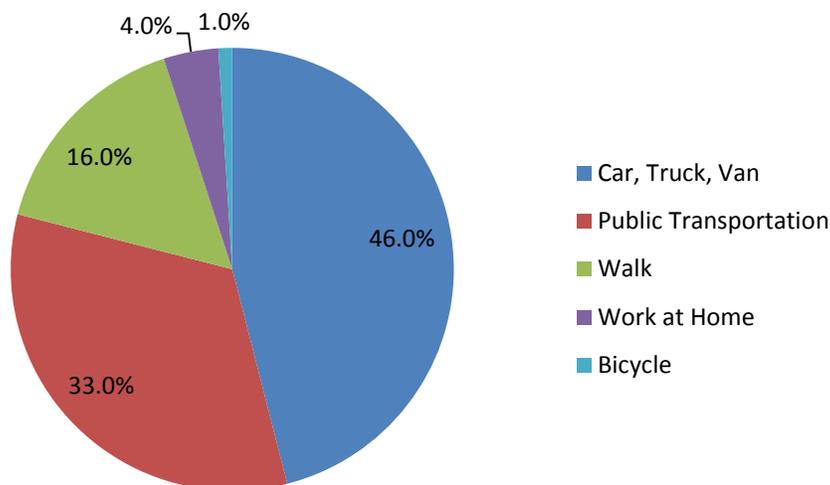
Geography	2008	2009	2010	2011	2012	2013	% decrease from 2008-2013
Boston	1,899	2,172	1,541	732	890	232	88.0%
North Dorchester	276	324	212	92	108	24	91.0%
South Dorchester	462	531	324	141	177	55	88.0%

DATA SOURCE: Department of Neighborhood Development, as reported by Health of Boston 2014-2015

Participants also discussed public transportation. Many residents and stakeholders stated that Dorchester has access to adequate public transportation, but did note that certain parts of the neighborhood were further from the MBTA system’s buses or trolleys. Seniors in particular noted that transportation services are available for the elderly population. However, some participants noted that transportation could be improved and described the buses as being particularly unreliable and infrequent. As one key informant stated, *“In this community, there’s one bus that goes up and down the main street – Dorchester Ave. It’s a long distance from Ashmont to South Station. That’s the only bus running in this street... it’s horrendous, it runs once an hour.”*

Quantitative data from the Health of Boston report indicate that the primary mode of transportation for Boston residents was a car, truck, or van (46%), followed by public transportation (33%), and walking (16%) (Figure 13).

Figure 13: Workers' Means of Transportation to Workplace in Boston, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 American Community Survey, as reported by Health of Boston 2012-2013

Violence and Neighborhood Safety

"I wouldn't raise a family here. Why would I be in a neighborhood where I can't feel safe all the time?" – Youth focus group participant

"When I moved here this block was terrible...Now, this neighborhood is calmer. It's not like it used to be." – Focus group participant

Issues related to violence and neighborhood safety were raised by almost all interview and focus group participants, and were especially prominent themes in the youth focus group discussion. While many residents described the neighborhood, particularly Field's Corner, as becoming safer in recent years, others noted that violence is still a concern in certain areas of Dorchester. As one focus group participant stated, the neighborhood is *"dangerous and improving."* Even as some areas become safer, stakeholders noted that the image of Dorchester as an unsafe area persists. As one interviewee noted, *"Data can change, reality can change, but people's perceptions can linger."*

Some participants described neighborhood violence, which can lead to injury and death, as specifically a health issue. For example, one youth focus group participant noted: *"Drugs and gangs [are a health problem]. You can die from having beef with other gangs."*

Table 7 illustrates violent and property crime rates in Boston overall and police district C-11 (Dorchester) as reported by the Boston Police Department crime statistics. Between January and December 2014, the City of Boston experienced 755.2 violent crimes and 2,788.3 property crimes per 100,000 population. By

contrast, district C-11 reported violent and property crime rates substantially below that of Boston, 363.1 and 1,326.8 per 100,000 population, respectively.

Table 7: Rate of Offenses Known to Law Enforcement per 100,000 Population by City and Neighborhood, January 1-December 31, 2014

Districts	Violent Crime Rate*	Property Crime Rate**
Boston	755.2	2,788.3
Dorchester (C-11)	363.1	1,326.8

DATA SOURCE: Part One crime Reported by the Boston Police Department by Offense and by District/Area, The Boston Police Department, Office Research and Development, Office of Police Commissioner, 2014

NOTE: Rates standardized to U.S. Department of Commerce, Bureau of the Census, 2010 Census Population data

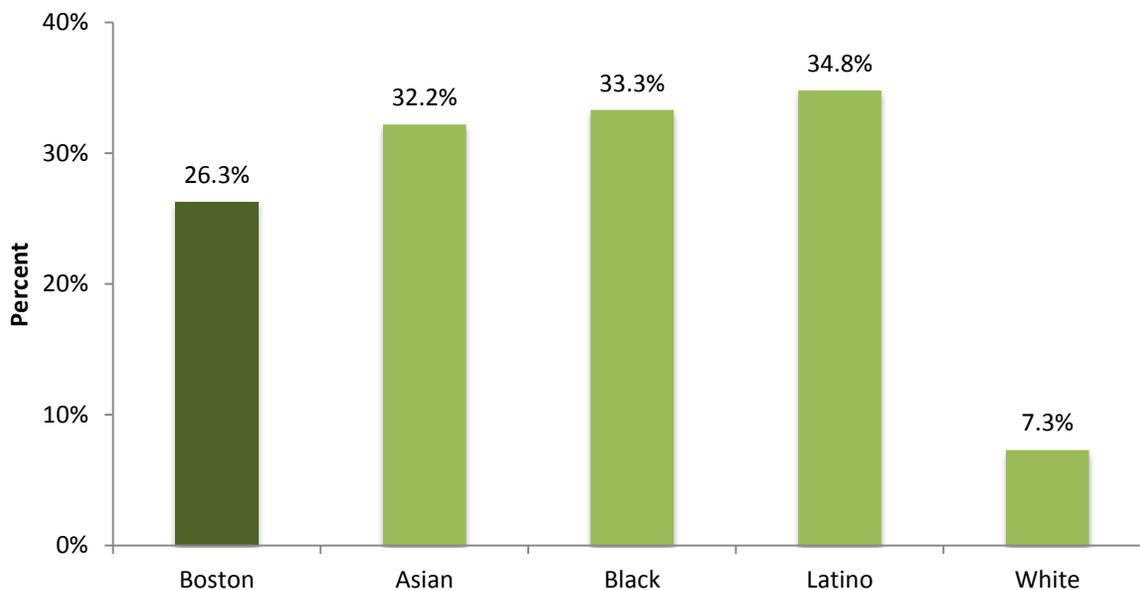
* Violent crime includes: murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault

**Property crime includes: burglary; larceny-theft; motor vehicle theft; and arson

NOTE: Dorchester population = sum of 2010 Census Population for North and South Dorchester

Figure 14 illustrates that across the city of Boston, 1 in every 4 parents or caregivers perceived their child to be unsafe in their Boston neighborhood. When stratified by race/ethnicity, Latino parents and caregivers were the most likely to report that they felt their child was either sometimes or never safe in the community or neighborhood (34.8%), followed by Black and Asian parents and caregivers (33.3% and 32.2%, respectively). The proportion of White parents and caregivers reporting the same was at least four times smaller than the next smallest racial/ethnic identity group.

Figure 14: Proportion of Parents/Caregivers Who Felt Child (Aged 0 to 17 years) was Unsafe* in Neighborhood by Boston and Race/Ethnicity, 2012

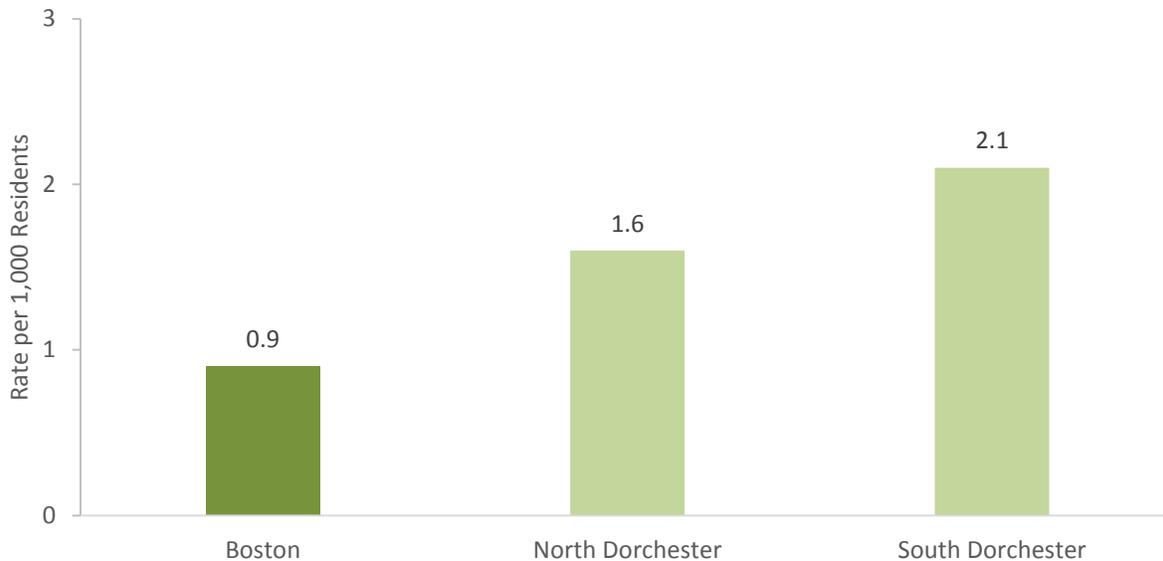


DATA SOURCE: Boston Survey of Children’s Health 2012, Public Health Commission, as reported by Health of Boston 2014-2015

* Parents/caregivers reported that they felt that child is either sometimes or never safe in community or neighborhood

Data from the 2012 – 2013 Health of Boston report shows that the average annual homicide rate from 2005 – 2011 in North and South Dorchester was 17.9 and 19.4 homicides per 100,000 residents, respectively – more than double the city-wide rate of 7.9 homicides per 100,000 residentsⁱⁱⁱ. Similarly, Figure 15 shows that rates of emergency department visits for nonfatal stabbing or gunshot wounds are higher in North and South Dorchester (1.6 and 2.1 visits per 1,000 residents, respectively) compared to Boston (0.9 visits per 1,000 residents); residents in South Dorchester experienced ED visits due to nonfatal gunshot and stab wounds at more than twice the rate of residents citywide.

Figure 15: Rate of Nonfatal Gunshot/Stabbing Emergency Department Visits per 1,000 Residents by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

ⁱⁱⁱ Boston Resident Deaths, Massachusetts Department of Public Health as reported by Health of Boston 2012-2013

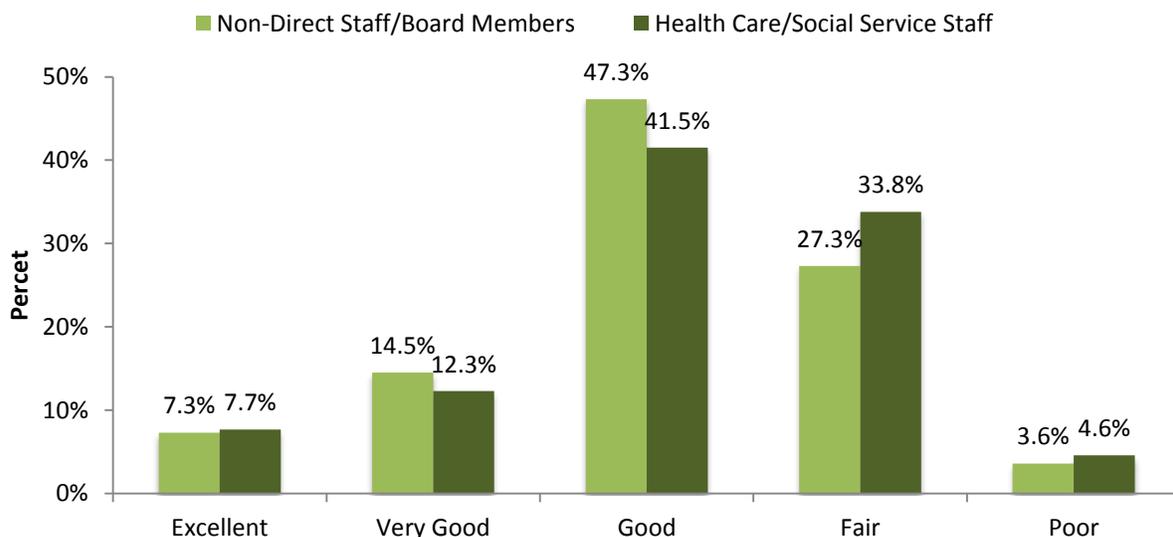
COMMUNITY HEALTH ISSUES

This section focuses on the health issues and concerns that emerged as the most prominent in DotHouse’s community health needs assessment process. Specifically, areas that rose to the top as far as severity and magnitude from the quantitative data, as well as issues of greatest concern and opportunity among interview, focus group, and survey participants included: chronic diseases – such as diabetes and asthma – and related behaviors, namely obesity, physical activity, and nutrition; mental and behavioral health; sexual health; and access to care.

Perceived Community Health Status

In the DotHouse CHNA survey, staff and board members were asked to describe, on a scale from poor to excellent, the health of the community they serve. Nearly half of non-direct and health care/social service staff described the community’s health as good (47.3% and 41.5%, respectively) (Figure 16). A slightly greater proportion of health care and social service staff considered the community’s healthy to be fair/poor than did non-direct staff.

