MASSACHUSETTS GENERAL HOSPITAL

FY18 Community Benefit Report
Massachusetts General Hospital

Organization Information

Organization Address and Contact Information	
Organization Name:	Massachusetts General Hospital
Address (1):	101 Merrimac Street
Address (2):	
City, State, Zip:	Boston, Massachusetts 02114
Web Site:	www.massgeneral.org/cchi
Contact Name:	Joan Quinlan
Contact Title:	Vice President, Community Health
Contact Department:	MGH Center for Community Health Improvement
Telephone Num:	617-724-2763
Fax Num:	617-726-2224
E-Mail Address:	jquinlan1@partners.org
Contact Address (1): (If different from above)	101 Merrimac Street, Suite 603
Contact Address (2):	Suite 603
City, State, Zip:	Boston, Massachusetts 02114

Organization Type and Additional Attributes	
Organization Type:	Hospital
For-Profit Status:	Not-For-Profit
DHCFP ID:	Not Specified
Health System:	Partners HealthCare
Community Health Network Area (CHNA):	Alliance for Community Health (Boston/Chelsea/Revere/Winthrop) (CHNA 19)
Regional Center for Healthy Communities (RCHC):	6
Regions Served:	Boston, Chelsea, Everett, Revere, Boston-Charlestown, Boston-North End, Boston-East Boston

CB Mission

Community Benefits Mission Statement
The MGH Center for Community Health Improvement (CCHI) collaborates with community and hospital partners to improve the health and well-being of the diverse communities we serve.

Target Populations

Name of Target Population	Basis for Selection
Chelsea Community	Commitment to the Health Center communities served by MGH and to vulnerable populations.
Revere Community	Commitment to the Health Center communities served by MGH and to vulnerable populations.
Charlestown Community	Commitment to the Health Center communities served by MGH and to vulnerable populations.
East Boston Community	Commitment to vulnerable populations.

Publication of Target Populations
Marketing Collateral, Website

Hospital/HMO Web Page Publicizing Target Pop.
http://www.massgeneral.org/cchi/default.aspx

Key Accomplishments of Reporting Year
The following are highlights from each of our primary areas:

Multi-Sector Coalitions:
- The Turn It Around youth group in Charlestown promoted the social marketing campaign and raised awareness of substance use through community events. The youth got the word out about the annual Prescription Take Back Day where 75pounds of prescriptions were collected.
- The Charlestown community navigator worked with over 202 (40 new in FY18) clients in recovery or struggling with addiction.
- The EASTIE Coalition received $140,840 in grant funding for substance use prevention
- Healthy Chelsea held its first Healthy and Affordable Food Summit, bringing 70 people together to address food insecurity and access to healthy food.
- Revere CARES formed a partnership with Union Capital Boston to train a network leader to connect residents to resources and each other to build a resilient and networked community.

Youth Development and Education:

- In FY18, 1081 youth (grades 3-college) were served in the MGH Youth Programs across all core and non-core programs.
- 100% of MGH Youth Scholars graduated from high school, 96% matriculated to college, and 73% persisted in college after their freshman year. A total of 92 Youth Scholars are currently enrolled in college.
- In FY18, 15 Youth Scholars Alumni graduated from college. 13 college graduates are employed full-time.

Access to Care for Vulnerable Populations:

- In FY18, 715 patients were referred for navigation assistance for cancer-related appointments, 503 patients arrived at a cancer-related appointment and 18 patients were diagnosed with cancer.
- Chelsea's Healthy Families America home visitors made 1148 home visits to 88 families to help build secure parent-child attachment, enrich child development and support families to reduce their stress to promote healthy childhood growth and development.
- Over 200 families registered, got an emergency food bag, voucher or attended the Chelsea food pantry.
- Case management and support services were provided to 548 suboxone patients at MGH health centers.
- In FY18, 187 patients with Hepatitis C received outreach. Seventy-nine patients were referred to the Hep C. clinic and 60 patients were successfully treated with HCV medications.
- In FY18, the Medical-Legal partnership, LINC, served 328 new families. Families had 540 appointments with 113 successful outcomes in the following areas: securing social security/unemployment/disability/public housing benefits; naturalization, preventing evictions; and improving living conditions to name a few.
- The Medical Interpreting/CHW Team at MGH Chelsea served 5411 patients with 17 staff members and reported 13,828 medical interpreting encounters and 4580 community health work encounters.
- In FY18, HAVEN, the intimate partner violence advocacy program, served 652 survivors (384 new referrals) and had 3590 contacts.
- In FY18, 637 patients were served by 9 MGH Recovery Coaches. In the 6 months before and 6 months after recovery coach engagement, there was a 44% increase in outpatient visits and a 25% decrease in inpatient admissions.

Plans for Next Reporting Year

In 2019, CCHI plans to work with communities and the hospital to address health priorities identified through two joint community health needs assessment processes. Through the North Suffolk Public Health Collaborative Needs Assessment made up of city leaders, hospitals and

community-based agencies and the Boston Collaborative made up of hospitals from the Conference of Boston Teaching Hospitals (COBTH), the Boston Public Health Commission, and other community-based agencies, we will conduct a joint assessment and an implementation plan that addresses the needs of Boston and North Suffolk (Chelsea, Revere & Winthrop) residents collaboratively. In addition, we plan on connecting the findings of community health needs assessments with the mandate to better manage the care and reduce the costs of high risk, vulnerable MGH patients as an Accountable Care Organization. This approach will integrate primary prevention in the community into MGH's care redesign model. As a hospital, substance use disorder prevention, intervention and treatment will continue to be our area of focus with special attention on youth prevention and mental health in our communities.

Community Benefits Process

Community Benefits Leadership/Team

The community benefit plan is carried out through the MGH Center for Community Health Improvement (CCHI). The Vice President for Community Health, Joan Quinlan, MPA, reports to the Vice President of Psychiatry at MGH, and has a matrixed reporting relationship to Partners HealthCare's Vice President of Community Health. Leslie Aldrich, MPH, serves as the Center's Executive Director.

Community Benefits Team Meetings

Community Health at MGH, which includes community benefit regulations, is overseen by governing, leadership and community committees coordinated and lead by CCHI. The MGH Board Committee on Community Health, made up of the hospital President, CEO of MGPO, 6 MGH Board Members, Chief of Medicine, VPs, and EDs meets quarterly and serves as the governing body for community health efforts at MGH. In addition, there are periodic presentations to the hospital's General Executive Committee, the senior leadership and decision-making body of the hospital.

The Executive Committee on Community Health (ECOCH) made up of hospital departmental and administrative leaders, chaired by the Chief of Medicine and Vice President of Community Health meets every other month to promote community health improvement and ensure health equity, leveraging all four components of the MGH mission: patient care, teaching, research and community health. To improve health across populations and the life course, ECOCH has a focus on social and economic determinants of health and has three committees working on 1) Social Determinants of Health, 2) Access to Quality Care 3) Race Equity.

The Community Advisory Board made up of 20 members from Boston, Chelsea & Revere meet quarterly to review and give input to MGH's community health agenda and community benefit filings and to help identify priorities and implementation plans for Determination of Need filings with the Department of Public Health.

Additionally, all CCHI staff meet quarterly and CCHI Directors meet monthly for management, planning and development purposes. Finally, the local work is guided through coalitions that meet continuously (e.g. The Charlestown Coalition) and maintain regular contact with all partners on the local level.

Community Partners

ABCD Boston Family Planning
Adult Literacy English Classes
After School and Beyond
American Civil Liberties Union
BayCove Human Services
Beachmont Improvement Committee

Community Action for Safe Alternatives(CASA) Winthrop
Revere Caring Alumni Supporting The Learning and Enrichment of Students (CASTLES)
Cataldo Ambulance, Inc.
Catholic Charities
Charlestown Against Drugs (CHAD)
Charlestown Boys and Girls Club
Charlestown Community Center
Charlestown Court: Probation Department
Charlestown High School
Charlestown Lacrosse and Learning Center
Charlestown Little League
Charlestown Mother's Association Charlestown Neighborhood Council
Charlestown Recovery House
Chelsea Board of Health
Chelsea Collaborative
Chelsea District Court
Chelsea Court: Probation
Chelsea Health and Human Services Department
Chelsea High School
Chelsea Housing Authority
Chelsea Human Service Collaborative Chelsea Planning and Development
Chelsea Police Department
Chelsea Public Schools Chelsea
REACH Program
Chelsea Senior Center
Children's Advocacy Center
City of Boston
Mayor's Office
City of Chelsea
City of Revere
Coastal School for Girls
Conference of Boston Teaching Hospitals (COBTH)
Cooking Matters
Cradles to Crayons
CREW (Chelsea, Revere, Everett, & Winthrop)
Elders Services
Deaf, Inc
Department of Children and Families (DCF)
District Attorneys' Offices
Massachusetts Department of Transitional Assistance (DTA)
Early Learning Center- Harbor Area Early Intervention
East Boston High School

Edward M. Kennedy Academy for Health Careers
Edwards Middle School
Elder Services
First Congregational Church,
Revere For Kids Only Afterschool, Inc.
FriendShip Works; Medical Escort, Friendly
Greater Boston Legal Services
Harbor Area Healthy Families
Harbor Health Services, Inc.
Harvard Medical School
Health Resources in Action (HRiA)
Healthy Families America
Healthy Steps
Institute for Health & Recovery International Institute of Boston
Islamic Center of North America
J. Maheras Company
James P. Timilty Middle School Jewish Vocational Services
John F. Kennedy Family Service Center
Jordan Boys and Girls Club of Chelsea
Kennedy Academy for Health Careers
KidSmart School Age Program
Lawyers' Committee for Civil Rights Under Law
MA Association for School-Based Health Care
MA Department of Public Health
Mass Law Reform Institute
Massachusetts Organization for Addiction and Recovery (MOAR)
Mattapan Community Health Center
Mediation for Results
Neighborhood Health Plan
Neponset Health Center
North Suffolk Mental Health Association
Olivia's Organics
Peabody Properties/Mishawum Park Apartment Complex
Pediatric SANE program
Phoenix Charter Academy
Project Bread - The Walk for Hunger
Raising a Reader
Refugee and Immigrant Assistance Center
Refugee and Immigrant Health Program, DPH
Retired Senior and Volunteer Program (RSVP)
Revere Afterschool Partnership
Revere Beach Partnership
Revere Beautification Committee

Revere Community Development Department
Revere Chamber of Commerce
Revere City Council
Revere Domestic Violence Task Force
Revere Fire Department
Revere Food Pantry
Revere Health Department
Revere High School Afterschool Peer Leaders & Service
Revere Library
Revere Journal
Revere Mayor's Office
Revere Parks and Recreation Department
Revere Police Department
Revere Public Schools
Revere Public Works
Revere School Committee Richard J. Murphy School
ROCA
Roxsam Homecare SAGE Boston
Science Club for Girls
SDC-Somali Development Center
SHINE (Serving the Health Information Needs of Elders)
State Garden, Inc.
Suffolk Law School Clinics
The Neighborhood Developers
The Posse Foundation
Tutors for All
United Way's Math Science Technology Initiative
Walk Boston
Warren Prescott School
Women, Infant, Children (WIC)
Winn Co./Charles Newtown
Women's Economic Empowerment
Yawkey Boys & Girls Club
Volunteer Lawyers' Project
Young Achievers Science and Math Pilot School
Youth Connect (A joint program of B&G Club and Boston Police)

Community Health Needs Assessment

Date Last Assessment Completed and Current Status

The latest Community Health Needs Assessment in Chelsea, Revere, Charlestown and East Boston was completed by September 30, 2016.

