CAMBRIDGE HEALTH ALLIANCE
DON APPLICATION # CHA-22061514-RE

DON REQUIRED EQUIPMENT
ADDITION OF PET-CT SERVICES AT CHA MALDEN CARE CENTER

AUGUST 31, 2022

CAMBRIDGE HEALTH ALLIANCE
DON APPLICATION # CHA-22061514-RE

TABLE OF CONTENTS

ATTACHMENT 2

EVIDENCE OF COMMUNITY ENGAGEMENT
A. PATIENT AND FAMILY ADVISORY COUNCIL PRESENTATION

CHA Cambridge Health Alliance

CHA Mobile PET/CT Proposal

Patient & Family Advisory Council (PFAC)

6-16-22

CHA Cambridge Health Alliance

What is PET/CT?

- Positron Emission Tomography (PET) is an imaging test that can help reveal the metabolic or biochemical function of your tissues and organs. PET images are then overlaid with the anatomic data of Computed Tomography (CT) or Magnetic Resonance (MR) images to identify the exact location and stage of disease.
- PET/CT allows both the PET images and CT images to be obtained at the same time assuring the positioning is the same for both sets of images.
- PET has been used for cancer detection and follow up care since inception and is becoming the standard of care for various cancers.
- Newer uses for PET include cardiac imaging to determine decreased blood flow and brain imaging for conditions such as tumors, Alzheimer's and seizures.

Present State

- Cambridge Health Alliance (CHA) currently does not provide this service so patients are referred externally to other healthcare organizations.
- There are no local providers in Malden which is an inconvenience for patients who may need to seek public transportation, disrupt their work schedule, and bear additional cost and hardship.
- CHA receives insurance claims data for the majority of our Primary Care panel patients (Adults and Children). The data indicated 150 unique Adult patients had PET/CT outside of CHA in Calendar Year 2019 and another 129 patients had it in Calendar Year 2020. We project demand for this service of 300-350 patients on 100% of our Primary Care Adult panel.
- The majority of CHA's patients went to Beth Israel Deaconess Medical Center in downtown Boston.

Proposal

- Pending budget approval from CHA's Board of Trustees, CHA will offer PET/CT services through a partnership with Alliance HealthCare Radiology. Alliance is a well known, established PET/CT provider in Massachusetts.
- This service will be offered in a state-of-the art mobile van adjacent to the Malden Care Center. Ample parking will be available and no existing green space will be converted to offer this service.
- A parking pad will need to be constructed to support the weight of the van.
- Mobile PET/CT will be initially offered one day per week, but can be ramped-up based on patient demand.
- Prospective patients will be registered at a check-in area within the Malden Care Center.
- The goal is to offer this service within a year subject to regulatory approval.

CHA Cambridge Health Alliance

Thank you!!!
Any questions???

ATTACHMENT 4

FACTOR 6 COMMUNITY HEALTH INITIATIVE MATERIALS

ATTACHMENT 4 (A)

COMMUNITY HEALTH INITIATIVE NARRATIVE

CHA Regional Wellbeing Assessment Process Overview

Cambridge Health Alliance (CHA) through the Community Health Improvement Department conducts Community Health Needs Assessments (CHNA) and Implementation Strategy (IS) within the Patient Service Area are on a 3 year cycle. This has evolved from single municipal assessments to a regional assessment that describes the strengths and challenges of the CHA service area, including the communities of Somerville, Medford, Malden, Everett, Chelsea, Revere and Winthrop. The municipalities are grouped into 3 sub-regions, each with a Community Advisory Board, also referred to as a CAB, to guide the local implementation of the regional process. The CHNA includes primary and secondary data sources used to guide discussions and prioritize implementation strategies. The goal of this process is for people to tell their stories, elevate priorities that matter to them, and collaborate to improve the health of their communities.

Through this process, CHA engages members of communities who are closest to the impact of inequitable health outcomes and are actively involved in what questions are asked, what information is collected, and how that information is examined. CHA developed two Community Advisory Boards (CABs) to guide the work at the local level. One CAB guided the assessment in Medford and Somerville, and one guided the work in Everett and Malden. CHA is integrated with the efforts of the North Suffolk Public Health Collaborative's Steering Committee, which continues its role in guiding assessment in Chelsea, Revere, and Winthrop. CAB members were recruited from diverse communities – across professional sectors, forms of power, and lived experience of the impacts of structural forms of inequity. Each CAB met regularly, about every 6–8 weeks. This work was connected with CHA's Community Health Advisory Committee. Cambridge Public Health Department implements a single community CHNA to fulfill their Accreditation requirements.

The CHA CHNA/IS is based on the framework called the Tool for Health + Resilience in Vulnerable Environments (THRIVE), co-developed by the Prevention Institute and the US Office for Minority Health. CHA chose THRIVE because it has an explicit focus on equity and addressing structural determinants of health by elevating the community conditions that contribute to inequitable health outcomes. THRIVE is also a tool for engaging community members in assessing community conditions, prioritizing them, and taking action to change them. THRIVE identifies three ways of describing community conditions, also known as social determinants of health. The first is PEOPLE, which refers to the social and cultural environment. The second is PLACE, or the natural and built environment. The third is EQUITABLE OPPORTUNITY, or the economic and educational environment. Each area includes factors that research and experience have shown are associated with health and wellbeing outcomes. THRIVE is designed to help communities focus their analysis of the factors that contribute to illness, injury, and inequity at the community level, and to determine where and how to take action to make an impact on these interacting factors.

The Health Improvement Team (HIT) leads this work, in coordination with the efforts of health system and municipal partners who are also engaging in assessments – including Beth Israel Lahey Health, Mass General Brigham, the North Suffolk Public Health Collaborative, and the Metropolitan Area Planning Council. The CHA CHNA/IS process and deliverable timeline has been as follows:

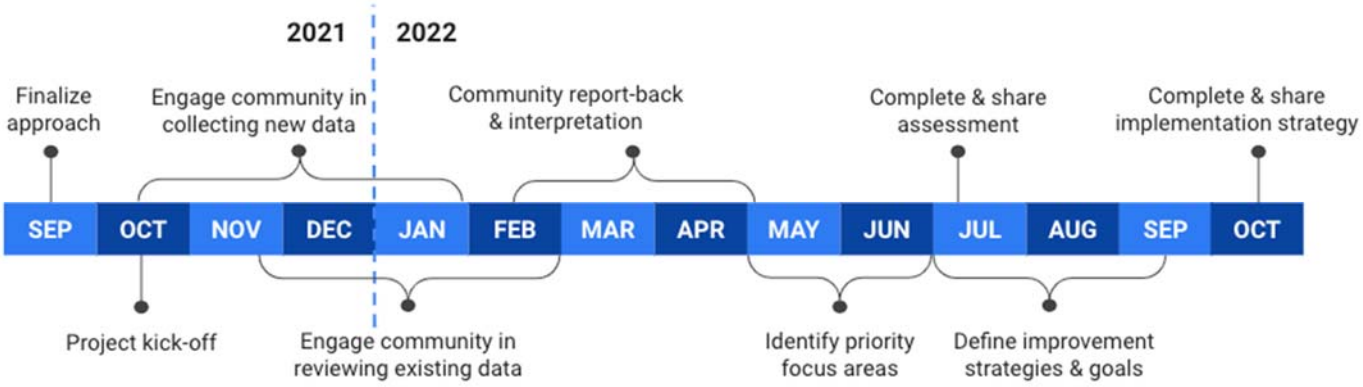
During Summer 2021, CAB members and other community members and advisors participated in defining the areas of inquiry, guiding principles, what information was needed, and how it should be collected. HIT staff and partners did the work of creating the tools and documenting the methods.

In Fall 2021, HIT staff, community researchers, interns, and partners began collecting and analyzing the data. This involved focus groups, key informant interviews, administering surveys, analyzing existing data from different sources, and other methods. 2,045 Surveys, 130 participants in Focus Groups and 52 participants in Key Informant (in depth) Interviews were held through CHA's Primary Service Area in 5 languages. Surveys were available in digital and written format.

In early 2022, we held community meetings to share initial findings and to make sense of the data together. The results of the assessment were interpreted in collaboration with community members, and shared in formats that were accessible to and of value to diverse communities.

In Spring 2022, CAB members continued to collaborate to select priority focus areas. **Through Summer 2022**, the HIT will work together with partners to develop implementation strategies and goals, including deciding on indicators to monitor progress. We will develop plans to secure and leverage, when appropriate, the resources necessary to realize the collaborative plans that have been developed.

By Fall 2022, plans will be finalized to guide collective efforts to strengthen wellbeing across the CHA region. As we collaborate toward shared goals, we will communicate openly and regularly, and ask what is working well, what needs to change, and how we can continue to improve.



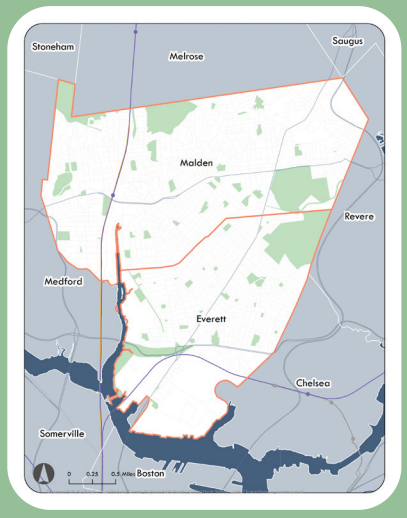
3965\0001\847903.1

ATTACHMENT4 (B)

EVERETT-MALDEN COMMUNITY HEALTH NEEDS ASSESSMENT (2019/2020)

2019/2020

Everett-Malden Community Health Needs Assessment



CHA Cambridge Health Alliance

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

MW Melrose Wakefield Healthcare

Proudly wellforce

This publication and other resources are available at the following locations online:
Cambridge Health Alliance: https://www.challiance.org/community/health-improvement
Mass General: https://www.massgeneral.org/community-health/cchi
MelroseWakefield Healthcare: https://www.melrosewakefield.org/in-the-community/community-benefits/community-benefits-programs/

Table of Contents

A Note to Readers

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

A new partnership

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

Why is this important?

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

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

We thank you for participating in this process.

What is a Community Health Needs Assessment?

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

What you will find in this report:

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

Guiding Principles: What drove this work?

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

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

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

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

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

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

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

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

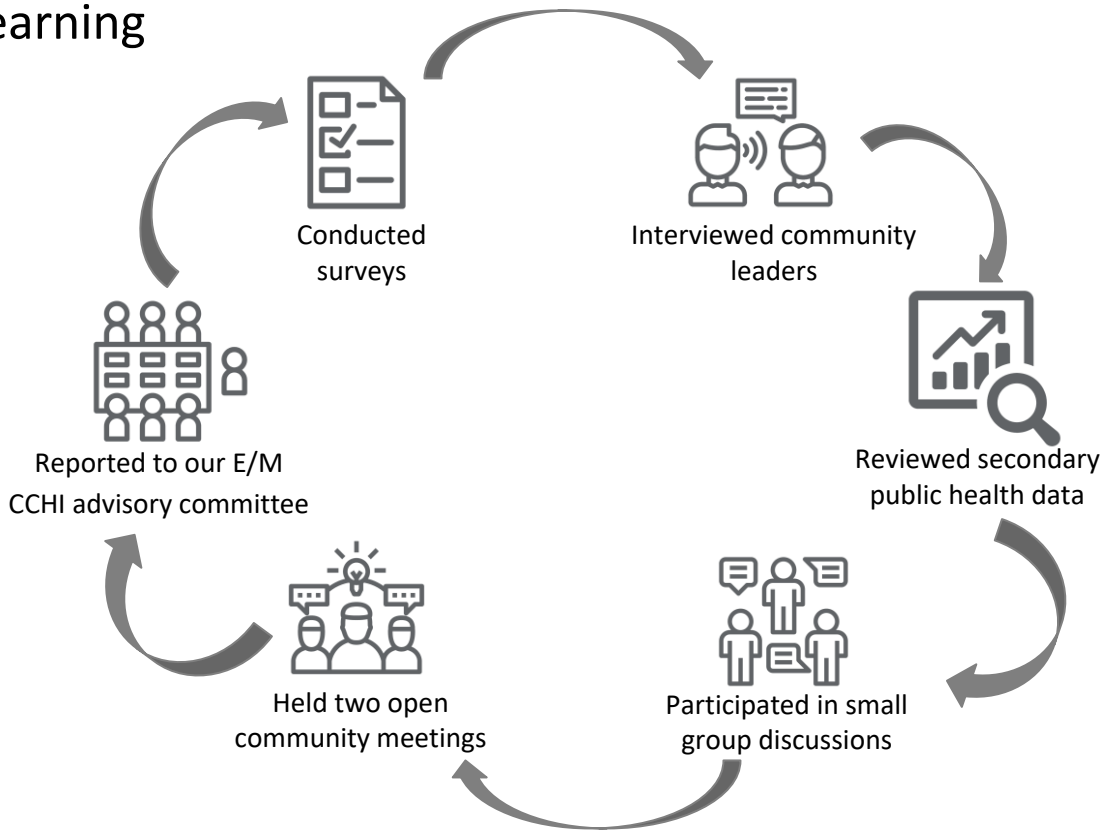
Health Equity: *Everyone* has a fair and just opportunity to be as healthy as possible.

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

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

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

Data Collection Process and Findings: Listening and Learning



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

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

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

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

Data Collection: How we listened and learned

Surveyed 67 individuals and interviewed various stakeholders

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

Conducted 4 small group sessions

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

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

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

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

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

English version of the flyer promoting community meetings

Participants from the Malden community meeting

Findings: What we heard and learned

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

Top Strengths of Our Communities[2]

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

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

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

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

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

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

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

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

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

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

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

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

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

Top Concerns Impacting Health

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

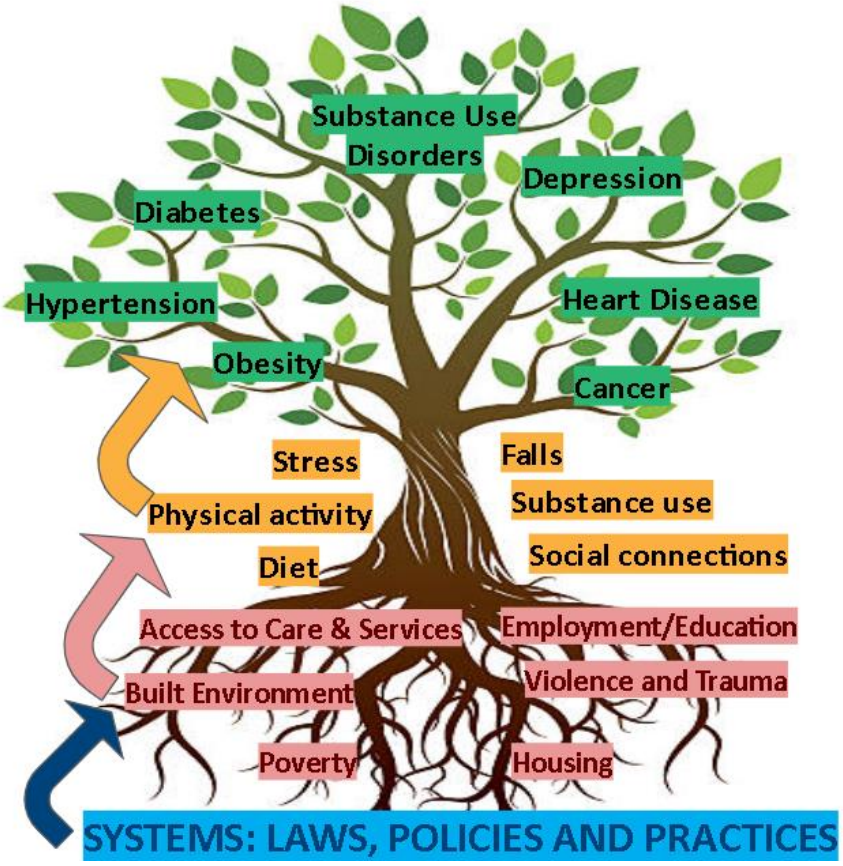
- **Housing affordability and stability (including homelessness)**
- **Access to healthy food**
- **Economic stability & mobility**
- **Access to care and services**

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

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

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

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



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

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

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

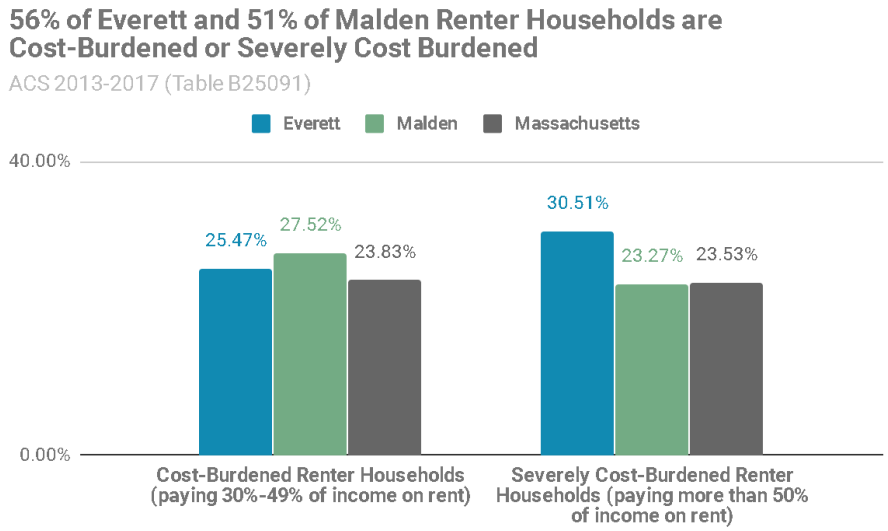
Social, Economic and Built Environment

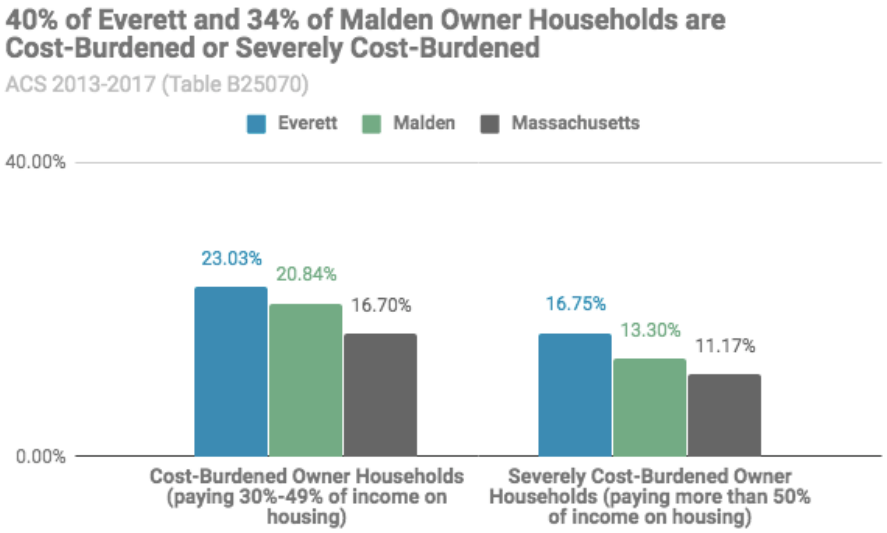
There are strong connections between social conditions, economic opportunities, and health - the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our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

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

Housing affordability, stability and safety

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





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

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

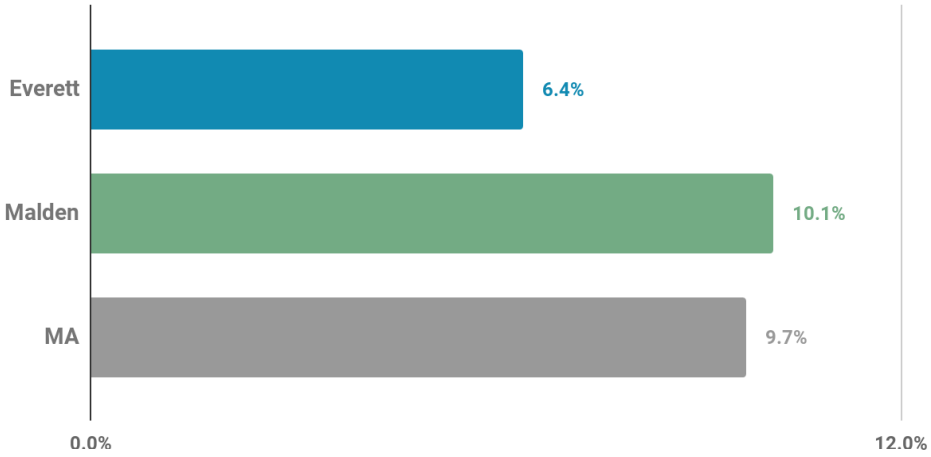
Churn rates: Unstable housing conditions can lead to **higher churn rates** within the schools. The churn rate measures the number of students transferring into or out of a public school district during the course of a school year, and is also referred to as "student mobility." The churn rate in 2018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

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

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

Everett has a lower percentage of subsidized housing than the State

Subsidized Housing Inventory as of September 14, 2017



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

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

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

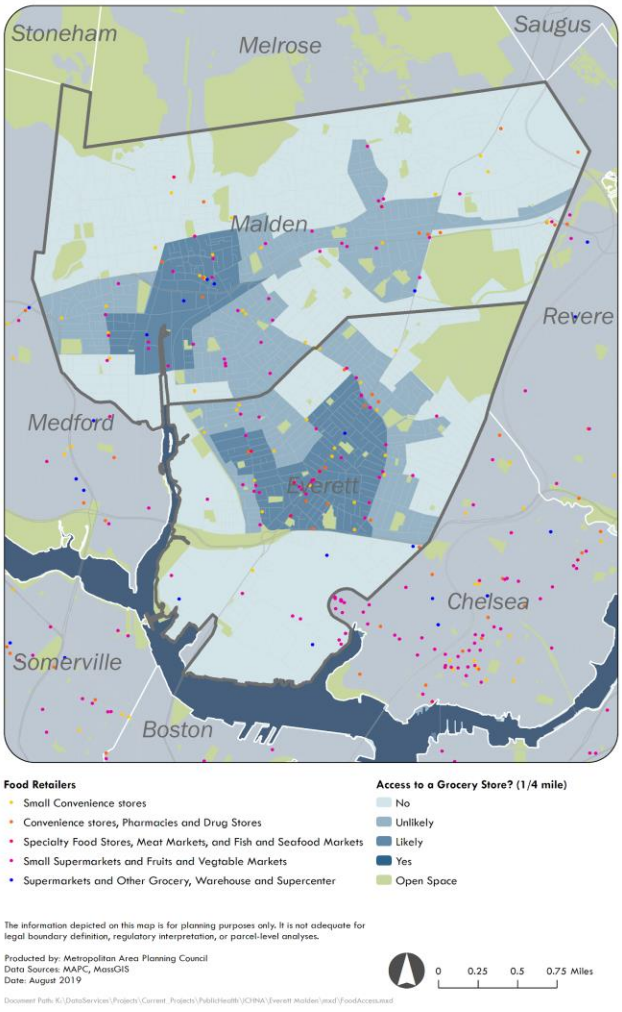
Focus groups also revealed community members' concerns regarding lead levels in homes and in the water supply. Lead can have short and long-term impacts on people. The threshold of the amount of lead that is "safe" in water is 15 parts per billion. As the table to the right shows, both Everett and Malden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

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

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

Healthy food access

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



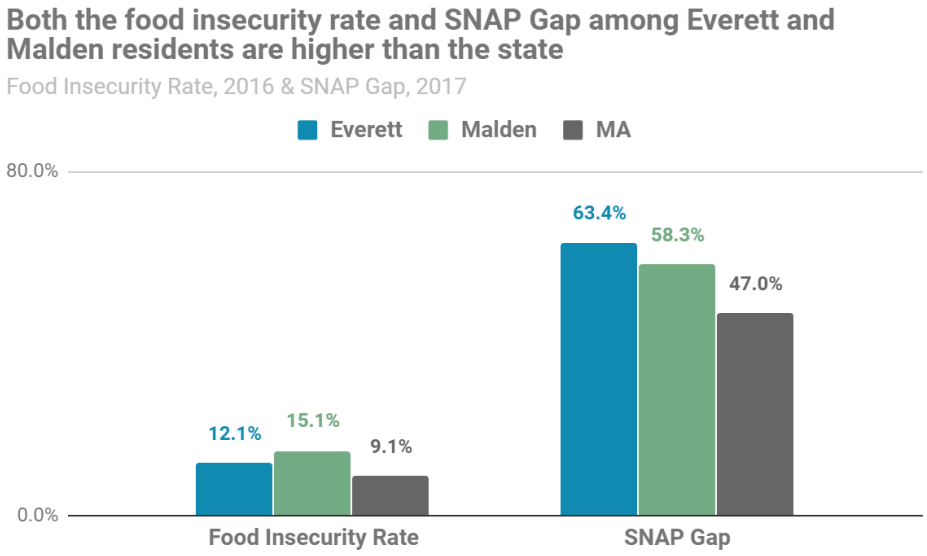
Access to a Food Retail Store within ¼ Mile