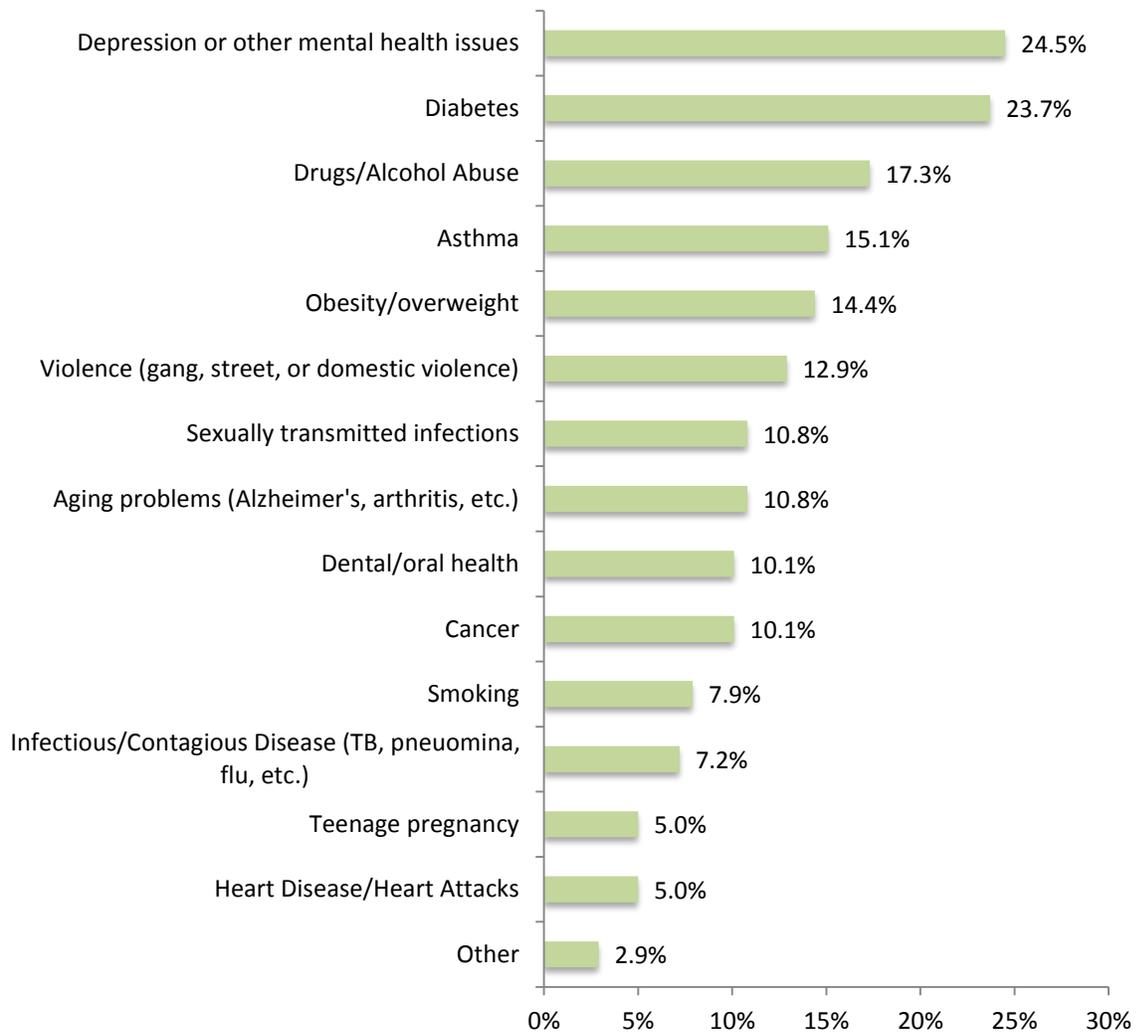
Figure 16: Perceived Health Status of Community Served by Non-Direct Staff/Board Members and Health Care/Social Service Staff, 2015



DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff and Board Survey, 2015

All survey respondents were asked to identify the primary issues that have the largest impact on the community they serve. Direct service provider (health care and social service staff) respondents were also asked about the top issues that affect their patients/clients. Among non-direct staff and board members, mental health, diabetes, and drug/alcohol abuse were viewed as the top health issues of concern (Figure 17). Among health care and social service staff, obesity, diabetes, and mental health were viewed as key concerns for the community overall as well as for their patients specifically (Figure 18). It should be noted that for both direct and non-direct staff, two out of the five top health issues identified as key community concerns were behavioral health issues (“depression and other mental health issues” and “drugs / alcohol abuse”).

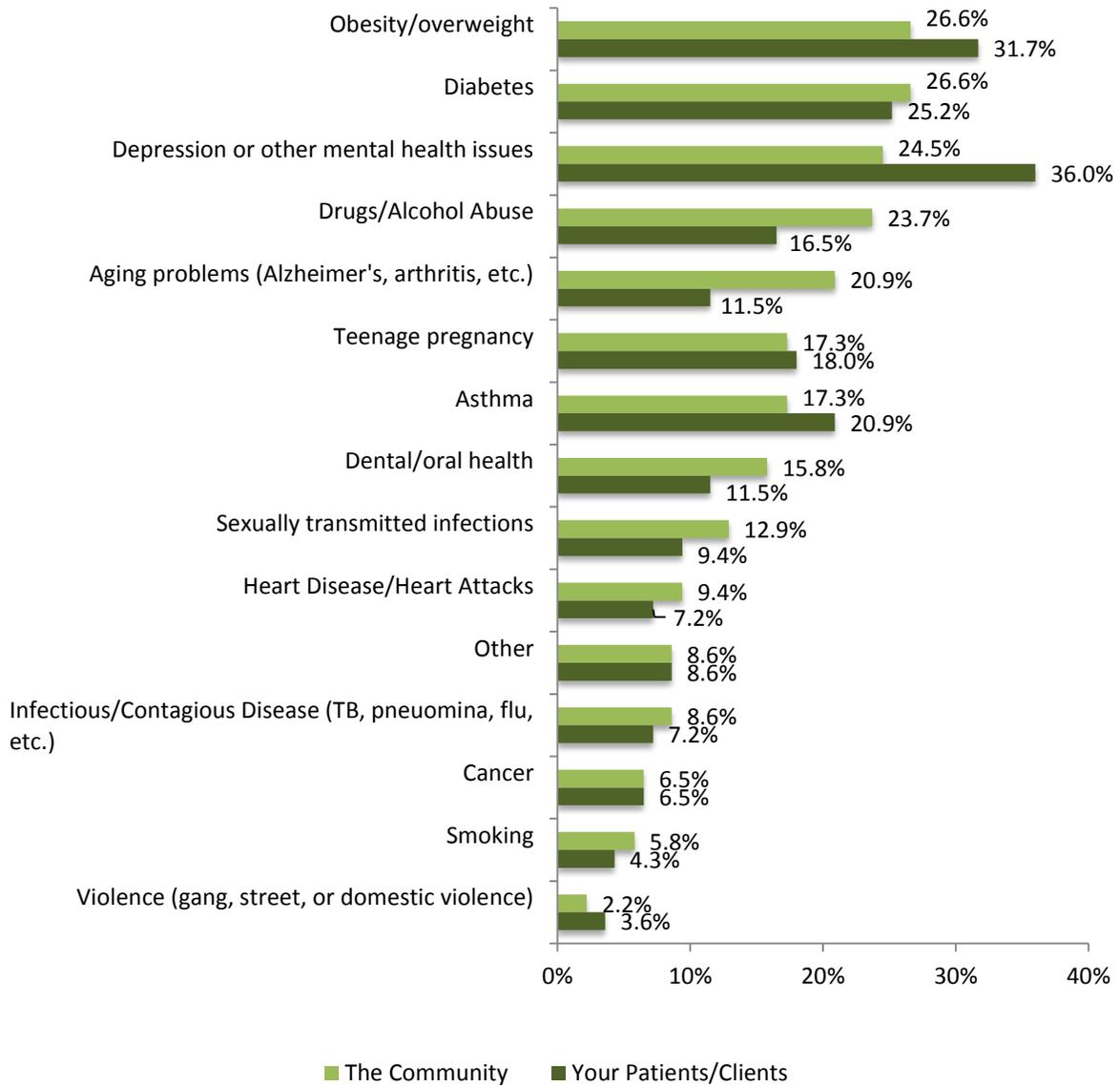
Figure 17: Top Health Issues with the Largest Impact on the DotHouse Community identified by Non-Direct staff/Board Members, 2015



DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

Note: Arranged in descending order

Figure 18: Top Health Issues with the Largest Impact on the DotHouse Community and Patients/Clients identified by Health Care and Social Service Staff, 2015



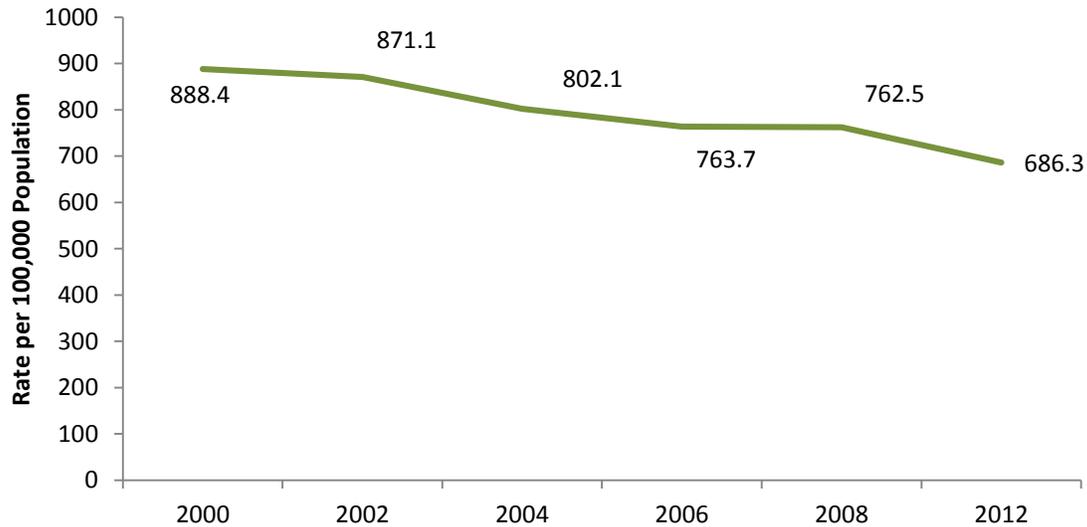
DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

Note: Arranged in descending order by "the Community"

Mortality and Morbidity

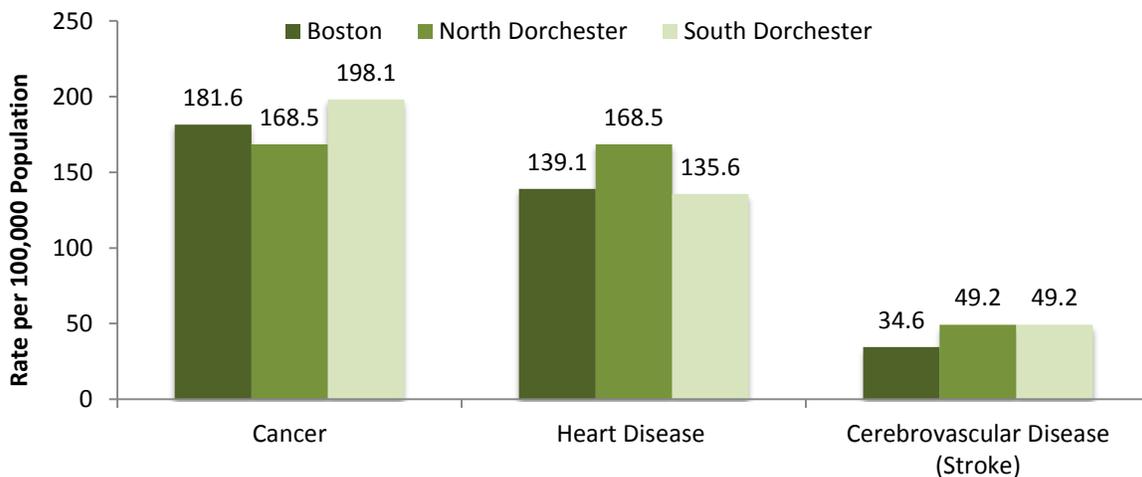
The overall mortality rate in the city of Boston has been steadily declining since 2000 (888.4 per 100,000 population) to 686.3 per 100,000 population in 2012 (Figure 19). Figure 20 specifies the leading causes driving mortality among Boston residents. These data indicate that cancer is the leading cause of death among city residents overall, followed by heart and cerebrovascular disease (including stroke). A similar pattern is seen in the neighborhoods of North and South Dorchester; however, in North Dorchester the mortality rates due to cancer and heart disease are identical (168.5 deaths per 100,000 population).

Figure 19: Rate of All-Cause Mortality per 100,000 Population in Boston, 2000-2012



DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health, as cited in Health of Boston, 2010 and 2014-2015

Figure 20: Rate of the Leading Causes of Death per 100,000 Population by City and Neighborhood, 2010

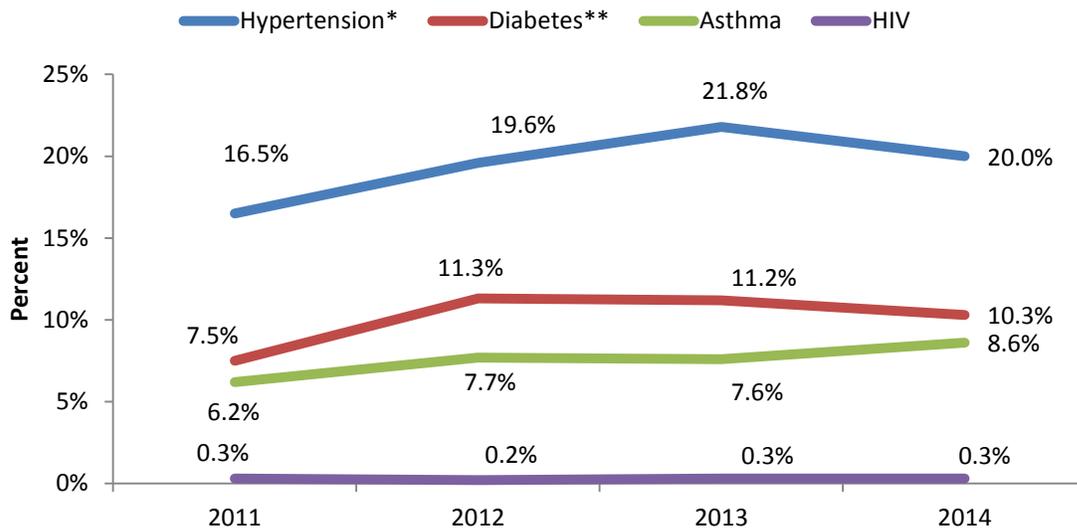


DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health

DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office as reported by Health of Boston 2012-2013

Figure 21 provides data on the percent of DotHouse patients with specific diagnoses as reported to the UDS in calendar years 2011 through 2014. Adult patients, aged 18 and older, have experienced a steady increase in hypertension diagnoses that continued until 2014 where the proportion dipped down to 20.0%. Diabetes diagnoses increased from 7.5% in 2011 to 11.3% in 2012 among adult patients before again decreasing in 2014. Asthma diagnoses have been steadily increasing since 2011 to a current 8.6% of DotHouse patients, while HIV diagnoses have remained stable over this time span, hovering 0.3%.

Figure 21: Percent of DotHouse Health Patients with Specific Medical Conditions, 2011-2014



DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

*Hypertensive adults as a percent of estimated adult medical patients of ages 18

**Diabetic adults as a percent of estimated adult medical patients of ages 18

Chronic Diseases and Related Risk Factors

Residents and stakeholders described issues related to overweight/obesity, diabetes, heart disease, and asthma as affecting their community. Cancer was also mentioned by a few participants who were themselves cancer survivors.

The Boston Behavioral Risk Factor Survey (BBRFS), a highly cited and well-respected telephone survey of Boston residents, asks respondents to self-report on a variety of health topics such as experiences with chronic diseases and certain health behaviors. Relevant BBRFS data is included in the sections below.