The Patient Protection and Affordable Care Act of 2010 required hospitals to conduct community health needs assessments every three years. Our last two assessments were done in 2012 and 2015. Although another assessment was not due to be completed until 2018 MGH CCHI identified three reasons to conduct another CHNA on the heels of the 2015 assessment.

1. **A Growing Concern** - The 2015 CHNA identified an increased concern in our communities around adolescent substance use and mental health issues. A goal of that implementation plan was to further explore the reasons associated with this concern.

2. The Benefit of a Regional Approach with Coalitions – As the backbone organization for four multi-sector community coalitions in the cities of Revere and Chelsea, as well as Charlestown and East Boston, the hypothesis that youth across these communities are experiencing the same factors that cause substance use and mental health issues, the assessment took a regional approach so the coalitions could work together to employ strategies, thus making a larger impact. Additionally, as the communities are contiguous, many of the coalitions partner with the same organizations, working across community borders. This provided a seamless way to conduct the assessment as well as an opportunity to identify common strategies. The four coalitions were an integral part of carrying out the assessment and will be responsible for creating work plans with their respective communities to implement the strategies prioritized through this process.

3. Greater Impact by Aligning with Other Boston Hospitals - There are many hospitals in the Boston area, most of which must also complete a CHNA every three years. MGH is a member of the Conference of Boston Teaching Hospitals (COBTH) and several years ago, through COBTH's Community Benefits Committee, committed to working together on community health needs assessments. The hospitals recognized that in many instances they were assessing the needs of the same neighborhood(s) and there would be real benefit, for both the hospitals and the community, to working together. MGH was on a CHNA schedule that differed by one year from most COBTH hospitals. Thus, by conducting a CHNA in 2016, MGH is now on the same schedule as other Boston teaching hospitals. The goal is that by conducting the CHNAs together, the hospitals can identify one to two common areas on which to work. By selecting common issues and strategies, COBTH hospitals could potentially have a greater impact on the Boston area.

Beginning February 2016, MGH CCHI worked with its multi-sector community coalitions to review and analyze quantitative data. MGH CCHI then conducted interviews and focus groups with over 200 youth, mental health experts, and those working with youth to provide insight into the issues. We brought that data back to the coalitions and researched the factors in the public health literature that create risk or protection for or against substance use and depression. We then asked the communities over the course of two meetings to prioritize the factors most relevant in their communities. Based on those factors, the coalitions developed strategies to either strengthen the protective factors or reduce the risk factors.

Summary of Factors that Prevent Adolescent Substance Use and Mental Health Issues:
Positive Relationships with Adults
Parental & Peer Disapproval of Substance Use
Accessible Extracurricular Activities
Lack of Access to Substances
Perception of Harm from Substances
Reducing & Managing Stress

Factors and Strategies to be addressed by MGH CCHI & Coalitions:

Factor	Strategy
Adult Relationships	Increase job shadowship programs and youth jobs
	Enhance adult capacities for informal and formal mentorships and communication with youth
Extracurricular Activities	Build infrastructure to connect youth and families to activities
	Collaborate with organizations to advocate for age-appropriate youth activities in each community
	Strengthen youth component of each community coalition
Stress	Increase coping skills of youth and adults to positively manage and reduce stress
	Create youth photo voice project to highlight positive stress management
Perception of Harm from Substances	Implement social marketing campaign to increase perception of harm of adolescent marijuana use
	Collaborate with schools and organizations to incorporate an evidence-based curriculum that addresses substance use and mental health

Consultants/Other Organizations

Health Resources in Action continued to provide guidance to grantees in Charlestown for the "Building a Healthier Charlestown" initiative.

Data Sources

Community Focus Groups, Hospital, Mass CHIP, Surveys, Other - MADPH, BPHC, DOE, YRBS, and ETO

Community Benefits Programs

HAVEN (Helping Abuse and Violence End Now)	
Program Type	Direct Services, Health Professional/Staff Training
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The program provides direct services to survivors of intimate partner abuse (patients, employees, community members) and training to MGH providers. Since program inception in 1997, nearly 8400 survivors have been helped, with 652 served in FY18.
Target Population	• **Regions Served:** Boston, Chelsea, Revere • **Health Indicator:** Injury and Violence, Other: Domestic Violence, Other: Safety, Other: Safety - Home • **Sex:** All • **Age Group:** All Adults • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Provide direct services to survivors of intimate partner abuse.	652 survivors were served in FY18, with 384 new referrals made to HAVEN. Of 167 Brief Interventions, 42% were for safety planning, 19% for housing/emergency shelter, and 14% for legal services.
Provide direct services to survivors of intimate partner abuse.	In FY18, HAVEN advocates had 3,590 contacts with clients. 27% of contacts were in Spanish; 18% of contacts included emotional support; 10% were for safety planning; 9% were for legal issues.
Provide direct services to survivors of intimate partner abuse.	In FY18, HAVEN clients reported the following: 92% emotional abuse; 70% physical abuse; 54% isolation; 50% economic abuse; 41% surveillance; 31% property damage; 20% sexual abuse; and 12% stalking.
Increase legal services for survivors of intimate partner abuse.	Through a partnership between MGH and Casa Myrna Vazquez, advocates consulted with a lawyer specializing in intimate partner violence 94 times in FY18.

Partners	
Partner Name, Description	**Partner Web Address**
Boston Regional DV Directors	
Greater Boston Legal Services Department of Justice Partnership	http://www.gbls.org/our-work/immigration
Conference of Boston Teaching Hospitals DV Council	http://www.cobth.org/dom_violence.html
Jane Doe, Inc.	http://www.janedoe.org/
Casa Myrna	https://www.casamyrna.org/
Contact Information	Debra Drumm, Director Haven at MGH Telephone: 617-726-7674, ddrumm@partners.org

MGH Youth Programs	
Program Type	Mentorship/Career Training/Internship, School/Health Center Partnership
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	MGH Youth Programs' mission is to provide youth (grades 3- college) with academic, life, and career skills that will expand and enhance their educational and career options. Through the assistance of MGH administrators, faculty, and staff, who volunteer their time, the program provides youth with hands-on enrichment opportunities, career exploration, employment and mentorship relationships that are connected to Science, Technology, Engineering, and Math (STEM) education. In FY18, 1081 youth were served across all programs.
Target Population	• **Regions Served:** Boston, Chelsea, Revere • **Health Indicator:** Other: Education/Learning Issues, Other: Nutrition, Overweight and Obesity, Physical Activity • **Sex:** All • **Age Group:** Adult-Young, Child-Teen • **Ethnic Group:** All • **Language:** English, Haitian Creole, Spanish

Goal Description	Goal Status
Serve 1000 youth participating in MGH Youth Programs throughout the academic year and summer months.	In FY18, 1081 youth (grades 3-college) were served in the MGH Youth Programs across all core and non-core programs.
Increase student interest and engagement in STEM for MGH STEM Club participants in grades 3-8.	In FY18, surveys indicated that 60% of students had an increased interest in science.

	Student engagement also increased by the end of the program.
Engage MGH professionals to provide science fair mentoring support to 7th and 8th grade students from the James P. Timilty Middle School in Roxbury.	In FY18, 60 MGH professionals mentored 51 Timilty students. Out of the 51 students, 13 students qualified to compete at the City-Wide Fair and 3 students advanced to the State Science Fair.
Ensure and support successful college graduation for participants of the MGH Youth Scholars Program.	In FY18, 100% of MGH Youth Scholars graduated from high school, 96% matriculated to college, and 73% persisted in college. A total of 92 Youth Scholars Alumni are currently enrolled in college.
Ensure and support high school graduation, college matriculation, and continual college persistence for MGH Youth Scholars.	In FY18, 15 Youth Scholars Alumni graduated from college. 13 of the 15 college graduates are employed full-time.

Partners

Partner Name, Description	**Partner Web Address**
Turner Construction	http://www.turnerconstruction.com/about-us/community-involvement/youth-and-education
Boston Private Industry Council	http://www.bostonpic.org/
Charlestown Boys and Girls Club	http://www.bgcb.org/locations_clubs_charlestown.cfm
East Boston High School	http://www.bostonpublicschools.org/school/east-boston-high-school
Edward M. Kennedy Academy for Health Careers	http://www.kennedyacademy.org/
Tutors for All	http://www.tutorsforall.org/
Yawkey Boys and Girls Club	http://www.bgcb.org/locations_clubs_yawkey.cfm
Chelsea High School	http://www.chelseaschools.com/cps/high-school.htm
Posse Foundation	www.possefoundation.org
Health Resources in Action	www.hria.org
Revere High School	http://www.revereps.mec.edu/reverehighschool/
Boston Leadership Institute	http://www.bostonleadershipinstitute.com/forensics.html

Big Brother Big Sisters of Mass Bay	http://www.bbbsmb.org
Harvard Kent	http://www.bostonpublicschools.org/school/harvardkent-elementary-school
Accelerated College Experiences	http://acceleratedcollegeexperiences.org
Blue Hills Boys & Girls Club	http:/www.bgcb.org
National Student Leadership	www.nslcleaders.org/
BoSTEM	http://unitedwaymassbay.org/what-we-do/helping-kids-succeed-in-school/bostem-boston-stem-initiative/
Chelsea/Jordan Boys & Girls Club	http://www.bgcb.org/find-your-club/jordan-club/
Mass Life Sciences	http://www.masslifesciences.com/
McLean Hospital-College Mental Health	https://www.mcleanhospital.org/programs/college-mental-health-program
Horizon Educational Consulting	https://www.camb-ed.com/americas/article/279/adrian-mims
Dearborn STEM Academy	https://www.bostonpublicschools.org/school/dearborn-middle-school
Becoming a Man (BAM)	https://www.youth-guidance.org/bam-boston/
uAspire	https://www.uaspire.org/
Boston University	http://www.bu.edu/

Contact Information	Christyanna Egun Director, Boston Youth Partnerships Telephone: 617-724-2950, cegun@partners.org

Boston Health Care for the Homeless Program (BHCHP) at MGH	
Program Type	Direct Services, Health Screening, Outreach to Underserved
Statewide Priority	Address Unmet Health Needs of the Uninsured, Chronic Disease Management in Disadvantaged Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The Boston Health Care for the Homeless Program delivers direct care in multidisciplinary teams in two hospital clinics and over 40 shelters and community sites throughout metropolitan Boston. MGH has been one of those sites for more than 30 years. In CY2018, BHCHP managed 3,754 primary care, mental health, and case management encounters for homeless individuals at MGH.