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

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

Food Insecurity Rates

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



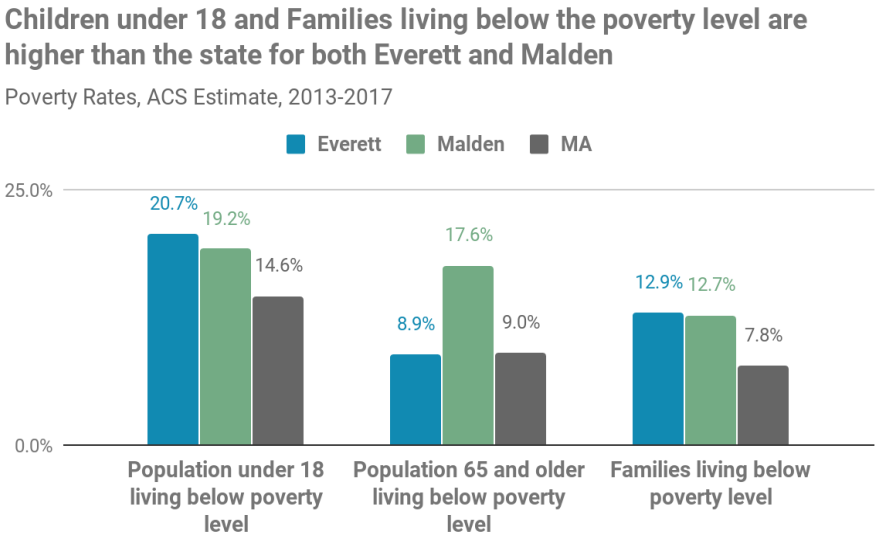
Data Sources: Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2016. Feeding America, 2018. Courtesy of The Greater Boston Food Bank. Food Bank of Western MA,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

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

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

Economic stability and mobility

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



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

Poverty Rates

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

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

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

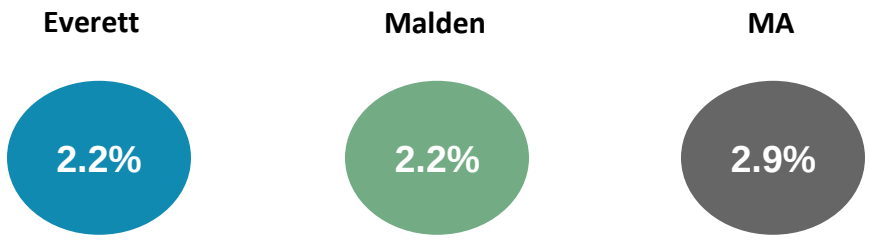
- Focus group and community meeting participants highlighted the challenge of having limited access to healthcare, including mental healthcare, because it is expensive; seniors noted that they have low income, creating a barrier to obtaining healthcare.
- They also noted that health insurance coverage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

Unemployment Rates

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

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

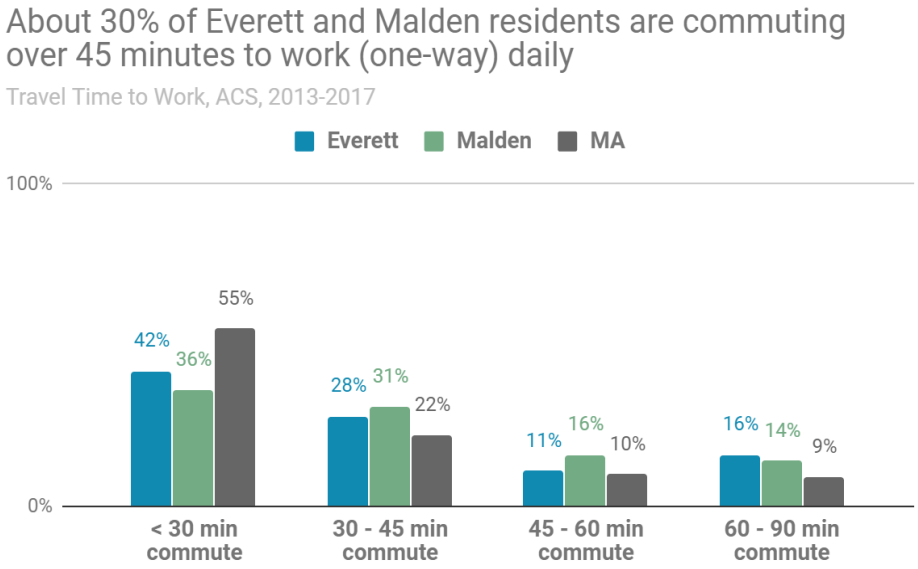
Unemployment Rate, April 2019



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

Commute Times

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



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

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

Access to care and services

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

Health Outcomes

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

Behavioral Health

What is it?

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

What contributes to it?

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

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

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

Why is it important?

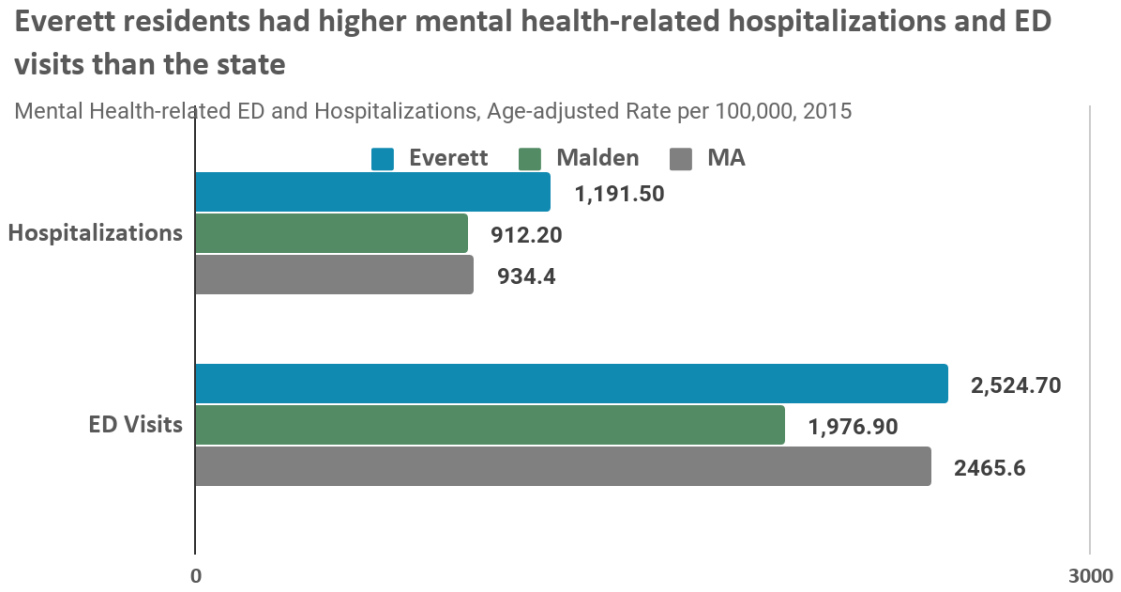
Areas of mental health (particularly youth depression and elder isolation) and substance use disorder (particularly the use of opioids, alcohol, youth vaping & marijuana) were issues that were voiced from participants through the community and stakeholder engagement process as the biggest health outcome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

Key findings:

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

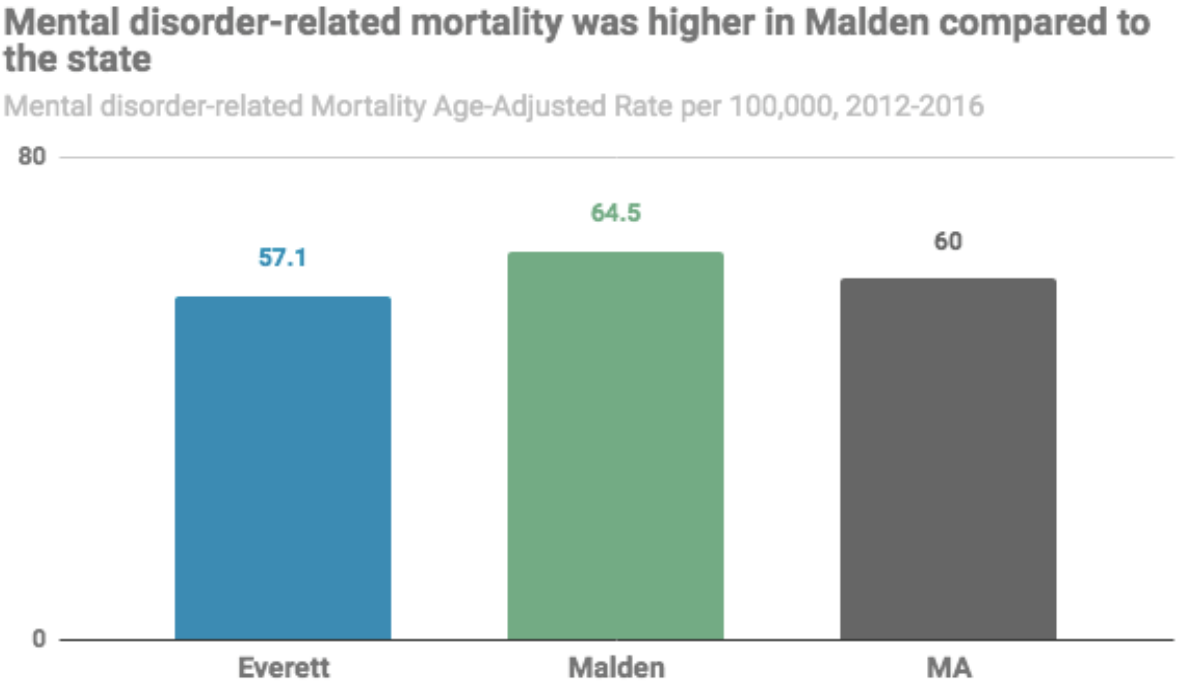
- What's unique?
  - **Mental Health:** Everett mental health-related hospitalizations, as well as middle and high school students who have attempted suicide in the past 12 months, are higher than the state. Malden's mental health-related mortality rates, as well as rates of elder isolation, (seniors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

Mental Health Data



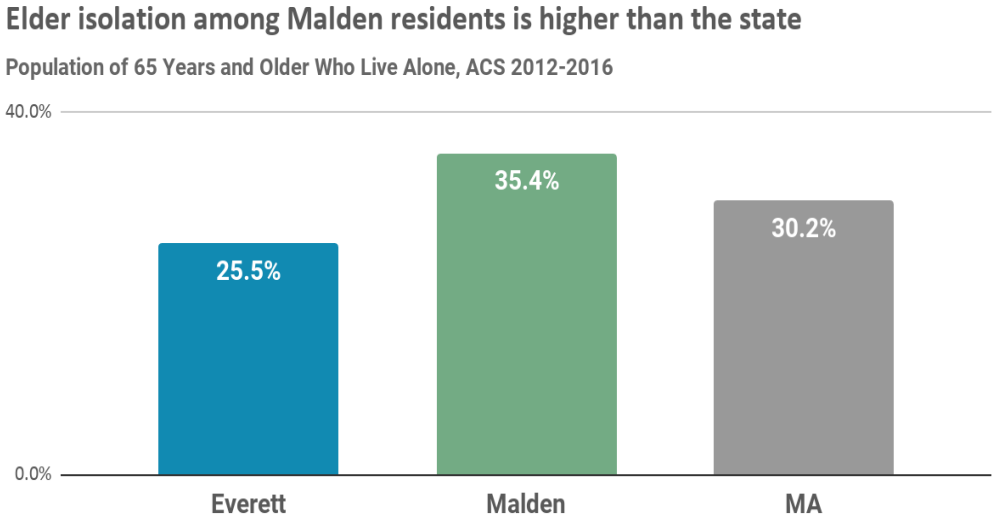
Note: These rates represent residents of the communities, not the location of the hospitalization or ED visit

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



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

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

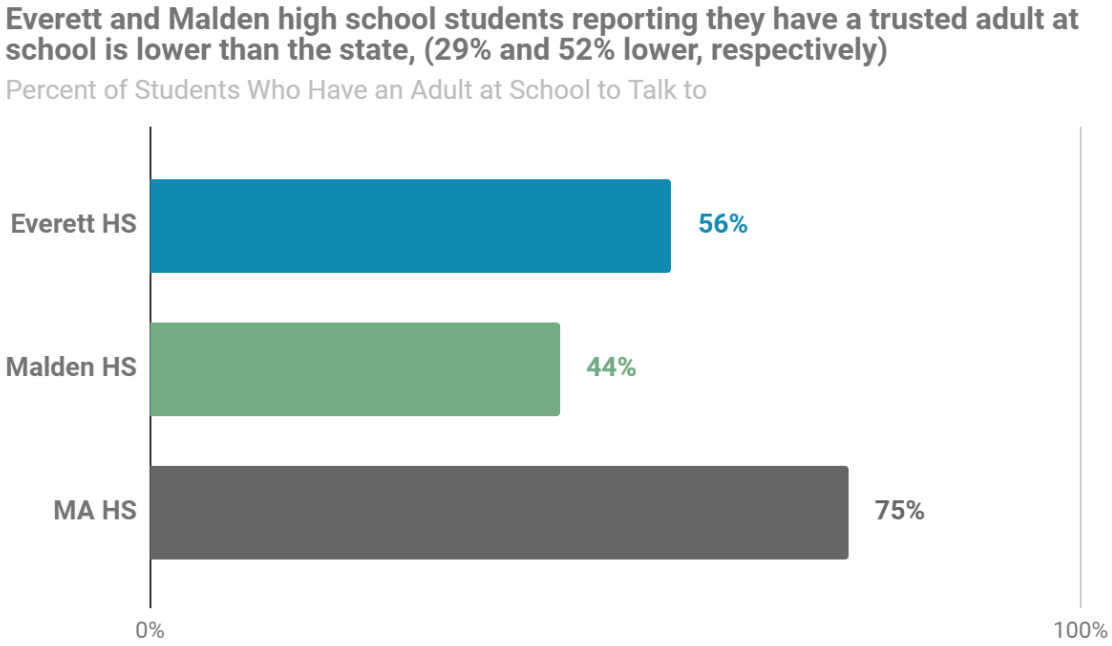


Data Source: ACS 2012-2016; found in Tufts 2018 Massachusetts Healthy Aging Community Profile report. Everett ACS 2013-2017 data was only available for population 60 years and older

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

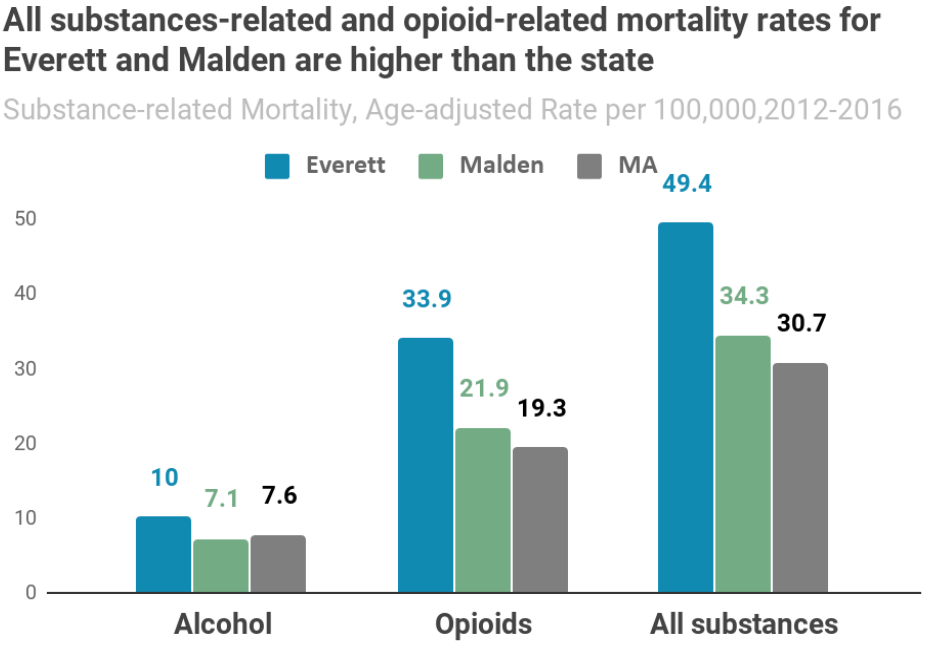
Data Source: 2018-2019 Everett YRBS, 2018 Malden YRBS, 2017 Massachusetts Youth Health Survey

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



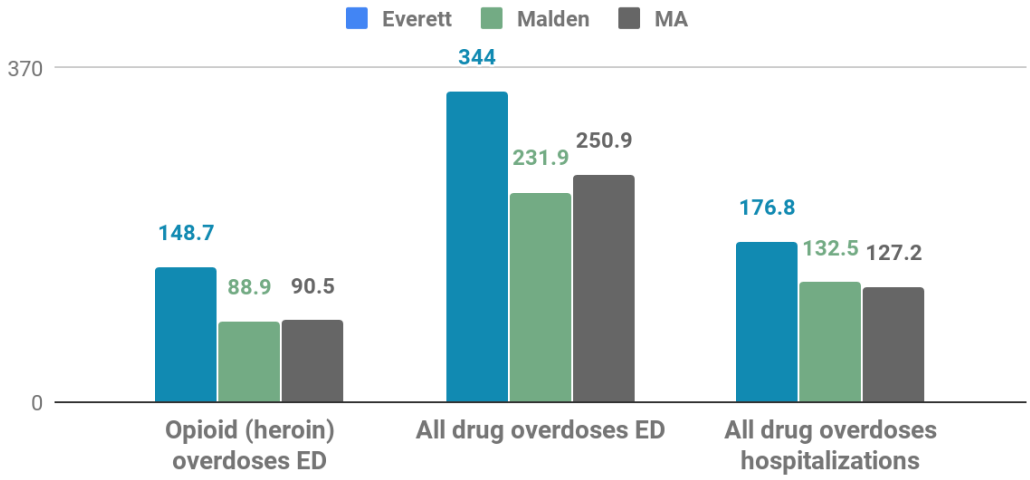
Data Source: 2018-2019 Everett YRBS, 2018 Malden YRBS, 2017 Massachusetts Youth Health Survey

Substance Use Data



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

Everett residents had higher rates of ED visits and hospitalizations* related to drug overdoses compared to the state.



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

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

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

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

Chronic disease

What is it?

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

What contributes to it?

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

Why is it important?

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

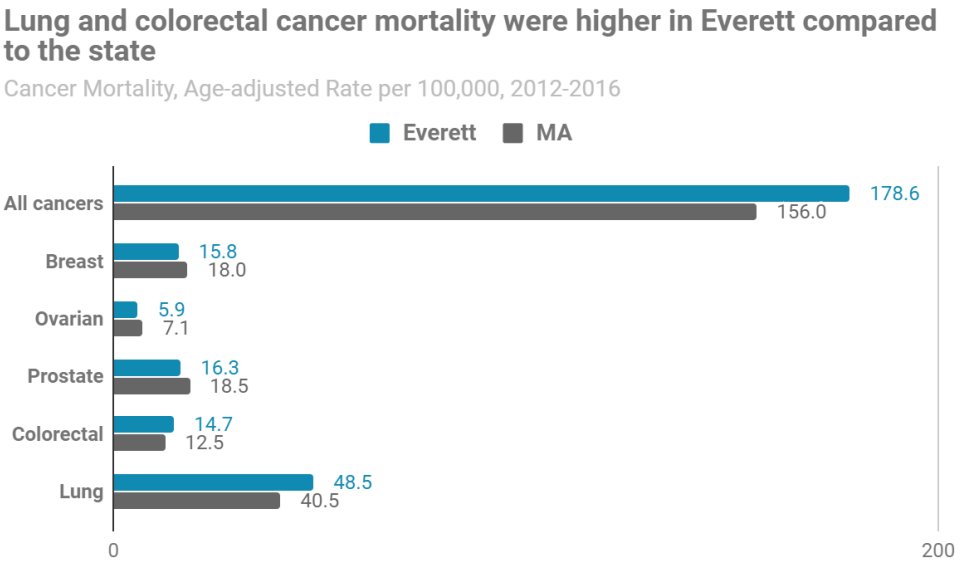
Key findings:

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

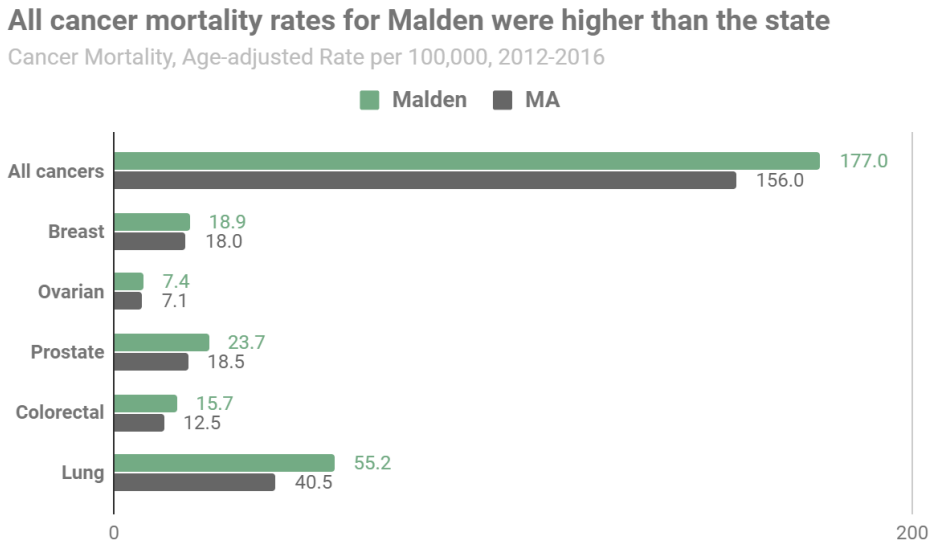
[11] Centers for Disease Control and Prevention: https://www.cdc.gov/chronicdisease/about/index.htm
[12] Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/copd/basics-about.html
[13] World Health Organization (WHO): https://www.who.int/cardiovascular_diseases/about_cvd/en/

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

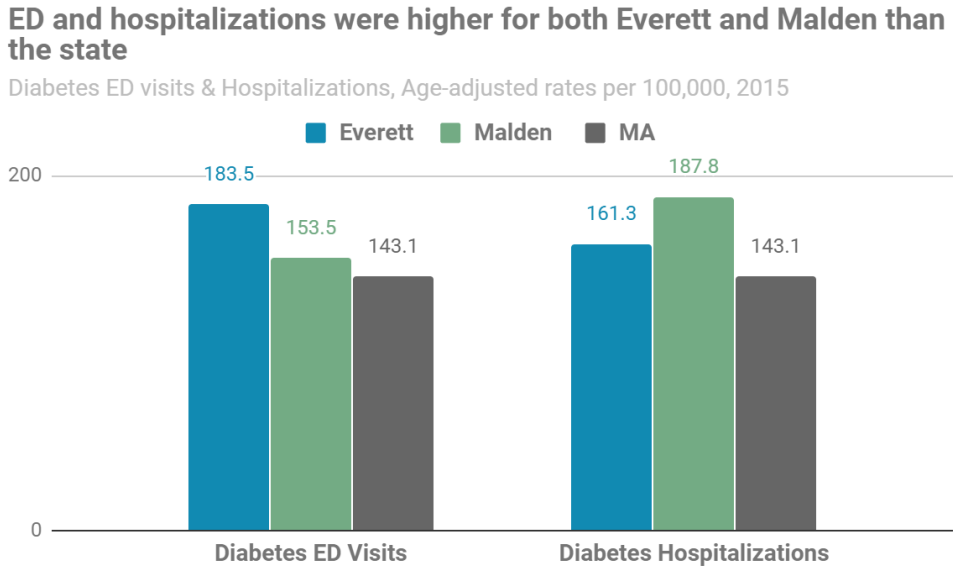
Cancer Data



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



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



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

Diabetes, Obesity and Cardiovascular disease data

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

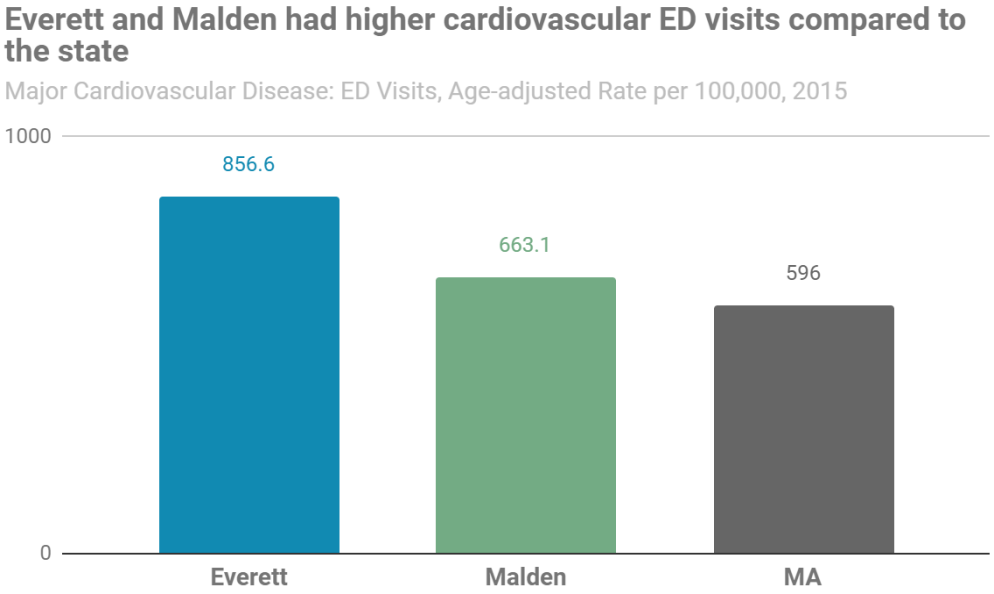
Diabetes Mortality	Everett	Malden	MA
Age-adjusted rate per 100,000, 2012-2016	22.1	22.9	14.8

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

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

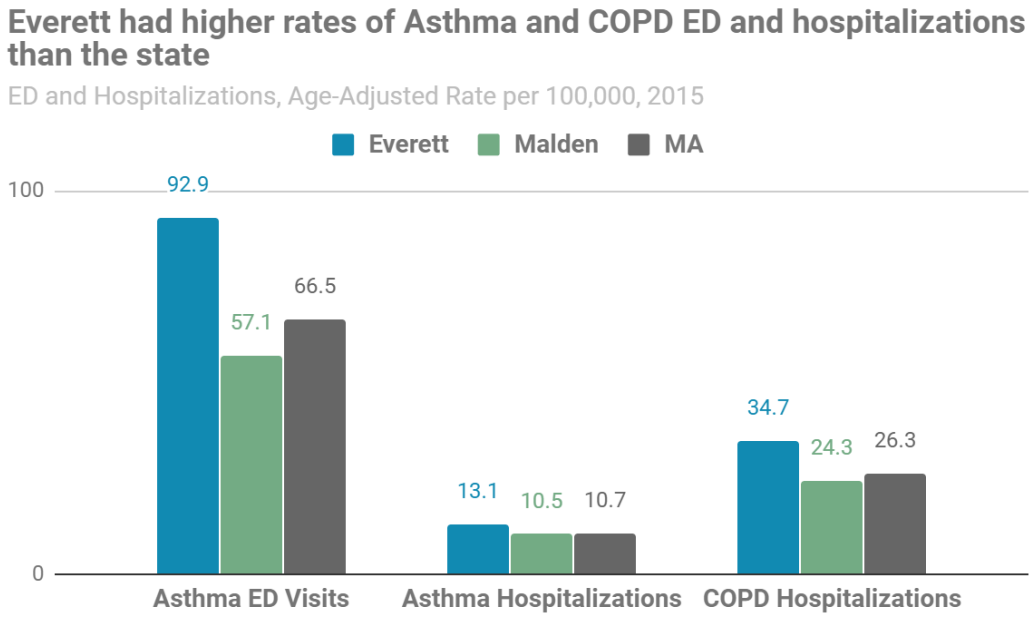
Percent of Overweight or Obese Public School Students	Everett (2016-2017)	Malden (2016-2017)	MA (2014-2015)
Grade 1	43%	34%	28%
Grade 4	56%	40%	34%
Grade 7	48%	46%	34%
Grade 10	36%	33%	33%

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



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

Respiratory Disease Data



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

Infectious disease

What is it?