Healthy Eating, Physical Activity, and Obesity

“Kids need to be outdoors – but parents won’t feel safe letting them play outside for an hour a day.” – Key informant interviewee

“The organizations come to the neighborhood and you can’t afford to use them. They tell you to eat healthy, exercise, but you can go into Whole Foods and can only buy half a bag. The YMCA costs an arm and a leg.” – Focus group participant

“There is a loss of cultural cooking understanding...The Americanized version of Dominican cooking is much less healthy than the traditional Dominican cooking. Patients don’t want to lose their cultural cooking practices, but they are cooking less healthy, Americanized versions of traditional meals.” – Key informant interviewee

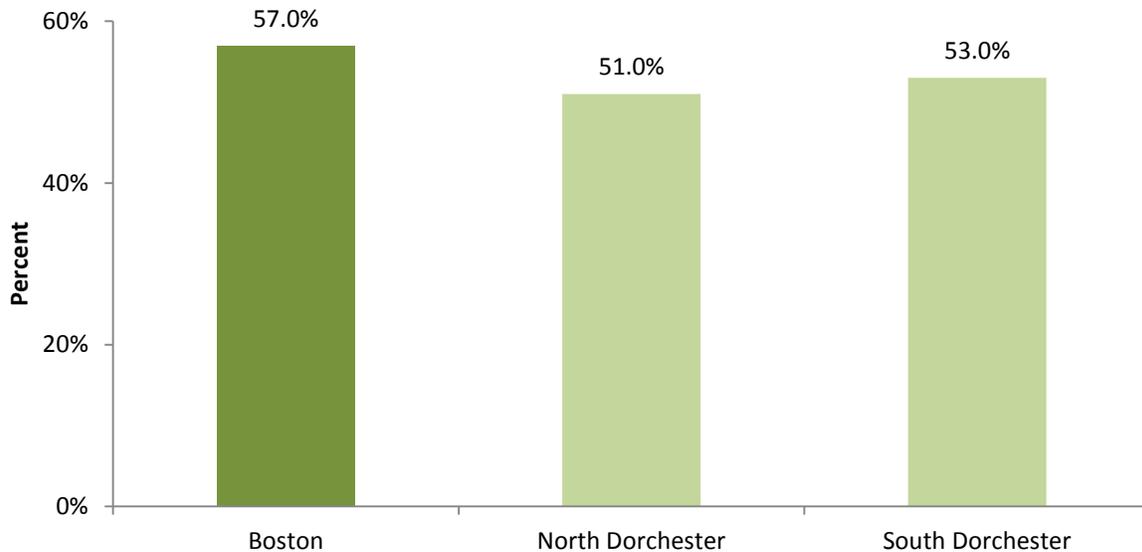
Residents and stakeholders discussed the connection between physical activity, healthy eating and overweight/obesity. Challenges related to healthy eating and physical activity were discussed frequently; interview and focus group participants did also note that overweight and obesity are issues in their community, as they are in many communities across the country.

Safety, affordability and weather were identified as the main barriers to exercise. Stakeholders noted that parents do not always feel safe letting their kids play outside. Gym memberships were described as being prohibitively expensive. One provider observed that among her patient population, many of whom have emigrated from warm-weather countries, some patients avoid going outside in the months of November through February and thus do not exercise regularly in the winter months.

Affordability of healthy foods, availability of fast food restaurants, and cultural practices were identified as challenges to healthy eating. Residents and stakeholders praised local farmer’s markets and a new grocery store (Daily Table) that has recently opened in Dorchester, but also stated that there is a high volume of fast food establishments in the area. Some participants noted that simply providing enough food for their families could be challenging, and that “healthy food” is often even more expensive. Finally, one interviewee shared that some residents prioritize cooking traditional meals; however, the meals they prepare are often less-healthy, “Americanized” versions of traditional dishes. According this interviewee, these individuals feel strongly about maintaining cultural cooking practices, and thus are hesitant to adopt an alternative diet.

BBRFS data presented in Figure 22 show that 57.0% of adults in the city of Boston reported engaging in regular physical activity in 2010. Adults in North and South Dorchester were generally less physically active when compared to adults citywide. Furthermore, just over one in four adults (26%) in Boston reported consuming the recommended daily servings of fruits and vegetables.

Figure 22: Adults who engage in Regular Physical Activity* by City and Neighborhood, 2010

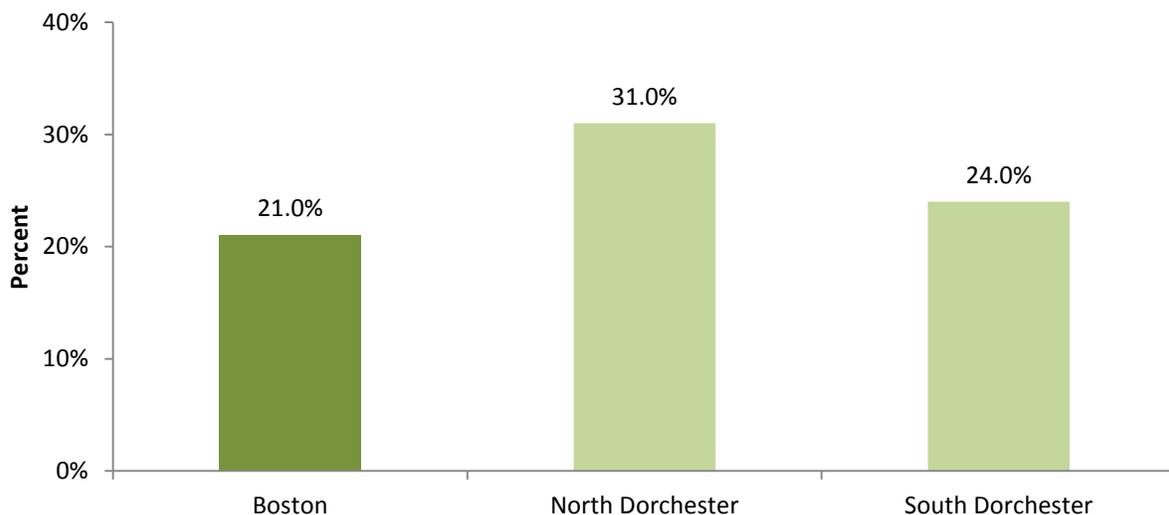


DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

*Adult regular physical activity is defined as vigorous activity for 20 minutes per day on 3 or more days a week or moderate activity for 30 minutes per day on 5 or more days a week.

Quantitative data capture the extent to which obesity and overweight are health challenges experienced by Boston residents (Figure 23). In 2010, the BBRFS reported that 21.0% of adult Boston residents were obese. The proportion of obese residents was even higher among North and South Dorchester residents. Specifically, in South Dorchester, nearly one in four adults were obese (24.0%) compared to nearly one in three North Dorchester residents (31.0%).

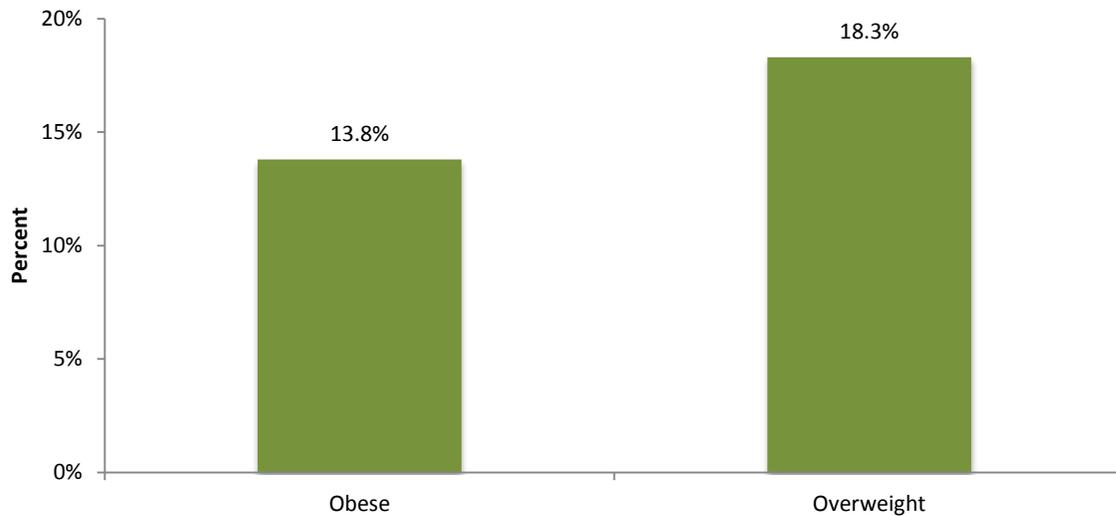
Figure 23: Percent of Obese Adults by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Figure 24 presents the percent of obese and overweight youth in Boston. Based on responses from the 2013 Youth Risk Behavior Survey (YRBS), nearly 14% of Boston's youth were obese compared to nearly 20% who were overweight.

Figure 24: Percent of Obesity and Overweight among Boston Secondary School Students, 2013



DATA SOURCE: Centers for Disease Control and Prevention, Youth Online: High School YRBS, Boston, MA 2013 Results

Table 8 presents DotHouse’s preventive health screening and services related to obesity. In 2012 and 2013, at least one-third of their adult patient population received weight screening and follow up compared to none of its adolescent patient population. In 2014, however, nearly half of the DotHouse adolescent patient population received these services, (41.6%) while the same was true for as many as 62.5% of adults.

Table 8: Obesity Prevention and Counseling among Adolescent and Adult DotHouse Health Patients, 2012-2014

	2012	2013	2014
Adolescent Weight Screening and Follow Up	0.0%	0.0%	41.6%
Adult Weight Screening and Follow Up	33.5%	41.4%	62.5%

DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

Diabetes

“Diabetes is very rampant and very common.” – Focus group participant

“Diabetes [is a concern]: families [are] not having enough finances to eat right.” – Focus group participant

Many focus group and interview participants noted that diabetes was prevalent in their community. Lack of knowledge about diabetes prevention, and difficulty affording healthy foods, were described as barriers to preventing and controlling diabetes.

In 2010, North and South Dorchester had a higher proportion of adult residents with diabetes (8.0% and 7.0%, respectively) compared to Boston (6.0%) Among DotHouse patients, the proportion diagnosed with diabetes (10.3%) in 2014 was nearly double the citywide proportion and far exceeded that of the health center’s service area (Figure 25).

Figure 25: Percent of Adults with Diabetes by Health Center, City, and Neighborhood, 2010* and 2014**



*DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

**DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

Asthma

“I think there are a lot of [asthma] triggers in the area. You’re in the city; there’s a lot of air pollution from the vehicles and businesses...The homelessness or lack of adequate housing: they’re packed in together; there’s dirt, mold, dust –all are triggers for asthma.” – Key informant interviewee

Many interview and focus group participants also described asthma as a key health issue. Participants noted that air pollution and inadequate housing can trigger asthma in local residents.

The citywide disease burden of asthma in 2010 was 11.0% - an identical proportion to that which was observed in South Dorchester that same year (Figure 26). By contrast, North Dorchester reported a particularly high prevalence of asthma (18.0%). Asthma diagnoses among DotHouse patients in 2014 was comparatively lower at 8.6%.

Figure 26: Asthma Prevalence among Adults by Health Center, City, and Neighborhood, 2010* and 2014**

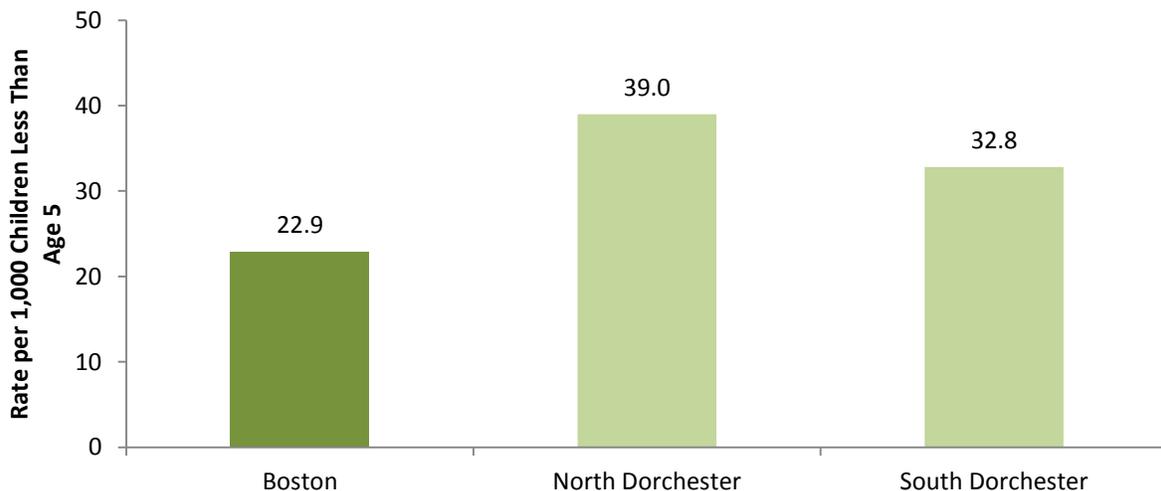


*DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

**DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

Asthma management can pose a particular challenge to children diagnosed with the disease. As illustrated in Figure 27, among Boston children less than five years old, the rate of asthma emergency department (ED) visits was 22.9 per 1,000 children in 2011. When stratified by neighborhood, Dorchester residents experienced substantially higher rates of asthma-related ED visits than reported citywide.

Figure 27: Rate of Asthma Emergency Department Visits per 1,000 Children Less Than Age 5 by City and Neighborhood, 2011



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Chronic Disease Management

DotHouse clinical data presented in Table 9 shows chronic disease management among its patient population. In 2014, a vast majority of diabetic, ischemic vascular disease, asthma, and coronary artery disease patients had their diseases effectively managed.

Table 9: Chronic Disease Management among DotHouse Health Patients, 2014

Type	Percent
Diabetes control (diabetic patients with HbA1c<=9%)	81.4%
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	89.9%
Asthma Treatment (Appropriate Treatment Plan)	82.4%
Blood pressure control (Hypertensive patients with blood pressure <140/90)	59.8%
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease patients)	88.4%

DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

Behavioral Health

Mental Health Status

“Mental health is really stigmatized. Unfortunately, there have been suicide attempts and suicides among teens in the Vietnamese community.” – Key informant interviewee

“Stress and depression [are] common – it ties back to stable housing or job – it’s really hard to live off their paycheck. It’s stressful to think about it.” – Key informant interviewee

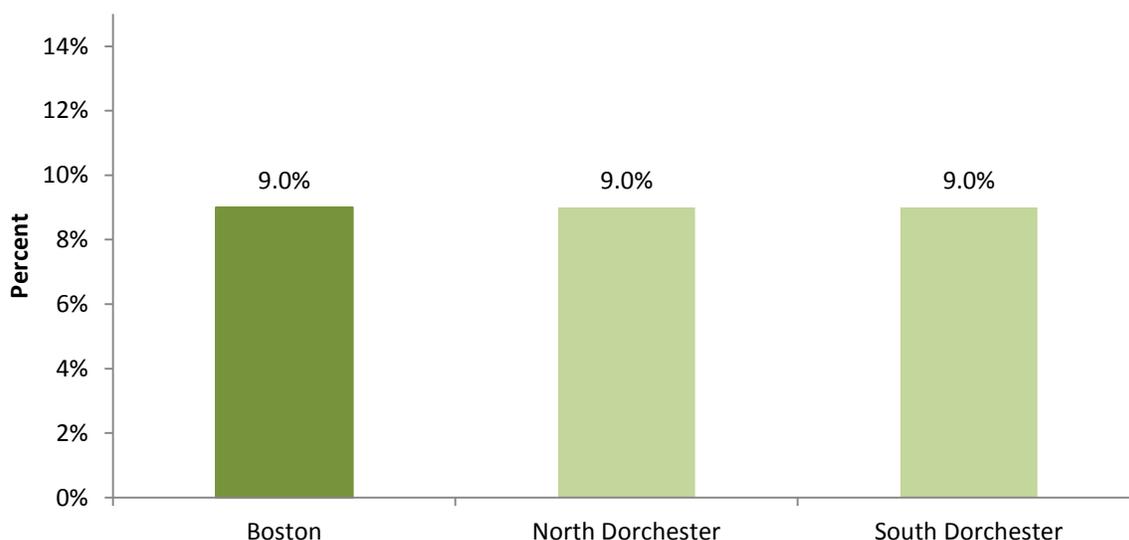
“Behavioral health concerns, social concerns, pain concerns, depression; these issues are so pressing that it’s so hard to get to talk about anything else with patients.” – Key informant interviewee

Mental health issues were raised as key concerns by many interview and focus group participants. Depression and stress were the most common mental health issues discussed, and participants frequently noted that these issues are a direct result of living in poverty and struggling to make ends meet. Suicide was also mentioned as a concern, particularly for youth. A few participants noted that child abuse and neglect are concerns, and that if these issues are unaddressed they can lead to a “chain reaction” and cycles of abuse. Youth focus group participants also stated that some youth are bullied for what they wear, how they talk, or their sexuality.