Target Population	• **Regions Served:** Boston • **Health Indicator:** Access to Health Care, Mental Health, Other: Homelessness • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Ensure access to care to patients living on the street through direct street outreach and access to the Thursday Street Team clinic at the MGH MWIU.	In CY2018, there were a total of 1,988 encounters at the MGH site during Thursday "street" clinic and 1,382 encounters through street outreach. Encounters include visits with primary care providers, behavioral health providers, nurses and case managers.
Promote services for housed Street Team patients through specialized clinics, home visits, and the use of medical respite as a supportive housing service.	In CY2018, medical and behavioral health clinicians and case managers made 476 home visits to 110 housed patients.
Assure services for housed Street Team patients through specialized clinics, home visits, and the use of medical respite as a supportive housing service.	In CY2018, 40% (43 out of 110) of the patients seen in home visits were also admitted to our medical respite facility, the Barbara McInnis House, for the purpose of clinical stabilization and housing support.
Foster further collaboration between MGH, Partners Healthcare, and BHCHP.	In CY2018, BHCHP nursing liaisons made 234 visits to homeless and formerly homeless inpatients at MGH and Brigham and Women's Hospital. They also assisted with discharge planning including screening for admission to the Barbara McInnis House after hospital discharge for 169 patients, and they were involved in the care coordination of 220 patients.
Foster further collaboration between MGH, Partners Healthcare, and BHCHP.	In CY2018, 410 patients received integrated medical and behavioral care for a total of 2,330 medical encounters, and 1,241 mental health encounters as part of a collaborative grant through MGH and the Department of Mental Health. In addition, there were 1,563 substance use related encounters by our Peer Recovery Coach.

Partners	

Partner Name, Description	Partner Web Address
Not Specified	

Contact Information	Jim O'Connell, MD, President BHCHP Telephone: 857-654-1006, joconnell@bhchp.org

Food for Families	
Program Type	Direct Services, Health Screening, Prevention
Statewide Priority	Address Unmet Health Needs of the Uninsured, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	Food for Families screens MGH Chelsea patients for food insecurity in the departments of Pediatrics, Obstetrics, and Adult Medicine. The program connects patients with local and federal food resources such as SNAP benefits (formerly known as Food Stamps), the WIC (Women, Infants, and Children) Program, food pantries, and community meal sites. Food for Families also coordinates the MGH Chelsea Food Pantry, which distributes food two days a week out of the health center. In FY18, 201 people received services from the Food for Families Program Coordinator.
Target Population	• **Regions Served:** Boston-East Boston, Chelsea, Everett, Malden, Revere • **Health Indicator:** Other: Nutrition • **Sex:** All • **Age Group:** All • **Ethnic Group:** Black/African American, Hispanic/Latino, White • **Language:** English, Other, Portuguese, Spanish

Goal Description	Goal Status
Screen for and identify patients with food insecurity.	Food insecurity is now included in the Social Determinants of Health screening. Of 131 patients referred to the program, 125 screened positive for food insecurity.
Meet with food insecure patients to connect them to appropriate services and resources.	In FY18, 273 contacts were completed; 192 of those were for SNAP application assistance; 7 emergency food vouchers were distributed.

Provide food to families through the MGH Chelsea food pantry and connect families in need to the food pantry.	In FY18, 178 families attended the food pantry at the Health Center, which distributed over 111,618 pounds of food. 21 new families registered for the food pantry, of which 20 (95%) were under 185% of the poverty level.

Partners

Partner Name, Description	Partner Web Address
Cooking Matters Massachusetts	http://cookingmatters.org/cooking-matters-massachusetts/
Department of Transitional Assistance, MA	http://www.mass.gov/eohhs/gov/departments/dta/
Project Bread	www.projectbread.org

Contact Information	Yahaira Guzman, Program Coordinator, yaguzman@partners.org

Healthy Chelsea

Program Type	Community Education, Healthy Communities Partnership, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	Healthy Chelsea is a community coalition focused on improving the overall health of Chelsea residents of all ages. Our mission is to engage all sectors of the community to promote healthy choices and development, decrease the effects of toxic stress and prevent substance misuse through a variety of prevention, education, advocacy and policy efforts. Healthy Chelsea is currently comprised of approximately 75 community leaders, organizations, and residents.
Target Population	• **Regions Served:** Chelsea • **Health Indicator:** Other: Nutrition, Overweight and Obesity, Physical Activity Access to Health Care, Other: Alcohol and Substance Abuse, Other: Smoking/Tobacco, Substance Abuse, Tobacco Use, Education • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Improve the overall physical health of Chelsea residents, especially youth, by	Organized the first Chelsea Healthy and Affordable Food Summit bringing 70 people

increasing opportunities for both healthy eating and active living throughout the community	together to address food insecurity and access to healthy food. Workgroups formed to assess the issue further in-depth.
Provide substance use, opioid overdose prevention/reduction, and trauma-sensitive education to providers, community members, and other professionals	Through an assessment and strategy prioritization, a vaping-marijuana workshop was developed and presented to 65 adults and 165 youth to educate the audience on the myths and facts of those substances.
Improve the developmental health of children ages 0-5 years through a collective impact approach	13 agencies hosted 24 events during the Week of the Young Child with over 70 families participating in activities to learn about community resources and ways to help their child develop their brain.
Create and Implement Trauma Sensitive City Initiatives	212 people participated in trainings, including from the public schools, Phoenix Charter School, Intergenerational Literacy Program, public libraries, CAPIC, MGH, & Science of the Positive attendees.
Increasing community collaboration, communication and access to services	A new coalition logo and website was developed. Community events/resources are promoted through the ourchelseama.org website and newsletter with the community resource guide added in FY18.

Partners

Partner Name, Description	Partner Web Address
Aramark	https://www.aramark.com/
Boys & Girls Club (Jordan Club)	https://www.bgcb.org/find-your-%20club/jordan-club/
CAPIC	http://www.capicinc.org/
Cataldo Ambulance	http://cataldoambulance.com/
Chelsea Chamber of Commerce	http://www.chelseachamber.org/
Chelsea Collaborative	https://www.chelseacollab.org/
Chelsea Community Garden	http://chelseacommunitygarden.weebly.com/
Chelsea Housing Authority	http://www.chelseaha.com/
Chelsea Police Department	https://chelseapolice.com/
Chelsea Public Library	https://www.chelseama.gov/public-library
Chelsea Public Schools	https://www.chelseaschools.com/cps/
Chelsea-Revere Family Network	http://www.capicinc.org/Eng/E_FamilyNetwork.html

City of Chelsea	https://www.chelseama.gov/
Community Schools	http://www.communityschools.org/
Dept. of Children and Families	https://www.mass.gov/orgs/massachusetts-department-of-children-families
FoodCorps	https://foodcorps.org/
For Kids Only Afterschool Program	http://www.fkoafterschool.org/
GreenRoots Chelsea	http://www.greenrootschelsea.org/
Harbor Area Early Childhood Services	http://northsuffolk.org/services/early-childhood-services/
Health Care Resource Centers	https://www.hcrcenters.com/
MA Department of Public Health	https://www.mass.gov/orgs/department-of-public-health
MA DPH Bureau of Substance Abuse Services	https://www.mass.gov/orgs/bureau-of-substance-addiction-services
Mass in Motion	https://www.mass.gov/orgs/mass-in-motion
Massachusetts Farm to School	http://ag.umass.edu/nutrition
MassBike	https://www.massbike.org/
Metropolitan Area Planning Council	https://www.mapc.org/
MGH Chelsea	https://www.massgeneral.org/chelsea/
North Suffolk Mental Health	http://northsuffolk.org/
NorthBound Ventures	http://www.northboundventures.com/
Nurtury	http://www.nurturyboston.org/
OutdoorRx	https://www.outdoors.org/
Phoenix Charter Academy	http://phoenixcharteracademy.org/
Project Bread	http://www.projectbread.org/
Raising a Reader	https://raisingareaderma.org/
Roca Inc	https://rocainc.org/
Salvation Army Chelsea	http://www.massachusetts.salvationarmy.org/MA/Chelsea
Social Capital Inc.	http://www.socialcapitalinc.org/
State Garden	http://stategarden.com/
Stop and Compare	http://www.stopandcompare.net/
KIND - Kids in Need of Defense	https://supportkind.org/
TerraCorps	https://terracorps.org/
The Neighborhood Developers	http://theneighborhooddevelopers.org/
United Way	https://unitedwaymassbay.org/
WalkBoston	https://walkboston.org/

WIC MGH Chelsea	https://www.wicprograms.org/ci/ma-chelsea
Contact Information	Jennifer Kelly, jkelly14@partners.org Maddy Herzog, mherzog@partners.org Ron Fishman, rfishman1@partners.org Yahya Noor, ynoor@partners.org Amy Izen, aizen@partners.org Yasmine Hung YHUNG1@mgh.harvard.edu Ryan Barry RBARRY2@mgh.harvard.edu

MGH Revere Adolescent Health Initiative

Program Type	Direct Services, Health Screening, School/Health Center Partnership
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	MGH Revere School Based HealthCare Center (SBHC), Adolescent HealthCare Center (AHC), and Revere HealthCare Center (RHC) provide care to teens and young adults. The SBHC and AHC are located at the Revere High School allowing us to increase student access, promote healthy lifestyles while engaging youth in their own care. The MGH Revere Youth Zone (YZ), located at 300 Broadway, is a no cost afterschool program and at-risk-youth, 9-17 years of age.
Target Population	• **Regions Served:** Revere and surrounding communities • **Health Indicator:** Access to Medical care, and Mental Health, Other: Alcohol and Substance Abuse, Child Care, Family Planning, Smoking/Tobacco. • **Sex:** All • **Age Group:** Adult-Young, Child-Preteen • **Ethnic Group:** All • **Language:** All

Goal Description

To educate parents, students and school faculty on teen sexual health.

Goal Status

SBHC clinicians participated in 12 teen sexual health classes at Revere HS. They also participated in a Self Care Fair and provided education monthly on various health topics through informational tables at the RHS cafeteria.

Increase adolescent and young adult access to confidential, free or low cost reproductive health care as well as urgent medical care and mental health services.	SBHC/AHC provided care to 578 students in 1508 total visits. These visits included urgent care, confidential reproductive care and sports physicals. The SBHC LICSW provided 578 mental health visits.
To provide a free, safe environment for youth (ages 9-17) in the city of Revere to develop healthy lifestyle skills, relationship building skills, and mentorship.	MGH Youth Zone served 167 students in 5504 visits. After school services, school vacation and summer camps focused on academic excellence, nutrition, physical activity, & positive peer relationships.