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

What contributes to it?

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

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

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

Why is it important?

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

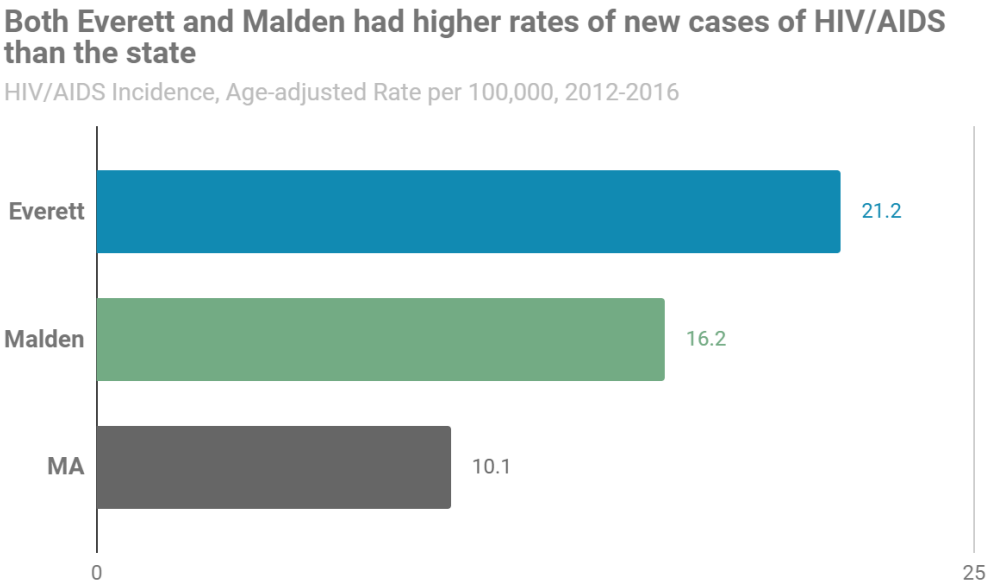
Key findings:

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

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

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

Infectious disease data

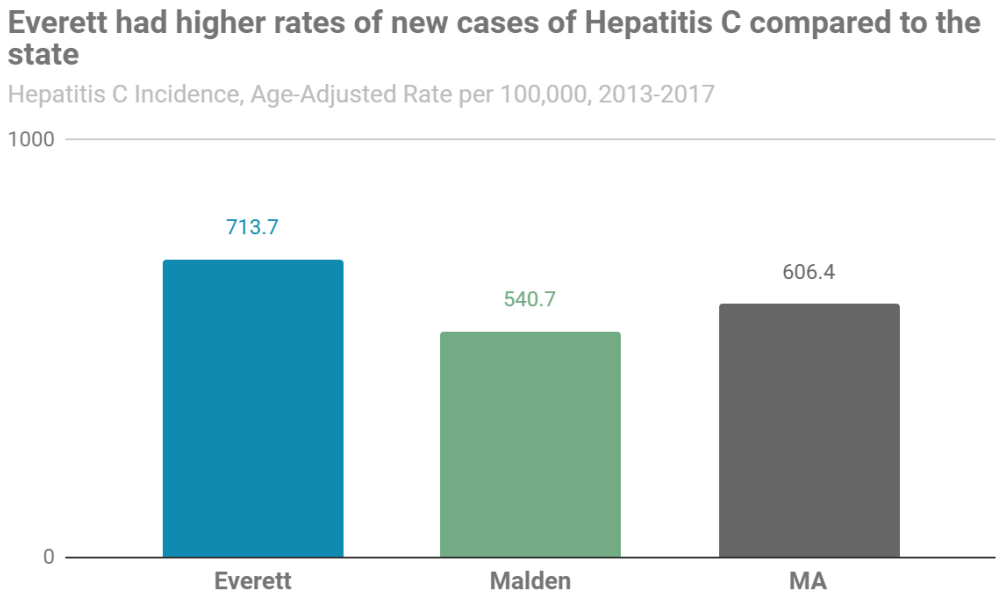


Data Source: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, HIV/AIDS Surveillance Program, 2012 -2016

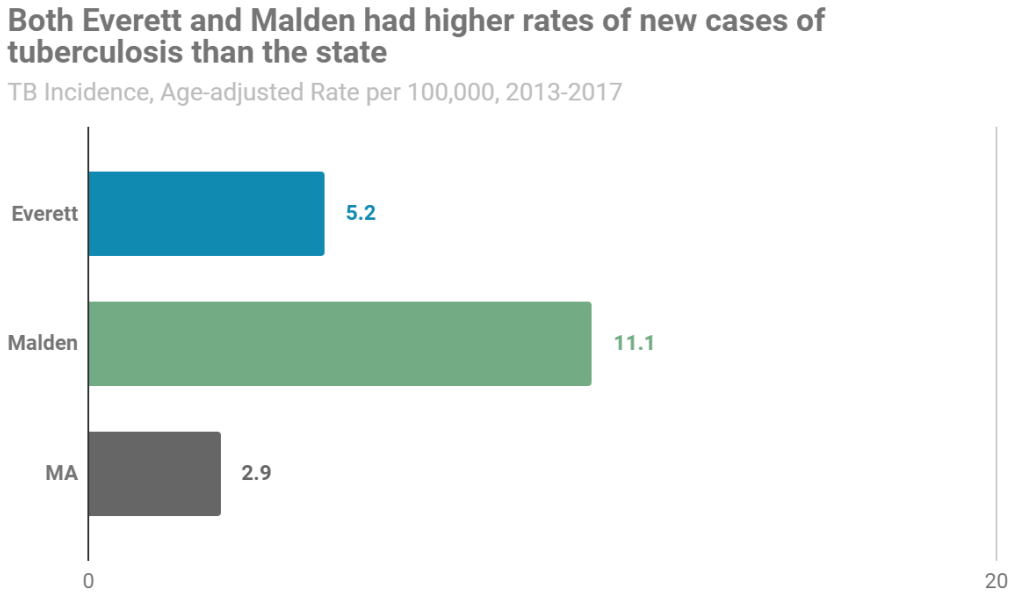
Both Everett and Malden had higher rates of chlamydia, gonorrhea and syphilis incidence than the state

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

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



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



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

Data Summary and Conclusion

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

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

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

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

Authors

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

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

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

Thank you to Partners & Reviewers

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

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

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

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

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

Appendices:

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

Appendix A: Secondary Data Sources
(In alphabetical order)

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

  - Center for Health Information and Analysis (CHIA), 2014
  - Division of Health Care Finance and Policy Uniform Hospital Discharge Dataset System (UHDDS), 2015, 2011 - 2015
  - Massachusetts Opioid Epidemic, A data visualization of findings from the Chapter 55 report
  - Percentage of obese children per grade in communities. Local Health Measures, 2016 – 2017
  - Registry of Vital Records, 2011 - 2015
  - Registry of Vital Records and Statistics, 2012 - 2016

- Massachusetts Environmental Public Health Tracking (EPHT), 2016, 2013-2017

- Massachusetts Water Resources Authority (MWRA), 2018, accessed at: http://www.mwra.com/annual/waterreport/2018results/2018results

- Massachusetts Youth Health Survey, 2017

- Metropolitan Area Planning Council (MAPC) Sidewalk/Bike Lane Data Map, 2019

- MIT Living Wage Calculator, Middlesex County, 2018

- Mystic River Watershed Association (MyRWA), accessed at: https://mysticriver.org/epa-grade

- The Trust for Public Land, ParkServe tool-data, May 2019

- US Bureau of Labor Statistics, BLS Data Finder, 2019

- US Census Bureau, American Community Survey (ACS) 5-Year Estimates, 2013-2017

- US Federal Bureau of Investigation, Crime Data Explorer, 2017

Appendix B: Survey Instrument

Everett and Malden Community Health Survey

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

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

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

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

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

Part 1: Your Community

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

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

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

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

Part 2: Health and Wellbeing Factors

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

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

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

6. People work together to improve our community.

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

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

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

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

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

9. My community looks and feels inviting and safe.

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

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

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

11. People have access to reliable transportation.

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

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

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

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

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

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

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

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

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

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

How true?

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

Priority for improvement?

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

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

How true?

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

Priority for improvement?

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

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

How true?

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

Priority for improvement?

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

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

How true?

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

Priority for improvement?

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

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

How true?

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

Priority for improvement?

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

Part 3: Strengths and Challenges

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Part 4 (Optional): About You

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

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

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

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

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

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

Appendix C: Focus Group Questions

Everett and Malden Community Health Assessment
Focus Group Discussion Guide

Please complete this section for each focus group:

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

General Instructions

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

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

Materials and Set-up

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

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

Opening Script

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

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

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

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

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

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

Does anyone have any questions before we begin?

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

Thank you again for participating in this discussion.

Turn on the audio recorder if all consented.

Section 1 Script: Community Perceptions

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

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

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

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

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

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

Section 2 Script: Exploring Key Factors

<u>If factor is in the Social-Cultural Environment (People) cluster:</u>

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

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

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

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

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

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

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

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

Section 3 Script: Final Remarks and Closing

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

Wrapping Up

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

Appendix D: Community Data Profile

EVERETT COMMUNITY DATA PROFILE 2019-2020

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

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

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

Sources

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

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

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

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

Sources

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

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

Table 3. Health Outcomes

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

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

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

Sources

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

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

MALDEN COMMUNITY DATA PROFILE 2019-2020

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

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

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

Sources

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

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

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

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

Sources

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

12. Malden Public Schools, Malden Student Health Survey/Youth Risk Behavior Survey (YRBS). 2018. Data presented as percentage of total numbers.
13. Massachusetts Department of Public Health, Youth Risk Behavior Survey (YRBS). 2017. Data presented as percentage of total numbers.
14. Secretary of the Commonwealth of Massachusetts, Massachusetts Voter Enrollment Breakdown. 2019. Presented as total numbers and percentage of total numbers.

Table 3. Health Outcomes *Emergency department, hospitalization and mortality data reflect Malden residents who received care anywhere, not just those people who received care in Malden.*	Malden		Massachusetts	
	#	%/Rate	#	%/Rate
Behavioral Health				
All ages mental health/mental illness *(age-adjusted rate per 100,000)*				
Suicide mortality[1]	20	6.4	3,110	8.7
Mental health related emergency department visits[2]	1,326	1,976.9	168,735	2,465.6
Mental health related hospitalizations[2]	600	912.2	65,671	934.4
Mental disorder-related mortality[1]	200	64.5	26,566	60.0
Youth mental health[3,4] *in past 12 months*				
High school students who experienced depression	---	28.0%	---	27.4%
High school students who seriously considered suicide	---	10.0%	---	12.4%
High school students who attempted suicide	---	5.0%	---	5.4%
All ages substance use visits *(age-adjusted rates per 100,000)*				
Total drug overdose emergency department visits [2] *	157	231.9	16,699	250.9
Total drug overdose hospitalizations[2]	88	132.5	8,920	127.2
Total substance-related mortality[1]*	112	34.3	10,710	30.7
Alcohol-related mortality	23	7.1	2,952	7.6
Opioid-related mortality	72	21.9	6,429	19.3
*Total drug overdose emergency department visits includes visits for heroin, non-heroin opioids and all other types of drug overdoses; total substance-related mortality includes mortality due to alcohol, opioids, and all other types of substances				
Youth substance use[3,4]				
High school students who have ever used alcohol	---	40.00%	---	56.20%
High school students who have used alcohol in the last 30 days	---	13.00%	---	31.40%
High school students who have ever used cigarettes	---	8.00%	---	19.60%
High school students who have used cigarettes in the last 30 days	---	2.00%	---	6.40%
High school students who have ever used e-cigarettes	---	27.00%	---	41.10%
High school students who have used e-cigarettes in the last 30 days	---	14.00%	---	20.10%
High school students who have ever used marijuana	---	22.00%	---	37.90%
High school students who have used marijuana in the last 30 days	---	10.00%	---	24.10%
Chronic Disease				
Cancer[1] *(age-adjusted rate per 100,000)*				
All cancer mortality*	532	177.0	63,929	156.0
Breast cancer mortality	33	18.9	4,100	18.0
Colorectal cancer mortality	47	15.7	5,143	12.5
Lung cancer mortality	163	55.2	16,503	40.5
Ovarian cancer mortality	13	7.4	1,635	7.1
Prostate cancer mortality	25	23.7	3,046	18.5
*All cancer mortality includes the five types of cancer listed above as well as deaths from all other types of cancer				
Cardiovascular disease *(age-adjusted rate per 100,000)*				
Major cardiovascular disease hospitalizations[2]	990	1,563.2	126,640	1,563.1
Major cardiovascular disease mortality[1]	501	165.4	77,337	179.7
Cerebrovascular disease (stroke) hospitalizations[2]	151	239.9	20,789	255.1
Cerebrovascular disease (stroke) mortality[1]	74	24.7	12,117	28.2

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

Sources

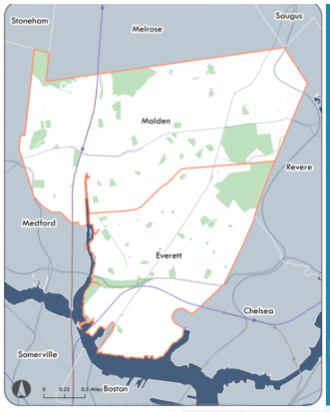
1. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Mortality and birth data. 2012-2016. Data presented as total number of cases and age-adjusted rate per 100,000.
2. Massachusetts Department of Public Health, MA Division of Health Care Finance and Policy Uniform Hospital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

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

Appendix E: 1-Page Community Snapshots

2019 Community Health Needs Assessment (CHNA) Highlights

Everett



Demographics at a Glance

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

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

What is a CHNA?

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

Data Approach & Collection Process

THRIVE* Framework

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

People + Place + Equitable Opportunity = Health Outcomes

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

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

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

Strengths of Community

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

Top Concerns Impacting Health

Behavioral Health Outcomes
- Mental health
- Substance use disorders

Chronic Diseases
- Cancer
- Obesity
- Diabetes
- Respiratory disease

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

Infectious Diseases
- HIV
- Hepatitis C

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

Next Steps

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

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

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

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

CHA Cambridge Health Alliance
MGH 1811 MASSACHUSETTS GENERAL HOSPITAL
MW Melrose Wakefield Healthcare
Proudly wellforce

2019 Community Health Needs Assessment (CHNA) Highlights

Malden

Demographics at a Glance

61,212 Total Population

43% Born Outside the US

13% Families Live in Poverty

39% Of population are 35-64 years old

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

What is a CHNA?

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

Data Approach & Collection Process

THRIVE* Framework

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

People + Place + Equitable Opportunity = Health Outcomes

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

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

303 community surveys collected

Review of publicly reported data

3 small group discussions

2 open community meetings

Development of community advisory board

Strengths of Community

Open space & recreation

Diversity of residents & businesses

Produce markets & community gardens

Access to free and low cost meals for students & seniors

Social services, civic/community engagement

Top Concerns Impacting Health

Behavioral Health Outcomes
- Mental health
- Substance use disorders

Chronic Diseases
- Cancer
- Obesity
- Diabetes
- Respiratory disease

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

Infectious Diseases
- HIV
- Hepatitis C

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

Next Steps

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

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

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

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

CHA Cambridge Health Alliance

MGH 1811 Massachusetts General Hospital

MW Melrose Wakefield Healthcare

Proudly wellforce

Appendix F: Resources

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

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

ATTACHMENT 4(C)

COMMUNITY HEALTH IMPLEMENTATION STRATEGY –EVERETT AND MALDEN (JULY 2021)

CHA Cambridge Health Alliance

Community Health Implementation Strategy

Everett and Malden

Department of Community Health Improvement

July 2021

CARE TO THE PEOPLE

Table of Contents

Introduction

Every three years, Massachusetts health systems and hospitals carry out a **Community Health Needs Assessment (CHNA)**, which informs an **Implementation Strategy.** A CHNA is a collaboration between a health system and the community it serves, to understand, prioritize, and take action on strengths and concerns related to community health. An Implementation Strategy documents the health system's efforts to address priorities identified in the CHNA in collaboration with the community. It serves as a guide for the health system's work. ***Figure 1*** depicts the CHNA & Implementation Strategy cycle.

Figure 1. Community Health Needs Assessment and Implementation Strategy Cycle

Association for Community Health Improvement, Community Health Assessment Toolkit, 2017

In 2019, Cambridge Health Alliance (CHA) partnered with Mass General Brigham and Melrose Wakefield Healthcare to carry out a CHNA in Everett and Malden. The final report was released in March 2020, but the development of CHA's Implementation Strategy was interrupted due to COVID-19.

In early 2021, CHA's Health Improvement Team launched a modified process to reflect and document how CHA's community health strategies – *in* and *with* our communities – address priorities that Everett and Malden residents had identified through the CHNA. This process of reflection frames the work that lies ahead for CHA – a Regional Wellbeing Assessment, which will launch in Fall 2021.

We are pleased to share CHA's Implementation Strategy report with you. In this document, you will find four main sections:

- In **Part 1,** we will review the process and findings of the 2019-2020 Everett-Malden CHNA.
- In **Part 2,** we will share why and how we modified the Implementation Strategy development process, and introduce you to the upcoming Regional Wellbeing Assessment.
- In **Part 3,** we will share the key findings that shaped the Implementation Strategy.
- In **Part 4,** we will share the goals, strategies, and collaborative efforts that compose the Department of Community Health Improvement's commitment to addressing the priorities identified in the 2019-2020 Everett-Malden CHNA.

Part 1: Everett-Malden CHNA Process & Findings

In 2019, CHA partnered with Mass General Brigham and Melrose Wakefield Healthcare to carry out a collaborative CHNA in Everett and Malden. The **2019-2020 Everett-Malden Community Health Needs Assessment** final report was released in March 2020. The cover image of the report is shown in ***Figure 2.***

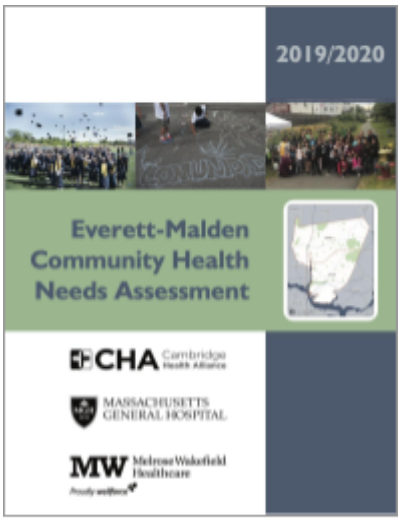


Figure 2. 2019-2020 Everett-Malden CHNA Final Report cover image

We used a framework called the Tool for Health and Resilience in Vulnerable Environments, or THRIVE, to guide the CHNA. THRIVE is a model for engaging community members in assessing community conditions and taking action on priorities to advance health equity. THRIVE identifies three main clusters of community conditions that influence the health of the community. These clusters are:

- PEOPLE, which refers to the social and cultural environment – factors like social cohesion and sense of collective efficacy.
- PLACE, or the natural and built environment – factors like housing, transit, air & water, and arts & cultural expression.
- EQUITABLE OPPORTUNITY, or the economic and educational environment – factors like the job market, local wealth, and schools.

Figure 3. THRIVE Model of Health and Resilience
Prevention Institute, 2003

As shown in ***Figure 3*****,** the framework emphasizes that the nature of community conditions emerges from structural drivers – such as racism and white privilege, class oppression and privilege, and gender inequity. In turn, the community conditions in which people live influence how health outcomes are distributed along lines of place, socioeconomic position, racial or ethnic group, or other elements of identity.

By orienting the assessment process around exploring these domains of People, Place, and Equitable Opportunity, we aimed to lay the groundwork for thinking about what strategies could be developed, and what barriers could be removed, to facilitate opportunity for better, equitable health outcomes.

THRIVE was developed by the Prevention Institute – for more information, visit their website.

Through interviews, focus groups, community surveys, and analysis of existing data sources, the assessment illuminated many strengths and concerns of the Everett and Malden communities.

Strengths of our communities

The main community strengths that were identified included:

- Cultural and language diversity
- Open space and recreation
- Meals for students and seniors
- Produce markets and community gardens
- Social service, civic, and community organizations

Concerns impacting health

The main concerns impacting health that were identified included:

- Housing affordability and stability
- Economic stability and mobility
- Access to healthy food
- Access to health care and services
- Mental health and substance use
- Chronic diseases and sexually transmitted infections

Equity concerns

Equity concerns were highlighted along lines of:

- Race and ethnicity
- Immigration status
- Language
- Age

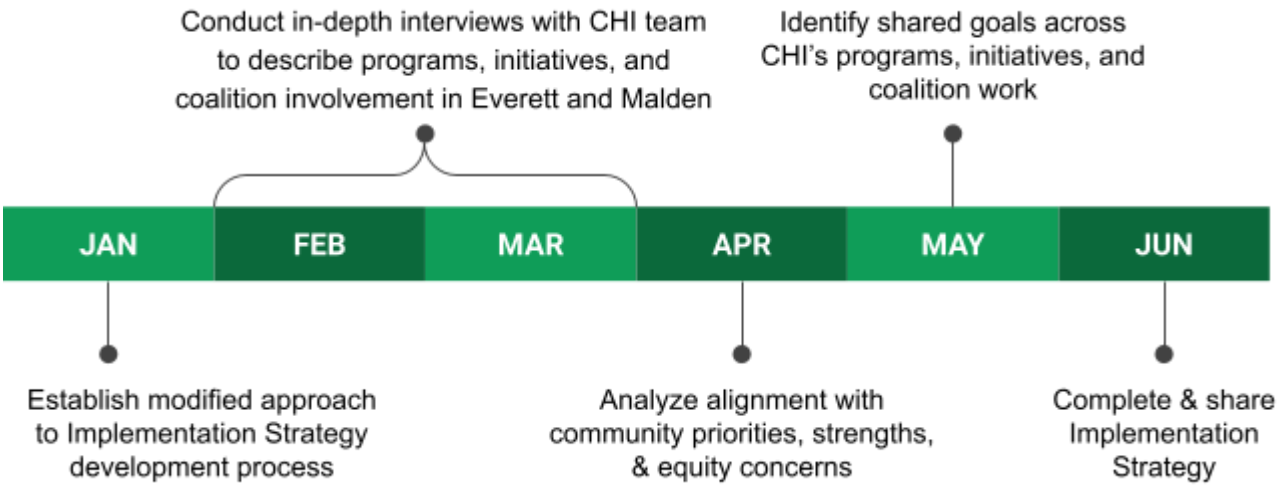
Part 2: Modified Implementation Strategy Process, and Looking Ahead to a Regional Wellbeing Assessment

Almost as soon as the CHNA was released in March 2020, CHA's Department of Community Health Improvement team had to shift our focus to responding to COVID-19. Nine months later, in early 2021, we decided to take a step back, review the 2019-2020 CHNA, and determine how we could develop an Implementation Strategy that took into account the new reality that COVID-19 had resulted in. We took this opportunity to establish a baseline of how CHI shows up in the community-identified priority areas, and aimed to respect the time and bandwidth of the people in Everett and Malden who would soon be asked to participate in a Regional Wellbeing Assessment starting in Fall 2021.