Residents and stakeholders also discussed barriers to mental health treatment. Stigma surrounding mental health concerns was noted, especially within the Vietnamese community. A few participants also stated that insurance coverage for continued mental health services, such as therapy, is lacking. Finally, one provider described how behavioral health issues are so severe and immediate in some patients that it is difficult to treat any other health issues before addressing the behavioral health concerns.

Figure 28 shows that North and South Dorchester had the same percent of adults reporting persistent sadness (feeling sad, blue, or depressed 15 or more of the past 30 days) as was reported citywide (9%).

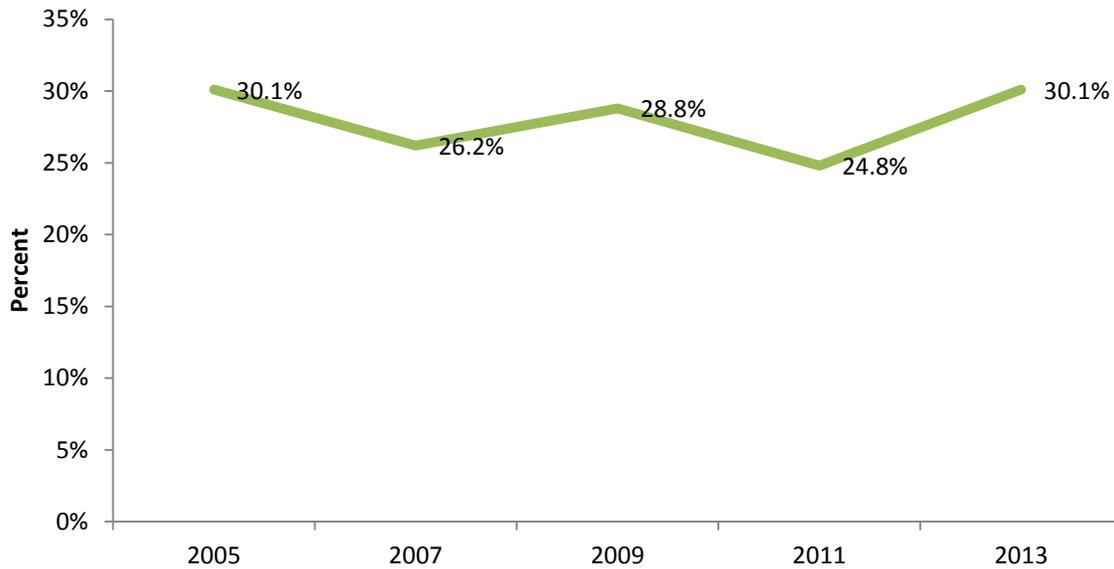
Figure 28: Percent of Adults Reporting Persistent Sadness by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

In 2005, almost 1 in 3 Boston youth reported having felt sad or hopeless for two straight weeks over the span of one year (Figure 29). The proportion of youth reporting this experience had been following a decreasing trend, until in 2013 when the proportion of youth reporting sadness or hopelessness again reached its 2005 proportion (30.1%).

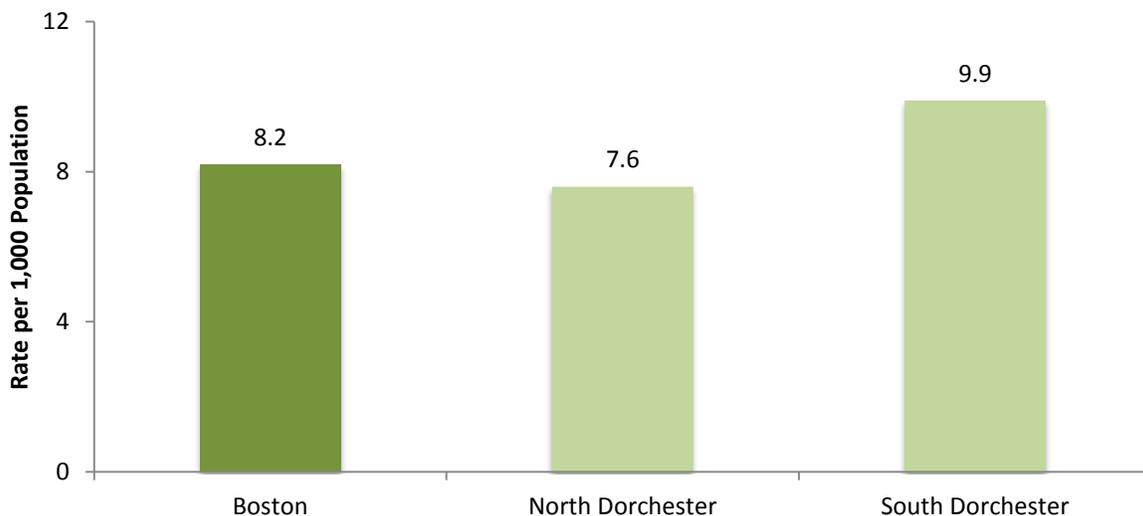
Figure 29: Percent of Boston Youth Reporting Feeling Sad or Hopeless for Two Weeks Straight over a Year, 2005-2013



DATA SOURCE: Centers for Disease Control and Prevention, Youth Online: High School YRBS, Boston, MA 2005-2013 Results

In 2012, the rate of mental health hospitalizations among Boston residents was 8.2 per 1,000 population. Naturally, this rate varied by Boston neighborhood. As illustrated in Figure 30, North Dorchester had a slightly lower rate of mental health hospitalizations compared with Boston, while South Dorchester had a slightly higher rate.

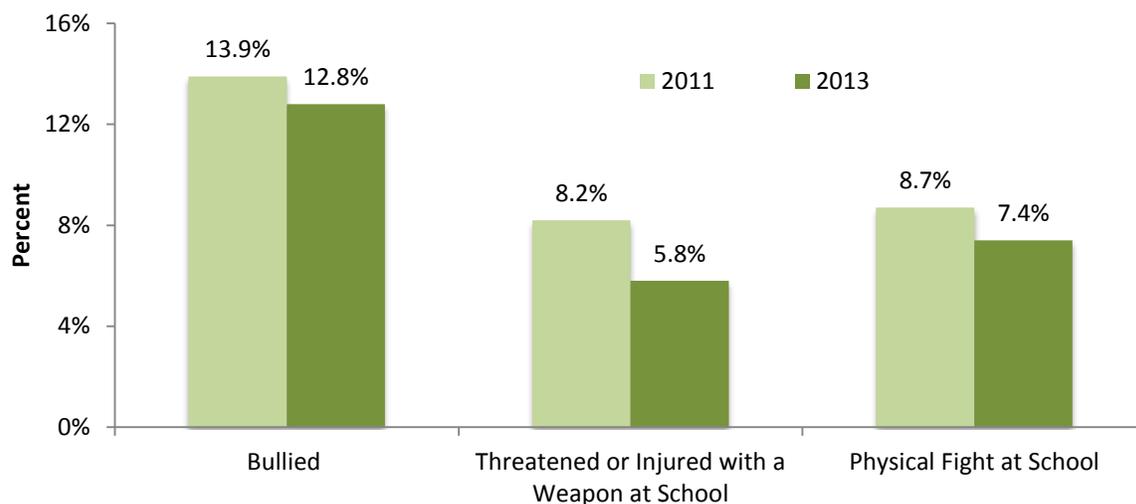
Figure 30: Rate of Mental Health Hospitalizations per 1,000 Population by Neighborhood and City, 2012



DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health, as cited in Health of Boston 2014-2015

Comparing the 2011 and 2013 Youth Risk Behavior Survey, it appears that reports of school-based violence experienced by high school students have decreased (Figure 31). Still bullying remains the most often reported type of school-based violence (12.8% in 2013), followed by physical fighting (7.4%) and threats or injury with a weapon (5.8%).

Figure 31: School-Based Experiences of Violence by Boston Youth, 2011 and 2013



DATA SOURCE: Centers for Disease Control and Prevention, Youth Online: High School YRBS, Boston, MA 2011 Results

Substance Abuse

“Among low-income Vietnamese, there’s a lot of habitual smokers, especially men.” – Key informant interviewee

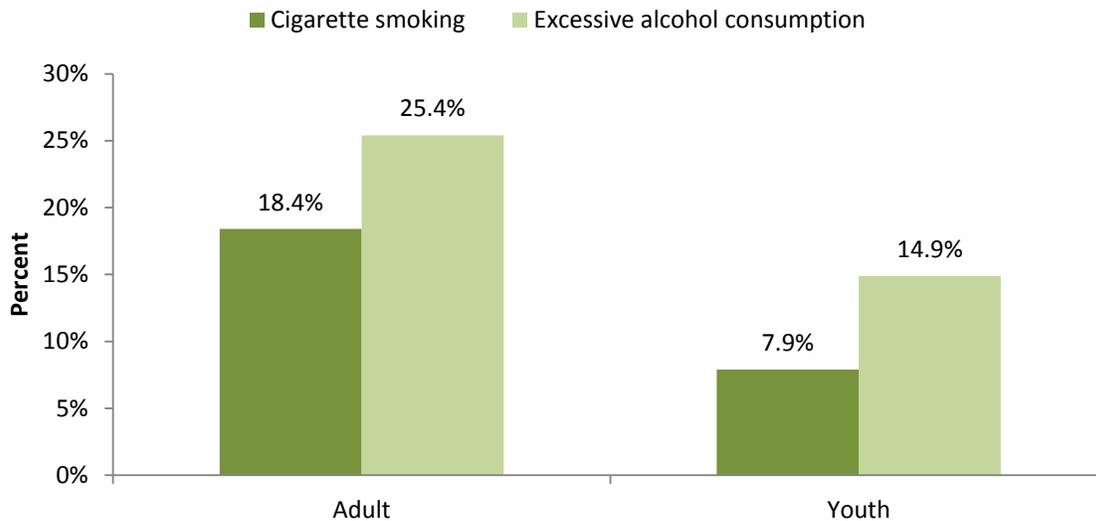
“[There is] opiate addiction. Lots of people strung out on Mass Ave – it’s called the methadone milestone.” – Focus group participant

“There is a cultural of medication use that combines with a culture of substance abuse. The way you fix pain is with pills. And marijuana.” – Key informant interviewee

Interview and focus group participants described different types of substance abuse as key health concerns for their community. Participants stated that alcohol abuse has historically been and continues to be an issue for residents. As one focus group participant noted, *“people self-medicate on liquor.”* Opiate abuse was also mentioned by many participants, as was marijuana use. Stakeholders discussed high rates of cigarette smoking among Vietnamese men in particular. Youth focus group participants described seeing youth, even younger than themselves, using drugs. Finally, many participants noted that substance abuse is a visible issue in the community, and described seeing individuals who are drunk or high on sidewalks and steps.

As illustrated in Figure 32, 18.4% of adults and 7.9% of youth in Boston reported smoking cigarettes. Further, 25.4% of adults and 14.9% of youth indicated that they participated in excessive alcohol consumption, defined as consuming an average of more than two drinks per day for men and more than one drink per day for women during a one month period. These data were not available by neighborhood.

Figure 32: Substance Use among Adults and Youth in Boston, 2013



DATA SOURCE: Boston Behavioral Risk Factor Survey 2013, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission as reported by Health of Boston 2014-2015

As presented in Table 10, tobacco use screening has been performed with the vast majority of DotHouse patients from 2011 to 2013 (between 96.0% and 97.2%). The proportion of smoking patients receiving tobacco cessation counseling tripled from 2011 to 2012 (11.7% and 38.5%, respectively). In 2014, these data were combined such that a single value was presented for adults screened for tobacco use *and* receiving cessation intervention. That data show that 91% of adults received these services.

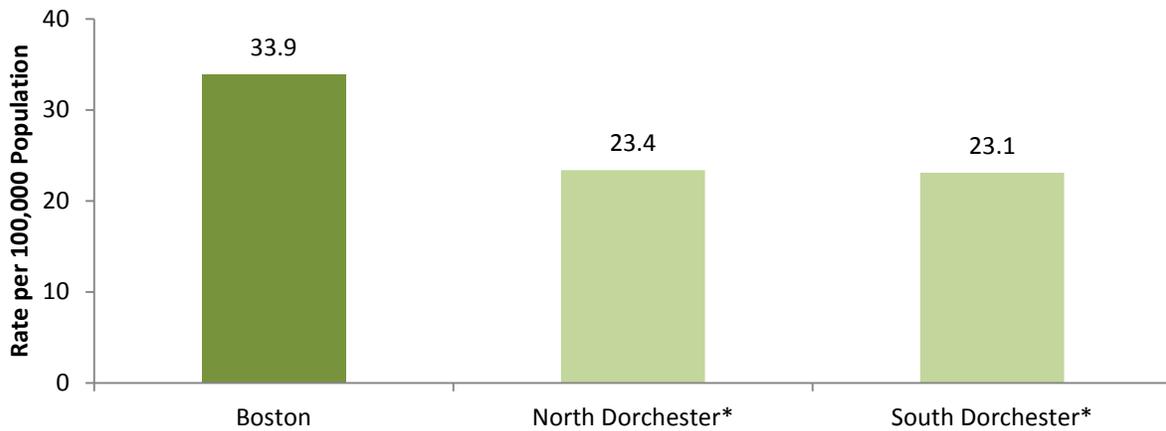
Table 10: Tobacco Screening and Counseling among DotHouse Health Patients, 2011-2013

Type	2011	2012	2013
Tobacco Use Screening	97.2%	96.0%	96.7%
Tobacco Cessation Counseling for Tobacco Users	11.7%	38.5%	37.3%

DATA SOURCE: DotHouse Health, UDS Summary Report, 2014

According to the Massachusetts Department of Public Health, in 2010, the substance abuse mortality rate in Boston was 33.9 deaths per 100,000 population (Figure 33). The death rate due to substance abuse in North and South Dorchester (23.4 and 23.1 deaths per 100,000 population) was lower than that of Boston.