Partners

Partner Name, Description	Partner Web Address
Revere Afterschool Partnership	
Revere Public Schools	http://www.reverek12.org/
City of Revere	www.revere.org

Contact Information	Debra Jacobson; Kerstin Oh, MD; dsjacobson@partners.org, koh@partners.org

Police Action Counseling Team (PACT)

Program Type	Direct Services, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The Police Action Counseling Team (PACT) is a police-mental health partnership which teams an MGH Social Work clinician with Chelsea Police officers to provide clinical intervention to children who have witnessed violence or who are victims of violence. Officers are trained to identify children (and sometimes other vulnerable persons) at the scenes of police calls. Additionally, the PACT clinician connects children and families to appropriate court, mental health and/or domestic violence services. The clinician also discusses safety plans and assists with filing of restraining orders or 51-A reports. The goal of PACT interventions is to lessen the impact of traumatic experiences on the health and mental health of these children. Timely interventions aim to facilitate children's active participation in their own well-being, promote resilience and to increase parental knowledge of the symptoms and longer-term effects of trauma.
Target Population	• **Regions Served:** Chelsea

- **Health Indicator:** Injury and Violence, Mental Health, Other: Domestic Violence, Other: Parenting Skills, Other: Rape, Other: Safety
- **Sex:** All
- **Age Group:** All, All Children
- **Ethnic Group:** All
- **Language:** All

Goal Description	Goal Status
Provide officer training about effects of trauma on children and train officers to identify children at the scenes of 911 calls.	In FY18 Chelsea police referred or collaborated with PACT on 90 cases. 77% (69) involved suspected child abuse/neglect. Police filed 94% (65) of 51A reports of suspected child abuse/neglect.
Provide timely clinical intervention and services to children and parents affected by trauma and domestic violence (DV).	Of total PACT cases receiving services, 87% (78) were directly related to DV, and 59% (53) had reported previous history of domestic violence, including 12 alleged strangulation injuries.
Connect children and their families to appropriate resources and services as needed.	Families received 46 total referrals: 41% to HAVEN and 43% to mental health services. 27 victims of abuse obtained Emergency Restraining Orders and 19 cases involved Safety Planning.

Partners

Partner Name, Description	Partner Web Address
Chelsea PD	http://www.chelseama.gov
Police Department Newcomer Program	http://www.chelseama.gov
CASA DIVERT Program	http://www.chelseama.gov
Department of Children and Families (DCF)	http://www.mass.gov/dcf

Contact Information

Georgia Green, LICSW, MGH Chelsea, ggreen1@partners.org
Lt. Thomas Dunn, Chelsea Police, tdunn@chelseama.gov

Chelsea High School Student Health Center

Program Type	Direct Services, Health Screening, School/Health Center Partnership
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The Student Health Center (SHC) is a satellite of MGH Chelsea located at Chelsea High School (CHS) and provides comprehensive health care, including

	primary care and behavioral health, to students. In FY18, there were 377 active participants in the SHC, with 1719 visits.
Target Population	• **Regions Served:** Chelsea • **Health Indicator:** Access to Health Care, All • **Sex:** All • **Age Group:** Child-Teen • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Substance Use Prevention and Intervention.	Following SBIRT model, all patients (377) screened for substance use using CRAFFT screening and received brief intervention using motivational interviewing and referral to treatment as needed.
Improve health and educational outcomes for pregnant and parenting students.	Worked with CHS expectant and parenting outreach worker; Case mgmt for approx. 35 pregnant/parenting students; Monthly support groups for teen parents; Serve on ROCA's Parent Advisory Board.
Promote student success through work training.	Coordinated internships at MGH Chelsea; Recruited 5 summer interns at MGH Chelsea through Jobs4Youth program. Participated in middle school career day – talked about nursing to 60 8th graders.
Improve services for new arrivals from Central America.	Spanish-speaking social worker provided behavioral health to 50 students; Pediatric Nurse Practitioner taught sexual health classes for 200 newly arrived non-English speaking students.
Promote Adolescent Sexual Health.	Chelsea Public Schools continues MA DESE grant to improve sexual health through sex health education, services, safe environment, and policy. Certified family planning counselor on SHC staff.

Partners

Partner Name, Description	**Partner Web Address**
Chelsea High School	http://www.chelseaschools.com/cps/high-school.htm

MGH Chelsea	http://www2.massgeneral.org/primarycareweb/primary_chelsea.htm
Contact Information	Jordan Hampton, RN, MSN, CPNP, jhampton@partners.org

Legal Initiative for Children (LINC)

Program Type	Direct Services, Outreach to Underserved
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	LINC provides civil legal services for all patients at the MGH HealthCare Center in Chelsea referred by their provider or by a community health worker. The program attorney, who is on-site two days a week, provides representation to low-income refugees and immigrants in areas such as disability benefits, housing appeals, guardianship, child support, and assisting in the naturalization process. The ultimate goal of LINC is to improve the health and well-being of low-income families by improving their environmental and social conditions of their families.
Target Population	• **Regions Served:** Boston, Chelsea, Everett, Lynn, Malden, Medford, Revere, Somerville • **Health Indicator:** Environmental Quality, Other: Homelessness, Other: Safety - Home, Other: Uninsured/Underinsured • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** Other, Spanish

Goal Description	**Goal Status**
Provide representation to patient families for areas such as disability benefits, housing appeals, guardianship, child support, and the naturalization process.	In FY18, 328 new families or families with new needs received civil legal services. Families had 540 appointments with 113 successful outcomes including eviction prevention and naturalization.
Conduct activities to address the complex ways that law interacts with race, immigration status, poverty, and healthcare.	In FY18, the program attorney conducted over 700 activities for clients' legal and other needs (e.g. filing appeals; consulting with doctors; negotiating with shelters; and attending hearings etc.)
Engage in a broad range of advocacy in close collaboration with the health care team.	The program attorney works with the healthcare team to engage in advocacy: representing patients in court; negotiating with

	landlords; appearing before administrative bodies to obtain public benefits.

Partners

Partner Name, Description	Partner Web Address
Volunteer Lawyers' Project	http://www.vlpnet.org
Suffolk Law School Clinics	http://www.law.suffolk.edu/academic/clinical/contact.cfm
International Institute of Boston	http://iine.us/
CONNECT at TND	https://www.connectnow.org/
Lawyers for Civil Rights Boston	http://lawyersforcivilrights.org/

Contact Information	Laura Maslow-Armand, Esq., Lawyers for Civil Rights , laurama@lawyersforcivilrights.org

Medical Interpreter and Community Health Worker Services

Program Type	Direct Services, Outreach to Underserved
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	Provides professional language and community health worker services to MGH Chelsea patients. Program staff facilitates communication between limited English proficient patients and providers, serve as patient advocates, and help patients navigate the healthcare system. In FY18, approximately 5,411 patients were served.
Target Population	• **Regions Served:** Chelsea • **Health Indicator:** Access to Health Care • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Provides professional language and community health worker services to MGH Chelsea patients.	In FY18, approximately 5411 patients were served. There are 17 staff members (14.2 FTE) who offer 15 different languages.
Meet the needs of existing and new patients at MGH Chelsea by bridging the language gap.	The Medical Interpreting/CHW Team reported 13,828 Medical Interpreting encounters and 4,580 Community Health Work encounters. 52% were for

	Spanish, 9% Portuguese, 8% Arabic, 8% Bosnian, 23% other.
Work closely with MGH and other community programs to help organize educational workshops for LEP patients.	MI/CHWs connected LEP patients to the Complex Patient Population program, the Food for Families Program, LINC (Medical-Legal Partnership), Healthy Beginnings, HAVEN, as well as other partners.

Partners

Partner Name, Description	Partner Web Address
CAPIC	http://www.capicinc.org/
Chelsea, Winthrop, Revere Elder Services	http://www.crwelderservices.org/default.asp
INCA Relief	http://icnarelief.org/site2/
Bosnian Community for Resource Development (Lynn)	http://www.bccrd.org/
Roca	http://www.rocainc.org/
Jewish Vocational Services	http://www.jvs-boston.org/
CONNECT at TND	https://www.connectnow.org/
Children Law Center of Massachusetts	http://www.clcm.org/
Massachusetts Coalition for the Homeless	http://www.mahomeless.org/
Parent Information Center Chelsea	https://www.chelseaschools.com/cps/parents.htm

Contact Information	Silvestre Valdez, Manager, SAVALDEZ@PARTNERS.ORG

MGH CHA: Access to Resources for Community Health (ARCH)

Program Type	Community Education, Outreach to Underserved
Statewide Priority	Promoting Healthy Living/Wellness of Vulnerable Populations; Addressing Social Determinants of Health
Brief Description or Objective	Access to Resources for Community Health (ARCH) increases access to high-quality health information and resources among MGH-served communities of Charlestown, Chelsea, Everett, and Revere. ARCH website: www.arch-mgh.org
Target Population	• **Regions Served:** Boston-Charlestown, Chelsea, Everett, Revere • **Health Indicator:** All • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Improve access to high-quality health education/promotion materials and services by identifying select resources at MGH, local, state, and national levels and address social determinants of health.	In FY18, ARCH developed a series of short videos to help patients and the general public understand the social determinants of health and encourage them to speak with clinicians about their concerns.
Increase resources available on the ARCH website.	In FY18, 55 new resources were added to www.arch-mgh.org under Social Determinants of Health and Other Useful Information & Resources. The website had 52,026 hits and 10,942 different visitors.

Partners

Partner Name, Description	Partner Web Address
Chelsea Senior Center	http://www.ci.chelsea.ma.us/Public_Documents/ChelseaMA_Elder/index
Revere Elderly Affairs	http://www.revere.org/departments/elder-affairs
Jack Satter House	http://www.hebrewseniorlife.org/jack-satter-house
CAPIC Head Start	http://www.capicinc.org/
JFK Family Service Ctr	http://bostonabcd.org/john-f-kennedy-fsc.aspx
MGH Treadwell Library	http://www2.massgeneral.org/library/default.asp
	http://www.ci.chelsea.ma.us/Public_Documents/

Contact Information	Ming Sun, MPH, CHES, msun@partners.org

MGH CHA: Family Planning Program

Program Type	Direct Services, Health Screening, Prevention, School/Health Center Partnership
Statewide Priority	Promoting Wellness and Reproductive Health of Vulnerable Populations - Adolescents
Brief Description or Objective	The Family Planning Program provides confidential reproductive health services to adolescents, young women and men. It ensures delivery of clinical family planning services at MGH Revere Pediatrics, MGH Revere School-Based Health Center, MGH Revere Adolescent Health Center, MGH Chelsea Pediatrics, and MGH Chelsea School-Based Health Center.
Target Population	• **Regions Served:** Chelsea, Revere • **Health Indicator:** Access to Health Care, Other: Family Planning, Other: Pregnancy, Other: Sexually Transmitted Diseases, Responsible Sexual Behavior • **Sex:** All

	• **Age Group:** Child-Preteen, Child-Teen • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Action for Boston Community Development provides access to youth reproductive health services such as family planning, counseling, education, prevention & treatment of sexually transmitted infections.	In FY18, the Family Planning Program served 854 patients with 1,600 visits (01/01/18 – 10/31/18) across the 5 MGH delivery sites including Chelsea Pediatric and Adolescent Medicine Department.