While the findings of the CHNA were still valid, we believed the priority needs and equity concerns had been amplified. Community strengths had been stretched and grown in new ways. Many people involved in the CHNA had moved to new jobs, or their roles had shifted. The pandemic had been a shock to our lives and systems – we would need to work together intentionally to recover and heal.

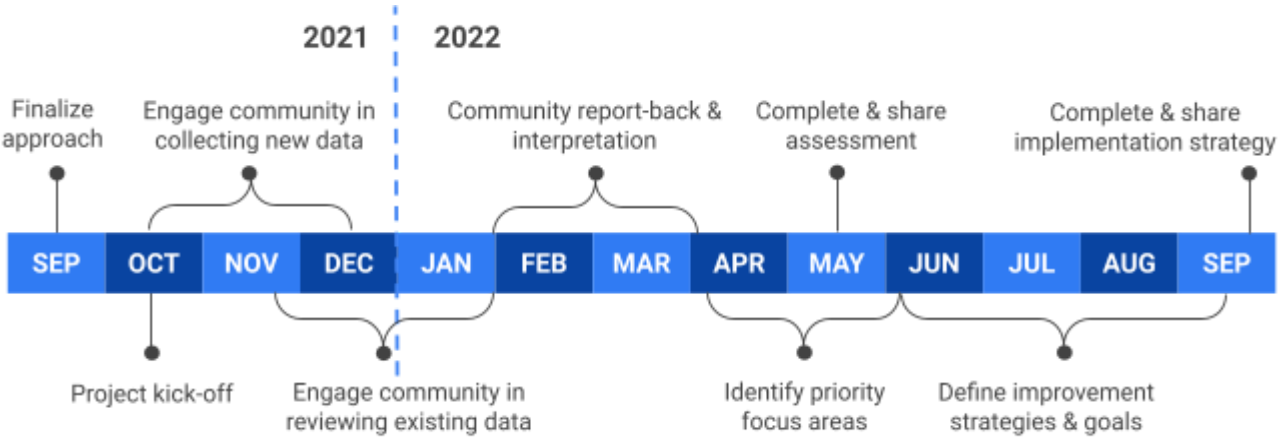
We decided to modify the Implementation Strategy development process to be carried out over the first six months of 2021, by orienting it around a new framing question:

How does the work of CHA's Department of Community Health Improvement (CHI) align with the priority needs, community strengths, and equity concerns identified in the Everett-Malden CHNA?



This modified process enabled us to reflect on the current state, and to lay the groundwork for moving forward collaboratively, effectively, and equitably – in coordination with other health systems, community partners, municipal partners, and within CHA, across clinical services, mental health, community health, and beyond.

To that end, we are planning a **Regional Wellbeing Assessment**, to launch in Fall 2021, that will include community members and partners in Everett and Malden, along with other municipalities in CHA's primary service area. This upcoming assessment represents an opportunity to collaborate on elevating the priorities that are now most important, particularly to communities most impacted by inequity. It will be aligned with the CHNA cycles that other health systems in our region are carrying out as well. A high-level timeline for the assessment is shown below.



Learn more about the Regional Wellbeing Assessment in this two-page concept overview.

Part 3: Key Findings

When we looked across CHI's programs, initiatives, and coalition involvement, we found that many of our CHI strategies align with multiple community-identified priorities. And, many focus on equity concerns voiced by and on behalf of multiple populations. ***Figure 4*** shows the number of strategies that are aligned with each priority need, and ***Figure 5*** shows the number of strategies that are aligned with equity concerns related to each population.

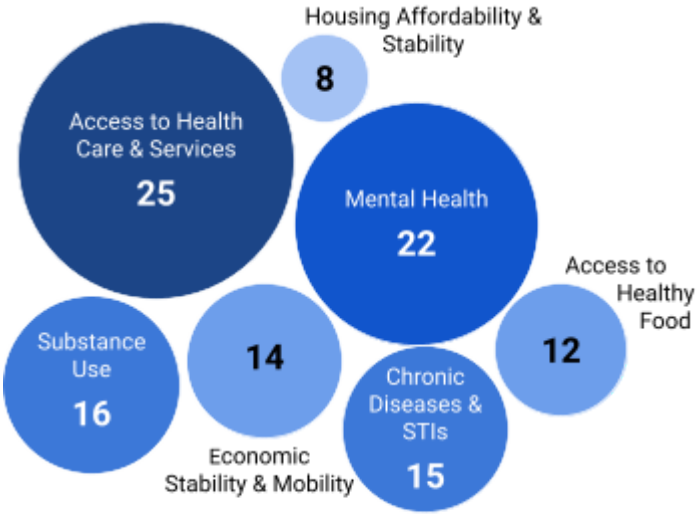


Figure 4. CHI strategies aligned with community-identified priorities

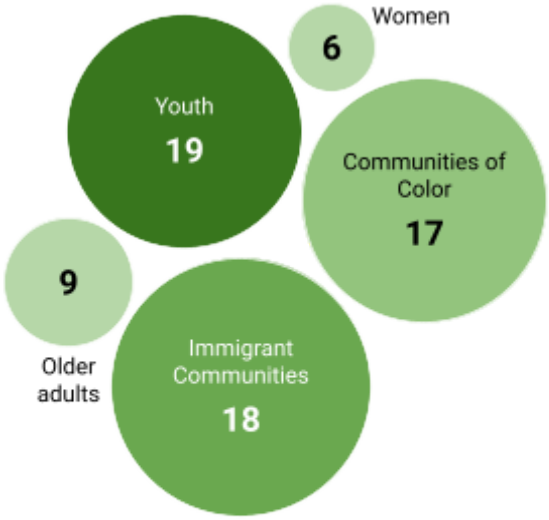


Figure 5. CHI strategies with specific focus on related equity concerns

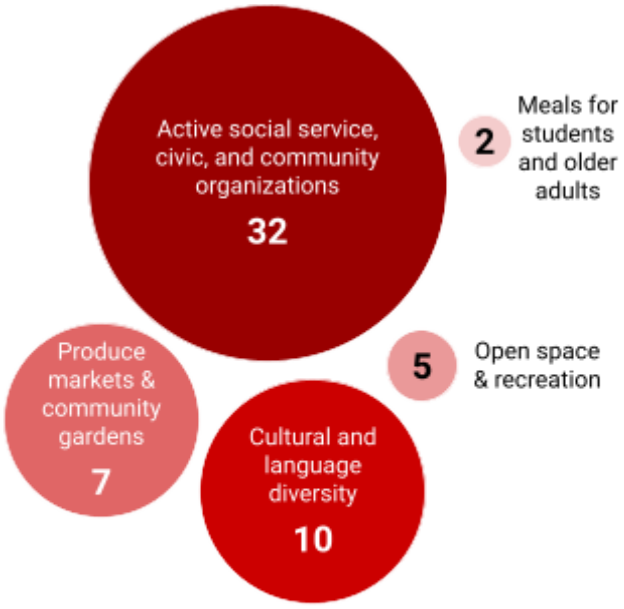


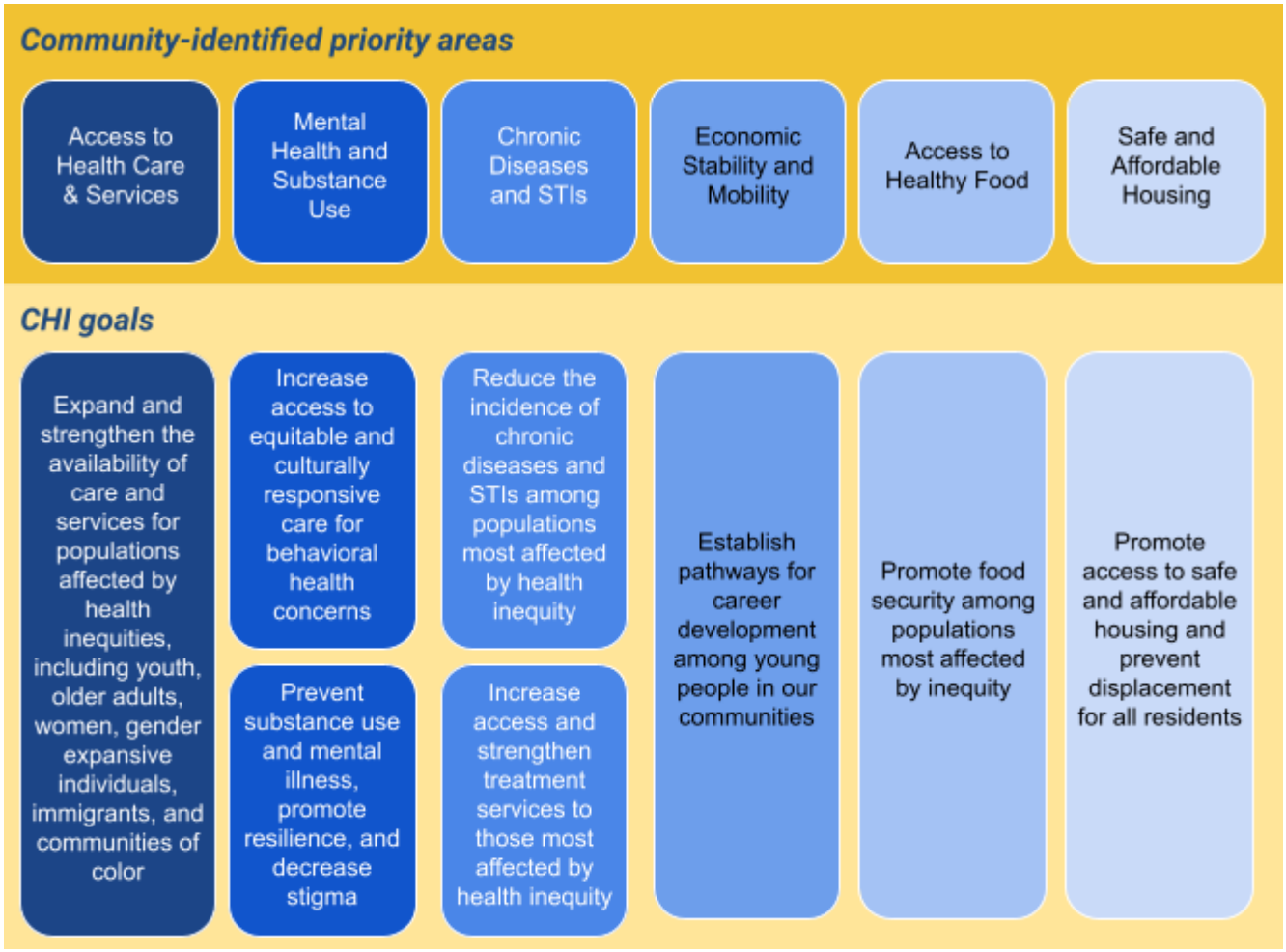
Figure 6. CHI strategies that build on community-identified strengths

We also found that our CHI strategies build on many community-identified strengths, especially in terms of collaborating with the many social service, civic, and community organizations that are active in Everett and Malden. ***Figure 6*** shows the number of strategies that build on the strengths that were identified through the CHNA process.

Part 4: Goals, Strategies, and Collaborative Efforts

Based on the key findings, we identified common themes, community partners, and aligned objectives. We synthesized these into **8 goals** across **6 community-identified priorities**, with **2–4 strategies per goal**. The tables below describe the Department of Community Health Improvement's commitment to addressing the priorities identified in the 2019-2020 Everett-Malden CHNA.

Quick Summary: Priority Areas and Goals



Implementation Strategy Details

***Priority:* Access to Health Care and Services**	
Our Goals: CHI works to...	*Our Strategies: We approach this goal by...*
1 Expand and strengthen the availability of care and services for populations affected by health inequities, including youth, older adults, women and gender expansive individuals, immigrant communities, and communities of color.	• Promoting affordability, language inclusivity, location + hours accessibility, and culturally responsive care options that address structural barriers to care. • Developing and maintaining systems of care navigation, screening, and referral. • Promoting peer learning, workshops, and health communication tailored to experiences. • Investing in current and future public health and health care professionals, including through internships and training opportunities that embody and emphasize anti-racism.

Key Programs and Collaborative Initiatives

- Health care, prevention, education, and referral services are offered in alignment with equity and access goals at the **Everett Care Center** and **Malden Care Center**, and **Everett Teen Health Center** and the **Starr Center** (Malden's pilot School Based Health Center), including:
    - **HIV and STI** screening, testing, and referral to treatment
    - **Sexual and reproductive health** counseling and family planning options
    - **Mental health** counseling and services
    - **Substance use** counseling and recovery, including Medication-Assisted Treatment
- **Community Connects** engages members of communities disproportionately impacted by COVID-19 in conversations about priority topics, such as myths and facts about the virus, preventing exposure and infection, keeping families safe, accessing testing and treatment, and promoting vaccine confidence.
- The **Volunteer Health Advisors (VHA)** program provides training to diverse community members to serve in a variety of community health worker roles, including connecting individuals to health care and other services, and supports community-based engagement activities tailored to the experiences and priorities of communities affected by health inequities.
- **Mental Health Awareness Training (MHAT)** and **Mental Health First Aid (MHFA)** provide training to community members to support mental health among adults and youth, including by responding and connecting individuals to appropriate care during a mental health crisis.
- The **Women's Health Program** promotes education and navigation to breast cancer screening, tailored to the experiences of women of diverse ethnic identities and language backgrounds.

- **Aging Wisely Everett** and **Senior to Senior** offer health education, information about available services, and engagement opportunities to older adults.
- **Healthy ME, Street Smart,** and **Helping Hands at Work** provide health education, leadership development, and information about available health care services to youth.
- The **Everett Youth Worker Network** and **summer internships** provide young people with opportunities to gain experience and skills in public health and health care.

Key Community Partners

- Everett Haitian Community Center
- Everett and Malden Mayor's Offices
- Everett and Malden Public Schools
- Greater Malden Asian American Community Coalition (GMAACC)
- La Comunidad, Inc.
- Malden YWCA and YMCA
- Sharewood Clinic

Approaches to Measurement

- Service utilization
- Community event participation
- Training participation
- Participant surveys

Priority: **Mental Health and Substance Use**	
Our Goals: CHI works to...	*Our Strategies: We approach this goal by...*
2 Increase access to equitable and culturally responsive care for behavioral health concerns	• Investing in developing services and outreach programs that are affordable, culturally relevant, accessible in diverse languages, and responsive to the needs of communities impacted by inequity. • Developing policies, systems, and infrastructure to increase access to mental health and substance use care.
3 Prevent substance use and mental illness, promote resilience, and decrease stigma	• Investing in assessment of risks and opportunities, and in the policies, systems, and infrastructure necessary to address those risks and leverage those opportunities. • Strengthening capacity for resilience among communities most affected by inequity, by investing in knowledge, self-efficacy, and connectedness

Key Programs and Collaborative Initiatives

- Behavioral health care, prevention, education, and referral services are offered in alignment with equity and access goals at the **Everett Care Center** and **Malden Care Center**, the

Everett Teen Health Center and **Starr Center** (Malden pilot School Based Health Center), and the **Bridge Recovery Center.**

- The **Volunteer Health Advisors (VHA)** program provides training to diverse community members to serve in a variety of community health worker roles, including connecting individuals to behavioral health care services, and supports community-based engagement activities on topics including mental health, substance use, and stigma.
- Participation in coalitions and cross-sector efforts, such as the **Mystic Valley Public Health Coalition**, **Malden Public School Wellness Committee, Healthy Neighborhoods Study, Malden's Promise Coalition,** and the **Regional Assessment of Casino Impact,** facilitate assessment, planning, advocacy, and collective efforts to address behavioral health priorities.
- **Mental Health Awareness Training (MHAT)** and **Mental Health First Aid (MHFA)** provide training to community members to support mental health among adults and youth, including responding to and de-escalating mental health crises, addressing stigma, and connecting individuals to appropriate prevention and treatment options in the community.
- **Aging Wisely Everett** and **Senior to Senior** offer health education and engagement opportunities that promote mental health among older adults.
- **TEASA (Teens in Everett Against Substance Abuse), Healthy ME, Street Smart, Helping Hands at Work, and Empowering Youth in our Community (EYC)** offer education, leadership development, and opportunities for youth to carry out campaigns and other collaborative activities related to promoting mental health, preventing substance use, combating stigma, and promoting resilience and connectedness.

Key Community Partners

- Eliot Community Human Services, Behavioral Health Clinic + Family Resource Center
- Everett Council on Aging
- Everett Haitian Community Center
- Everett and Malden Mayor's Offices
- Everett and Malden Public Schools
- Housing Families, Inc.
- Joint Committee for Children's Health Care in Everett (JCCHCE)
- La Comunidad, Inc.
- Latinos Unidos en MA (LUMA)
- Malden Senior Center
- Malden Teen Enrichment Center (MTEC)

Approaches to Measurement

- Service utilization
- Community event participation
- Training participation
- Participant surveys
- Public health surveillance data and health outcome data
- Student health surveys

Priority: **Chronic Diseases and STIs**	
Our Goals: CHI works to...	*Our Strategies: We approach this goal by...*
4 Reduce the incidence of chronic diseases & STIs among populations most affected by health inequity	• Developing education and prevention resources and programs to encourage preventive behaviors. • Collaborating to develop and advocate for policies, systems, and environments that promote healthy behaviors and reduce exposures that lead to chronic diseases and STIs
5 Increase access and strengthen treatment services to those most affected by health inequity	• Promoting affordability, language inclusivity, location + hours accessibility, and culturally responsive care options for chronic disease and STI treatment services. • Developing and maintaining systems of care navigation, screening, and referral for chronic diseases and STIs

Key Programs and Collaborative Initiatives

- Care, prevention, education, and referral services are offered in alignment with equity and access goals for chronic diseases and STIs, including HIV, at the **Everett Care Center** and **Malden Care Center**, and the **Everett Teen Health Center** and **Starr Center** (Malden pilot School Based Health Center).
- Participation in coalitions and cross-sector efforts, such as **Malden Is Moving**, **Malden Public School Wellness Committee,** and the **Healthy Neighborhoods Study,** facilitate assessment, planning, advocacy, and collective efforts to address and prevent chronic diseases and STIs.
- **Mental Health Awareness Training (MHAT)** and **Mental Health First Aid (MHFA)** provide training to community members to support mental health among adults and youth, including responding to and de-escalating mental health crises, addressing stigma, and connecting individuals to appropriate prevention and treatment options in the community.
- **Aging Wisely Everett**, **Senior to Senior,** and **My Life My Health** offer health education and engagement opportunities related to living with a chronic illness for older adults.
- **Healthy ME, Street Smart, Helping Hands at Work, and Empowering Youth in our Community (EYC)** offer education, leadership development, and opportunities for youth to carry out campaigns and other collaborative activities related to promoting health, preventing chronic disease and STIs, combating stigma, and promoting resilience and connectedness.

Key Community Partners

- Everett Council on Aging
- Everett and Malden Public Schools
- Malden YWCA

Approaches to Measurement

- Service utilization
- Community event participation
- Training participation
- Participant surveys

- Public health surveillance data and health outcome data
- Student health surveys

Priority: **Economic Stability and Mobility**	
Our Goals: CHI works to...	*Our Strategies: We approach this goal by...*
6 Establish pathways for career development among young people in our communities	• Creating youth jobs and internship opportunities and offering resources for leadership development among young people that embody and emphasize anti-racism. • Strengthening capacity for resilience among communities most affected by inequity, by investing in promoting knowledge, self-efficacy, and connectedness.

Key Programs and Collaborative Initiatives

- **TEASA (Teens in Everett Against Substance Abuse)** and **Empowering Youth in our Community (EYC)** offer leadership development and opportunities for youth to carry out campaigns and other collaborative activities related to community health and systems change.
- The **Everett Youth Worker Network** and **summer internships** provide young people with opportunities to gain experience and skills in public health and health care.
- The **Volunteer Health Advisors (VHA)** program provides training to diverse community members to serve in a variety of community health worker roles.
- Co-located free VITA Tax Preparation Services at CHA through partnership with **ABCD**

Key Community Partners

- Action for Boston Community Development
- Everett Haitian Community Center
- Everett Public Schools
- Malden YMCA
- Malden YWCA

Approaches to Measurement

- Job/internship placements
- Training participation
- Participant surveys

Priority: **Access to Healthy Food**	
Our Goals: CHI works to...	*Our Strategies: We approach this goal by...*
7 Promote food security among populations most affected by inequity	• Investing in local food production and distribution by leveraging community strengths around gardens, farms, and markets. • Collaborating to assess and evaluate the food environment, and to develop and advocate for policies that promote food security.

Key Programs and Collaborative Initiatives

- **Everett Community Growers** grows and distributes fresh produce from urban farms, partnering with residents and organizations invested in promoting food security through sustainable agriculture.
- **Aging Wisely Everett** and **Senior to Senior** engage older adults in gardening.
- **Farmer Dave's CSA** is a partnership with a local farm, offering reduced cost community-supported agriculture (CSA) shares to CHA patients and staff.
- Participation in coalitions and cross-sector efforts, such as the **Malden Community Food Assessment; Healthy Neighborhoods Study; Tri-City Hunger Network; Housing, Health, and Hunger Advocates;** and CHA's **Food Security Strategic Plan**, facilitate assessment, planning, advocacy, and collective efforts to address hunger and promote food security.

Key Community Partners

- Bread of Life
- Eliot Family Resource Center
- Everett Council on Aging
- Everett and Malden Public Schools
- La Comunidad, Inc.
- Malden YWCA
- Malden YMCA
- Metropolitan Area Planning Council (MAPC)

Approaches to Measurement

- Produce distributed (pounds)
- Program participation
- Participant surveys
- Public survey data related to food security

Priority: **Safe and Affordable Housing**	
Our Goals: CHI works to...	*Our Strategies: We approach this goal by...*
8 Promote access to safe and affordable housing and prevent displacement for all residents	• Co-developing and advocating for policies that protect tenants' rights, preserve and expand affordable housing, and provide emergency financial support. • Investing in assessment of housing concerns, and in resources to address those issues.

Key Programs and Collaborative Initiatives

- Participation in coalitions and cross-sector efforts, such as the **Everett Housing Task Force; Tri-City Hunger Network; Housing, Health, and Hunger Advocates; Healthy Neighborhoods Study;** and **Regional Assessment of Casino Impact,** facilitate assessment, planning, advocacy, and collective efforts to address emergency and long-term housing issues.

Key Community Partners

- Action for Boston Community Development
- Housing Families, Inc.
- Joint Committee for Children's Health Care in Everett (JCCHCE)
- Malden Warming Center
- Malden Housing Stability Taskforce

Approaches to Measurement

- Service utilization
- Public data on eviction, housing cost burden, homelessness, and housing affordability

Conclusion

As the COVID-19 pandemic continues to impact communities in Everett and Malden, CHI recognizes the importance of collaboration to advance strategies that address structural challenges and root causes of inequity. CHI's current initiatives in and with the communities of Everett and Malden reflect our commitment to offering health care and community health resources tailored to the diverse communities CHA serves, and to collaborating with community members and partners to invest in strengths, remove barriers to health and opportunity, and promote equity. It is essential that the voices of people who are closest to the impact of health inequities in our society are centered in defining our next steps and collective goals. The upcoming Regional Wellbeing Assessment will create the space to build on these findings, to continue to improve, and to nurture new strategies in collaboration with communities, focused on the priorities that matter most.

Acknowledgements

Cambridge Health Alliance thanks all of the community members and partner organizations in Everett and Malden, as well as our health system partners at Mass General Brigham and Melrose Wakefield Healthcare, whose participation in the collaborative 2019 Community Health Needs Assessment (CHNA) created the foundation for this Implementation Strategy.

We thank our colleagues in the Department of Community Health Improvement for their collaboration in weaving together and documenting our department's collective work in and with the communities of Everett and Malden.

We thank our Masters in Public Health graduate student intern, Maryam Abdul-Rahman from Tufts University School of Medicine, who conducted interviews, synthesized findings, and assisted with all aspects of this project.

The Cambridge Health Alliance Community Health Implementation Strategy in Everett and Malden was authored by members of the Health Improvement Team, including Renée Cammarata Hamilton, Jean Granick, Laura McNulty, and Kathleen O'Brien.