Figure 33: Age-Adjusted Substance Abuse Mortality Rate per 100,000 Population by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

* NOTE: Rates based on counts less than 20 should be interpreted with caution

Sexual Health, Teenage Pregnancy, and Birth Outcomes

Sexual Health

“On my walk to work... [I see] prostitutes out in the early morning; my judgment is that they’re on drugs – in a horrible cycle. They need to continue this work to buy drugs.” – Key informant interviewee

“Prostitution, if I work late, and am standing on a corner of Adams and Christopher waiting for a taxi, I see it... Mostly in Vietnamese populations.”- Key informant interviewee

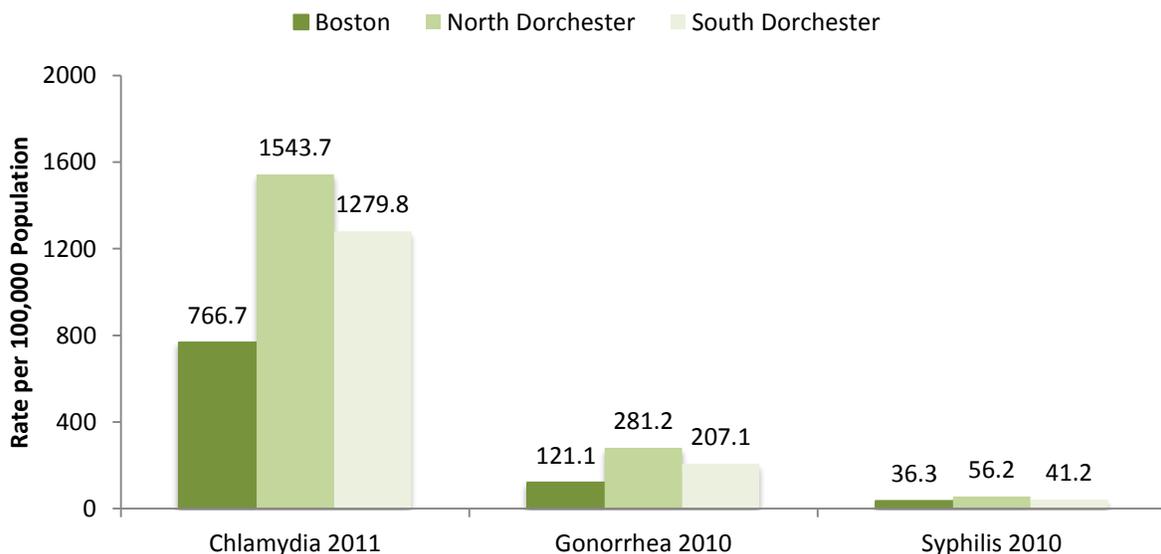
“More community centers that talk about teen pregnancy and STIs and give out stuff to prevent it [are needed]. Like here they give out condoms – you just have to ask.” – Youth focus group participant

A few stakeholders described prostitution as an issue in the community, and described seeing prostitutes on certain streets either late at night or early in the morning. These stakeholders noted that these prostitutes, who may be recent immigrants, are a vulnerable population who may be especially at risk for substance abuse and sexually transmitted infections.

Sexually transmitted infections (STIs) were mentioned by some stakeholders and residents, and was discussed most prominently during the youth focus group. Youth noted that there is a need for more education and awareness about STIs, and also suggested that more local organizations provide free condoms.

As illustrated in Figure 34, rates of sexually transmitted infections are higher in North and South Dorchester compared to Boston overall. While Boston reported a rate of 766.7 cases of Chlamydia per 100,000 population, North and South Dorchester (1,543.7 and 1,279.8 per 100,000 population, respectively) had substantially higher rates. The incidence rates for chlamydia and gonorrhea in North Dorchester more than double those of Boston.

Figure 34: Sexually Transmitted Infection Incidence Rates per 100,000 Population by City and Neighborhood, 2010* and 2011**



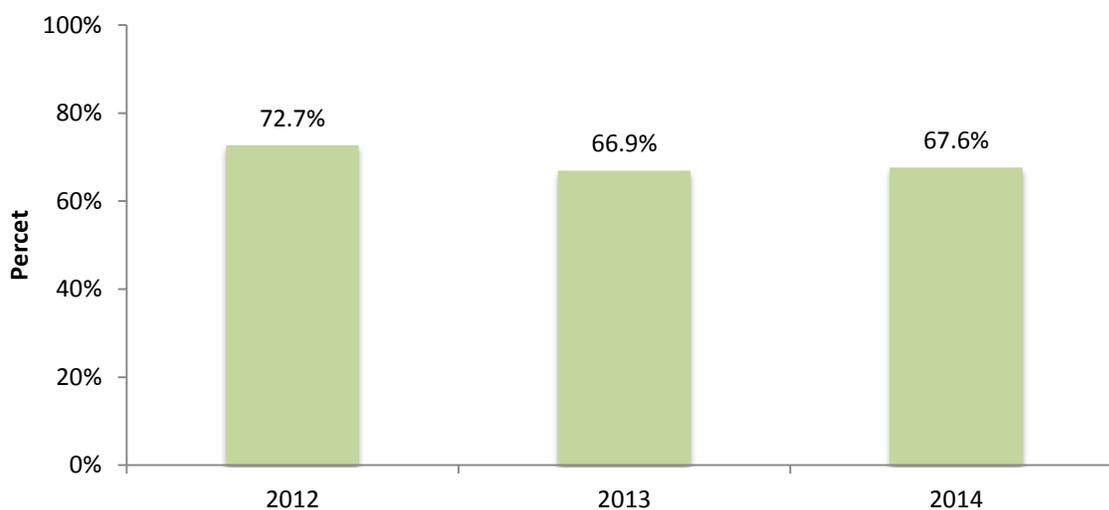
* DATA SOURCE: Massachusetts Department of Public Health, STD Division, as reported by Health of Boston 2011

** DATA SOURCE: Massachusetts Department of Public Health, STD Division, as cited in BPHC Health of Boston 2012-2013

Cervical Cancer

One key informant interviewee noted that the Vietnamese population is at risk for cervical cancer. Quantitative data show that screening for cervical cancer among female DotHouse patients has largely remained consistent between the years of 2012 to 2014, hovering around 70% (Figure 35).

Figure 35: Cervical Cancer Screening among Female DotHouse Health Patients, 2012-2014



DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

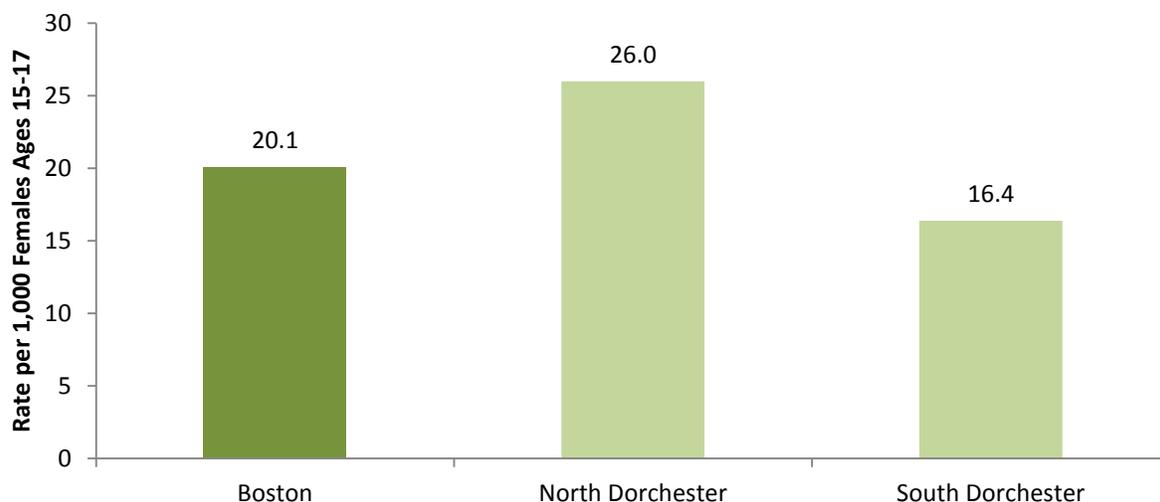
Teenage Pregnancy

"I have a son who is 17 and he is a father now...he is 17 years old; if he doesn't have a balanced meal for himself, then how is he going to feed others?" – Focus group participant

Some interviewees and participants in the men and youth focus group participants cited teenage pregnancy as a key health issue. A lack of education, both at home and in schools, was noted as a possible cause of teenage pregnancies, and leads to, in the words of one focus group participant, *"children raising children."* Participants also noted that this is an issue for both males and females, and that it is a concern for *"not just Blacks, but White families as well."*

The rate of teen pregnancy in North Dorchester (26 births per 1,000 females ages 15-17) exceeded that of Boston (20.1 births per 1,000 females ages 15-17) in 2010. By contrast, the rate of teen pregnancy in South Dorchester (16.4 births per 1,000 females ages 15-17) was lower (Figure 36).

Figure 36: Rate of Births per 1,000 Females Ages 15-17 by City and Neighborhood, 2010



DATA SOURCE: Boston Behavioral Risk Factor Survey 2010, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Public Health Commission, as reported by Health of Boston 2012-2013

Prenatal Care and Birth Outcomes

Prenatal care and birth outcomes were not discussed specifically during the interviews and focus groups. The DotHouse data show that prenatal patients have comprised less than 3% of their total patient population from 2011 through 2014 (Table 11). Of these patients, the majority had their first prenatal visit in the first trimester; this proportion has fluctuated over the past four years from 88.2% in 2011 to 88.0% in 2013 and back down to 84.5% in 2014.

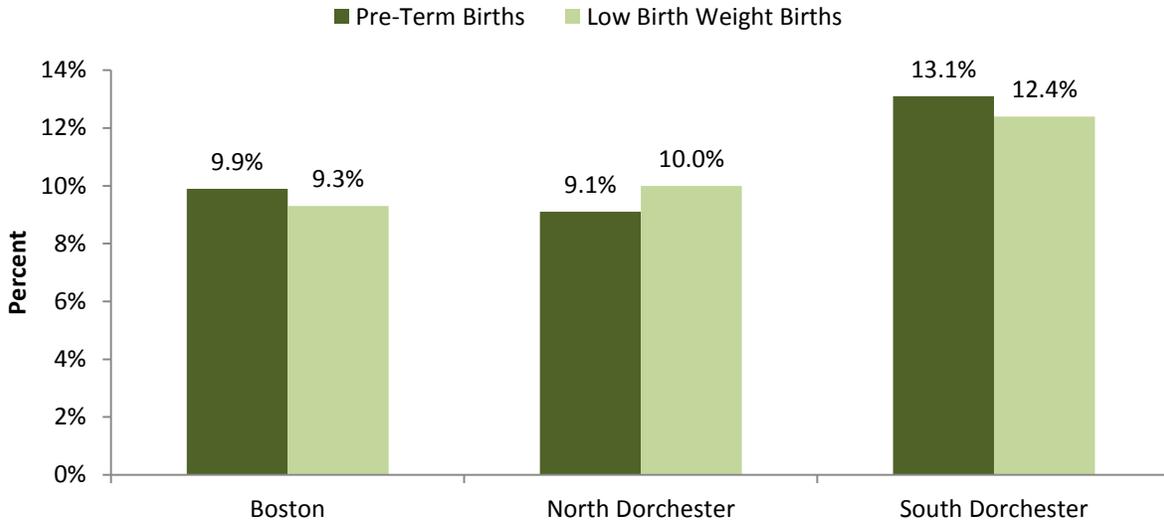
Table 11: DotHouse Health Prenatal Data, 2011-2014

	2011	2012	2013	2014
Prenatal patients (among total health center patients)	2.3%	1.7%	1.1%	1.8%
Had first prenatal visit in 1st trimester	88.2%	86.7%	88.0%	84.5%

DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

In Boston, nearly 10% of residents reported a pre-term birth (before 37 weeks gestation) (Figure 37). The percent of pre-term births in North Dorchester (9.1%) was lower than that of Boston, while the percent in South Dorchester (13.1%) was higher. South Dorchester (12.4%) also reported the highest percent of low birth weight babies (less than 2,500 grams), followed by North Dorchester (10.0%). As illustrated in Figure 38, low birth weight births have comprised between 7.3% and 10.8% of live births to DotHouse patients from 2011 to 2014.

Figure 37: Percent of Preterm and Low Birth Weight Births by City and Neighborhood, 2010



DATA SOURCE: Boston Resident Live Births, Massachusetts Department of Public Health, as reported by Health of Boston 2012-2013

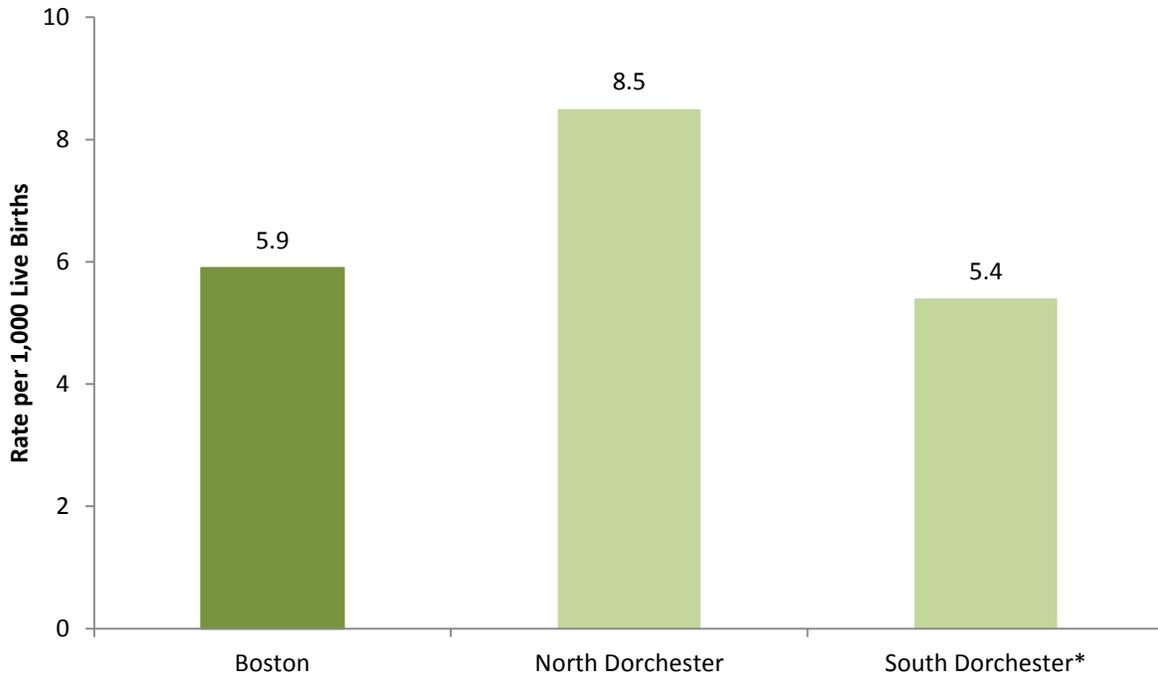
Figure 38: DotHouse Health Low Birth Weight Births, 2011-2014



DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

As presented in Figure 39, the aggregate infant mortality rate between 2006 and 2010 for the city of Boston was 5.9 deaths per 1,000 live births. Stratifying this data by neighborhood show that Dorchester experienced an infant mortality rate (8.5 deaths per 1,000 live births), above that of Boston overall. Stratifying this data by race/ethnicity indicate that Blacks experienced the highest infant mortality rate (10.9 per 1,000 live births), at nearly twice the rate of Boston overall.

Figure 39: Infant Mortality Rate per 1,000 Live Births by City and Neighborhood, 2006-2010



DATA SOURCE: Boston Resident Live Births and Deaths, Massachusetts Department of Public Health as reported by Health of Boston 2012-2013

*NOTE: Represents rate based on counts less than 20 and should be interpreted with caution.

Other Community Health Issues

A few other health issues were mentioned by some interview and focus group participants, although they did not emerge as prominent concerns. First, a few residents and stakeholders noted that domestic violence is an issue in the community. Second, one focus group conversation briefly focused on the needs of caretakers in the community, especially among seniors. Participants described the emotional stress that caregivers themselves experience, and noted that more support for caregivers is needed. Finally, one interviewee cited chronic pain as a key health concern, and noted its overlap with behavioral health in general and depression specifically.