Partners

Partner Name, Description	**Partner Web Address**
Boston ABCD	http://www.bostonabcd.org
MGH Chelsea	http://www.massgeneral.org/chelsea/
Chelsea High School	http://www.chelseaschools.com/cps/high-school.htm
Revere High School	http://www.reverek12.org/
MGH Revere	http://www.massgeneral.org/revere/

Contact Information	Ming Sun, MPH, CHES, msun@partners.org

MGH CHA: Healthy Steps for Young Children

Program Type	Community Education, Direct Services, Health Screening, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	Program provides timely well child visits/immunizations and increased parental knowledge of child development, healthy eating habits, and obesity prevention. In addition, the program seeks to improve access to care for all patients and their families. Child development specialists in the Healthy Steps program conduct joint office visits with the pediatricians during well child checks for children between the ages of birth and three years. Healthy Steps is offered to all first-time parents bringing their newborns to MGH Revere for pediatric care. Healthy Steps services include extended well-child office visits, lactation support, child development telephone information line, parent groups, developmental screenings, written information materials for parents that emphasize prevention, links to community resources, and collaboration with Early Intervention. The Healthy Steps Specialists also utilize books and written materials provided by Reach Out and Read to promote early literacy and

	decrease screen time. The program also works with the Parents as Teachers (PAT) program to promote optimal early development by engaging parents and caregivers.
Target Population	• **Regions Served:** Boston-East Boston, Chelsea, Lynn, Revere, Winthrop • **Health Indicator:** Access to Health Care, Other: Child Care • **Sex:** All • **Age Group:** All Adults, Child-Infant • **Ethnic Group:** All • **Language:** English, Arabic, Portuguese, Spanish

Goal Description	**Goal Status**
To provide timely well child care and developmental surveillance, to improve access for all patients and their families, and to provide additional developmental and behavioral information.	In FY18, Healthy Steps (HS) had 640 families with young children enrolled. HS specialists conducted 1,772 joint office visits with pediatricians, and they conducted 70 early intervention screenings.
To provide home-visiting services to families of young children with multiple high-need characteristics to focus on enhancing parental skills and improving child development.	Parent educators provided home visits to 36 families with children ages birth-5 years; 63% of families had 3 or more risk factors. 434 home visits were conducted; 53 visits included fathers.
To provide support to new parents in a group to discuss breastfeeding, newborn care and adjusting to parenthood, and to screen for post-partum depression and provide referrals to supports as needed.	In FY18, one HS specialist and a PAT social worker facilitated a weekly breastfeeding support group for 92 mothers called Mother Infant Lactation Club (MILC) with 248 individual visits in total.
To improve the executive functioning skills of parents at MGH Revere.	5 staff members have been trained in EMPath's mobility mentoring tools. EMPath has been introduced to two families with the goal of enrolling more families during FY19.

Partners

Partner Name, Description	**Partner Web Address**
CAPIC Head Start	http://www.capicinc.org/
Cradles to Crayons	http://cradlestocrayons.org/
HAVEN	http://www.mghpcs.org/socialservice/programs/haven/
Food For Families	http://www.massgeneral.org/cchi/services/treatmentprograms.aspx?id=1502

Harbor Area EIP	http://www.talkreadplay.org/?q=content/harbor-area-early-intervention-program
Raising a Reader	http://raisingareaderma.org/
Chelsea Revere Family Network	http://www.capicinc.org/Eng/E_FamilyNetwork.html
Northeast Arc EI- North Shore	http://www.ne-arc.org/services/early-intervention-2/

Contact Information	Jennifer Bronsdon, Program Coordinator, jbronsdon@partners.org

MGH CHA: Hepatitis C Program

Program Type	Community Education, Direct Services
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The program works to improve clinical care and increase the understanding of the Hepatitis C Virus (HCV) through provider and patient education, and community outreach activities.
Target Population	• **Regions Served:** Boston-Charlestown, Chelsea, Revere, Everett • **Health Indicator:** Other: Hepatitis • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Provide outreach to patients with Hepatitis C residing in Charlestown, Chelsea, and Revere.	187 patients with Hepatitis C received outreach visits by a Community Health Worker (CHW) at each of the Health Centers and at community events.
Provision of improved clinical care and access to care to Hepatitis C patients.	79 patients were referred to the MGH Health Center Hep C Clinics: 67 patients were evaluated; 60 patients were successfully treated with HCV medications.

Partners

Partner Name, Description	**Partner Web Address**
MA State Laboratory	http://www.mass.gov/dph/bls

Contact Information	Ann-Marie K. Duffy-Keane, MPH, aduffy@partners.org

MGH CHA: Living TOBACCO-FREE program (formerly "Pack It In": Tobacco Treatment and Referral Program)

Program Type	Direct Services,
Statewide Priority	Chronic Disease Management in Disadvantage Populations
Brief Description or Objective	MGH Community Health Associates' Living TOBACCO-FREE (LTF) program provides free tobacco cessation services and information to MGH patients and community members, in addition to advocating for tobacco policy reform. LTF also does primary prevention work in the communities by collaborating with other organizations.
Target Population	• **Regions Served:** Boston-Charlestown, Chelsea, Everett, Revere • **Health Indicator:** Access to Health Care, Other: Smoking/Tobacco, Tobacco Use • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Reduce smoking among MGH patients by offering free cessation coaching in Health Centers	Got 505 coaching/consultation referrals. Other types of referrals: 16 pregnancy; 122 prescription med follow-up; 62 hospital discharges; 45 info only; 20 other. LTF sent info to all 770 referrals.
Reduce smoking among adults in MGH communities through distribution of "Quit Kits" for Great American Smokeout and community presentations.	Distributed about 350 informational "Quit-Kits" (Eng.+ Span.) to MGH Health Center patients, health fairs & community orgs. Also educated about 15 ROCA participants on tobacco addiction & cessation.
Educate policy makers about e-cigarettes and vaping.	Co-chaired state-wide working group on e-cigarettes. Educated Winthrop Public Health Nurse and Board of Health on tobacco & vaping. Met with Revere Board of Health Chair.
Prevent initiation of smoking, vaping and other tobacco use in the community.	Provided vaping education to: 2 Winthrop community forums (approx. 65); approx. 60 Revere High staff; 96 Charlestown middle schoolers; approx. 80 Revere youth at RHS health fair and MGH Youth Zone.

Prevent exposure to 2nd hand smoke.	Consulted with housing developers and/or met with residents at properties going or already smoke free: Peabody Properties (2); Neighborhood Developers (1).

Partners

Partner Name, Description	Partner Web Address
Roca	https://rocainc.org/
Revere Public Schools	http://www.reverek12.org/
Massachusetts Tobacco Cessation & Prevention Program	http://www.mass.gov/eohhs/gov/departments/dph/programs/mtcp/
The Neighborhood Developers	http://beta.somervillema.gov/departments/programs/six-city-tobacco-initiative
MGH Youth Zone	https://www.massgeneral.org/revere/youth-zone/mgh-revere-youth-zone.aspx
MGH Revere Cares Community Coalition	http://reverecares.org/
Peabody Properties	http://www.peabodyproperties.com/communities/component/jea/
Tobacco Free Mass	https://tobaccofreema.org/

Contact Information	Jonina Gorenstein, Program Manager, JTgorenstein@partners.org

VIAP (Violence Intervention Advocacy Program)

Program Type	Direct Services, Mentorship/Career Training/Internship, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The program provides direct services to victims of community violence (stab wounds, gunshot wounds, and assaults), most of whom have come through the MGH Emergency Department. The mission of the program is to assist victims of violence to recover from physical and emotional trauma and empower them with skills, services and opportunities, so they can return to their communities, make positive changes in their lives, strengthen others who have been affected by violence, and contribute to building safer and healthier communities. In FY18, 74 patients were served.
Target Population	• **Regions Served:** Boston, Cambridge, Chelsea, Lynn, Revere, Somerville • **Health Indicator:** Injury and Violence, Mental Health, Other: Public Safety, Substance Abuse • **Sex:** All

- **Age Group:** All
- **Ethnic Group:** All
- **Language:** All

Goal Description	Goal Status
Connect and meet with victims of community violence while they are in the hospital.	In FY18, 65 victims of community violence were seen for intake or brief intervention. Of these cases, 39% involved a stab wound, 33% involved assault, and 20% involved gunshot(s).
Provide direct services and referrals to resources to victims of community violence (support and/or referrals for mental health, housing, employment, education, substance abuse, financial, and legal).	In FY18, 177 contacts were provided. These include emotional support, referrals to Victim's Compensation, safety planning, referrals to housing, education, and employment services.
Provided internal and external trainings based on the challenges and strategies for addressing community violence.	VIAP provided trainings to hospital providers, including ED residents, nurses and social workers, and community programs. VIAP is also a member of the multidisciplinary gun violence coalition at MGH.
Increased VIAP visibility through collaboration with community providers.	VIAP participated as a member of the Chelsea and East Boston HUBs (city-wide case management programs for high-risk residents). VIAP also participated in meetings with police and DA departments.

Partners

Partner Name, Description	Partner Web Address
Massachusetts Violence Intervention Advocacy Program (Boston Medical Center and Baystate Hospital)	http://nnhvip.org/network-membership/massachusetts-violence-intervention-advocacy-program
National Network of Hospital Based Violence Intervention Programs (NNHVIP)	http://nnhvip.org/
Louis D. Brown Institute of Peace	http://ldbpeaceinstitute.org/
Roca	http://rocainc.org/
BMC Streetworker Program	https://www.bmc.org/violence-intervention-advocacy.htm

Contact Information Debra Drumm, Director of HAVEN, ddrumm@partners.org

Immigrant and Refugee School Program

Program Type	Direct Services, Outreach to Underserved, School/Health Center Partnership
Statewide Priority	Address Unmet Health Needs of the Uninsured, Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The Immigrant and Refugee School Program supports recently arrived refugees and immigrants and their families in integrating into public education. The program strives to serve as a key cultural advisor to all Chelsea Public schools, collaborate with medical and health providers, empower parents to be academic advocates for their children and motivate students to successfully complete high school and attend post-secondary schools. Through community referrals and collaboration, the program seeks to improve children's experience and integration in the community. Since 2015 the program has focused on newly arriving immigrant children from Central America.
Target Population	• **Regions Served:** Chelsea • **Health Indicator:** Access to Health Care, Other: Education/Learning Issues, Other: Uninsured/Underinsured • **Sex:** All • **Age Group:** All Children • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Provide a continuum of care across multiple settings to ensure the well-being of immigrants, refugees, and asylees in Chelsea.	In FY18, 60 students and family members in Chelsea Public Schools were served; Countries of origin include: El Salvador, Guatemala and Honduras.
Support refugee and newly arrived immigrant students transitioning into school.	In FY18, the Immigrant and Refugee School coordinator had 486 contacts with students and families.
Address top concerns of refugee and newly arrived immigrant students transitioning into school.	In FY18, the top concerns addressed were mental health, physical health, home issues, registration, and attendance.

Partners

Partner Name, Description	Partner Web Address
MA Department of Public Health Refugee resettlement agencies	http://www.mass.gov/dph/refugee

Catholic Charity Boston, International Institute of Boston	www.ccab.org www.iiboston.org
ROCA	http://rocainc.org/
REACH	http://www.chelseaschools.com/cps/
Chelsea School System	http://www.chelseaschools.com/cps/
DTA	www.mass.gov/eohhs/gov/departments/dta
CAPIC	www.capicinc.org
Chelsea Collaborative	http://www.chelseacollab.org/
Boys and Girls Club	http://www.bgcb.org/

Contact Information	Cynthia Koskela, Immigrant and Refugee School Program Coordinator, CKOSKELA@MGH.HARVARD.EDU

MGH CHA: Stay in Shape

Program Type	Community Education, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Supporting Healthcare Reform
Brief Description or Objective	The Stay In Shape program addresses the issue of healthy living among adolescent girls and boys in selected public schools in MGH Health Center served communities of Charlestown, Chelsea and Revere.
Target Population	• **Regions Served:** Boston-Charlestown, Chelsea, Revere • **Health Indicator:** Other: Nutrition, Other: Stress Management, Physical Activity • **Sex:** Female, Male • **Age Group:** Child-Preteen, Child-Teen • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Promote and nurture healthy lifestyles among adolescents by delivering an evidence-informed health education curriculum in selected public schools located in 3 MGH Health Center-served communities.	In FY18, Stay in Shape served 509 participants at 7 public schools and 1 community site, with demonstrated outcomes of improved knowledge, skills, and behavior changes towards healthy living.
Eat 5+ servings of fruits and vegetables a day.	In FY18, the number of participants who reported knowing about eating 5+ servings of

	fruits and vegetables daily increased to 50% at program completion from 38% at program start.
Read the Nutrition Labels	In FY18, the number of participants who reported always checking the Nutrition Labels increased to 22% at program completion from 17% at program start.
Know how and do deep breathing regularly as an evidence-based tool to control daily stress	In FY18, the number of participants who know how and do deep breathing to control stress increased to 93% at program completion from 82% at program start.
Spend more than 1 hours on being physically active every day	In FY18, the number of students who spend more than 1 hour a day being physically active increased to 66% at program completion from 55% at program start.