For more information about Cambridge Health Alliance and the Department of Community Health Improvement, please visit our website:

https://challiance.org/community-health

ATTACHMENT 4(D)

CHNA/CHIP SELF-ASSESSMENT FORM

Massachusetts Department of Public Health
Determination of Need
Community Health Initiative
CHNA / CHIP Self Assessment

Version: 8-1-17

This self-assessment form is to understand the Community Engagement process that has led/ will lead to the identification of priorities for community health planning processes. It is being used to demonstrate to DPH that an existing community health planning process adequately meets DPH standards for community engagement specific to Determination of Need, Community Health Initiative purposes.

This form will provide the basic elements that the Department will use to determine if additional community engagement activities will be required. When submitting this form to DPH, please also submit your IRS Form 990 and Schedule H CHNA/CHIP and/or current CHNA/ CHIP that was submitted to the Massachusetts Attorney General's Office. Additionally, the Applicant is responsible for ensuring that the Department receives Stakeholder-Assessments from the stakeholders involved in the CHNA / CHIP process.

All questions in the form, unless otherwise stated, must be completed.

Approximate DoN Application Date: 09/01/2022 DoN Application Type: DoN-Required Equipment

What CHI Tier is the project? (•) Tier 1 ( ) Tier 2 ( ) Tier 3

1. DoN Applicant Information

Applicant Name: Cambridge Public Health Commission d/b/a Cambridge Health Alliance

Mailing Address: 1493 Cambridge Street

City: Cambridge State: Massachusetts Zip Code: 02139

2. Community Engagement Contact Person

Contact Person: Doug Kress Title: Chief Community Officer

Mailing Address: 1035 Cambridge Street

City: Cambridge State: Massachusetts Zip Code: 02141

Phone: 7813380309 Ext: E-mail: dkress@challiance.org

3. About the Community Engagement Process

Please indicate what community engagement process (e.g. the name of the CHNA/CHIP) the following form relates to. This will be use as a point of reference for the following questions and does not need to be a fully completed CHNA or implemented CHIP.
(please limit the name to the following field length as this will be used throughout this form):

2019-2020 Everett-Malden CHNA/CHIP

4. Associated Community Health Needs Assessments

In addition to the above engagement process, please list Community Health Needs Assessments and/or Community Health Improvement Planning Processes, if any that the Applicant been involved with in the past 5 years (i.e. CHNA/CHIP processes not led by the Applicant bur where the Applicant was involved?

(Please see page 22 of the Community-Based Health Initiative Guidelines for reference http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf)

Add/ Del Rows	Lead Organization Name / CHNA/CHIP Name	Years of Collaboration	Name of Lead Organizer	Phone Number	Email Address of Lead Organizer
+ -	North Suffolk CHNA CHIP 2019-22	4	North Suffolk Public Health Collaborative - Barry Keppard		bkeppard@mapc.org
+ -	North Suffolk CHNA CHIP 2022-24	4	North Suffolk Public Health Collaborative - Barry Keppard		bkeppard@mapc.org
+ -	Mt Auburn BILH CHNA CHIP 2021 and 2022-2024	4	Mary DeCourcey		mdecourc@mah.harvard.edu
+ -		4			

5. CHNA Analysis Coverage

Within the 2019-2020 Everett-Malden CHNA/CHIP , please describe how the following DPH Focus Issues were analyzed DoN Health Priorities and Focus Issues (please provide summary information including types of data used and references to where in the submitted CHNA/CHIP documents these issues are discussed):

5.1 Built Environment

The 2019-2020 Everett-Malden CHNA/CHIP explored both the experiences of the built environment of the residents of Everett and Malden as well as the environment itself, through primary (surveys, focus groups, interviews) and secondary (Subsidized Housing Inventory, rates of housing cost burden, eviction rates, food retail access, rates of food insecurity, etc.) data collection and analysis. CHA recognized a need for a strong focus on the impact that a community's environment and distribution of its resources has upon its health. To better understand these, CHA piloted the use of a framework called A Tool for Health & Resilience In Vulnerable Environments (THRIVE) - a tool for assessing community conditions, prioritizing them, and taking action to change them to improve both health outcomes and health equity. We chose to use this framework because we believe that expertise about community wellbeing exists in the community. Using the THRIVE framework as our conceptual guide, the issues of top concern can be found on pages 13 - 17, and all indicators can be found in the Community Data Profiles in Appendix D. The challenges and areas of highest priority that came up most often in primary and secondary data analysis included (1) housing affordability and stability, (2) access to healthy food, (3) economic stability & mobility and (4) access to care & services. Components of the built environment came up as both strengths as well as challenges. The availability of parks, open spaces and bike paths/bike lanes in both Everett and Malden was highlighted as a strength in focus groups and interviews (p. 11). Challenges included lack of affordable housing stock (evidenced by low Subsidized Housing Inventory or SHI, which is used to measure a community's stock of low- or moderate-income housing: Everett at 6.4% and Malden at 10%; (p. 15) and poor quality, unsafe, unaffordable housing (focus group and interview themes; p. 15); and lack of access to healthy affordable food (illustrated in maps of the food environment (p. 16), as well as focus group and interview themes (p. 17)). Youth in Everett mentioned that Dunkin and Pizza Hut are right next to their school, and that it would be better to have healthier options closer to school; Malden participants noted that junk food is cheaper and often more available than healthy food; for example, a lot of the convenience stores in Malden do not carry fresh produce, which limits access to healthier foods.

5.2 Education

Primary source data was captured through surveys, focus groups and key informant interviews. Quantitative secondary data from the most recent Census/ACS was analyzed to understand the education attainment of Malden and Everett residents, and can be found in Appendix D. Data from the most recent Youth Risk Behavior Survey/Student Health Survey in each community was analyzed as well. This survey is used to understand the behaviors and perceptions of the students in the two public school systems in Malden and Everett. DESE data was also analyzed to understand student demographics and statistics related to health, such as churn rates, which can be used as an indicator of unstable housing conditions (reported on page 15). Churn measures the number of students transferring into or out of a public school district during the course of a school year, and is also referred to as "student mobility." The churn rate in 2018 was 19% in Everett and 18.5% in Malden, twice as high as the MA state rate of 8.6%. Research shows that each time students switch schools, they generally lose the equivalent of 3 months of reading and math learning in the classroom, and that school districts with higher concentrations of mobile students had higher percentages of students with disabilities and fewer students in gifted education programs. Additionally, it was noted that Everett and Malden both had lower graduation rates during the previous school year (2018-19) than the state (74.9% in Everett, 79.5% in Malden versus 88% in Massachusetts.)

5.3 Employment

Quantitative data captured from the most recent Census/ACS data available to understand the employment status of the Malden and Everett communities is reported on page 17. A top concern was economic stability & mobility, particularly due to the lack of good jobs (jobs that pay a living wage and have benefits that meet the needs of individuals and families). Available data on income and employment (pages 17-18) illustrate that our communities have high rates of poverty (especially among youth and families); long commute times; and high housing cost burden (indicating that wages do not keep up with housing costs and other necessary household expenses). Both Everett and Malden have a higher percentage of residents under 18 living below poverty level than the state. For those 65 and older, almost 18% in Malden are living below poverty level compared to 9% in MA. Additionally, both communities have a higher percentage of families living below poverty level than the state. Although median household income has increased since 2000 in both Everett (by 41%) and Malden (by 37%), it has been at a lower rate of growth than the state (47%). Conversely, the percentage of families living below poverty level in Everett and Malden has increased at a much higher rate than the state. Thirty percent of Everett and Malden residents have long commute times (over 45 minutes) than the state. This means that at least 1.5 hours of their time is spent getting to and from work, taking time away from family/personal responsibilities. It is important to note that wages are not sufficient to keep up with housing costs in these two cities. 56% of Everett renters and 51% of Malden renters are cost-burdened or severely cost-burdened, while 40% of Everett home owners and 34% of Malden home owners are cost-burdened or severely cost-

burdened. Malden and the surrounding communities of Everett and Revere have been designated Gateway City communities; which recognizes that these cities all had a legacy of economic success, but have struggled in recent years.

5.4 Housing

Housing Affordability, Stability and Safety was by far the biggest challenge identified and an area of high priority voiced from participants throughout the engagement process. Secondary data analysis supported this concern, as it was found that in comparison to the state, the communities of Malden and Everett had high housing cost burden (especially among renters), high eviction rates, and low Subsidized Housing Inventory (SHI). This is reported on pages 14-15. As mentioned previously, 56% of Everett renters and 51% of Malden renters are cost-burdened or severely cost-burdened, while 40% of Everett home owners and 34% of Malden home owners are cost-burdened or severely cost-burdened. Both Everett and Malden have had higher eviction rates than the state. In 2016 (most recent data available), 2.17% of Everett renters and 1.71% of Malden renters were evicted from their households. The Subsidized Housing Inventory (SHI) is used to measure a community's stock of low- or moderate-income housing. Massachusetts SHI was at 9.7%. Everett was lower than the state with 6.4% subsidized housing. Malden was slightly higher than the state at 10.1%.

5.5 Social Environment

Primary data from community engagement sessions was analyzed and the common themes that emerged indicated that social services and civic and community engagement are largely seen as strengths in the communities of Everett and Malden. Many participants voiced appreciation of the various agencies and organizations in the area that offer services and opportunities for civic and community engagement, making special note of those organizations and entities that offered interpretation services. Also, secondary data illustrated that more residents in Everett and Malden are registered to vote compared to the state (52.8% of Everett residents, 48.1% of Malden residents, 44.5% of MA.) all available on page 11. However, certain populations expressed a need for improvement in their social environments. In particular, during focus groups with the senior populations, they discussed a lack of connection within their neighborhoods. We would like to note that COVID has exacerbated issues related to isolation and this emerged from the most recent CHNA. During COVID-19, each of the communities were also designated as Vaccine Equity Initiative communities.

5.6 Violence and Trauma

Quantitative secondary data from Federal Bureau of Investigation and Youth Risk Behavior Survey surveys from Malden and Everett were collected and analyzed. This data is reported in Appendix D. In Everett, violent crime rate was higher than the state (368/100,000 vs. 338/100,000 in MA) and property crime was higher than the state (1457/100,000 vs. 1263/100,000 in MA.) In Malden, violent crime rate was lower than the state (293/100,000 vs. 338/100,000 in MA) and property crime was lower than the state (957/100,000 vs. 1263/100,000 in MA.) Additionally, focus group data were analyzed and themes that emerged included safety concerns and neighborhood attrition have led to a limited sense of community. Seniors stated that people no longer know their neighbors-one example of this is older people selling their houses and leaving the neighborhood. Furthermore, seniors recalled that neighbors used to watch each other's children but said that is no longer the case. In addition, youth participants stated that Everett is culturally diverse, which is a strength because it helps build community, but it also sometimes pits people against those in their own culture. Participants also brought up safety concerns; one participant's home was broken into by a neighbor, and participants mentioned there were no street lights and often needles on the ground in public spaces. There were also reports of community violence-youth mentioned that violence is normalized, as there have been shootings in the community. Lastly, in one focus group, youth felt that social media helps spread ideas of hate and violence in the community.

5.7 The following specific focus issues

a. Substance Use Disorder

Both communities see higher age-adjusted rates of opioid-related mortality than the state (33.9/100,000 in Everett, 21.9/100,000 in Malden compared to 19.3/100,000 in MA) as well as all substance-related mortality rates (49.4/100,000 in Everett, 34.3/100,000 in Malden compared to 30.7/100,000 in MA). Everett had higher opioid-related ED visits and hospitalizations than the state (148.7/100,000 compared to 90.5/100,000 in MA), and total drug overdose ED visits than the state 344/100,000 compared to 250.9/100,000 across MA (see page 21). For youth substance use, the data appears to contradict the perceptions of high youth rates of substance use, as most data indicators show Everett and Malden at lower rates than the state (pages 20 - 25). Thematic analysis of youth focus group data indicated that alcohol and vaping/ smoking are normalized and widespread. Youth stated that weed, vaping, and alcohol are very accessible; as a result, people are more inclined to use these substances. In addition, youth mentioned that smoking occurs regularly in the bathrooms at school, and there are empty nip bottles in public areas on the way to school. In addition, alcohol is easily accessible because there is a liquor store next to the school in Everett. Youth mentioned that YouTube ads and commercials that attempt to get people to stop smoking do not work because kids do not listen to their parents. Similarly, youth reported that these types of ads aren't effective in changing behavior.

b. Mental Illness and Mental Health

Areas of mental health (particularly youth depression and elder isolation) and substance use disorder (particularly the use of opioids, alcohol, youth vaping & marijuana) were issues that were voiced from participants through the community and stakeholder engagement process as the biggest health outcome concerns in our communities (pages 20 - 25). Review and analysis of public health data (from MA Department of Public Health and the 2018/2019 Youth Risk Behavior Survey) on these areas indicate that these issues show up differently in each community. CHA reviewed and analyzed various indicators for mental health and substance use in each community, in comparison to the state of Massachusetts. These data are reported in the respective Community Data Profiles in Appendix D. While age-adjusted suicide rates were lower than the state rate in both Everett and Malden, both communities see higher rates of youth depression and lack of a trusted adult to talk to compared to the state. This issue also came up in our focus groups, as some youth stated that the lack of adults who they can identify with (linguistically, culturally, etc.) causes them to feel distrustful. Among youth, rates of both Everett and Malden middle school (MS) students who experienced depression in the past 12 months were higher than the state (41.7% and 44.9% higher, respectively). Similarly, Everett and Malden high school (HS) students' rates of depression were also higher than the state, particularly in Everett, which was almost 40% higher than the state. Everett middle and high school students reported higher rates of attempted suicide in the past 12 months than the state; 44% higher for middle school students and 7% higher for high school students. Additionally, Everett high school students who had seriously considered suicide in the past 12 months was higher than the state; 14% of students compared to 12% of the state.

c. Housing Stability / Homelessness

Using primary and secondary data, housing stability was identified as a key issue of concern. For housing stability, please see above. For homelessness, secondary data was not illustrative of need in Malden and Everett, since in 2019 - 2020 there was no shelter for homeless individuals and Point in Time counts did not identify homeless individuals. The need for a homeless shelter in the greater Malden and Everett areas was identified as an issue of concern in primary data collection, especially with regard to homeless students and their families. In Everett there were 166 students who identified as homeless and in Malden there were 150 students who identified as homeless in 2019. This was collected from the DESE Office of Family and Student Support, McKinney-Vento Homeless Education Data (2019-2020). After this assessment was completed, two new resources for homeless individuals were opened. The first was a shelter for individuals opened in Malden by Housing Families, Incorporated. The second was a warming center operated by volunteers convened and located at the First Church of the Nazarene in Malden.

d. Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes

Qualitative data on chronic disease rates were gathered from primary sources such as from DPH and secondary qualitative data sources and were reported on pages 26-29. During community and stakeholder engagement, the chronic diseases of concern that came up most often were cancer, diabetes, and obesity. Review and analysis of public health data for cancer showed that age adjusted rates of lung and colorectal cancer mortality were higher in Everett compared to the state. Lung cancer mortality rate was 48.8 in Everett compared to 40.5 in MA. The colorectal mortality rate in Everett was 14.7 compared to 12.5 in Massachusetts. In Malden, age adjusted all cancer mortality rates were higher than the state (Breast, Ovarian, Prostate, Colorectal and Lung) The all cancer mortality rate was 177/100,000 in Malden compared to 156/100,000 in Massachusetts. Review of Department of Public Health data showed that age adjusted diabetes mortality, ED visit and hospitalization rates for Everett and Malden residents were higher than the state rates. Age adjusted diabetes mortality rates (Everett 22.1, Malden 22.9 and Massachusetts 14.8 per 100,000 respectively) diabetes ED visit rates (Everett 183.5, Malden 153.5, and Massachusetts 143.1 per 100,000 respectively) and diabetes hospitalization rates (Everett 161.3, Malden 187.8 and Massachusetts 143.1 per 100,000 respectively.) Pediatric obesity rates in both Everett and Malden are higher than the state (with the exception of Malden Grade 10, which is the same as the state). Everett and Malden also had higher age adjusted rates of cardiovascular ED visits compared to the state. (856.6 in Everett, 663.1 in Malden compared to 596 in MA.) Most recent data for age adjusted percentage rate of chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis (lifetime) among adults was higher in Everett (6.5%) and Malden (5.8%) versus the statewide percentage rate (4.4%). Also, most recent data for age adjusted percentage rate of coronary heart disease or angina (lifetime) among adults was higher in Everett (5.9%) and Malden (5.6%) versus the statewide percentage rate (3.2%). Lastly, age adjusted asthma hospitalization rates were higher in Everett (100.1) and Malden (97.9) versus the statewide rate (87.1).

6. Community Definition

Specify the community(ies) identified in the Applicant's 2019-2020 Everett-Malden CHNA/CHIP

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
+ -	Malden	
+ -		Everett (doesn't populate in the list)

7. Local Health Departments

Please identify the local health departments that were included in your 2019-2020 Everett-Malden CHNA/CHIP . Indicate which of these local health departments were engaged in this 2019-2020 Everett-Malden CHNA/CHIP . For example, this could mean participation on an advisory committee, included in key informant interviewing, etc. (*Please see page 24 in the Communit further description of this requirement* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf.)

Add/ Del Rows	Municipality	Name of Local Health Dept	Name of Primary Contact	*Email address*	Describe how the health department was involved
+ -	*Type first letter then scroll*	Everett Health Department	Sabrina Firicano	sabrina.firicano@ci.everett.ma.us	Key informant, member of Community Advisory Board
+ -	Malden	Malden Health Department	Peter Finn	pfinn@cityofmalden.org	Key informant, member of Community Advisory Board

8. CHNA / CHIP Advisory Committee

Please list the community partners involved in the CHNA/CHIP Advisory Committee that guided the 2019-2020 Everett-Malden CHNA/CHIP . (please see the required list of sectorial representation in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) Please note that these individuals are those who should complete the *Stakeholder Engagement Assessment* form. It is the responsibility of the Applicant to ensure that DPH receives the completed *Stakeholder Engagement Assessment* form:

Add/Del Rows	Sector Type	Organization Name	Name of Primary Contact	Title in Organization	Email Address	Phone Number
	Municipal Staff	City of Malden	Chris Webb	Director, Health Department	cwebb@cityofmalden.org	
	Education	Malden Public Schools	John Oteri	Superintendent	joteri@maldenps.org	
	Housing	Housing Families, Inc.	Heather Van Orman	Pro Bono legal services	hvanorman@housingfamilies.org	
	Social Services	Joint Committee for Children's Health Care in Everett	Nicole Graffam	Executive Director	ngraffam@ci.everett.ma.us	
	Planning + Transportation	City of Everett	Tony Sousa	Director of Planning and Development	tony.sousa@ci.everett.ma.us	
	Private Sector/ Business	Cataldo Ambulance	Dan Hoffenberg	VP of Operations	dhoffenberg@cataldoambulance.com	
	Community Health Center	Melrose Wakefield Healthcare *CHA Filled role of CHC, and MWHC provided services at the time.	Barbara Kaufman	Manager, Community Benefits	bkaufman@hallmarkhealth.org	
	Community Based Organizations	Mass Senior Action/Friends of Fellsmere Heights	Dee Campbell	member	dcampitup@comcast.net	

Add/Del Rows	Sector Type	Organization Name	Name of Primary Contact	Title in Organization	Email Address	Phone Number
+ -	Additional municipal staff (such as elected officials, planning, etc.)	City of Everett	Sabrina Firicano	Director of Health and Human Services	sabrina.firicano@ci.everett.ma.us	
+ -	Education	City of Everett Public Schools	Julie Ann Whitson	Director of Health Education	jwhitson@everett.k12.ma.us	
+ -	Community-based organizations	ABCD	Aiesha Washington	Operations Director, Mystic Valley Opportunity Center	awashington@bostonabcd.org	
+ -	Community-based organizations	YMCA	Gregg Ellenberg	Director of Programs	gellenberg@ymcamalden.org	
+ -	Community-based organizations	Mystic Valley Elder Services	Lauren Reid	Director of Community Outreach	lreid@mves.org	
+ -	Additional municipal staff (such as elected officials, planning, etc.)	Malden School Committee	Jen Spadafora	School Committee Member	jspadafora@maldenps.org	

8a. Community Health Initiative

For Tier 2 and Tier 3 CHI Projects, is the the Applicant's CHNA / CHIP Advisory Board the same body that will serve as the CHI advisory committee as outlined in the Table 1 of the Determination of Need Community-Based Health Initiative Guideline (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-chi-planning.pdf)?

○ Yes ○ No

9. Engaging the Community At Large

Thinking about the extent to which the community has been or currently is involved in the 2019-2020 Everett-Malden CHNA/CHIP , please choose one response for each engagement activity below. Please also check the box to the left to indicate whether that step is complete or not. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
☒ Assess Needs and Resources	○	○	○	○	◉	○
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	The purpose of this assessment was to develop a full picture not only of health needs in Everett and Malden, but also of community strengths and assets. Over the course of the process, both secondary (publicly reported and existing) and primary (first-hand and new) data were collected and analyzed. The Community Advisory Board (CAB) was instrumental in identifying how primary data could be collected and ensuring that the surveys, focus groups and key informant interviews would be with individuals representative of the community. The CAB was involved in reviewing initial analysis of primary and secondary data and advising on how to ensure stratifications of data should be analyzed to better understand dimensions of equity.					
☒ Focus on What's Important	○	○	○	○	○	◉
Please describe the engagement process employed during the "Focus on What's Important" phase.	After the review of primary and secondary data, and throughout the CHNA process, CAB members provided continuous feedback to refine data analysis and focus. Members of the CAB used the data and themes that emerged from the assessment process to set priorities. The priorities were set as a result of a collaborative review of all data sources (primary/ secondary as well as qualitative and quantitative) that was collected from a diverse cross sector of community members and community leaders.					
☒ Choose Effective Policies and Programs	○	○	◉	○	○	○
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	Almost as soon as the CHNA was released in March 2020, CHA's Department of Community Health Improvement team had to shift our focus to responding to COVID-19. We reviewed the 2019-2020 CHNA to develop an Implementation Strategy that took into account the new reality that COVID-19 had resulted in. We recognized the community-identified priority needs and equity concerns had in fact been amplified by the pandemic.					
☒ Act on What's Important	○	○	○	◉	○	○
Please describe the engagement process employed during the "Act on What's Important" phase.	Cambridge Health Alliance is committed to collaborating with our community partners to improve the health of our patients and communities. In our drive to Care for All, CHA works closely with community members, community based organizations, municipal departments, places of worship, civic and cultural organizations to elevate the voices of those who are most directly impacted by the society's injustices which lead to health inequities. Consistent and persistent presence in the community by our teams allow for ongoing community engagement on the issues we collaboratively work to address.					
☒ Evaluate Actions	○	○	◉	○	○	○

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
Please describe the engagement process employed during the "Evaluate Actions" phase.	Community partners provide feedback on various programs and initiatives to help evaluate efforts. Cambridge Health Alliance works with Community Advisory Board to communicate outcomes and evaluation measures. This is done through formal means (reports, presentations to Board of Trustees, Community Health Advisory Committee, and others throughout CHA. CHA staff also ensure information and results from the CHNA/CHIP is shared through ongoing partnerships where regular communication exchange occurs.					

10. Representativeness

Approximately, how many community agencies are currently involved in 2019-2020 Everett-Malden CHNA/CHIP within the engagement of the community at large?

25 Agencies

Approximately, how many people were engaged in the process (please include team members from all relevant agencies and independent community members from the community at large)?

60 Individuals

Please describe the diversity of the people who have been engaged in the process both within the CHNA/CHIP Advisory Committee and the community at large. Explicitly describe how the process included diverse representation from different groups/individuals with varied gender, sexual orientation, race/ethnicity, disability status, international status and age. Please see page 10 and Appendix A of *the Community Engagement Standards for Community Health Planning Guideline* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf) for further explanation of this.

The Community Advisory Board is comprised of men, women and non-gender conforming individuals representing and/or serving a variety of populations. The membership includes individuals who work with youth, older adults, those with cognitive and physical disabilities, LGBTQ individuals, BIPOC individuals, low income individuals and immigrants. Partnerships with school personnel and youth serving CBOs provide insight into the youth population; Elder Service personnel provide information about the elder population, civic and cultural organization leadership provide insights into community members from diverse religious, linguistic and cultural backgrounds. And participation from CBOs help gain insight into a variety of other populations such as low income, food insecure and housing insecure populations. The CAB membership evolves as positions change within respective organizations. Over time, CHA will add additional organizations to ensure our CABs are representative of the communities served.

Please describe the type of representation that was/is employed in the community engagement process and the rationale for that type of representation. For more information on types of representation and representativeness, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf). Please include descriptions of both the Advisory Board and the Community at large.

CAB members provided input and insights into key health issues in the communities. Community members of the CAB provided input from their own experiences, and what they heard from their constituents and those who they represented. Additionally, the members of the CHA CAB guided the process for deeper engagement in the community through identification of key informants, focus group participants and survey location sites.

To your best estimate, of the people engaged in 2019-2020 Everett-Malden CHNA/CHIP approximately how many: Please indicate the number of individuals.

Number of people who reside in rural area	0
Number of people who reside in urban area	60
Number of people who reside in suburban area	0

11. Resource and Power Sharing

For more information on Power Sharing, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf).

By community partners, we mean agencies, organizations, tribal community, health departments, or other entities representing communities.