Health Care Access and Utilization

“There’s not enough primary care providers to see these kids because they’re so burnt out. Those coming out of medical school are going into specialties and have an hour to see patients.” – Key informant interviewee

“Doctors tell you that they can only focus on one thing at a time. They don’t have time to deal with all your problems.” – Focus group participant

“They say you can get an interpreter but it’s hard because sometimes it’s a machine; sometimes the interpreter isn’t available and they say to come later.” – Focus group participant

“Dentist are easy to find. If you have insurance.” – Focus group participant

Interview and focus group participants noted a lack of primary care providers and dentists in the community, which leads to long wait times for dental appointments in particular. Other participants stated that dental providers are available; however, they had trouble accessing dental care without dental insurance. Patients also expressed a desire to spend more time with providers during appointments. In general, participants praised DotHouse for providing services and materials in many languages. However, some participants in the Spanish-language and Vietnamese-language focus groups described challenges finding interpreters, especially during dental care and at pharmacies. Participants also noted that, in general, interpreters may only be available at certain times, and thus it can be challenging to schedule appointments at convenient times and on short notice.

Resources and Use of Health Care Services

Table 12 shows the percent of patients using specific services at DotHouse from 2011-2014. In 2014, the most widely used service among DotHouse patients was the medical service (78.1%) followed by vision and dental services (33.7% and 17.9%, respectively).

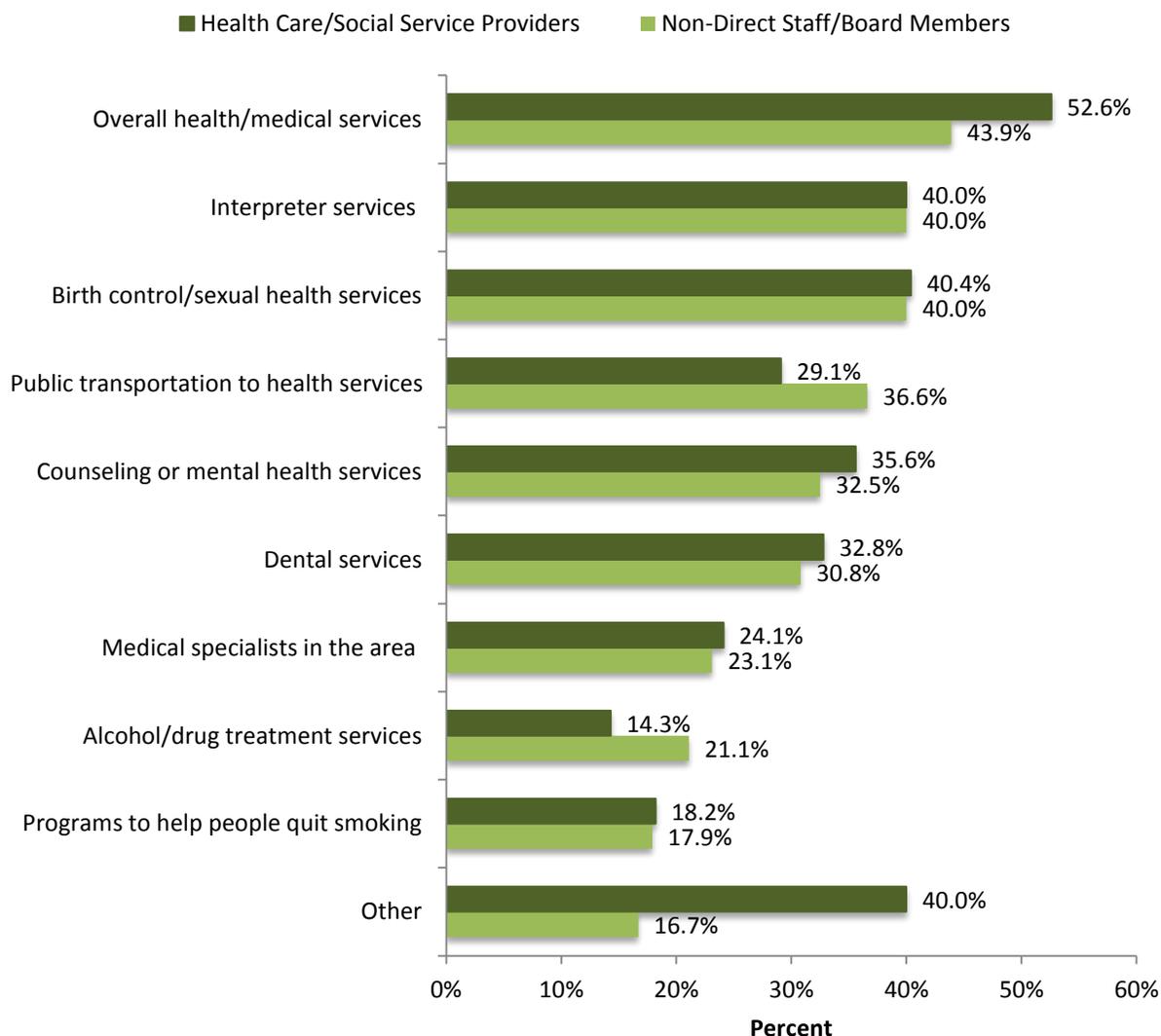
Table 12: Percent of Patients at DotHouse Health Using Specific Services, 2011-2014

	2011	2012	2013	2014
Medical Services	78.1%	80.5%	79.2%	78.1%
Vision	31.8%	32.3%	31.2%	33.7%
Dental Services	21.8%	22.0%	21.0%	17.9%
Mental Health	8.6%	7.7%	7.5%	12.0%
Enabling	4.0%	3.5%	3.4%	4.8%
Substance Abuse	0.2%	0.5%	0.4%	0.9%

DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

DotHouse CHNA staff and board member survey respondents were asked to comment on their level of satisfaction with the availability of services. Non-direct staff and board members were most likely to be very satisfied with the overall health and medical services in the communities they serve (43.9%), while only 17.9% were very satisfied with the availability of programs to help community members quit smoking (Figure 40). Similarly, 52.6% of health care and social service providers were very satisfied with the overall health and medical services availability. However, these respondents were least likely to report satisfaction with the availability of alcohol and drug treatment services (14.3%).

Figure 40: Health Care and Social Service Providers & Non-Direct/Board Members Very Satisfied with the Availability of Services in Community Served, 2015

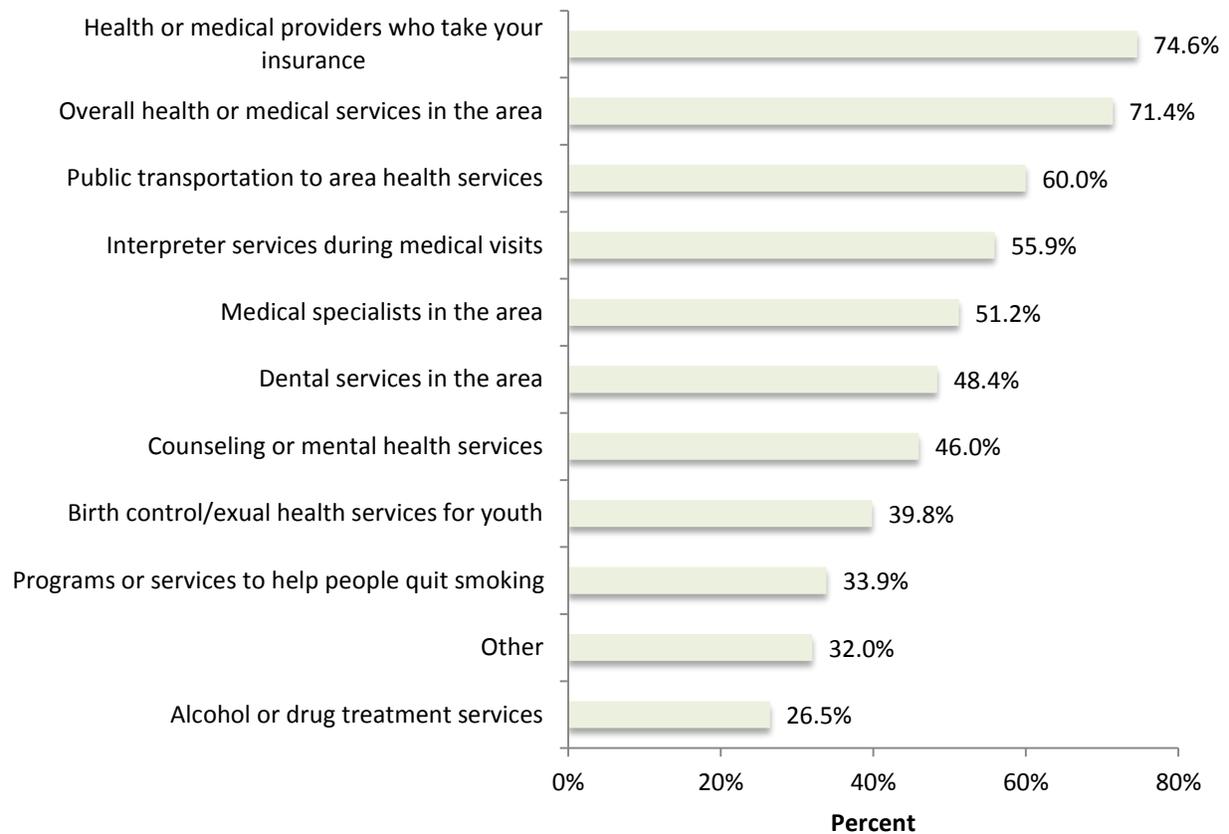


DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff/Board Member Survey, 2015

NOTE: Arranged in descending order by Health care/social service provider responses

Overall, most patient respondents reported being very satisfied with the availability of health or medical providers who take their insurance (74.6%) and overall health or medical services in the area (71.4%). They were least likely to report being very satisfied with the availability of alcohol or drug treatment services (26.5%). For both Spanish and Vietnamese language survey takers, interpreter services during medical visits and when being given health information was among the top two services whose availability was reported as very satisfying (80.0% and 84.4%, respectively).

Figure 41: Patients Very Satisfied with the Availability of Services in Community Served, 2015

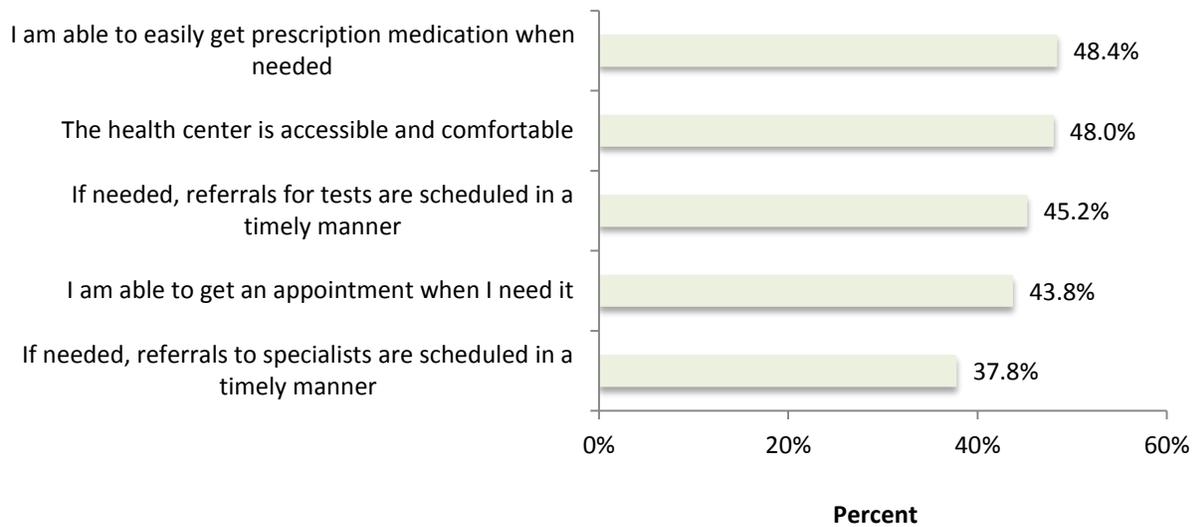


DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

NOTE: Arranged in descending order

Figure 42 illustrates the proportion of patient survey respondents who strongly agree to the five statements regarding ease of access to care. The majority of respondents either agreed or strongly agreed with each of the statements, with most in strong agreement that they are able to easily get prescription medication when needed (48.4%). By contrast, respondents were least likely to strongly agree that they could access necessary referrals to specialists in a timely manner (37.8%). When stratified by language in which the survey was conducted, Spanish speakers were more likely than English speakers to report strong agreement while Vietnamese speakers were less likely.

Figure 42: Patients Strongly Agreeing with Ease of Access to Services, 2015

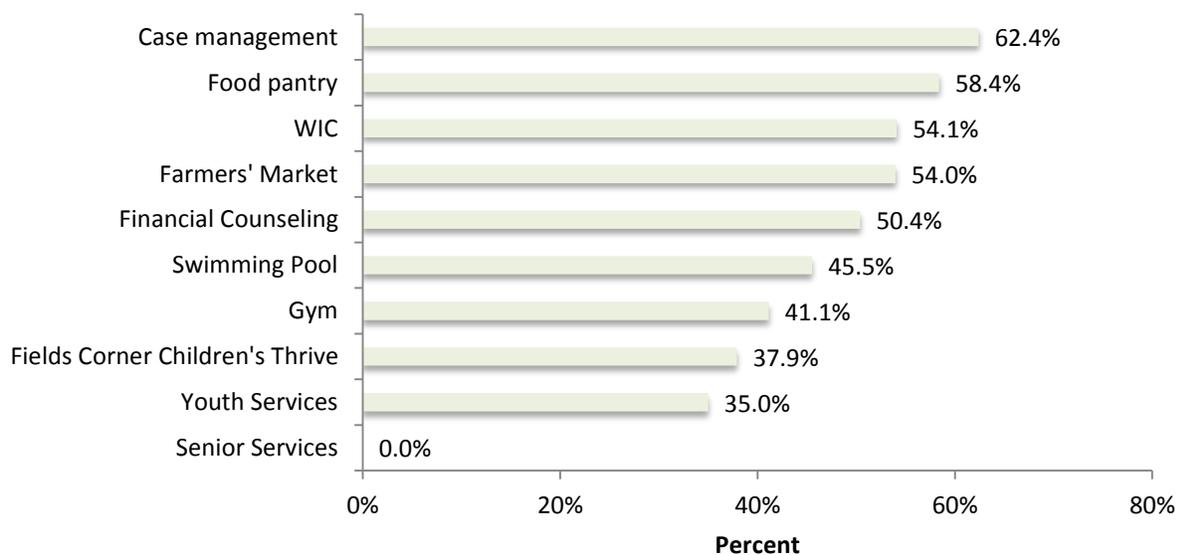


DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

NOTE: Arranged in descending order

Among DotHouse patient respondents, case management services were found to be most useful followed by food pantry and WIC services (62.4%, 58.4%, and 54.1%, respectively). While case management was reported as 'very useful' by 50% of English language survey respondents, 80% of Spanish language respondents and 75% of Vietnamese language respondents reported the same, suggesting increased need/use by primary language. None of the respondents reported senior services as very useful, which may be associated with a dearth of survey respondents aged 75 years and older.