Partners

Partner Name, Description	**Partner Web Address**
Revere High School	http://www.reverek12.org/
Rumney Marsh Academy	http://www.revereps.mec.edu/Schools/Rumney/index.html
Eugene Wright Middle School	http://www.chelseaschools.com/cps/schools/wright.htm
Clark Avenue Middle School	http://www.chelseaschools.com/cps/schools/middle-schools/clark.htm
Harvard-Kent Elementary School	http://www.bostonpublicschools.org/school/harvardkent-elementary-school
Warren-Prescott K-8 School	http://www.chelseaschools.com/cps/schools/sokolowski-elementary.htm
Chelsea High School	https://www.chelseaschools.com/cps/schools/high-school.htm
MGH Revere Health Center / Youth Zone (Stay in Shape Mentor Program)	http://www.massgeneral.org/cchi/services/treatmentprograms.aspx?id=1490
Clarence R. Edwards Middle School	https://www.bostonpublicschools.org/school/edwards-middle-school
Clarence R. Edwards Middle School	https://www.bostonpublicschools.org/school/edwards-middle-school

Contact Information Ming Sun, MPH, MCHES, msun@partners.org

MGH Chelsea Complex Patient Population (CPP) Program

Program Type	Direct Services
Statewide Priority	Address Unmet Health Needs of the Uninsured, Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The MGH Chelsea Complex Patient Population (CPP) Program works with MGH patients who have barriers to accessing health care resources. Community Health Workers (CHWs) are referred patients who need help navigating to appointments, accessing social services, or have other barriers that keep them from accessing the health care services they need. Most CPP patients are immigrants or refugees, who have limited English proficiency, little social support, and/or not familiar with the US medical system. CPP CHWs meet patients where they are at in their care, help create and accomplish goals, and ultimately increase their connection to primary care, arrive at needed appointments, and reduce ER visits and hospitalizations. In FY18, CPP CHW's worked with 705 patients (excluding Cancer Navigation).
Target Population	• **Regions Served:** Chelsea, Everett, Lynn, Revere • **Health Indicator:** Access to Health Care • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Work with MGH patients to address barriers to care.	In FY18, the CPP program was referred 572 new patients and worked with 705 in total.
Help patients make and achieve goals.	In FY 18, 2,338 goals were created with patients. These goals include medication adherence, health motivation, psycho-social needs, and resources. In FY18, 2,053 (89%) of those goals were completed.
Help patients address health access needs.	In FY18, 11,318 contacts were made to or on behalf of patients to help reduce barriers to health care resources. These contacts include accompanying patients to appointments, communication to their PCP, helping with transportation, helping to schedule

	appointments, and emotional support. The average contact was 29 minutes in length.
Improve self-reported health status	84% of patients reported their health status as "Very Good" or "Good" at graduation, as opposed to 65% when first referred.
Create a Community Health Worker model to be expanded across the Partners Medicaid ACO initiative.	The MGH Chelsea CHW model is being used to solidify best practices for hiring, training, supervising, and integrating CHWs into practices across Partners' sites.

Partners

Partner Name, Description	**Partner Web Address**
Not specified	

Contact Information	Sarah Oo, Director, Community Health Programs, Chelsea HealthCare Center, soo@partners.org

Charlestown Family Support Circle (CFSC)

Program Type	Direct Services
Statewide Priority	Address Unmet Health Needs of the Uninsured, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity, Supporting Healthcare Reform
Brief Description or Objective	Our mission is to provide supportive services to Charlestown youth and families that are at risk or in need of support to ensure all Charlestown youth can develop and grow to reach their full potential. The Charlestown Family Support Circle (CFSC) provides clinical case management and care coordination services to the community. The FSC Clinician is the central referral point for Charlestown families and residents, who have children and youth between the ages of 7-14 years old. The FSC Clinician will work with families to determine their strengths, needs, and goals, as well as provide families' referrals to appropriate services and treatment. Additionally, the FSC Clinician will remain with families until they are connected to community resources while also providing a consistent, ongoing, community support. The program will also work with Charlestown providers to improve care coordination and the way in which providers work together.
Target Population	• **Regions Served:** Boston-Charlestown • **Health Indicator:** All • **Sex:** All

- **Age Group:** Child-Preteen, Child-Primary School, Child-Teen, Families
- **Ethnic Group:** All
- **Language:** All

Goal Description	Goal Status
The CFSC will provide clinical case management, care coordination services, and stress management to families and individuals.	25 individuals & families were provided with supportive case management and care coordination services. The CFSC program met with 230 students at the Charlestown Adult Learning Center.
The CFSC will form a task force and create goals for FY18 in an attempt to improve care coordination among Charlestown providers.	The task force meets monthly with approx. 10 providers in attendance addressing the goal of improved care coordination. A work plan was created this year outlining their goals and strategies.
The CFSC will strengthen current partnerships and collaborations with area organizations.	16 organizations currently participated in the task force this FY, including local health care providers, youth serving organizations, schools and mental health providers in the community.
The CFSC clinician will outreach and promote the CFSC program to community organizations and members in an effort to develop new partnerships and collaborations as well provide more information.	The CFSC outreached to 20 new community organizations and groups to promote the work of the family support circle program. Outreach caused 13 organizations to collaborate with the task force.
The CFSC will identify Charlestown and surrounding community resources.	The CFSC continues to update and promote the Family Resource Guide at meetings and through the Charlestown Coalition website.

Partners

Partner Name, Description	Partner Web Address
Boys and Girl Club 15 Green Street Charlestown, MA 02129	http://www.bgcb.org/our-location/charlestown-club/
Massachusetts General Hospital Charlestown Clinic	http://www.massgeneral.org/charlestown/
John F Kennedy Center	http://www.kennedycenter.org/
Winn Companies- Cooperative of CharlesNewton	http://winn.prospectportal.com/charlestown/charlesnewtown/

Mishawum Park –Peabody Properties, Inc	http://www.peabodyproperties.com/our-communities/view-all-communities/64-mishawum-park.html
Smart from the Start	http://smartfromthestartinc.org/locations/boston/
Harvard Kennedy Elementary School	http://www.bostonpublicschools.org/school/harvardkent-elementary-school
Children of Alcoholism and Substance Abuse	http://www.rfkchildren.org/our-work/community-based-services/children-of-alcoholism-and-substance-abuse-coasa/
Boston Housing Tenant Task Force	http://bostonhousing.org/en/BHA-Blog/July-2015/Getting-to-know-Charlestown-s-Big-Mama.aspx
Teamsters Local 25	http://www.teamsterslocal25.com/
Mass Society for the Prevention of Cruelty to Children	http://www.mspcc.org
The Federation for Children with Special Needs	http://fcsn.org/
Warren Prescott Elementary School	http://warrenprescott.com/
Edwards Middle School	http://www.bostonpublicschools.org/school/edwards-middle-school
Saint Mary's Church	http://stmarystcatherine.org/
National Alliance for Mental Health	http://www.nami.org/
MGH Institute of Health Professions	https://www.mghihp.edu/
Charlestown Adult Learning Center	http://adultlearning-center.com/CharlestownMassachusettsadultlearningcenter

Contact Information	Phenice Zawatsky Family Support Clinician Telephone: 617-726-0058, pzawatsky@partners.org

MGH Chelsea Pediatric Asthma Program

Program Type	Direct Services
Statewide Priority	Address Unmet Health Needs of the Uninsured, Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The program strives to improve management of asthma care for adolescent and pediatric patients and improve health outcomes through patient navigation, education, referrals to services, and collaboration within the health center and with outside agencies. In FY18, 174 patients were served.
Target Population	• Regions Served: Chelsea, Everett, Revere • Health Indicator: Other: Asthma/Allergies • Sex: All • Age Group: All Children (Average Age is 10) • Ethnic Group: All • Language: All (52% speak Spanish)

Goal Description	**Goal Status**
Conduct home visits of asthmatic patients when appropriate.	Conducted 78 home visits to identify and address environmental health hazards. 33 Healthy Home Kits distributed (may include HEPA vacuum, insect traps, white vinegar, baking soda, swiffer).
Improve management of asthma care for adolescent and pediatric patients.	Pediatric Asthma Coordinator provided 1520 services to patients, including reviewing prescription medications (285), providing patient asthma education (315), and assisting with lung exams (179).
Improve management of asthma care for adolescent and pediatric patients.	Of the 41 children who were assessed for asthma control status over time, 34 (83%) maintained well-controlled asthma or improved their asthma control during their involvement in the program.
Improve management of asthma care for adolescent and pediatric patients.	94 children have personalized Asthma Action Plans as recommended by their healthcare providers. Asthma Action Plans help families manage medication type and usage based on asthma severity.

Partners

Partner Name, Description	**Partner Web Address**

Chelsea High School	http://www.chelseaschools.com/cps/schools/high-school.htm
Chelsea Collaborative	http://www.chelseacollab.org/
Neighborhood Health Plan	http://nhp.org/Pages/home.aspx
MGH ASIG Asthma Special Interest Group MGPO	www.partners.org/

Contact Information	Erik Hinderlie, Pediatric Asthma Coordinator, ehinderlie@partners.org

MGH Institute of Health Professionals

Program Type	Health Professional/Staff Training, Mentorship/Career Training/Internship
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity, Supporting Healthcare Reform
Brief Description or Objective	MGH Institute of Health Professions is an interdisciplinary graduate school in Boston that prepares its approximately 1,600 full- and part-time students to become skilled health care practitioners who are leaders in the clinical disciplines of nursing, occupational therapy, physical therapy, physician assistant studies, speech-language pathology, health professions education, and rehabilitation sciences. More than 125 faculty, a majority of whom are practicing clinicians, accomplish this mission by: • Integrating academic and clinical curricula; • Expanding and refining the scientific basis for health care through teaching, research, and scholarship; • Developing innovative educational methods • Developing new models of practice to foster provision of effective, affordable, and ethical health care; and • Building collaboration with Charlestown and neighboring communities to improve health. Incorporating classroom learning with research and clinical experience, the MGH Institute grants professional degrees to baccalaureate-educated individuals entering health care from another field, awards certificates of advanced study, and offers continuing education to practicing clinicians. The Institute is accredited by the New England Association of Schools and Colleges (NEASC). www.mghihp.edu; www.facebook.com/MGHInstituteofHealthProfessions; Twitter@MGHInstitute
Target Population	• **Regions Served:** Boston-Charlestown, Boston-Greater • **Health Indicator:** Other: Education/Learning Issues • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Provide pro-bono speech, aphasia, occupational therapy, physical therapy and nursing services to area low-income residents while exposing students to needs of myriad populations.	Students provided more than $1 million in faculty-supervised free health care, volunteered at more than 60 non-profits, and IHP signed formal agreement with local public school to aid its pupils.