By Applicant partners, we mean the hospital / health care system applying for the approval of a DoN project

	Community Partners	Applicant Partners	Both	Don't Know	Not Applicable
Which partner hires personnel to support the community engagement activities?	○	◉	○	○	○
Who decides the strategic direction of the engagement process?	○	○	◉	○	○
Who decides how the financial resources to facilitate the engagement process are shared?	○	○	◉	○	○
Who decides which health outcomes will be measured to inform the process?	○	○	◉	○	○

12. Transparency

Please describe the efforts being made to ensure that the engagement process is transparent. For more information on transparency, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines*.

The reports are posted on https://www.challiance.org/community-health/community-health-data-and-reports/community-health-data-and-reports for public access and utilization. We ensure that community members and leaders interested in exploring and using our analyses, reports, and recommended resources have the ability to do so freely. In addition to the reports, we include community-specific data profiles as well as our approach to the community health needs assessment process. Results of the reports were presented to the Community Advisory Board, CHA Board Committee on Population Health and to various municipal groups and community based organizations. This report was also shared informally at a variety of community and coalition meetings. Our Community Advisory Board members have open access to all materials shared during the CHNA-CHIP process through a collaborative Google platform. This ensures that the CAB members may access and use meeting agendae, minutes, presentations and other important documents at any time, during and after the CHNA-CHIP process.

13. Formal Agreements

Does / did the 2019-2020 Everett-Malden CHNA/CHIP have written formal agreements such as a Memorandum of Agreement/ Understanding (MOU) or Agency Resolution?

○ Yes, there are written formal agreements ◉ No, there are no written formal agreements

Did decision making through the engagement process involve a verbal agreement between partners?

○ Yes, there are verbal agreements ◉ No, there are no verbal agreements

14. Formal Agreement Specifics

Thinking about your MOU or other formal agreement(s), does it include any provisions or language about:

	Yes	No	Don't Know	Doesn't Apply
Distribution of funds	○	○	○	◉
Written Objectives	○	○	○	◉
Clear Expectations for Partners' Roles	○	○	○	◉
Clear Decision Making Process (e.g. Consensus vs. Voting	○	○	○	◉
Conflict resolution	○	○	○	◉
Conflict of Interest Paperwork	○	○	○	◉

15. Document Ready for Filing

When the document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the"E-mail submission to DPH" button.

This document is ready to file: ☐ Date/time Stamp: 08/16/2022 3:18 pm

E-mail submission to DPH

E-mail submission to Stakeholders and CHI Advisory Board

When providing the Stakeholder Assessment Forms to the community advisory board members(individuals identified in Section 8 of this form), please include the following information in your correspondence with them. This will aid in their ability to complete the form:

A) Community Engagement Process: 2019-2020 Everett-Malden CHNA/CHIP

B) Applicant: Cambridge Public Health Commission d/b/a Cambridg

C) A link to the DoN CHI Stakeholder Assessment

ATTACHMENT 5

NOTICE OF INTENT

Hub smashes another record; temps near 100

By Rick Sobey
and Grace Zokovitch
MediaNews Group

The summer of scorchers added another record-setting day on Monday before the brutal heat wave finally comes to an end Tuesday with comfortable temps on the way.

Boston hit a wicked hot 98 degrees on Monday, shattering the city's record-high temp for Aug. 8. The previous hottest Aug. 8 was in 1983, when it reached 96 degrees in the Hub.

Tuesday is expected to be another heater, with temps jumping into the mid-90s yet again. It will be the sixth straight day of 90-plus degrees. The city as a result extended its heat emergency through Tuesday.

"Luckily an end to this heat is coming up," Bill Simpson, meteorologist at the National Weather Service's Boston office, told the Herald on Monday.

The break in the heat will be arriving on Wednesday, with high temps expected to fall down into the 70s as a cold front swings through the Bay State.

The Boston area has not seen high temps below 80 degrees in weeks. Monday was the 25th straight day of 80-plus degrees, which broke the previous mark of 24 consecutive days set in 1953. Tuesday will be the 26th straight of 80-plus degrees.

Because of the continuing heat and humidity, Boston Mayor Michelle Wu has extended the previously announced heat emergency through Tuesday. Cooling centers will be open at 16 Boston Centers for Youth & Families community centers, and splash pads will be open at parks and playgrounds throughout the city.

"... It is a burden on residents to see the continued acceleration of climate change," Wu said during a Monday press conference.

"The heat emergency declaration makes it so that we are specifically preparing and being proactive about resources, activating communications with residents and deploying cooling, misting, heat resilience measures all throughout our neighborhoods," the mayor added.

Boston EMS from Thursday through Sunday responded to 51 incidents that were directly attributed to the heat, in addition to higher overall daily call volume.

"Everyone, regardless of how healthy or young you are, is susceptible to heat-related illness," said Boston EMS Chief James Hooley. "As we look forward to relief in the future forecast, continue to increase your water intake, scale back on outdoor exercise, and seek indoor air conditioned places during peak temperatures."

CHRIS CHRISTO / HERALD STAFF

COOL PURSUITS People enjoy the water of Lake Quinsigamond at Regatta Point Park on Monday.

HEALTH

Researchers start testing Lyme vaccine

Associated Press

DUNCANSVILLE, Pa. — Researchers are seeking thousands of volunteers in the U.S. and Europe to test the first potential vaccine against Lyme disease in 20 years — in hopes of better fighting the tick-borne threat.

Lyme is a growing problem, with cases rising and warming weather helping ticks expand their habitat. While a vaccine for dogs has long been available, the only Lyme vaccine for humans was pulled off the U.S. market in 2002 from lack of demand.

Now Pfizer and French biotech Valneva are aiming to avoid previous pitfalls in developing a new vaccine to protect both adults and kids as young as 5 from the most common Lyme strains on two continents.

"There wasn't such a recognition, I think, of the severity of Lyme disease" and how many people it affects the last time around, Pfizer vaccine chief Annaliesa Anderson said.

Robert Terwilliger, an avid hunter and hiker, was first in line Friday when the study opened in central Pennsylvania. He's seen lots of friends get Lyme and is tired of wondering if his next tick bite will make him sick.

"It's always a worry, you know? Especially when you're sitting in a tree stand hunting and you feel something crawling on you," said Terwilliger, 60, of Williamsburg, Pa. "You've got to be very, very cautious."

Exactly how often Lyme disease strikes isn't clear. The Centers for Disease Control and Prevention cites insurance records suggesting 476,000 people are treated for Lyme in the U.S. each year. Pfizer's Anderson put Europe's yearly infections at about 130,000.

The infection initially causes fatigue, fever and joint pain. Often — but not always — the first sign is a red, round bull's-eye rash.

Early antibiotic treatment is crucial, but it can be hard for people to tell if they were bitten by ticks, some as small as a pin. Untreated Lyme can cause severe arthritis and damage the heart and nervous system. Some people have lingering symptoms even after treatment.

LEGAL NOTICES

Public Announcement Concerning a Proposed Health Care Project

Cambridge Public Health Commission d/b/a Cambridge Health Alliance ("Applicant") with a principal place of business at 1493 Cambridge St., Cambridge, MA 02139 intends to file a Notice of Determination of Need ("Application") with the Massachusetts Department of Public Health for the establishment of part-time mobile service to provide positron emission tomography ("PET")/computed tomography ("CT") diagnostic services three days per week at its Malden campus - CHA Malden Care Center, 195 Canal Street, Malden, MA, 02148 (the "Proposed Project"). The total value of the Proposed Project based on the maximum capital expenditure is $430,000.00. The Applicant does not anticipate any price or service impacts on the Applicant's existing Patient Panel as a result of the Proposed Project. Any ten Taxpayers of Massachusetts may register in connection with the intended Application no later than 30 days of the filing of the Notice of Determination of Need by contacting the Department of Public Health Determination of Need Program, DPH.DON@MassMail.State.MA.US (preferred) or 250 Washington Street, 4th Floor, Boston, MA 02108.

NOTICE OF TIER CLASSIFICATION
2147-2163 WASHINGTON STREET
ROXBURY, MA
RTN 3-35970

A release of oil and/or hazardous materials has occurred at this location, which is a disposal site as defined by M.G.L. c. 21E, § 2 and the Massachusetts Contingency Plan, 310 CMR 40.0000. To evaluate the release, a Phase I Initial Site Investigation was performed pursuant to 310 CMR 40.0480. The site has been classified as TIER II pursuant to 310 CMR 40.0500. On August 4, 2022, 2147 LIHTC Owner LLC filed a TIER II Classification Submittal with the Department of Environmental Protection (MassDEP). To obtain more information on this disposal site, please contact Kerry Tull of Cooperstown Environmental LLC 23 Main Street, Andover, MA 01810, 978-470-4755. The Tier Classification Submittal and the disposal site file can be viewed at MassDEP website using Release Tracking Number (RTN) 3-35970 at https://eeaonline.eea.state.ma.us/portal#!/search/wastesite or at MassDEP, Northeast Regional Office, 205B Lowell Street, Wilmington, MA 01887, 978-694-3246. Additional public involvement opportunities are available under 310 CMR 40.1403(9) and 310 CMR 40.1404.

08/09/2022

#NY0056052

PROBATE CITATIONS

Commonwealth of Massachusetts The Trial Court - Probate and Family Court Docket No. Mt22P4034EA Middlesex Probate and Family Court 10-U Commerce Way, Woburn, MA 01801 (781)865-4000 CITATION ON PETITION FOR FORMAL ADJUDICATION

Estate of: Francis Farley Also known as: Francis P.V, Farley, Francis P, Farley, Francis Patrick Vincent Farley, and Vincent Farley Date of Death: 03/27/2022, To all interested persons: A Petition for Adjudication of Intestacy and Appointment of Personal Representative has been filed by Catherine F. Lanza of Leominster MA requesting that the Court enter a formal Decree and Order and for such other relief as requested in the Petition. The Petitioner requests that Catherine F, Lanza of Leominster MA be appointed as Personal Representative(s) of said estate to serve Without Surety on the bond in an unsupervised administration.

IMPORTANT NOTICE: You have the right to obtain a copy of the Petition from the Petitioner or at the Court. You have a right to object to this proceeding. To do so, you or your attorney must file a written appearance and objection at this Court before: 10:00 a.m. on the return day of 08/31/2022.. This is NOT a hearing date, but a deadline by which you must file a written appearance and objection if you object to this proceeding. If you fail to file a timely written appearance and objection followed by an affidavit of objections within thirty (30) days of the return day, action may be taken without further notice to you. UNSUPERVISED ADMINISTRATION UNDER THE MASSACHUSETTS UNIFORM PROBATE CODE (MUPC): A Personal Representative appointed under the MUPC in an unsupervised administration is not required to file an inventory or annual accounts with the Court. Persons interested in the estate are entitled to notice regarding the administration directly from the Personal Representative and may petition the Court in any matter relating to the estate, including the distribution of assets and expenses of administration. Witness, Hon. Maureen H Monks, First Justice of this Court, Date: August 03,2022. Tara E. DeCristofaro, Register of Probate

August 9

#NY0056078

PROBATE CITATIONS

Commonwealth of Massachusetts The Trial Court - Probate and Family Court Docket No. MI22P4104EA Middlesex Probate and Family Court 10-U Commerce Way, Woburn, MA 01801 (781)865-4000 CITATION ON PETITION FOR FORMAL ADJUDICATION

Estate of: Mary J. Frontino Date of Death: May 19, 2018, To all interested persons: A Petition for Formal Adjudication has been filed by John D. Leone, Esq. of Arlington, MA requesting that the Court enter a formal Decree and Order and for such other relief as requested in the Petition. The Petitioner requests that Jason J. Frontino of Dover, NH be appointed as Personal Representative(s) of said estate to serve Without Surety on the bond in an unsupervised administration.

IMPORTANT NOTICE: You have the right to obtain a copy of the Petition from the Petitioner or at the Court. You have a right to object to this proceeding. To do so, you or your attorney must file a written appearance and objection at this Court before: 10:00 a.m. on the return day of September 2, 2022. This is NOT a hearing date, but a deadline by which you must file a written appearance and objection if you object to this proceeding. If you fail to file a timely written appearance and objection followed by an affidavit of objections within thirty (30) days of the return day, action may be taken without further notice to you. UNSUPERVISED ADMINISTRATION UNDER THE MASSACHUSETTS UNIFORM PROBATE CODE (MUPC): A Personal Representative appointed under the MUPC in an unsupervised administration is not required to file an inventory or annual accounts with the Court. Persons interested in the estate are entitled to notice regarding the administration directly from the Personal Representative and may petition the Court in any matter relating to the estate, including the distribution of assets and expenses of administration. Witness, Hon. Maureen H Monks, First Justice of this Court, Date: August 5, 2022. Tara E. DeCristofaro, Register of Probate

August 9, 2022

#NY0056151

PROBATE CITATIONS

Commonwealth of Massachusetts The Trial Court - Probate and Family Court Docket No. MI22P3798EA Middlesex Probate and Family Court 10-U Commerce Way, Woburn, MA 01801 (781)865-4000 CITATION ON PETITION FOR FORMAL ADJUDICATION

Estate of: Stelita M. Cronin Also known as: Stelita Cronin Date of Death: 08/22/2019, To all interested persons: A Petition for Formal Probate of Will with Appointment of Personal Representative has been filed by Christine M. Cronin-Allcock of North Attleboro MA requesting that the Court enter a formal Decree and Order and for such other relief as requested in the Petition. The Petitioner requests that Christine M Cronin-Allcock of North Attleboro MA be appointed as Personal Representative(s) of said estate to serve Without Surety on the bond in an unsupervised administration.

IMPORTANT NOTICE: You have the right to obtain a copy of the Petition from the Petitioner or at the Court. You have a right to object to this proceeding. To do so, you or your attorney must file a written appearance and objection at this Court before: 10:00 a.m. on the return day of 08/16/2022. This is NOT a hearing date, but a deadline by which you must file a written appearance and objection if you object to this proceeding. If you fail to file a timely written appearance and objection followed by an affidavit of objections within thirty (30) days of the return day, action may be taken without further notice to you. UNSUPERVISED ADMINISTRATION UNDER THE MASSACHUSETTS UNIFORM PROBATE CODE (MUPC): A Personal Representative appointed under the MUPC in an unsupervised administration is not required to file an inventory or annual accounts with the Court. Persons interested in the estate are entitled to notice regarding the administration directly from the Personal Representative and may petition the Court in any matter relating to the estate, including the distribution of assets and expenses of administration. Witness, Hon. Maureen H Monks, First Justice of this Court, Date: July 19, 2022. Tara E. DeCristofaro, Register of Probate

August 9

#NY0055183

PHANTOM: By Lee Falk

JUMBLE SOLUTION

Jumbles: VAULT SNORT KETTLE PASTOR

CartoonCaption: The Jumble creators enjoy making puzzles that are —

"PUN" TO SOLVE

CROSSWORD SOLUTION

R	O	A	R		T	Y	P	E	B		A	L	A	N
A	N	T	E		H	A	I	K	U		L	I	N	E
S	E	A	S		O	L	S	E	N		L	E	A	D
P	U	R	E	B	R	E	A	D	D	O	G			
S	P	I	L	L					T	A	O	I	S	M
			L	O	T	S	A			T	O	N	K	A
A	F	T		C	H	A	L	L	A	H	D	A	Y	S
E	L	O			A	F	O	O	T			P	P	O
T	O	R	T	E	R	E	F	O	R	M		T	E	N
N	O	S	E	S			T	P	A	I	N			
A	R	O	M	A	S					R	O	A	M	S
			P	U	N	I	N	T	H	E	O	V	E	N
A	C	H	E		A	D	O	R	E		N	E	R	O
H	A	I	R		R	O	T	O	R		E	R	G	O
A	R	M	S		E	L	E	N	A		S	T	E	P

SUDOKU SOLUTION

3	6	2	9	4	7	5	1	8
8	7	4	1	5	6	3	2	9
1	5	9	8	3	2	6	4	7
7	8	6	5	1	4	9	3	2
2	9	1	6	7	3	8	5	4
4	3	5	2	9	8	1	7	6
5	4	3	7	6	9	2	8	1
6	1	8	4	2	5	7	9	3
9	2	7	3	8	1	4	6	5

ATTACHMENT 6

HPC ACO CERTIFICATION APPROVAL LETTER

The Commonwealth of Massachusetts
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MASSACHUSETTS 02109
(617) 979-1400

STUART H. ALTMAN
CHAIR

DAVID M. SELTZ
EXECUTIVE DIRECTOR

April 12, 2022

Glover Taylor
Cambridge Public Health Commission d/b/a Cambridge Health Alliance
1493 Cambridge Street
Cambridge, MA 02139

RE: ACO LEAP Certification

Dear Mr. Taylor:

Congratulations! The Health Policy Commission (HPC) is pleased to inform you that Cambridge Health Alliance meets the requirements for ACO Certification under our Learning, Equity, and Patient-Centeredness (LEAP) standards. This certification is effective from January 1, 2022, through December 31, 2023.

The ACO Certification program, in alignment with other state agencies including MassHealth, is designed to accelerate care delivery transformation in Massachusetts and promote a high quality, efficient health system. ACOs participating in the program have met a set of objective criteria focused on core ACO capabilities demonstrating dedication to patient-centered care, use of evidence-based and data-driven strategies to improve care delivery, and commitment to addressing long-standing health inequities. Cambridge Health Alliance meets those criteria.

The HPC will promote Cambridge Health Alliance as a Certified ACO on our website and in our marketing and public materials. Enclosed you will find an ACO Certification logo for your organization to use in accordance with the attached Terms of Use. We hope you will use the logo on promotional materials when you highlight your ACO Certification to your patients, payers, and others.

The HPC looks forward to ongoing engagement with you over the next two years. We intend to follow up shortly to provide an overview and some reflections on what we saw in the Health Equity Responses, a new feature of the ACO Certification application this year, across the cohort of Certified ACOs. We hope your organization will find that information helpful as we all continue to explore ways to improve health equity in the Commonwealth.

Thank you for your dedication to providing accountable, coordinated health care to your patients, and to continued learning and improvement over time. If you have any questions about this letter or the ACO Certification program, please do not hesitate to contact Mike Stanek, Senior Manager, at HPC-Certification@mass.gov or (617) 757-1649.

Best wishes,

David Seltz
Executive Director

ATTACHMENT 7

FORMATION DOCUMENTS: CHAPTER 147 OF THE ACTS OF 1996, AS AMENDED BY CHAPTER 365 OF THE ACTS OF 1998

any officer or duly appointed agent of the commonwealth or the city. The commission shall submit an annual report in writing concerning its operations to the mayor and collector-treasurer of the city and the president of the city council and shall file a copy of such report with the city clerk within one hundred and twenty days following the close of its fiscal year. Such report for the fiscal year ending June thirtieth, nineteen hundred and ninety-seven, and for each fiscal year thereafter, shall include financial statements relating to the operations and properties of the commission maintained in accordance with generally accepted accounting principals to the extent applicable and audited by an independent certified public accountant or firm of certified public accountants.
St.1995, c. 147, § 10.

§ 2–11. Termination of commission; title to assets

Upon termination or dissolution of the commission, the title to all funds and other properties owned by it which remain after payment or the making of provision for payment of all obligations of the commission shall vest in the city.
St.1995, c. 147, § 11.

§ 2–12. Conflict with other laws

The provisions of this act shall be deemed to provide an exclusive, additional, alternative and complete method for the doing of the things authorized hereby and shall be deemed and construed to be supplemental and additional to, and not in derogation of, powers conferred upon the commission by law; provided, however, that insofar as the provisions of this act are inconsistent with the provisions of any general or special law, administrative order or regulation or any limitation imposed by a corporate or municipal charter, the provisions of this act shall be controlling.
St.1995, c. 147, § 12.

§ 2–13. Construction and application

This act, being necessary for the welfare of the city and its inhabitants, shall be liberally construed to effect the purposes hereof.
St.1995, c. 147, § 13.

§ 2–14. Constitutionality

This act shall be construed in all respects so as to meet all constitutional requirements. In carrying out the purposes and provisions of this act, all steps shall be taken which are necessary to meet constitutional requirements whether or not such steps are required by statute.
St.1995, c. 147, § 14.

§ 2–15. Effective date

This act shall take effect upon its passage.
St.1995, c. 147, § 15.

CAMBRIDGE PUBLIC HEALTH COMMISSION

Section

Section

St.1996, c. 147, enacted the provisions set out as §§ 3-1 to 3-21 of this Appendix.

§ 3-1. Declaration of public necessity

(a) It is hereby declared for the benefit of the people of the city of Cambridge and the commonwealth, in order that there be an increase in their welfare and an improvement in their living conditions, that a new public health care system should be established for the city of Cambridge that can meet the challenges of a rapidly changing health care environment and ensure the continuous delivery of quality health care to the residents of the city and other citizens of the commonwealth within the service area of the city's public health care facilities; that the new public health care system must be able to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation, and long-term care services in order to create a comprehensive and integrated continuum of care with the goals of promoting the health and well-being of all in the system's service area, meeting the public health needs of the city of Cambridge and educating future physicians and caregivers; that a new public health commission should be created in the city of Cambridge as the successor to the city's department of health and hospitals in order to better administer, enhance and expand the public health services provided by the city; that the new public health system should be committed to the historic mission of the city's health care system, including the provision of excellent and accessible health care services to the community and programs that are responsive to the multicultural and multilingual composition of the service area and to the particular needs of specific populations, including the elderly, women and children, adolescents, cultural and linguistic minorities and people at high risk for health problems; and that the new public health care system should consist of a network of health care providers joining the city's traditional public health services and facilities with private hospitals or other health care providers, community health centers and other associated community-based organizations and providers.

(b) It is hereby further declared for the benefit of the people of the city of Cambridge and the commonwealth that the city be authorized to include in the new public health care system the facilities and operations of Somerville hospital; that such an affiliation would best provide for the maintenance and expansion of existing community health, primary care, specialty, emergency and inpatient services based upon shared philosophies regarding community-based services, preventive care, improving health status, increasing access by the underserved, collaboration with community agencies and city departments and developing services based on assessments of community needs; and that such an affiliation would maximize cost effectiveness, opportunities for future

managed care contract growth and opportunities for participation with or in other regional health care systems, networks and payors.

(c) It is hereby further declared for the benefit of the people of the city of Cambridge and the commonwealth that the city should be empowered to provide for other possible future affiliations with a private, nonprofit hospitals or other health care providers. St.1996, c. 147, § 1.

Historical and Statutory Notes

St.1996, c. 147, enacting the provisions designated as §§ 3-1 to 3-21 of this Appendix, was approved June 30, 1996.

Library References

Health ⇨235, 363.
WESTLAW Topic No. 198H.

§ 3-2. Definitions

As used in this act, the following words shall, unless the context otherwise requires, have the following meanings:

"Bonds", bonds, notes and other obligations or evidences of indebtedness issued under the provisions of this act.

"Cambridge hospital network", The Cambridge Hospital Community Health Network, including The Cambridge Hospital and the Neville Manor Nursing Home located in the city and currently operated under the care and control of the department of health and hospitals, and all branches thereof heretofore or hereafter established, and all other hospital and health care facilities comprising the same or appurtenant thereto or facilities necessary or convenient for the operation thereof including, except as otherwise provided in this act, all interests in property, equipment, appurtenances, structures, facilities and other property, tangible or intangible, held by the city in connection with the ownership, maintenance and operation thereof, including the Cambridge Hospital Professional Services Corporation, Inc.

"City", the city of Cambridge.

"City commissioner", the commissioner of health and hospitals of the city of Cambridge.

"Commission", the Cambridge public health commission, established by section four or, if such commission shall be abolished, the board, body or commission succeeding to the principal functions thereof or to whom the powers given by this act to the commission shall be given by law.

"Department", the department of health and hospitals of the city of Cambridge.

"Implementation date", a date determined by the city manager which shall be not earlier than July first, nineteen hundred and ninety-six nor later than December thirty-first, nineteen hundred and ninety-six.

"Revenues", all revenues, rates, fees, charges, rents and other receipts derived from the facilities and properties of the commission including, but not limited to, bond proceeds, proceeds of any grant or loan to the commission, investment earnings and the proceeds of insurance, condemnation, sale or other disposition of properties.

"Somerville hospital", a nonprofit charitable corporation organized and existing under the laws of the commonwealth, located in the city of Somerville, and all other hospital and health care facilities comprising the same or appurtenant thereto or necessary or convenient for the operation thereof, including, except as otherwise provided in this act, all interest in real and personal property, equipment, appurte-

nances, structures, facilities and other property, tangible or intangible, of such corporation.
St.1996, c. 147, § 2.

§ 3–3. Acquisition of Somerville hospital; consolidation with Cambridge hospital network

(a) Notwithstanding the provisions of any general or special law to the contrary, on and after the effective date of this act, the city, acting by the city commissioner with the approval of the city manager, is hereby authorized to execute, deliver and perform its obligations under one or more agreements with Somerville hospital and to take such other action as may be necessary and appropriate to provide for acquisition by the city, or through entities controlled by the city, of all or a portion of the operations, assets and liabilities of Somerville hospital, including all or any portion of the facilities thereof, wherever located. Upon acquisition, the operations, assets and liabilities of Somerville hospital shall be consolidated with those of the Cambridge hospital network, subject to subsection (e). All agreements between the city and Somerville hospital necessary or desirable to effect such acquisition and consolidation of operations shall be in such form and shall have such terms and conditions as the city commissioner, with the approval of the city manager, may determine to be in the best interest of the city. All actions taken by the city and its officers and employees to effectuate such acquisition and consolidation of operations prior to the effective date of this act are hereby ratified, validated and confirmed.