Figure 43: Patients' Reporting Community Services Perceived as Being Very Useful, 2015



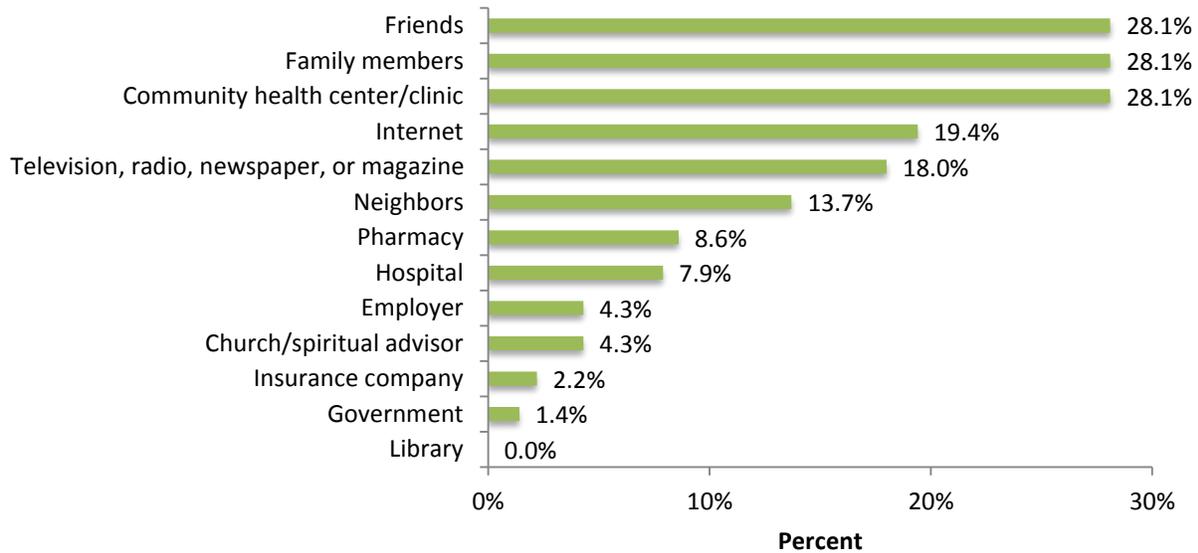
DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

NOTE: Arranged in descending order

Health Information Sources

As reported by health care and social service providers, community members who seek services at DotHouse receive health information from a variety of sources. Specifically, family members (28.8%), community health centers/clinics (28.1%), and friends (28.1%) were the top three cited sources for health information (Figure 44). Respondents perceived that their patients/clients were least likely to seek health information from an insurance company (2.2%), the government (1.4%), or a library (0.0%).

Figure 44: Health Care and Social Service Providers' Perceptions of where Majority of Their Patients'/Clients' Health Information is Received from, 2015

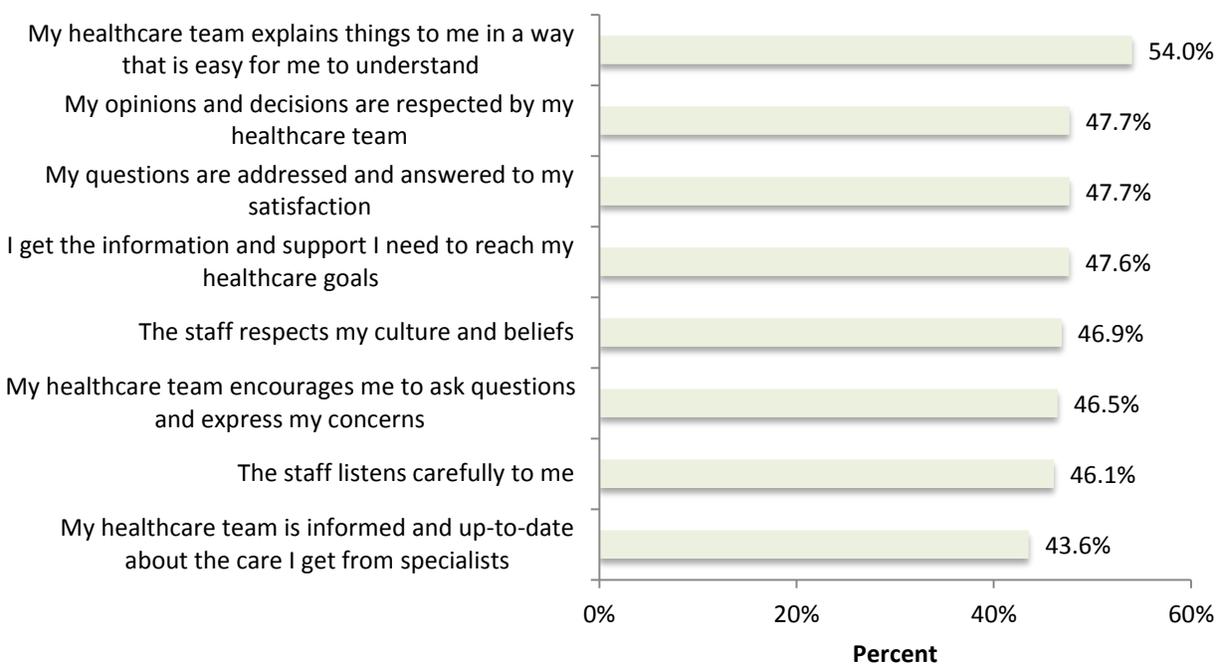


DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

NOTE: Arranged in descending order

As illustrated in Figure 45, a majority of patient survey respondents strongly agreed that their DotHouse healthcare team explains things in a way that is easy to understand (54.0%). The fewest respondents strongly agreed that their health care teams are informed and up-to-date about the care they have received from their specialists (43.6%). By contrast, Spanish-language survey respondents were far more likely to report strong agreement with each of the statements (ranging from 66.7% to 80.0% in strong agreement) compared to English speakers, while Vietnamese-language survey respondents were slightly less likely (ranging from 28.9% to 39.1% in strong agreement).

Figure 45: Patient Survey Respondents Strongly Agreeing With Perceptions on Quality of Health Communication Received at DotHouse Health, 2015



DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

NOTE: Arranged in descending order

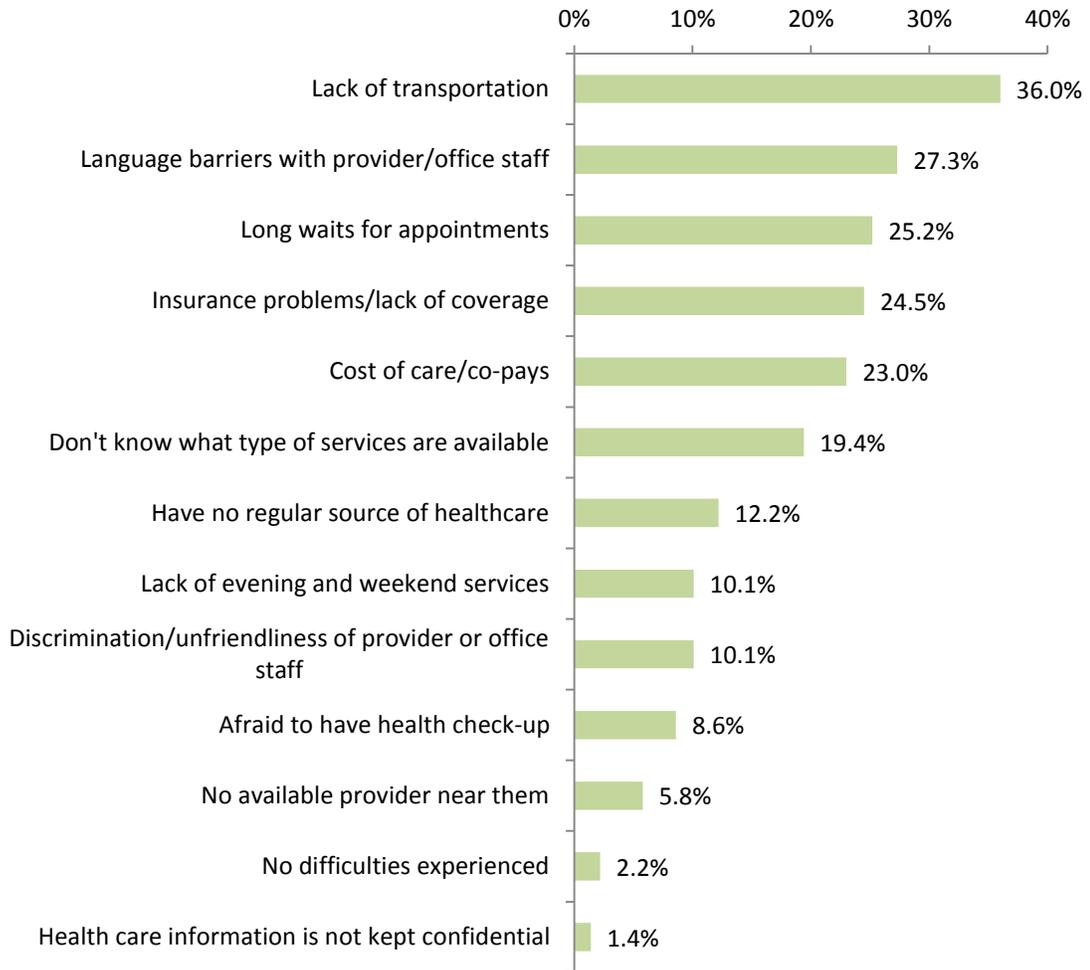
Challenges to Accessing Health Care Services

Among health care and social service providers, 87.9% indicated that most of their patients/clients have one person they think of as their personal doctor, nurse practitioner, or health care provider. Furthermore, the majority (91.2%) reported that their patients/clients main medical provider was a community health center or clinic.

Health care and social service providers were also asked about their patient’s/client’s challenges to accessing care (Figure 46). Chief among those challenges were lack of transportation (36.0%), language barriers with provider/office staff (27.3%), and long wait times for appointments (25.2%).

When patients were asked this same question, they were most likely to respond, “I have never experienced any difficulties getting care” (41.9%) (Figure 47). This was consistent across respondents in each language category in which the survey was administered. Challenges that were faced by patients overall included long wait to schedule an appointment (30.9%), long wait at appointment time to see doctor (21.1%), and health care information is not kept confidential (20.2%).

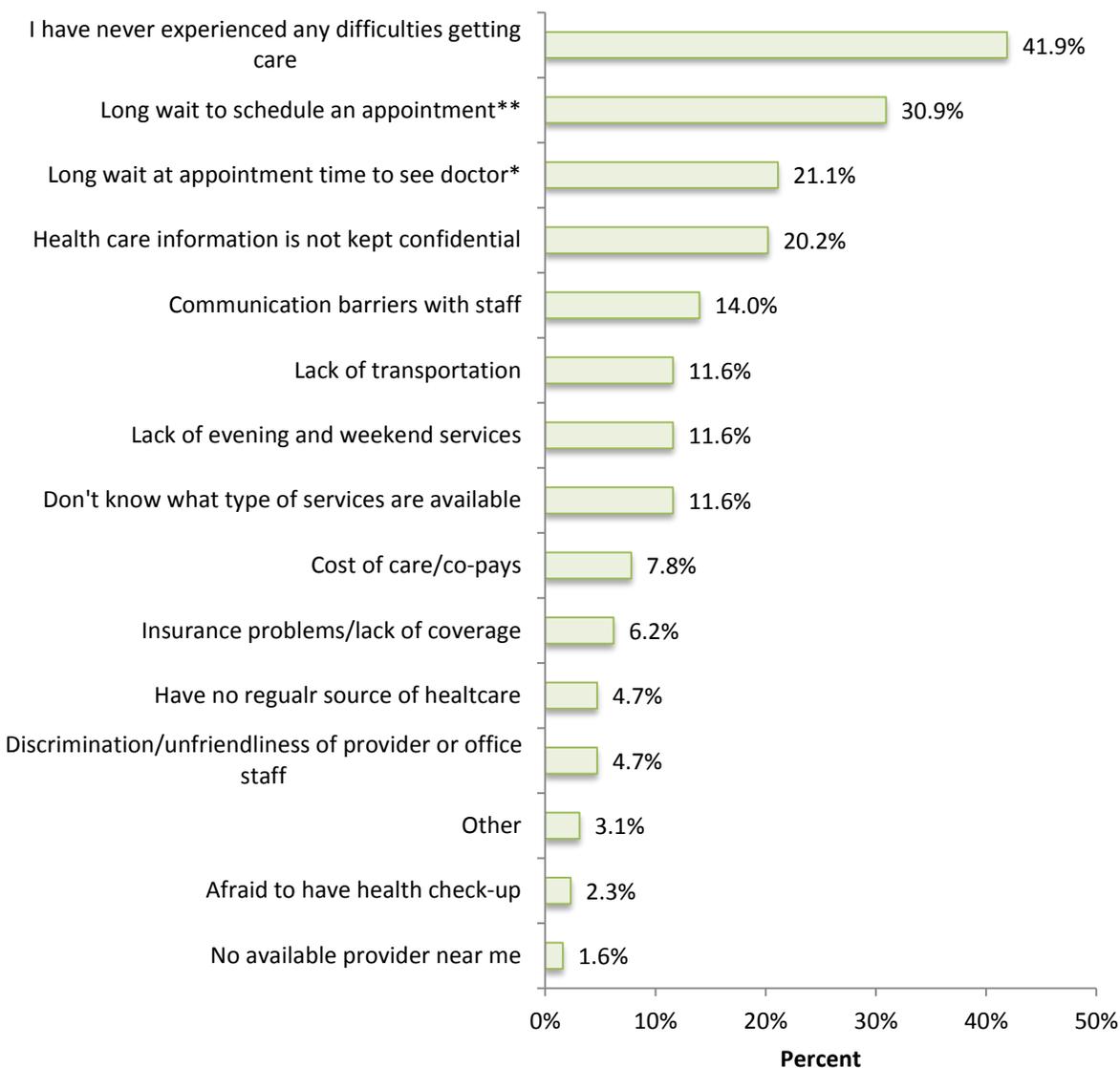
Figure 46: Health Care and Social Service Provider Respondents' Perceived Challenges for Patients/Clients in Accessing Care, 2015



DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

NOTE: Arranged in descending order

Figure 47: Patient Respondents' Perceived Challenges in Accessing Care, 2015



DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

NOTE: Arranged in descending order

*Original survey: respondents n=19

**Revised survey: respondents n=110

As illustrated in Table 13, survey respondents were asked more targeted true/false questions on accessing care in the community. All staff survey respondents were most likely to answer true to the statement, “The health or social services in the community should focus more on prevention of disease or health conditions.” Non-direct staff were most likely to find the statement “To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their race, ethnicity, or language” to be false; however, health care and social service staff were most likely to find the statement “To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their income” false.

Table 13: Percent of All Staff/Board Members Who Perceived the Following Statements to be True about Health Care Access, 2015

Percent of Survey Respondents Answering True	Non-Direct Staff	Health Care and Social Service Staff
The health or social services in the community should focus more on prevention of disease or health conditions	81.4%	83.1%
To my knowledge, when trying to get medical care, health center patients/clients have had a negative experience with the staff in the office	36.6%	30.5%
To my knowledge, the health center patients/clients have not received care needed because the costs were too high	21.4%	18.6%
To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their income	14.3%	10.2%
To my knowledge, when trying to get medical care, health center patients/clients have felt discriminated against because of their race, ethnicity, or language	9.5%	13.6%

DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

NOTE: Arranged in descending order by 'Non-Direct Staff'

Patient survey respondents were most likely to answer true to the statement, “The health care institutions in my community should focus more on prevention of diseases or health conditions” (Table 14).