Partners

Partner Name, Description	Partner Web Address
Not Specified	

Contact Information	John Shaw, Associate Director of Communications, jmshaw@partners.org

Patient Navigation - Cancer

Program Type	Direct Services, Health Screening, Outreach to Underserved, Prevention
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The Cancer Patient Navigation Program, based at the MGH Chelsea HealthCare Center, strives to improve access to cancer care for vulnerable or high risk patients. The navigators work with patients who need breast, cervical, colon, lung, or other types of cancer screening and help them through the cancer screening process at MGH. In addition, the navigators work with patients with abnormal findings and cancer diagnoses and help decrease barriers to timely follow-up care.
Target Population	• **Regions Served:** Chelsea • **Health Indicator:** Other: Cancer • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Provided navigation assistance to vulnerable patients in need of breast, cervical, colorectal, lung and other types	715 patients received navigation assistance for cancer-related appointments, 503 patients

of cancer screening and/or follow-up on abnormal findings.	arrived to a cancer-related appointment and 18 patients were diagnosed with cancer.
Address barriers to accessing and receiving timely, quality health care for all patients.	19,905 patient activities conducted for cancer-related needs – e.g appointment reminders, clinical communication, patient education, language translation, emotional support, and scheduling assistance.
Early detection of colorectal cancer amongst patients served through screening.	108 colonoscopies completed for 104 patients (48 adenomas removed for 27 patients, 104 polyps removed for 49 patients).
Continue the breast health programs through MGH Healthcare centers in Chelsea, Revere, Charlestown and Everett.	The breast health program reached 268 patients in Chelsea, 11 patients in Revere, 7 in Charlestown and 22 in Everett.

Partners

Partner Name, Description	**Partner Web Address**
Not Specified	

Contact Information	Ana N. Cabral, ancabral@partners.org Ali Abdullahi, aabdullahi1@mgh.harvard.edu

The Charlestown Coalition

Program Type	Community Education, Community Participation/Capacity Building Initiative, Outreach to Underserved, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The Charlestown Coalition works to increase access to and resources for successful treatment and recovery from substance use disorders. The Charlestown Coalition also strengthens protective factors and decreases risk factors to prevent substance use and trauma. The coalition's mission is to advance communities and transform lives by developing and supporting activities that promote overall health and bring about change, helping to end the cycles of addiction, poverty, violence, and racism.
Target Population	• **Regions Served:** Boston-Charlestown

- **Health Indicator:** Access to Health Care, Other: Alcohol and Substance Abuse, Other: Drunk Driving, Other: Smoking/Tobacco, Substance Abuse, Tobacco Use; Mental Health
- **Sex:** All
- **Age Group:** All
- **Ethnic Group:** All
- **Language:** All

Goal Description	Goal Status
Increase youth engagement and empowerment in the schools, coalition and community.	40 Turn It Around members participated in community events, including the annual basketball tournament (100 attendees) and the annual Prescription Take Back Day (75 lbs. of prescriptions collected).
Identify needs and provide resources for substance use disorder services to Charlestown residents and drug court clients.	The Charlestown Navigator worked with 202 (40 new in FY18) clients in recovery or struggling with addiction to connect them with needed resources, including getting into treatment.
Provide substance use prevention education to youth, parents, and providers through schools, local agencies, trainings, meetings etc.	The Life Skills/Stay-in-Shape program was presented to ~ 96 middle school students. Approx. 15 youth participated in the Gavin Group, a weekly after-school group to reduce their marijuana dependence.
Enhance the support and capacity for community clinicians and lay people to both prevent and respond to traumatic situations.	A park was revitalized as a Peace Park creating a sanctuary to have a peaceful place to remember their loved ones and celebrate their life. Approx. 100 people attended the unveiling and Peace Walk.
Increase availability of NARCAN to families and bystanders.	The coalition partnered with the Boston Public Health Commission to host 15 community trainings, with 168 people at the three housing developments, Charlestown Recovery House, and Recovery Community.

Partners

Partner Name, Description	Partner Web Address
Representatives from Elected Officials Charlestown residents	
Massachusetts General Hospital - Charlestown Health Center	https://www.massgeneral.org/charlestown/

Charlestown NEW Health	https://newhealthcharlestown.org/
Boston Public Health Commission	http://www.bphc.org/Pages/default.aspx
John F. Kennedy Family Service Center	https://www.kennedycenter.org/
MissionSAFE	https://www.missionsafe.org/
Boston Police Department Area A-1: Community Service Office	http://bpdnews.com/district-a-1-a-15/
Charlestown Boys & Girls Club	https://www.bgcb.org/find-your-club/charlestown-club/
Charlestown Recovery House	http://www.gavinfoundation.org/programs/charlestown-recovery-house
The Gavin Foundation	http://www.gavinfoundation.org/
Charlestown Against Drugs (CHAD)	http://www.chad02129.org/
Charlestown Neighborhood Council	http://www.charlestownneighborhoodcouncil.org/
Charlestown Community Center	https://www.boston.gov/departments/boston-centers-youth-families/bcyf-charlestown
Charlestown Mother's Association	http://www.charlestownmothersassociation.org/
Charlestown Lacrosse and Learning Center	http://charlestownlacrosse.com/
Peabody Properties/Mishawum Park Apartment Complex	http://www.peabodyproperties.com/communities/component/jea/64-mishawum-park.html
Bunker Hill Housing Development	https://www.bostonhousing.org/en/Departments/Planning-and-Real-Estate-Development/Mixed-Finance-Development/Charlestown.aspx
Boston Alliance for Community Health (BACH)	http://bostonalliance.org/
Winn Co./Charles Newtown	https://www.winncompanies.com/winnresidential
Charlestown High School	https://www.charlestownhs.org/
Harvard Kent Elementary School	http://www.harvardkent.org/
Edwards Middle School	https://www.bostonpublicschools.org/edwards
Warren Prescott School	http://warrenprescott.com/
Charlestown Adult Learning Center	https://bhacharlestownadulted.weebly.com/
Smart from the Start	http://smartfromthestartinc.org/
Charlestown Division of the Boston Municipal Court	https://www.mass.gov/locations/charlestown-division-boston-municipal-court
First Church	https://www.fccharlestown.com/
St Catherine's	https://dev.stmarystcatherine.org/
Charlestown YMCA	https://ymcaboston.org/charlestown
Justice Resource Institute SMART Team	https://jri.org/services/acute-care-and-juvenile-justice/juvenile-justice/smart
North Suffolk Mental Health	http://northsuffolk.org/
MOAR	http://www.moar-recovery.org/
Office of Recovery Services	https://www.boston.gov/departments/recovery-services

Contact Information	Sarah Coughlin, scoughlin1@partners.org, Shannon Lundin, smlundin@partners.org, Ginaya Greene Murray, ggreene-murray@partners.org

MGH CHA Suboxone Program

Program Type	Direct Services
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The Office Based Opioid Treatment Program (Suboxone Program) provides nursing case management and support for patients with substance abuse disorders, specifically opioid addiction. This program provides an innovative approach to substance use disorder treatment within the primary care practice.
Target Population	• **Regions Served:** Boston-Charlestown, Chelsea, Revere • **Health Indicator:** Access to Health Care, Substance Abuse • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
To provide supportive nursing case management services to patients dealing with substance use disorders.	In FY18, the program provided case management and support services to 101 patients from Chelsea, 131 patients in Revere, and 316 patients in Charlestown.
To encourage patients to participate in individual or group counseling as part of their recovery process.	100% of patients (521) are referred to treatment within the health centers or within the community.
Increase the numbers of Primary Care Providers (PCP) who prescribe suboxone.	Currently, there are 44 providers at the Health Centers who prescribe suboxone. MGH Charlestown – 12 PCPs, 1 NP; MGH Chelsea – 11 PCPs; MGH Everett – 5 PCPs, and MGH Revere – 15 PCPs.

Partners

Partner Name, Description	**Partner Web Address**
MA DPH Bureau of Substance Abuse	http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/

Office Based Opioid Treatment with Buprenorphine Program – Boston Medical Center	http://www.bumc.bu.edu/care/clinical-programs/obot/
North Suffolk Mental Health Association	http://northsuffolk.org/

Contact Information	Ann-Marie K. Duffy-Keane, MPH , aduffy@partners.org

MGH Substance Use Disorders Initiative-Recovery Coaches

Program Type	Direct Services
Statewide Priority	Address Unmet Health Needs of the Uninsured, Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The MGH Substance Use Disorders (SUDs) initiative was developed in response to community health needs assessments in Chelsea, Revere and Charlestown, where residents identified substance use, particularly opioids, as the single greatest issue in their communities. The MGH SUDs initiative was designed to improve the quality, clinical outcomes and value of addiction treatment for all MGH patients with SUDs while simultaneously reducing the cost of their care. To accomplish this mission, patients must have access to evidence based treatment that is readily available and standardized across the system. The MGH initiative is focused on re-designing care across the system to meet this goal. Recovery coaches, who are essentially community health workers for addiction, are assigned to each of our health centers, Boston Health Care for the Homeless, and high utilizers in the ED. They are paired with MGH patients who have been diagnosed with a substance use disorder.
Target Population	• **Regions Served:** Boston, Boston-Charlestown, Chelsea, Revere • **Health Indicator:** Other: Alcohol and Substance Abuse, Substance Abuse • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Pair MGH patients with a SUDs diagnosis with a Recovery Coach.	In FY18, 637 patients were served by 9 MGH Recovery Coaches. Coaches had a total of 2,321 contact hours with patients.
Address barriers to accessing services for all SUDs patients.	Recovery coaches helped patients access treatment services, provided emotional support, advocacy and support for legal issues, assistance with housing, transportation GED programs, and educating patients on overdose prevention.
Change culture and stigma that exists in primary care settings.	Among primary care providers, there has been a 57% reduction in the perception that drug use is a crime and an 11% reduction in the perception that SUDs is a choice, not a chronic disease.
Work with patients to engage in outpatient care and avoid hospital admissions.	A review of service utilization, in the 6 months before and 6 months after recovery coach engagement, shows a 44% increase in outpatient visits and a 25% decrease in inpatient admissions.
Offer peer support opportunities.	Recovery coaches are leading 7 different groups which include NA/AA groups, art groups, and general peer support groups.