(b) In addition to the powers and rights granted to the city by the foregoing provisions of this section, at any time after the effective date of this act the city, acting by the city commissioner with the approval of the city manager, may enter into one or more agreements with Somerville hospital to provide for the management of all or any portion of the facilities and operations of Somerville hospital by the city acting through the department, on such terms and conditions and for such period as the city commissioner with the approval of the city manager shall determine to be in the best interests of the city.

(c) All agreements executed and delivered by the city pursuant to the authorizations contained in subsections (a) and (b), shall be assumed by and imposed upon the commission on the implementation date in accordance with section six.

(d) On and after the implementation date, all rights and powers granted to the city under subsections (a) and (b) shall be exercised only by the commission, except as otherwise provided by agreement between the city and the commission.

(e) The acquisition and consolidation of Somerville hospital by the city or the commission may be effected by any means authorized by this act, which shall include the designation of the city or the commission as the sole corporate member of Somerville hospital pursuant to chapter one hundred and eighty of the General Laws.

(f) Except as otherwise provided in this act, chapters 31, 32, 32B and 268A of the General Laws and all other provisions of law applicable to government entities but inapplicable to nonprofit corporations, shall not apply to the operations and employees of Somerville hospital upon acquisition or management thereof by the city or the commission, for so long as said Somerville hospital shall be construed as a nonprofit corporation, nor shall said chapters and provisions apply to any other nonprofit corporation owned or controlled by the commission. Chapter 150E of the General Laws shall apply to employees of said Somerville hospital upon the acquisition or management thereof by the city or the commission and said chapter 150E shall apply to any other nonprofit corporation owned or controlled by the commission. Notwithstanding the foregoing, upon the acquisition of Somerville hospital or the establishment or maintenance of any other nonprofit corporation owned or controlled by the commission, Somerville hospital and any other such corporation owned or controlled by the commission shall be liable in tort in accordance with and to the extent provided in chapter two hundred and fifty-eight of the General Laws.

(g) Notwithstanding the provisions of any general or special law to the contrary, passage of this act shall constitute a determination under section fifty-one of chapter one hundred and eleven of the General Laws that there is a need for the entity, together with its hospitals, clinics, health centers and operations, that results from any acquisition, merger or consolidation under this section. All licenses, approvals, permits, determinations, findings, awards, decisions, applications, reviews and processes applicable to the Cambridge hospital network shall, upon acquisition and consolidation of the facilities and operations of Somerville hospital as provided in this section, be deemed applicable to the same extent to such facilities and operations of Somerville hospital. Any licenses, approvals, permits, determinations, findings, awards, decisions, applications, reviews or processes applicable to the facilities and operations of Somerville hospital acquired by the city shall be re-issued in the name of, or transferred to, the Cambridge hospital as soon as possible after request by the city or the commission.

Added by St.1996, c. 147, § 3. Amended by St.1998, c. 365.

Historical and Statutory Notes

St.1998, c. 365, approved Oct. 23, 1998, in subsec. (f), in the first sentence, substituted "chapters 31, 32, 32B, and 268A" for "chapters thirty-one, thirty-two, thirty-two B one hundred and fifty E and two hundred and sixty-eight A", deleted "by" preceding "commission", inserted "said" preceding "Somerville" and inserted a comma following "nonprofit corporation" and inserted the second sentence.

Library References

Health ⇐236.
WESTLAW Topic No. 198H.

§ 3-4. Cambridge public health commission; creation; powers; membership

(a) There is hereby created in the city of Cambridge a body politic and corporate to be known as the Cambridge public health commission. The commission is hereby constituted a public instrumentality and the exercise by the commission of the powers conferred by this act shall be deemed and held to be the performance of an essential public function. The commission shall not be subject to the supervision of any other department, commission, board, bureau, agency or officer of the city except to the extent and in the manner provided by this act.

(b) The powers of the commission shall be exercised by or under the supervision of a board, hereinafter called the board or the commission board to consist of nineteen members, including the chief executive officer of the commission who shall serve ex officio. The members shall also include a representative of the medical staff and two city officers or employees, all appointed by the city manager. The remaining fifteen members of the initial commission board shall be members of the general public who shall be appointed by the city manager after consultation with the city health policy board; thereafter, the fifteen public members of the commission board shall be nominated by the commission board and appointed by the city manager, who may require that more than one nomination be submitted for a particular appointment. The commission board shall make a good faith effort to have its nominations be representative of the diversity of the community. At least ten of the fifteen public members shall be residents of the city of Cambridge. The city manager shall provide for staggered terms of one, two or three years for the fifteen public members so that, as nearly as possible, one-third of the terms shall expire annually; thereafter, each public member shall be appointed for a term of three years or, in the case of an appointment made to fill a vacancy, for the remainder of the unexpired term; and until a successor is appointed and qualified. Should the commission enter into an affiliation or merger with another entity, the city manager, upon recommendation of the commission board, may expand the board to a maximum of twenty-nine members. At all times, at least two-thirds of the public members of the board shall be Cambridge residents. The board shall establish a

subcommittee which shall concern itself primarily with issues relating to public health services in the city and may establish such other subcommittees and advisory boards as it deems appropriate. Any member of the board may be removed at any time by the city manager for cause which shall include but not be limited to, not meeting their responsibilities to ensure that the commission adheres to its mission and purpose as set forth in subsection (a) of section one. The two members appointed in their capacity as city officers or employees may be removed by the city manager at any time and shall be removed upon termination of their employment by the city. The members of the board shall not be entitled to compensation for their services as such, but shall be reimbursed for actual and reasonable expenses necessarily incurred in the performance of their duties.

(c) No vacancy in the membership of the board shall impair the right of a quorum to exercise the powers of the commission. A majority of the members of the board shall constitute a quorum and the affirmative vote of a majority of the members voting at a meeting at which a quorum is present shall be necessary for any action taken by vote of the board. The board shall annually elect one of its members as chairman and such other officers as it deems necessary. The provisions of sections twenty-three A to twenty-three C, inclusive, of chapter thirty-nine of the General Laws shall apply to meetings of the board and the provisions of section ten of chapter sixty-six of the General Laws relating to the availability of public records as defined in clause Twenty-sixth of section seven of chapter four of the General Laws shall apply to the commission; provided, however, that all writings and other records concerning the following shall not be deemed to be public records for the purposes of said section ten and executive sessions may be held to discuss or implement the following: peer review proceedings; credentialing; rates and charges; third-party payor contracts; medical records; and marketing strategies, strategic plans or other plans, analyses, evaluations, data or programs if disclosure is deemed by the board to be likely to give an unfair competitive or bargaining advantage to any person or entity. The commission shall not be deemed to be an agency for the purposes of chapter thirty A of the General Laws or a governmental body for the purposes of chapter two hundred and sixty-eight B of the General Laws.

(d) Except as provided in subsection (f) of section three, the provisions of chapter two hundred and sixty-eight A of the General Laws shall apply to board members, officers and employees of the commission and the commission shall be deemed to be a municipal agency for the purposes of said chapter two hundred and sixty-eight A; provided, however, that members of the board shall be deemed to be special municipal employees for the purposes of said chapter two hundred and sixty-eight A.

St.1996, c. 147, § 4.

Library References

Health ⇐361.
WESTLAW Topic No. 198H.

§ 3–5. Chief executive officer; employees; liability

(a) The board shall appoint, employ and determine the compensation, duties and conditions of employment of a chief executive officer, who may be removed at any time by the board, without prejudice to any contract rights. The chief executive officer shall administer the affairs of the commission including, without limiting the generality of the foregoing, matters relating to contracting, procurement, personnel and administration, under the supervision of the board, in accordance with such authorizations as the board may from time to time reasonably adopt and continue in force.

(b) The chief executive officer shall appoint and establish reasonable compensation, benefits and other terms of employment for other employees of the commission as he deems necessary, including management and professional personnel. Except as other-

wise herein provided, employees of the commission shall serve at the pleasure of the chief executive officer, subject to the terms of any applicable collective bargaining agreements or contracts of employment.

(c) The commission may indemnify any present or past board member, officer, employee or agent of the commission against any liabilities, claims, costs and expenses, including legal expenses, in connection with any actual or threatened proceeding, including any settlement thereof approved by the board, arising by reason of any act or omission within the scope of his duties for the commission; provided, however, that no indemnification shall be provided to a person concerning a matter as to which such person is finally adjudicated to have acted either (i) without a good faith belief that his conduct was in the best interests of the commission; or (ii) with reason to believe that his conduct was unlawful. Costs and expenses may be paid prior to a final disposition upon receipt of an undertaking, which the commission may accept without regard to the financial resources of the person indemnified; provided, however, that the person receiving the benefit of payments shall repay such payments if he shall be finally adjudicated not to be entitled to indemnification hereunder. The commission may purchase insurance on behalf of itself or any of its board members, officers, employees or agents against any liability arising out of such person's status as such, whether or not the commission would have the power to indemnify such person against such liability.

(d) Chapter thirty-one of the General Laws shall not apply to the officers, employees and other personnel of the commission, except as provided in subsection (f) of section six. Except as otherwise provided in this subsection or in subsection (f) of section three, chapter one hundred and fifty E of the General Laws shall apply to the commission, and for the purposes of said chapter one hundred and fifty E the commission shall be considered an "employer" or "public employer" as defined therein. The commission may designate a representative to act in the interest of the commission in labor relations matters with its employees. The commission shall have the authority to bargain collectively with labor organizations representing employees of the commission and to enter into agreements with such organizations relative to wages, salaries, hours, working conditions, health benefits, pension and retirement allowances and the submission of grievances and disputes to arbitration.

St.1996, c. 147, § 5.

Library References

Health ⇐361.
WESTLAW Topic No. 198H.

§ 3-6. Implementation of act; transfer of functions, property, contracts, moneys and employees from department to commission; retirement benefits

(a) Notwithstanding any provision of this act to the contrary, except as otherwise expressly provided in this subsection, from the effective date of this act until the day preceding the implementation date the rights and powers granted by the provisions of this act to the commission shall be exercised by the department, acting by the city commissioner, with the approval of the city manager. Thirty days prior to the scheduled implementation date or as soon thereafter as the members of the commission board are appointed, the commission shall undertake the following: (i) to provide for the appointment of a chief executive officer and such additional staff as shall be necessary for the management and operation of the commission, after consideration of the employees of the department to be transferred to the commission as provided herein; (ii) to adopt its public health services budget for the fiscal year, or any portion thereof, commencing on the implementation date; and (iii) to provide for the transfer of the functions and employees of the department to be effective on the implementation date, as provided herein including, without limitation, the negotiation of any new collective bargaining agreements with such employees to be effective on or after the implementation date. Notwithstanding the provisions of any general or special law to the contrary, the rights

and powers of the commission authorized by the provisions of this paragraph to be exercised by the commission prior to the implementation date, upon request of the commission to, and with the approval of, the city manager, may be exercised by the personnel of the department. All expenses of the commission incurred in the performance of the rights and powers provided in this subsection shall be borne by the city, provided that such expenses, or a budget therefor, shall have been first approved by the city manager. The city manager shall submit to the city council such supplementary appropriation orders for such expenses as he shall deem appropriate.

(b) Effective on the implementation date, the department is hereby abolished and all rights, powers, appropriations, obligations and immunities of the department under law or contract shall be transferred to and assumed by the commission. Without limiting the generality of the foregoing, on the implementation date the commission shall assume the general care and control of the Cambridge hospital network, including any facilities and operations of Somerville hospital acquired as provided in section three, except as otherwise provided herein. In addition to the other rights or powers granted to the commission by the provisions of this act, from and after the implementation date, unless and until the city exercises its rights under section fifteen, the commission shall have the powers and shall perform the duties from time to time conferred or imposed upon boards of health of cities in the commonwealth by general laws applicable to the city and the chief executive officer shall be deemed to be the city's commissioner of public health for all purposes under city ordinances and state law.

(c) On the implementation date, ownership, possession and control of the Cambridge hospital network and all other personal property under the care and custody of the department and all contracts, books, papers, records, and documents of whatever description pertaining to the Cambridge hospital network or otherwise to the affairs of the department on such date shall pass to and be vested in the commission without consideration or further evidence of transfer and shall thereafter be in the ownership, possession and control of the commission; provided, however, that the lease or transfer to the commission of real property now under the care and custody of the department shall be effected by agreement in accordance with the provisions of subsection (c) of section seven; and all debts, liabilities and other obligations of the city pertaining to or on account of the department shall be assumed by and imposed upon the commission including, without limitation, liabilities in tort and the obligations of the city to pay the interest and principal requirements on all bonds, notes and other evidences of indebtedness then outstanding or issued by the city at a later date in accordance with subsection (m) of section nine for purposes pertaining to the Cambridge hospital network; provided, however, that all such city bonds or notes shall remain general obligations of the city. Except as above provided, all actions and proceedings duly pending before, all actions and proceedings duly pending against, and all actions and proceedings duly begun by the department shall continue unabated and remain in full force and effect notwithstanding the passage of this act and the transfer of control contemplated hereby and may, at the discretion of the court, commission, board or other body having jurisdiction, be completed before, against or by the commission.

(d) All contracts, including leases, mortgages, obligations, benefits, rights and liabilities of the city and the department which are transferred to the commission under any provision of this act, shall continue in full force and effect in accordance with law and, unless prohibited by federal law or by contract terms, shall be transferred to, assumed by and imposed upon the commission by operation of law. General city ordinances relating to zoning, land use and other matters including, but not limited to, any neighborhood conservation districts or landmarks designated by city ordinance, shall apply to the commission and its successors and assigns to the same extent as they would apply to any private hospital or health care provider and, for so long as the chief executive officer is deemed to be the city's commissioner of public health, all city ordinances relating to the duties and responsibilities of the commissioner of public health shall apply to the commission and to the chief executive officer to the extent they

are not inconsistent with the provisions of this act. No other ordinances or regulations of the city in effect on the implementation date shall apply to the commission.

(e) On the implementation date, all unexpended balances of moneys in accounts of, for or on behalf of the department including, without limitation, accounts receivable, grants, public trusts, bequests, gifts and other funds pertaining to the Cambridge hospital network or any other property, right or operation of the department, each as determined by the treasurer of the city with the approval of the city manager, including moneys and investments, if any, held for the payment or security of interest and principal of then outstanding bonds, notes and other evidences of indebtedness of the city as provided in this section, but excluding money and investments held by or for the account of the city retirement board on account of accrued retirement benefits under chapter thirty-two of the General Laws for employees of the department, shall be deemed to be held in trust for and shall be transferred to the commission. Subsequent to such date, all moneys collected or received by the city from any source on account of the Cambridge hospital network and any other property, right or operation of the department transferred to the commission by operation of this act, as determined by the treasurer of the city, other than any such moneys properly allocable to a right, liability or obligation retained by the city under any provision of this act, shall be deemed to be held in trust for and shall be forthwith transferred and paid over to the commission.

(f) On the implementation date, every employee of the department shall become an employee of, and shall be transferred to, the commission without any loss of accrued rights to holidays, sick leave, vacations or other benefits of employment and, by such transfer except as otherwise provided, such employee's seniority, wages, salaries, hours, working conditions, health benefits, pensions and retirement allowances under law or contract shall not be impaired; provided, however, that thereafter each such employee shall perform his duties under the direction, control and supervision of the chief executive officer. Employees of the department who are tenured employees, as defined in section one of chapter thirty-one of the General Laws, on the day before the implementation date shall retain their existing rights under said chapter thirty-one during their period of employment in the same or a similar position by the commission; employees of the commission shall not otherwise be subject to said chapter thirty-one. Rights and obligations under collective bargaining agreements with respect to employees transferred to the commission from the department shall be assumed by and imposed upon the commission and employees transferred to the commission who are subject to such agreements shall continue to be represented by the labor organizations that are parties to such agreements until such time as they elect to be otherwise represented in accordance with the provisions of chapter one hundred and fifty E of the General Laws. Employees transferred to the commission who are not represented by labor organizations as of the day before the implementation date shall not be accepted into bargaining units existing on that date, but they shall thereafter be afforded the right to representation pursuant to state or federal law, as the case may be. Immediately after organization of the commission on the implementation date, the commission and each labor organization representing employees who have transferred to the commission shall begin bargaining for a successor agreement to replace any such agreement between the city and the labor organization representing those transferred employees. Each existing collective bargaining agreement shall remain in effect for ninety days after the implementation date or until a new agreement is reached, whichever shall occur first. Notwithstanding the foregoing, no employee of the city who is hired by the commission subsequent to the implementation date shall be entitled to transfer to the commission any accrued or credited vacation, sick or personal time.

(g) Every employee of the department who immediately prior to being transferred to the commission, is a member of the Cambridge retirement system established under chapter thirty-two of the General Laws shall continue to be a member thereof and subject to the laws applicable thereto. No other employees of the commission shall have the right to become members of the Cambridge retirement system, except and to the extent that the commission, in its sole discretion, permits or requires any employees to

become members of that system; employees who thus become members of the Cambridge retirement system shall be subject to the same laws, rules and regulations as city employees who are members of that system. The commission shall deduct from the wages of its employees who are members of the Cambridge retirement system and pay over to the Cambridge retirement board such sums as the city would deduct and pay over if such person were an employee of the city. The commission shall annually reimburse the city for its share of any amounts appropriated by the city under the provisions of chapter thirty-two of the General Laws for or on account of retirement allowances for employees of the commission, and for its share of any amounts appropriated by the city for administrative costs of the city retirement board, based on an allocation determined by such retirement board of the years of creditable service of such employees with the commission and with the city.

(h) Notwithstanding the provisions of chapter thirty-two of the General Laws or any other general or special law to the contrary, but subject to subsection (g), the commission may contract with any employee of the commission with respect to the establishment, continuation, maintenance and funding of any deferred compensation or other pension or retirement plan or program under state or federal law which has been maintained for such employee prior to his employment by the commission or which the commission thereafter agrees to maintain and, for such purpose, the commission may become a trustee or sponsor of and may make contributions to any such plan or program. For purposes of this subsection, the word "employee" shall have the same meaning as "employee" as defined in section one of chapter thirty-two of the General Laws and shall also include consultants and independent contractors who are natural persons paid by the commission and whose duties require that their time be devoted to the service of the commission during regular business hours.

(i)(1) Notwithstanding the provisions of chapter thirty-two of the General Laws or any other general or special law to the contrary, the commission may, with the approval of the city manager of Cambridge, as of an effective date to be determined by the commission with the approval of the city manager of Cambridge, establish that employees of the commission who are members of the Cambridge retirement system and otherwise eligible for a superannuation retirement, who shall have filed a written application for superannuation retirement pursuant to section five of said chapter thirty-two no earlier than thirty days after such effective date, but no later than ninety days after such effective date, specifying a retirement date no later than one hundred and twenty days after such effective date, shall have their normal yearly amount of the retirement allowance as determined under paragraph (a) of subdivision (2) of section five of said chapter thirty-two computed according to the table contained in said paragraph (a) based upon the age of such member and his number of years and full months of creditable service at the time of his retirement increased, at the option of the employee, by up to three years of age or by up to three years of creditable service or by a combination of additional years of age and service the sum of which shall not be greater than three; provided that the commission, with the approval of the city manager of Cambridge, may limit the amount of additional credit for service or age or a combination of service and age offered and the number of employees for whom it will approve a retirement calculated under the provisions of this section; provided further, however, that if participation is limited, the retirement of employees with the greatest creditable service so applying shall be approved before approval is given to employees with lesser creditable service.

(2) For the purposes of this section, words used herein shall have the same meaning as in chapter thirty-two of the General Laws unless the context clearly requires otherwise. An employee who retires and receives an additional benefit in accordance with the provisions of this section shall be deemed to be retired for superannuation under the provisions of said chapter thirty-two of the General Laws and shall be subject to the provisions of said chapter thirty-two.

(3) The total normal yearly amount of the retirement allowance, as determined in accordance with the provisions of section five of said chapter thirty-two, of any employee who retires and receives an additional benefit in accordance with the provisions of this section shall not exceed four-fifths of the average annual rate of his regular compensation received during the periods, whether consecutive or not, constituting his last three years of creditable service preceding retirement.

(4) The Cambridge retirement board shall prepare a funding schedule which shall reflect the costs and the actuarial liabilities attributable to the additional benefits payable under this section and said schedule shall be designed to reduce the Cambridge retirement system's additional pension liability attributable to such costs and liabilities to zero on or before June thirtieth, two thousand and twelve; provided, however, that said retirement board shall triennially update such schedule until June thirtieth, two thousand and twelve. In each of the fiscal years until the actual liability determined under this section shall be reduced to zero, it shall be deemed an obligation of the commission to reimburse the city for such liability as shall be appropriated to the applicable pension reserve fund in such fiscal year in the amount required by the funding schedule and the updates thereto.

St.1996, c. 147, § 6.

§ 3-7. Annual assessment of public health needs; contracts; funding

(a) Not later than January fifteenth in each year, the commission shall prepare and file with the city manager and the city clerk an annual assessment of the public health needs of the city. The annual public health assessment shall include an evaluation of existing local, state and federal programs and services to address the public health needs of the city and the adequacy of funding sources available for such programs and services, an assessment of programs, services and other activities provided by private public health providers to address the public health needs of the city, including the performance of providers under contract with the commission in accordance with this act, and proposals by the commission to revise, enlarge or enhance its response to the public health needs of the city including new, expanded or revised programs or services to be provided by the commission or by public health providers under contract with it for the ensuing fiscal year.

(b) Subject to the limitations provided herein, the city and the commission shall enter into a contact [sic] for an initial period not to exceed seven years for the provision of public health services in accordance with the annual public health assessments provided pursuant to subsection (a). Said contract shall include projected funding for that period, commencing on the implementation date, to address the anticipated public health needs of the city and to contribute to the health care of city residents. The projected funding for that period will provide a budgetary framework for the city and the commission, with the annual funding amounts to be subject to annual appropriation by the city. The city shall reserve the right to terminate the contract if the commission does not adequately provide for the public health needs of the city or if the commission violates the terms of the contract. The contract may be amended, renewed or extended by agreement of the city and the commission.

(c) In addition to the authority granted elsewhere in this act and by other applicable laws, the commission and the city may enter into contracts from time to time to provide for one or more of the following: (i) the payment of sums appropriated pursuant to subsection (b); (ii) the payment of any other sums for health care or other services provided to the city; (iii) services to be provided by the city to or on behalf of the commission; (iv) indemnification by the commission to the city for claims associated with the establishment and operation of the commission and its health facilities; (v) the gift, grant, sale, conveyance, loan, license or lease by the city to the commission of any real property or any other assets, property or facilities useful in connection with the exercise by the commission of any of its powers under this act and not transferred pursuant to the authority granted in subsection (c) of section six; (vi) any such

conveyance, transfer or other disposition of real property or other assets, property or facilities by the commission to the city; (vii) the payment by the commission of debt service on indebtedness issued by the city on behalf of the commission; and (viii) such other matters as may be appropriate to accomplish the purposes hereof. No such contracts shall be subject to the provisions of chapter thirty B of the General Laws or any other law or ordinance requiring competitive bidding or other procurement or disposition procedures by either the city or the commission. Any such contracts shall include such terms and conditions, shall be for such consideration, if any, and shall have such terms of years, as the city and the commission may agree.

St.1996, c. 147, § 7.

[1] So in original; probably should read "contract".

Library References

Health ⇐361.
WESTLAW Topic No. 198H.