Table 14: Percent of All Patients Who Perceived the Following Statements to be True about Health Care Access, 2015

	TRUE
The health care institutions in my community should focus more on prevention of diseases or health conditions	91.2%
When trying to get medical care, I have had a negative experience with the staff in the office	22.8%
I or someone in my household has not received the medical care needed because the costs were too high	7.3%
When trying to get medical care, I have felt discriminated against because of my race, ethnicity, or language	6.4%
**When trying to get medical care, I have felt discriminated against because of my gender identity and/or sexual orientation	2.7%
When trying to get medical care, I have felt discriminated against because of my income	5.4%

DATA SOURCE: DotHouse Health Community Health Needs Assessment Patient Survey, 2015

NOTE: Arranged in descending order

**Revised question. Only asked of n=110 respondents

Health Insurance Coverage and Cost

While interview and focus group participants generally stated that community members have access to health insurance, some noted that, as described above, access to dental insurance was a challenge and that insurance coverage for mental health services is lacking.

According to DotHouse health care and social service providers, the majority of their patients have government insurance (e.g., MassHealth, Medicaid, etc.) and just 1.8% of patients have private insurance (Table 15). Of note, none of the respondents perceived their patients to have no health insurance.

Table 15: Health Care and Social Service Providers' Reports on their Patients'/Clients' Health Insurance Status, 2015

	(N=56)
Yes, other government plan (MassHealth/Medicaid or other)	83.9%
Yes, Medicare	12.5%
Yes, private insurance (through employer/spouse's employer or bought own)	1.8%
No health insurance	0.0%

DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

NOTE: Arranged in descending order

Table 16 presents trend insurance status data for the DotHouse patient population. In 2014, the most widely used insurance type was Medicaid/CHIP (55.3%), followed by other third party insurance providers (27.8%) –this pattern has been consistent across data from 2011 to 2014. In 2014, 6.7% of the DotHouse patient population was uninsured. Further, 1.6% of children under age 18 who seek care at DotHouse were also uninsured, down from 6.9% reporting uninsurance in the previous year.

Table 16: Trend in Percent of Patients at DotHouse Health by Insurance Status, 2011-2014

	2011	2012	2013	2014
Uninsured	10.2%	12.6%	15.3%	6.7%
Children Uninsured (age 0-17 years)	-	-	6.9%	1.6%
Medicaid/CHIP	46.9%	44.9%	43.3%	55.3%
Medicare	10.8%	11.1%	9.7%	10.2%
Other Third Party	32.1%	31.5%	31.7%	27.8%

DATA SOURCE: DotHouse Health, UDS Summary Report, 2015

NOTE: Data on the proportion of uninsured children in 2011 and 2012 were not available

COMMUNITY ASSETS AND PROGRAMS

“It’s crowded and noisy, but exciting and lively. We like it that way.” – Focus group participant

“Dorchester has a lot of people really committed to being involved in their community. [There are a] large number of civic associations.” – Key informant interviewee

“[There is] support for moderate income families – social services, public transportation, and a sense of community.” – Key informant interviewee

Diversity, Energy, and Local Amenities

Residents and stakeholders described many assets and strengths of their community. Dorchester was described as “diverse,” “energetic,” and “lively”. Interview and focus group participants described many local amenities including churches and historical sites. Public transportation is available, although it can be unreliable and is less accessible in certain neighborhoods. Youth focus group participants noted that there are “things to do” in the neighborhood like play basketball.

Sense of Community and Civic Pride

Many participants also described a strong sense of community and civic pride. Participants stated that people know each other and look out for each other in the neighborhood, and stated that, perhaps because it is a diverse area, many residents have an open “live and let live attitude.” Stakeholders noted that a number of formal civic associations exist in Dorchester. More informally, participants shared that residents are actively involved in developing their communities. For example, as one youth focus group participant stated, *“It’s our neighborhood – if we want to make it better, we have to put in. We can’t expect others to make it better for us.”*

Available Social Services and Other Resources

Many stakeholders stated that numerous local non-profits and social service providers are present in the community, and either provide direct services to residents or are working on issues of broader community and economic development. While stakeholders noted that awareness of these services and communication amongst them could be improved, they described the availability of these resources as a community strength.

COMMUNITY SUGGESTIONS FOR FUTURE PROGRAMS, SERVICES, AND INITIATIVES

“Clinically you see obesity, and hypertension and diabetes... you also see lack of access to good nutritional foods, safe places to exercise outside, and education gaps.” – Key informant interviewee

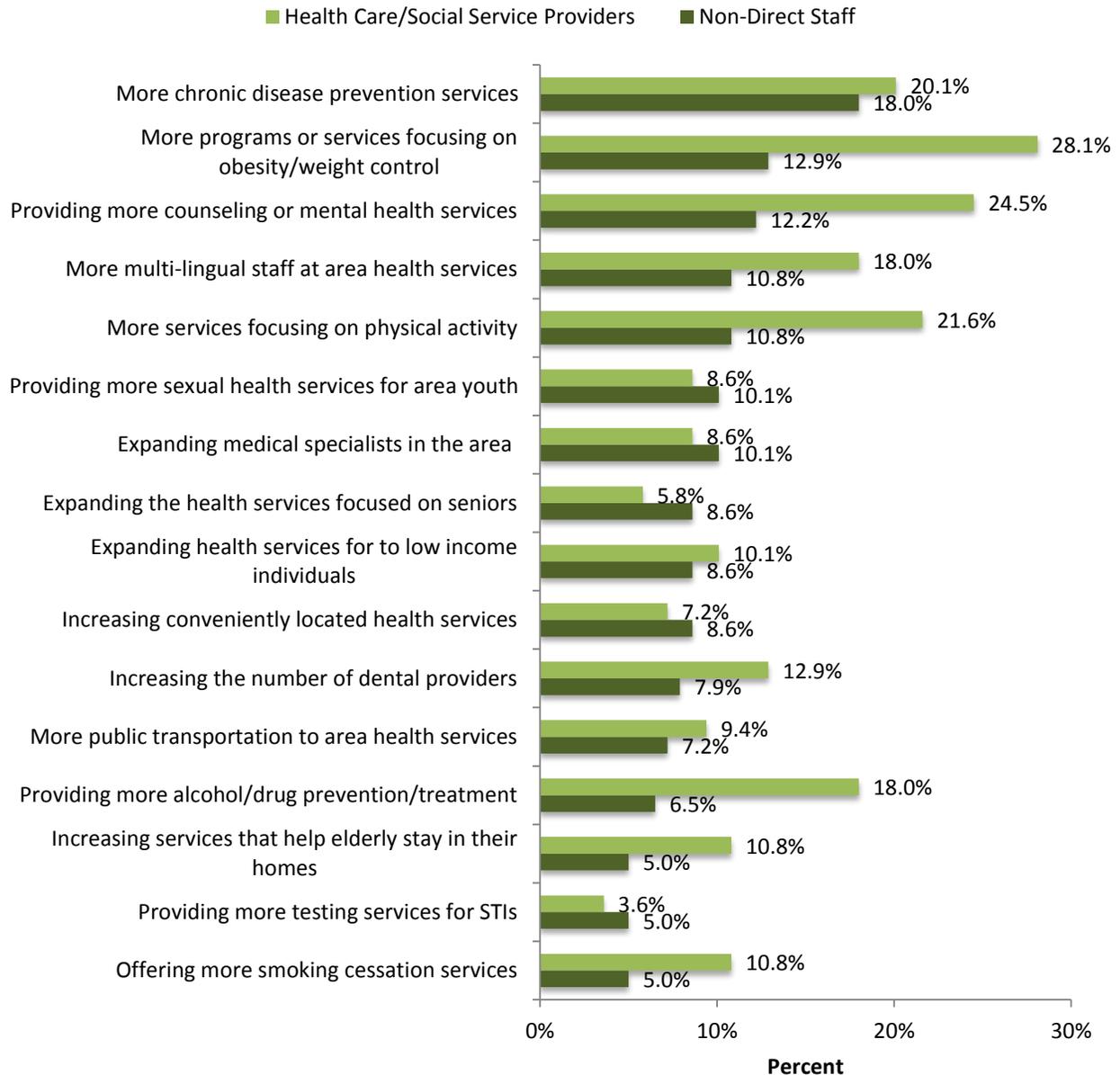
“Have more teen pregnancy and neglect programs. There’s a lot of teen pregnancy – it will keep happening if we don’t educate.” – Focus group participant

“Most of the care we give is crisis-oriented. Someone loses their home, needs food, they come to us versus trying to access WIC to get them food before that happens. Part of it is cultural – they don’t always understand they can access these things. Some are embarrassed to come.” – Key informant interviewee

Assessment participants were asked about their vision for the future of their community, and ideas for programs, services and initiatives. Prominent themes that emerged related to the future program and service environment included intervening to address poverty as a root cause of mental and physical health issues, supporting employment opportunities through education and affordable child care, addressing safety and built environment issues, providing health education focused on prevention, and coordinating communication and referrals amongst local health care and social service agencies.

Survey respondents were asked to identify key areas they considered priorities for addressing in the future. Among non-direct staff survey respondents, ‘more chronic disease prevention services’ were identified as the highest priority area (18.0%), followed by ‘more programs or services focusing on obesity/weight control’ (12.9%) (Figure 48). Health care and social service provider respondents also identified obesity/weight control programming as top priority (28.1%), followed by ‘providing more counseling or mental health services.’

Figure 48: Percent Non-Direct Staff & Health Care/Social Service Providers Noting Areas as “High Priority” for the Future, 2015



DATA SOURCE: DotHouse Health Community Health Needs Assessment Staff Survey, 2015

NOTE: Arranged in descending order by Non-Direct Staff

Other ideas for future programs, services and initiatives that were discussed during the interviews and focus groups included:

Intervene at the Socioeconomic Level to Improve Mental and Physical Health

During focus groups and interviews, poverty was viewed as a root cause for many health issues. For example, participants and stakeholders described challenges and trade-offs in affording basic needs such as food, housing, medications, and child care, with one interviewee stating that: “If [patients] have no food, the prescription won’t work.” Residents noted that buying healthy foods and maintaining gym memberships can be expensive. Stakeholders praised local organizations, such as DotHouse and the

Daily Table, which provide affordable, healthy food and physical activity opportunities, and suggested that the community could benefit from additional organizations that support healthy lifestyles at an accessible price point. Residents and stakeholders also mentioned interventions at more upstream levels, such as connecting residents with social services before crises, increasing the provision of housing vouchers, and developing additional career opportunities locally (see below for more information).

Some participants also noted that poverty can have an impact on mental health, in addition to physical health. Stakeholders described that living with a constant level of stress about meeting basic needs can have implications for mental health issues such as depression. Other participants mentioned that, as certain parts of Dorchester gentrify, current residents may be increasingly vulnerable to rising costs of living.

Support Employment Opportunities through Education and Provision of Child Care

When asked about their vision for the future of the community, many participants stated that they hope to see increased career opportunities for local residents. Stakeholders and residents noted that education and affordable child care will be two key facilitators for expanding job opportunities. Stakeholders indicated that there have been “*good strides*” in improving local schools, but that more could be done to improve the quality of local public schools. Participants also expressed that different types of education and training should be offered to students, ranging from vocational schools to preparation for colleges, so that there are opportunities for residents to go into “*plumbing, health care, or Harvard*”. Many stakeholders also described a lack of affordable child care being a barrier for parents to maintain full-time employment, and noted that increasing the volume of child care vouchers and raising income eligibility limits for vouchers could facilitate employment.

Address Safety and Built Environment Issues

Many stakeholders and residents described safety issues as being a concern for the neighborhood and having a direct impact on health. While specific suggestions for improving safety were not frequently discussed, when asked about the future of their community participants did point to improved safety as a priority, noting that, “*if it were safer, this community would be perfect.*” A few stakeholders also noted that substandard housing and air quality can have an impact on health in general and specifically on asthma prevention and control.

Provide Health Education Focused on Prevention

Many stakeholders and residents described the provision of health education focused on prevention as a high priority. Parents and youth stressed that sexual health education is needed, especially to prevent cycles of teenage pregnancy and sexually transmitted infections. Prevention of chronic diseases, specifically diabetes and asthma, was also noted by some participants, with one interviewee stating: “*it’s the diabetes and asthma that need a bit more education.*” Finally, participants mentioned a need for additional substance abuse prevention programs for alcohol abuse and, especially among the Vietnamese community, tobacco smoking.

Coordinate Communication and Referrals Among Local Agencies

Health care and social service stakeholders frequently noted that, while many local services exist, there are opportunities to improve communication and referrals amongst them to maximize reach and avoid duplication of effort. For example, one interviewee stated that: “*If you have 5 different places giving out food on the same day, you’re competing with each other. Why don’t we all get together and see who’s giving it out food when – we can coordinate.*” Some stakeholders also cited a need for greater awareness of the availability of local services. For example, one health care provider described a need for “*things that I can refer patients to in the community – yoga, tai chi, meditative options for treatment, osteopaths, chiropractors. I need to know what is there and who is good. I need to have a vetted list.*”

KEY THEMES AND CONCLUSION

Through a review of the secondary data, surveys of DotHouse staff, board members, and patients, as well as discussions with community residents and leaders, this assessment report provides an overview of the social and economic environment of the community served by DotHouse, health conditions and behaviors that most affect the population, and perceptions of strengths and gaps in the current environment. Several overarching themes emerged from this synthesis:

- ***Dorchester, and Field’s Corner specifically, is a vibrant, diverse neighborhood with a strong sense of community and many local amenities and services.*** Almost all assessment participants noted diversity as a positive aspect of their community. They also appreciated the strong sense of community and ownership among residents who are committed to being involved in constantly improving community. The availability of health and social services as well as public transportation were also noted as assets.
- ***Safety, housing and employment are key concerns for many residents.*** While some participants described Field’s Corner as safer compared to previous years, others still consider the neighborhood to be dangerous. The ability to afford housing was a prominent concern, especially among seniors, and gentrification was viewed as exacerbating the housing situation. Residents also expressed the need for increased employment opportunities – including access to education and affordable child care.
- ***Chronic diseases, such as obesity and asthma, and sexual health emerged as prominent health issues among Dorchester residents.*** Risk factors for chronic diseases, including healthy eating and physical activity, were described by participants as pressing issues. Quantitative data show that Dorchester is disproportionately affected by obesity, asthma, and STIs. Community residents cited a need for increased sexual health education to prevent transmission of STIs and cycles of teenage pregnancy.
- ***Behavioral health concerns were frequently noted, especially the need for additional services and insurance coverage.*** Participants emphasized the stress and depression among residents created by living in poverty. Gaps in mental health services included limited availability of treatment beds and insurance coverage. Substance abuse also emerged as a concern – specifically the use of alcohol, marijuana, tobacco, and opiates as a coping mechanism for mental health issues.
- ***Opportunities exist to improve access to care, particularly mental health, dental health, and interpreter services.*** While health care is available, long wait times for appointments - especially for dentists - and the need for interpreter services, were described as impeding access to care. Lack of health insurance coverage was noted as a barrier to receiving mental health and dental services. While interpreter services were considered to be strong, gaps were identified in the areas of dental and pharmacy services. Transportation was also identified by some as a barrier to care.