§ 3–8. Powers and duties of commission

(a) In addition to its other powers enumerated in this act, the commission shall have the following rights and powers:

(1) to adopt by-laws for the regulation of the affairs and the conduct of its business, and to prescribe rules, regulations and policies in connection with the performance of its functions and duties;

(2) to adopt an official seal and alter the same at pleasure;

(3) to maintain an office at such places as it may determine;

(4) to establish its fiscal year, which shall otherwise be July first through June thirtieth;

(5) to receive, administer, expend and comply with the conditions and requirements respecting any gift, grant, donation or appropriation of any property or money;

(6) to receive and apply its revenues to the purpose of this act without appropriation or allotment by the city except as otherwise expressly provided herein and to invest any moneys of the commission or under its control in such investments as are legal investments for moneys of the commonwealth;

(7) to maintain, repair, operate and improve the Cambridge hospital network and all other public health facilities under its custody and control and to provide for the cost of the foregoing and its other activities and programs and project from its revenues, appropriations, grants, the proceeds of loans or from any other moneys legally available to the commission;

(8) to provide health care services, directly, by duly licensed health care providers or by contract;

(9) to mortgage, pledge or assign any real or personal property of the commission, subject to approval of the city manager to the extent required by clause (13), and any money, fees, charges, or other revenue of the commission and any proceeds derived by the commission from the sale of property, insurance or condemnation awards;

(10) to make application for, receive, accept and expend any private, federal, commonwealth or city loans or grants for or in aid of any program or operations of the commission or of any facilities or other property of the commission and to receive and accept contributions from any source of either money, property, labor or other things of value;

(11) to sue and be sued, to prosecute and defend actions relating to its properties and affairs and to be liable in tort as a public employer as defined in section one of chapter two hundred and fifty-eight of the General Laws; provided, however, that the commis-

sion shall not be authorized to become a debtor under the United States Bankruptcy Code;

(12) to appoint or employ personnel as provided herein and to engage legal, accounting, management, financial, medical, consulting and other professional services and agents;

(13) to acquire by purchase, lease, gift or devise or to obtain options for the acquisition of any property or any interest therein, real or personal, improved or unimproved, tangible or intangible; to make contracts and agreements of all kinds including, but not limited to, contracts for the management of its hospital and public health facilities and for the provision to the commission of public health services and contracts for the sale, lease, as lessor or lessee, or purchase of real or personal property of any kind or description and to execute and deliver instruments necessary or convenient for carrying out any of its purposes; to provide, develop or participate in prepaid health care services, managed care programs and insurance programs and other alternative health care delivery programs, including programs involving the acceptance of capitated payments or premiums that include the assumption of financial and actuarial risk; to establish, develop or participate in health maintenance organizations or preferred provider organizations; and to acquire, create, be a voting member of, choose directors to serve on the boards of, share common officers and directors with, be a partner in or participate in or control, any venture, corporation, partnership or other organization, public or private, which the commission finds operates for purposes consistent with, and in furtherance of, the purposes of the commission, including a corporation organized under chapter one hundred and eighty of the General Laws in the manner specified in subsection (e) of section three; provided, however, that no contract or agreement for the management of all or substantially all of the operations of the Cambridge hospital network shall be effective without the prior approval of the city manager, and, in no case, shall any such contract or agreement be inconsistent with the mission of the commission as set forth in subsection (a) of section one or be inconsistent with the terms of this act; and, provided further, that the commission shall not mortgage, assign, pledge, sell or otherwise dispose of, or lease as lessor other than in the ordinary course of business, any of the real property transferred from the city to the commission with a value in excess of two hundred and fifty thousand dollars except upon the approval of the city manager and, if the value is in excess of one million dollars, the approval of the city council, unless a different value limitation is set by agreement between the city and the commission;

(14) to manage or to contract with the city, acting by the treasurer of the city with the approval of the city manager, for the management of public trusts, bequests and other endowment funds held by or on behalf of the commission for application to the operations of the Cambridge hospital network or any other corporate purpose of the commission;

(15) to adopt, amend and repeal reasonable health regulations not inconsistent with any public health regulation of the state department of public health or with any other provision of law and prescribe a reasonable fine for any violation of a health regulation promulgated hereunder; and

(16) consistent with the constitution and laws of the commonwealth, to exercise such other powers, including all powers pertaining to the department and to the properties under their custody and control held by the city on the effective date of this act not inconsistent herewith, as may be necessary or convenient for or incident to carrying out the foregoing powers and the accomplishment of the purposes of this act.

St.1996, c. 147, § 8.

Library References

Health ⇐366, 367.
WESTLAW Topic No. 198H.

§ 3–9. Bonds and notes

(a) The commission may issue bonds or notes for any of its corporate purposes, including borrowing from the Health and Educational Facilities Authority established by chapter six hundred and fourteen of the acts of nineteen hundred and sixty-eight, which is hereby authorized to make loans to the commission. Except as otherwise provided in this act, the principal of, premium, if any, and interest on all bonds shall be payable solely from the particular funds provided therefor under the documents governing the issuance of the bonds and consistent with this act. The bonds shall be issued in such amounts as the commission may authorize. Bonds of each issue shall be dated, shall bear interest at such rate or rates, including rates variable from time to time as determined by such index, banker's loan rate, remarketing or index agent, or other method as may be determined by the commission and shall mature at such times as may be determined by the commission; provided, however, that no bond shall mature more than forty years from the date of issuance or beyond the expiration of the expected useful life of any facilities being financed by the bonds as determined by the commission. Bonds may be made redeemable before maturity at such prices and under such terms and conditions as may be fixed by the commission prior to the issuance of such bonds. The commission shall determine the form and details and the manner of execution of bonds. The commission may sell its bonds in such manner, either at public or private sale, for such price, at such rates of interest, or at such discount in lieu of interest, as the commission may determine.

(b) In addition to other lawful items, the costs to be financed by the issuance of bonds under this act may include interest during construction and for up to one year after completion of any revenue-producing facilities being financed as estimated by the commission, the cost of architectural, engineering, financial and legal services, plans, specifications, studies, expenses as may be necessary or incident to determining the feasibility or practicability of constructing such revenue-producing facilities, the financing of such construction and the placing of the facilities in operation and such other related expenses as may be determined by the commission.

(c) Any bonds issued under this act may be secured by a resolution or by a trust or security agreement between the commission and a corporate trustee, which may be any trust company or bank having the powers of a trust company within or without the commonwealth, or by a trust or security agreement directly between the commission and the purchasers of the bonds and such resolution or trust or security agreement shall be in such form and executed in such manner as may be determined by the commission. Such trust or security agreement or resolution may pledge or assign, in whole or in part, the revenues held or to be received by the commission, including the revenues from any facilities already existing when the pledge or assignment is made, and any contract or other rights to receive the same, whether then existing or thereafter coming into existence and whether then held or thereafter acquired by the commission, and the proceeds thereof. Such trust or security agreement or resolution may contain such provisions for protecting and enforcing the rights, security and remedies of the bondholders as may, in the discretion of the commission, be reasonable and proper and not in violation of law. Without limiting the generality of the foregoing, such agreement or resolution may include provisions defining defaults and providing for remedies in the event of default, which may include the acceleration of maturities, and covenants setting forth the duties of and limitations on the commission in relation to the custody, safeguarding, investment and application of moneys, the issue of additional or refunding bonds, the fixing, revision and collection of fees, charges and other revenues, the use of any surplus bond proceeds, the establishment of reserves, the construction and operation of facilities of the commission, and the making and amending of contracts relating to the bonds. It shall be lawful for any bank or trust company to act as a depository or trustee of the proceeds of bonds, revenues or other moneys under a trust or security agreement or resolution and to furnish such indemnification or to pledge such securities

and issue such letters or lines of credit or other credit facilities as may be required by the commission acting under this act. Any such trust or security agreement or resolution may set forth the rights and remedies of bondholders and of the trustees and may restrict the individual right of action by bondholders.

(d) Any bonds issued under authority of this act may be issued by the commission pursuant to lines of credit or other banking arrangement under such terms and conditions not inconsistent with this act, and under such agreements as the commission may determine to be in the best interests of the commission. Bonds so issued may also be secured, in whole or in part, by insurance or by letters or lines of credit or other credit or liquidity facilities issued to the commission by any bank, trust company or other financial institution, within or without the commonwealth, and the commission may pledge or assign any of its revenues as security for the reimbursement by the commission to the issuers of such issuance or letters or lines of credit or credit or liquidity facilities of any payments made thereunder.

(e) Any pledge of revenues, contract or other rights to receive revenues or the proceeds thereof made by the commission under this act shall be valid and binding and shall be deemed continuously perfected for the purposes of chapter one hundred and six of the General Laws from the time when the pledge is made; the revenues, moneys, rights and proceeds so pledged and then held or thereafter acquired or received by the commission shall immediately be subject to the lien of such pledge without any physical delivery or segregation thereof or further act; and the lien of such pledge shall be valid and binding against all parties having claims of any kind in tort, contract or otherwise against the commission, irrespective of whether such parties have notice thereof. Neither the resolution nor any trust or security agreement nor any other agreement by which a pledge is created need be filed or recorded except in the records of the commission and no filing need be made under said chapter one hundred and six.

(f) Any owner of a bond issued by the commission under the provisions of this act and any trustee under a trust or security agreement or resolution securing the same, except to the extent the rights herein given may be restricted by such agreement or resolution, may bring suit upon the bonds and may, either at law or in equity, by suit, action, mandamus or other proceeding for legal or equitable relief, including proceedings for the appointment of a receiver to take possession and control of the business and properties of the commission, to operate and maintain the same, to make any necessary repairs, renewals and replacements in respect thereof and to fix, revise and collect fees and charges, protect and enforce any and all rights under the laws of the commonwealth or granted hereunder or under such trust or security agreement resolution and may enforce and compel the performance of all duties required by this act or by such agreement or resolution to be performed by the commission or by any officer of the commission.

(g) The commission may issue refunding bonds for the purpose of paying any of its bonds issued pursuant to this act at or prior to maturity or upon acceleration or redemption. Refunding bonds may be issued at such times prior to the maturity or redemption of the refunding bonds as the commission may determine. The refunding bonds may be issued in sufficient amounts to pay or provide the principal of the bonds being refunded, together with any redemption premium on the bonds, any interest accrued or to accrue to the date of payment of such bonds, the expenses of issue of the refunding bonds, the expenses of redeeming the bonds being refunded and such reserves for debt service or other expenses from the proceeds of such refunding bonds as may be required by a trust or security agreement or resolution securing the bonds. The authorization and issue of refunding bonds, the maturities and other details of such bonds, the security for the bonds, the rights of the holders of the bonds, and the rights, duties and obligations of the commission in respect to the same shall be governed by the provisions of this act relating to the issue of the bonds other than refunding bonds insofar as the same may be applicable.

(h) Bonds issued by the commission under this act shall not be deemed to be a debt or a pledge of the faith and credit of the commonwealth or of any city or town but shall be payable solely from the revenues of the commission. All bonds, notes and other evidences of indebtedness of the commission shall contain on the face thereof a statement to the effect that neither the commonwealth nor any city or town shall be obligated to pay the same and that neither the faith and credit nor the taxing power of the commonwealth or of any city or town is pledged to the payment of the principal of or interest on such bonds or notes.

(i) All moneys received pursuant to the provisions of this act, whether as proceeds from the issue of bonds or as revenues or otherwise, shall be deemed to be trust funds to be held and applied solely as provided in this act.

(j) Bonds issued under the provisions of this act are hereby made securities in which all public officers and public bodies of the commonwealth and its political subdivisions, all insurance companies, trust companies in their commercial departments, savings banks, co-operative banks, banking associations, investment companies, executors, administrators, trustees and other fiduciaries may properly and legally invest funds, including capital in their control or belonging to them. Such bonds are hereby made securities which may properly and legally be deposited with and received by any state or municipal officer or any agency or political subdivision of the commonwealth for any purpose for which the deposit of bonds or obligations of the commonwealth is now or may hereafter be authorized by law.

(k) Notwithstanding any of the provisions of this act or any recitals in any bonds issued under this chapter, all such bonds shall be deemed to be investment securities under chapter one hundred and six of the General Laws.

(*l*) Bonds may be issued under this act without obtaining the consent of the emergency finance board established under the provisions of chapter forty-nine of the acts of nineteen hundred and thirty-three or of any department, division, commission, board, bureau or agency of the commonwealth or the city and without any other proceedings or the happening of any other conditions than those proceedings or conditions which are specifically required therefor by this act and the validity of and security for any bonds issued by the commission shall not be affected by the existence or nonexistence of any such consent or other proceedings or conditions.

(m) The city may authorize and incur indebtedness on behalf of the commission in accordance with chapter forty-four of the General Laws, including indebtedness authorized by an order of the city council passed on June seventh, nineteen hundred and ninety-three, as amended, for certain ambulatory care and parking facilities. The obligation of the city to pay interest and principal on indebtedness issued by the city shall be assumed by and imposed upon the commission unless otherwise provided by agreement as authorized by subsection (c) of section seven, but such indebtedness shall remain a general obligation of the city.

St.1996, c. 147, § 9.

§ 3-10. Exemption from taxation

The commission and all its revenues, income and real and personal property used solely by the commission in furtherance of the mission declared in section one shall be exempt from taxation and from betterments and special assessments and the commission shall not be required to pay any tax, excise or assessment to or for the commonwealth or any of its political subdivisions. Bonds issued by the commission and their transfer and the income therefrom, including any profit made on the sale thereof, shall at all times be exempt from taxation by the commonwealth.

St.1996, c. 147, § 10.

§ 3–11. Additional powers, rights, benefits, status and characteristics of commission

(a) Subject to any limitations thereon or any approval required therefor under any other general or special law, the commission is hereby authorized to fix, revise, determine and collect fees, rates, rents and other charges for the services, programs and other activities provided by it or as a result of the operation of the properties under its custody and control. The fees, rates, rents and other charges established by the commission shall be so fixed and adjusted in respect of the aggregate thereof so as to provide revenues to the commission at least sufficient, together with all other moneys available to the commission, including all amounts appropriated to the commission as provided in this section, to pay or provide for all operating expenses of the commission and all debts and other obligations of the commission as the same becomes due, to create and maintain such reserves as may be reasonably required for its operations or to secure its debts and other obligations; and to pay or provide for all necessary repairs, replacements and renewals to the properties under its custody and control and any other amounts which the commission may be obligated to pay or provide for by law or contract.

(b) Any application, review or process in relation to or in furtherance of the purposes of or contemplated by this act heretofore filed or undertaken or any proceeding heretofore commenced or any determination, finding or award made by the city with the federal government, the department of public health or any other public corporation shall inure to and for the benefit of the commission to the same extent and in the same manner as if the commission had been a party to such application, review, process or proceeding from its inception and the commission shall be deemed to be a party thereto, to the extent not prohibited by federal law. Any license, approval, permit, determination, finding, award or decision heretofore or hereafter issued or granted pursuant to or as a result of any such application, review, process or proceeding shall inure to the benefit of and be binding upon the commission and shall be assigned and transferred by the city to the commission unless such assignment and transfer is prohibited by federal law.

(c) Notwithstanding the establishment of the commission, acquisition by the city or the commission of facilities and operations of Somerville hospital or establishment of Somerville hospital or any other entity as a subsidiary of the commission, the Cambridge hospital and any such subsidiary shall be deemed to retain the status and characteristics of a public service hospital as defined by 114.1 CMR 36.13(2)(j)(3), of a disproportionate share hospital as defined by 114.1 CMR 36.13(10) and of a public hospital for purposes of determining eligibility for and determination of all payments from all governmental units for the provision of general health supplies, care or rehabilitative services and accommodations, as those terms are defined in section thirty-one of chapter six A of the General Laws including, without limitation, for purposes of determining eligibility for payments to high public payer hospitals pursuant to 114.1 CMR 36.13(10)(a); disproportionate share adjustments for safety net providers pursuant to 114.1 CMR 36.13(10)(c); payments owed to or from the uncompensated care pool in accordance with regulations established pursuant to chapter one hundred and eighteen F of the General Laws; and entitlement to payment from and participation in medical assistance programs established under chapter one hundred and eighteen E of the General Laws.

St.1996, c. 147, § 11.

§ 3–12. Procurement of services, supplies and materials

(a) The commission shall establish procedures for the procurement of services, supplies and materials to encourage fair and open competition and to obtain satisfactory prices thereon, but shall not be subject to general or special laws regulating the procurement of services, supplies and materials including, but not limited to, section thirty-nine M of chapter thirty of the General Laws, sections forty-four A to forty-four J, inclusive, of chapter one hundred and forty-nine of the General Laws, sections thirty-eight A½ to thirty-eight O, inclusive, of chapter seven of the General Laws and chapter

thirty B of the General Laws; provided, however, that the provisions of sections twenty-six to twenty-seven F, inclusive, and section twenty-nine of chapter one hundred and forty-nine of the General Laws shall apply to all construction contracts procured by the commission.

(b) Notwithstanding the statutory provisions specified in subsection (a), or any other general or special law to the contrary, the city may employ alternative methods for procuring design and construction services for the development of its hospital network capital facility projects, including the negotiation of a construction management or design/build contract with the selected construction manager for the design and construction of the facilities upgrading project known as the Hospital Master Plan Project and as revised through the Memorandum of Understanding dated May fourteenth, nineteen hundred and ninety-three, as amended, its checkpoint reports and the order of the city council passed on June seventh, nineteen hundred and ninety-three, as amended.
St.1996, c. 147, § 12.

§ 3-13. Annual report; financial statements

The commission shall at all times keep full and accurate accounts of its receipts, expenditures, disbursements, assets and liabilities, which shall be open to inspection by the city manager or any other duly appointed agent of the commonwealth or the city. The commission shall submit an annual report in writing concerning its operations to the city manager of the city and shall file a copy of such report with the city clerk within one hundred and twenty days following the close of its fiscal year unless otherwise agreed by the city and the commission. Such report for the fiscal year ending June thirtieth, nineteen hundred and ninety-seven, and for each fiscal year thereafter shall include financial statements relating to the operations and properties of the commission maintained in accordance with generally accepted accounting principles to the extent applicable and audited by an independent certified public accountant or firm of certified public accountants.
St.1996, c. 147, § 13.

§ 3-14. Board of health; public health commissioner; right to designate by ordinance

Notwithstanding the provisions of subsection (b) of section six, the city shall retain the right to provide by ordinance for the designation of a new board of health or public health commissioner, who shall have the powers and perform the duties conferred or imposed by applicable general laws upon boards of health of cities, and in accordance with the terms of such ordinance. Any ordinance designating a new public health commissioner under this section may provide for reestablishment of a separate health policy board.
St.1996, c. 147, § 14.

Library References

Health ⇐161.
WESTLAW Topic No. 198H.

§ 3-15. Repeal of St.1946, c. 108

Chapter one hundred and eight of the acts of nineteen hundred and forty-six is hereby repealed.
St.1996, c. 147, § 15.

§ 3-16. Vesting of title in city upon termination or dissolution of commission

Upon termination or dissolution of the commission, the title to all funds and other properties owned by it which remain after payment or the making of provision for payment of all obligations of the commission shall vest in the city.
St.1996, c. 147, § 16.

§ 3–17. Conflict with other laws

The provisions of this act shall be deemed to provide an exclusive, additional, alternative and complete method for the doing of the things authorized hereby and shall be deemed and construed to be supplemental and additional to, and not in derogation of, powers conferred upon the commission by law; provided, however, that insofar as the provisions of this act are inconsistent with the provisions of any general or special law, ordinance, administrative order or regulation or any limitation imposed by a corporate or municipal charter, the provisions of this act shall be controlling.
St.1996, c. 147, § 17.

§ 3–18. Construction and application

This act, being necessary for the welfare of the city and its inhabitants, shall be liberally construed to effect the purposes hereof.
St.1996, c. 147, § 18.

§ 3–19. Constitutionality

This act shall be construed in all respects so as to meet all constitutional requirements. In carrying out the purposes and provisions of this act, all steps shall be taken which are necessary to meet constitutional requirements whether or not such steps are required by statute.
St.1996, c. 147, § 19.

§ 3–20. Effective date of section 3–15

Section fifteen shall take effect as of the implementation date.
St.1996, c. 147, § 20.

§ 3–21. Effective date of act

This act shall take effect upon its passage.
St.1996, c. 147, § 21.

INDEX

See volume 17B, containing Index to Part I, Title XVI, Chapters 111 to 114, Public Health

See, also, M.G.L.A. General Index

END OF VOLUME

ATTACHMENT 8

AFFIDAVIT OF TRUTHFULNESS AND COMPLIANCE

Massachusetts Department of Public Health
Determination of Need
Affidavit of Truthfulness and Compliance with Law and Disclosure Form 100.405(B)

Version: 7-6-17

Instructions: Complete Information below. When complete check the box "This document is ready to print:". This will date stamp and lock the form. Print Form. Each person must sign and date the form. When all signatures have been collected, scan the document and e-mail to: **dph.don@state.ma.us** Include all attachments as requested.

Application Number: CHA-22061514-RE

Original Application Date: August 31, 2022

Applicant Name: Cambridge Public Health Commission d/b/a Cambridge Health Alliance

Application Type: DoN-Required Equipment

Applicant's Business Type: ○ Corporation ○ Limited Partnership ○ Partnership ○ Trust ○ LLC ◉ Other

Is the Applicant the sole member or sole shareholder of the Health Facility(ies) that are the subject of this Application? ○ Yes ◉ No

Describe the role /relationship: N/A

The undersigned certifies under the pains and penalties of perjury:

1. The Applicant is N/A ;
2. I have ~~read~~ * 105 CMR 100.000, the Massachusetts Determination of Need Regulation;
3. I understand and agree to the expected and appropriate conduct of the Applicant pursuant to 105 CMR 100.800;
4. I have ~~read~~ * this application for Determination of Need including all exhibits and attachments, and ~~certify that~~ ** all of the information contained herein is accurate and true;
5. I have submitted the correct Filing Fee and understand it is nonrefundable pursuant to 105 CMR 100.405(B);
6. I have submitted the required copies of this application to the Determination of Need Program, and, as applicable, to all Parties of Record and other parties as required pursuant to 105 CMR 100.405(B);
7. I have caused, as required, notices of intent to be published and duplicate copies to be submitted to all Parties of Record, and all carriers or third-party administrators, public and commercial, for the payment of health care services with which the Applicant contracts, and with Medicare and Medicaid, as required by 105 CMR 100.405(C), et seq.;
8. I ~~have~~ ** ~~caused~~ proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR 100.405(E) and 301 CMR 11.00;
9. If subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00, I have submitted such Notice of Material Change to the HPC - in accordance with 105 CMR 100.405(G);
10. Pursuant to 105 CMR 100.210(A)(3), I certify that both the Applicant and the Proposed Project are in material and substantial compliance and good standing with relevant federal, state, and local laws and regulations, as well as with all ~~previously issued~~ Notices of Determination of Need ~~and the terms and Conditions attached therein;~~ ***
11. I have ~~read~~ * and understand the limitations on solicitation of funding from the general public prior to receiving a Notice of Determination of Need as established in 105 CMR 100.415;
12. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions pursuant to 105 CMR 100.310, as well as any applicable Other Conditions as outlined within 105 CMR 100.000 or that otherwise become a part of the Final Action pursuant to 105 CMR 100.360;
13. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and
14. Pursuant to 105 CMR 100.705(A), I certify that the Proposed Project is authorized under applicable zoning by-laws or ordinances, whether or not a special permit is required; or,
    a. If the Proposed Project is not authorized under applicable zoning by-laws or ordinances, a variance has been received to permit such Proposed Project; or,
    b. The Proposed Project is exempt from zoning by-laws or ordinances.

Other Business Type:

Define Business Type: Public Instrumentality per Chapter 147 of the Acts of 1996

All parties must sign. Add additional names as needed.

*been informed of the contents of
**have been informed that
***issued in compliance with 105 CMR 100.00, the Massachusetts Determination of Need Regulation effective January 27, 2017 and amended December 28, 2018

Assaad Sayah, MD, CEO		8/31/2022
Name:	Signature:	Date

This document is ready to print: ☐ Date/time Stamp: ☐

ATTACHMENT 9

FILING FEE

Cambridge Public Health Commission
The Cambridge Hospital
100 Cummings Park Drive Woburn, MA

CHECK NUMBER: 175163
CHECK DATE: 08/25/22
VENDOR NUMBER: C002488

VENDOR COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
250 WASHINGTON STREET
6TH FLOOR
BOSTON, MA 02108
-0

REMITTANCE ADVICE
CONTROLLED DISBURSEMENT ACCOUNT

INVOICE NO.	INVOICE DATE	DESCRIPTION	GROSS AMOUNT	DISCOUNT	NET AMOUNT
CHA22061514-RE	08/24/22	CHA MALDEN CARE	960.00	0.00	960.00
		TOTALS	960.00	0.00	960.00

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND WITH A VOID PANTOGRAPH

Cambridge Public Health Commission
The Cambridge Hospital
100 Cummings Park Drive Woburn, MA

Sovereign Bank, N.A.
Boston, MA

60-7269/2313

CHECK NO. 175163
VENDOR NO. C002488
DATE 08/25/22

AMOUNT
*****$960.00

PAY NINE HUNDRED SIXTY 00/100

TO THE ORDER OF
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
250 WASHINGTON STREET
6TH FLOOR
BOSTON, MA 02108
-0

VOID AFTER 180 DAYS
CONTROLLED DISBURSEMENT ACCOUNT

Jill A Beatty
AUTHORIZED SIGNATURE

⑈175163⑈ [redacted]

Cambridge Public Health Commission
The Cambridge Hospital
100 Cummings Park Drive Woburn, MA

CHECK NUMBER: 176942
CHECK DATE: 10/13/22
VENDOR NUMBER: C002488

VENDOR COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
250 WASHINGTON STREET, 6TH FLOOR
BOSTON, MA 02108

REMITTANCE ADVICE
CONTROLLED DISBURSEMENT ACCOUNT

INVOICE NO.	INVOICE DATE	DESCRIPTION	GROSS AMOUNT	DISCOUNT	NET AMOUNT
DON RELATED	10/06/22		399.00	0.00	399.00
		TOTALS	399.00	0.00	399.00

SO-8827047 • 11C-VG

U.S. Pat # 6,695,497

TO REORDER CALL THE ALLIED GROUP • 781-444-8989

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND WITH A VOID PANTOGRAPH

Cambridge Public Health Commission
The Cambridge Hospital
100 Cummings Park Drive Woburn, MA

Sovereign Bank, N.A.
Boston, MA

CHECK NO. 176942
VENDOR NO. C002488
DATE 10/13/22

AMOUNT
*****$399.00

PAY THREE HUNDRED NINETY-NINE 00/100

TO THE ORDER OF
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
250 WASHINGTON STREET, 6TH FLOOR
BOSTON, MA 02108

VOID AFTER 180 DAYS
CONTROLLED DISBURSEMENT ACCOUNT

AUTHORIZED SIGNATURE