Partners

Partner Name, Description	Partner Web Address
Boston Health Care for the Homeless Program	https://www.bhchp.org/

Contact Information	Elizabeth Powell, eapowell@partners.org

Boys and Girls Club Partnership

Program Type	Direct Services, Grant/Donation/Foundation/Scholarship, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	MGH has partnered with the Boys and Girls Clubs of Boston (BGCB) to provide nursing staff and a community health specialist

	to the staff and youth participants of the Boys and Girls Clubs of Boston. The staff focus on providing nursing services and health education to all of the Boys and Girls Clubs, as well as summer camps provided by BGCB.
Target Population	• **Regions Served:** Boston • **Health Indicator:** Access to Health Care, Asthma/Allergies, Family Planning, Nutrition, Sexually Transmitted Diseases, Physical Activity • **Sex:** All • **Age Group:** All Children • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Provide health education members.	Work with 160 BGCB members on healthy relationships and expressing emotions; 174 members were involved in healthy eating and active living activities.
Provided Afterschool and Summer Meals oversight.	Trained new culinary staff in CACFP and SFSP regulations, meal production process, and ordering; Completed online education binder with basic information on regulations, ordering, and recipes- available for culinary staff to access.
Create Healthier Club Cultures.	Attended staff meetings at Clubs to discuss promotion of Health360 policies. A Simmons College Nutrition intern engaged BGCB members in making healthier decisions aligning with the Club's Health360 policies.
Provide substance use prevention education to members.	Began weekly sessions with members on vaping, impact of drugs on health and dispelling drug myths, laws surrounding drugs, and school policies around substance use.

Partners

Partner Name, Description	**Partner Web Address**
Hope and Comfort	http://hopeandcomfort.org/
Breathe & Believe Yoga	https://www.breatheandbelieveyoga.com/
Peer Health Exchange	https://www.peerhealthexchange.org/
Boston College School of Nursing	https://www.bc.edu/bc-web/schools/cson.html
Fresh Truck	www.freshtruck.org/
Weston Ski Track	https://www.paddleboston.com/skitrack/skitrack.php
One Love Foundation	https://www.joinonelove.org
Dignity Matters	www.dignity-matters.org

Contact Information	Lauren B. Cook, lcook@bgcb.org

The EASTIE Coalition

Program Type	Community Education, Community Participation/Capacity Building Initiative, Outreach to Underserved, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The EASTIE Coalition works to strengthen protective factors and decrease risk factors to prevent substance use and abuse for youth, adults and families through education, prevention, and intervention strategies.
Target Population	• **Regions Served:** Boston – East Boston • **Health Indicator:** Other: Alcohol and Substance Abuse, Other: Smoking/Tobacco, Substance Abuse, Tobacco Use • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Increase community's awareness of and membership in the EASTIE coalition.	Tabled/volunteered at approx. 7 different community events, including: Donald McKay parent open house, East Boston HS freshmen orientation, National Night Out, and Shore Plaza Housing Development.
Facilitate communication and collaboration between community members, providers, patients, CCHI staff and other professionals.	Coalition meetings held quarterly with approx. 20 members in attendance and participation at relevant meetings. Received $140,840 in grant funding for substance use prevention.
Provide Substance Use prevention education to youth, parents, and providers through schools, local agencies, trainings, meetings etc.	Implemented the prevention curriculum, Life Skills to approx. 37 7th and 8th graders. Chris Herren discussed his struggles with addiction and his path to recovery to 523 students grades 6th-8th.
Facilitate communication and collaboration between community members, providers, patients, CCHI staff and other professionals.	Coordinated the newly formed HUB Task Force designed to bring service providers together to strategize ways to remove risk from individuals

	or families by connecting them to services they need.
Raise awareness about recovery and substance use disorders services available for East Boston residents.	Collaborated with the Boston Public Health Commission/AHOPE to host 2 Narcan trainings (27 participants). Held the 1st annual Overdose Vigil where 15 people were remembered.

Partners

Partner Name, Description	Partner Web Address
East Boston Neighborhood Health Center/School-based Health Clinic	www.ebnhc.org
MGH Center for Community Health Improvement	http://www.massgeneral.org/cchi/
East Boston High School	http://ebhsjets.net/
East Boston YMCA	http://ymcaboston.org/eastboston
EB/Salesian Boys and Girls Club	http://www.salesianclub.com/
Boston Police Department	http://bpdnews.com/district-a-7
East Boston Collaborative for Families	https://www.facebook.com/eastbostoncollaborative
Peer Health Exchange	http://www.peerhealthexchange.org/our-sites/boston/
East Boston Family Engagement Network	https://www.facebook.com/EastBostonFamilyEngagementNetwork/
Soccer without Borders	http://www.soccerwithoutborders.org/boston
East Boston Times	http://www.eastietimes.com/
El Heraldo	http://www.elheraldo.co/
Families First	http://www.families-first.org/
North Suffolk Mental Health Association	http://northsuffolk.org/
Boston Public Health Commission/Boston Recovery Services	http://www.bphc.org/Pages/default.aspx http://www.bphc.org/whatwedo/Addiction-Services/Pages/AddictionServices.aspx
Boston Children's Hospital	http://www.childrenshospital.org/
Excel Academy High School	https://www.excelacademy.org/
Donald McKay School	https://www.bostonpublicschools.org/school/mcka y-k-
MOAR	http://www.moar-recovery.org/
East Boston Community Soup Kitchen	http://www.ebkitchen.org/

Contact Information Joanna Cataldo, cataldoj@ebnhc.org

Massachusetts General Hospital Certified Application Counselors	
Program Type	Direct Services
Statewide Priority	Address Unmet Health Needs of the Uninsured, Supporting Healthcare Reform
Brief Description or Objective	Massachusetts General Hospital Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by EOHHS and the Health Connector. Our CACs help individuals complete an application or renewal; work with the individual to provide required documentation; submit applications and renewals for the Insurance Programs; interact with EOHHS and the Health Connector on the status of such applications and renewals; and help facilitate enrollment of applicants or beneficiaries in Insurance Programs. In FY18, MGH CACs contributed to the nearly 70 patient financial counselors that served patients who needed assistance with their coverage.
Target Population	• **Regions Served:** Boston- East Boston, Boston- North End, Chelsea, Everett, Lynn, Revere, Salem • **Health Indicator:** Access to Health Care • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Provide information about the full range of insurance programs offered by EOHHS and the Health Connector.	In FY18, MGH CACs contributed to the nearly 70 patient financial counselors that served approximately 73,000 patients who needed assistance with their coverage.

Partners

Partner Name, Description	**Partner Web Address**
Massachusetts Health Connector	https://betterhealthconnector.com/
Mass Health	http://www.mass.gov/eohhs/gov/departments/masshealth/
Health Care For All	https://www.hcfama.org/
Massachusetts Hospital Association	https://www.mhalink.org/

Massachusetts League of Community Health Centers	http://www.massleague.org/
Contact Information	Kim Simonian, Director for Public Payer Patient Access, Community Health, Partners Healthcare, ksimonian@partners.org

Connect to Wellness

Program Type	Direct Services, Community Education
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations
Brief Description or Objective	Connect to Wellness is a partnership between Massachusetts General Hospital and Boston Senior Home Care that began in April 2017 and offers on-site health and social services to residents living in three apartment buildings surrounding the hospital campus in Boston's West End and Beacon Hill. Through a part time staff that includes a registered nurse, licensed independent clinical social worker, and community resource specialist, the Connect to Wellness program is a resource available to over 400 elderly and disabled adults who are living in these buildings – Beacon House, Blackstone Apartments, and Amy Lowell Apartments. The team spends one day per week at each location and offers services such as office hours, informational sessions, and evidence based training. The objective of this community collaborative is to assist all residents in maintaining independence as they age in place by identifying social and health related needs and providing intervention.
Target Population	• **Regions Served:** Boston – Beacon Hill, Boston – West End • **Health Indicator:** Mental Health, Elder Care • **Sex:** All • **Age Group:** All Adults • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Provide health and social services to residents of Amy Lowell, Beacon House, and Blackstone Apartments.	In 2018 the Connect to Wellness team has engaged with 127 residents from all three buildings– 44 from Beacon House, 37 from Amy Lowell, 44 from Blackstone, and 2 not answered.

Support older adults' and adults with disabilities to live safely and independently in the community.	877 total contacts made in 2018 by the Connect to Wellness team. There were 502 encounters by a registered nurse, 84 by a social worker, and 291 by a community resource specialist.
Provide older adults and adults with disabilities with education.	In 2018 Connect to Wellness offered group informational sessions & wellness presentations focusing on 6 different topics to a total of 53 participants. Topics included Winter Illnesses & Heart Health.
Improve older adults and adults with disabilities ability for self-health management and independence through education and health promotion.	Exercise classes at Amy Lowell included Chair Yoga (12 attendees) and Balance Exercise (4 attendees). A 6-week long evidence-based training on Healthy Eating at Beacon House graduated 8 participants.
Improve care management of MGH high risk patients through connection and communication with care managers.	Of the 127 residents that Connect to Wellness made contact with in 2018, 21 residents are enrolled in the MGH iCMP program.

Partners

Partner Name, Description	Partner Web Address
Boston Senior Home Care	http://bostonseniorhomecare.info/
Amy Lowell Apartment	http://www.amylowellapartments.com/amy-lowell-apartments-boston-ma
Beacon House – Rogerson Communities	https://www.rogerson.org/site/beacon-house/
Blackstone Apartments – Preservation of Affordable Housing	http://www.blackstone-apts.com/

Contact Information	Molly Vespa, MAVESPA@mgh.harvard.edu

Health Starts at Home (HSAH)

Program Type	Community Participation/ Capacity Building Initiative
Statewide Priority	Promoting Wellness of Vulnerable Populations
Brief Description or Objective	The objective of Health Starts at Home (HSAH) is to provide a housing stability intervention and to assess its impact on health care utilization and select health outcomes. HSAH is a partnership between MGH, The Neighborhood Developers, and Roca. Patients at MGH Chelsea are screened for housing insecurity. If they are

	housing insecure, they are referred to CONNECT, a partnership of six agencies that work with clients on housing and financial stability.
Target Population	• **Regions:** Chelsea • **Health Indicator:** Mental Health, Asthma, Homelessness, Overweight/ Obesity • **Sex:** All • **Age Group:** Children under 12 years of age and their caregivers. • **Language:** English and Spanish Speakers

Goal Description	**Goal Status**
Enroll 150 participants.	101/150 = 67.3% (As of December 2017)
Deliver housing services and counseling.	In FY18, participants attended an average of 2.4 housing sessions, and average of 107 minutes per participant.
Improve child health.	More caregivers rated the health of the index child as Excellent or Very Good at the 12-month follow-up than at baseline (61.2% at 12-month follow-up vs. 42.9% at baseline).
Improve child health.	The number of index children under age 4 that were identified by the PEDS screening as high or moderate risk remained stable between baseline (32.8%) and 12-month follow-up (33.9%).
Improve caregiver health.	More caregivers enrolled in HSAH rated their own health as Excellent or Very Good at the 12-month follow-up than at baseline (40.9% at 12-month follow-up vs. 31.8% at baseline.
Improve housing stability.	Reported satisfaction with housing increased from baseline and the 12-month follow up (51.4% were Very Satisfied or Satisfied at 12 months vs. 26.6% at Bassline).

Partners

Partner Name, Description	Partner Web Address
The Neighborhood Developers, housing and economic mobility non-profit organization.	http://theneighborhooddevelopers.org
Roca, Inc. Young Mothers Program, non-profit organization addressing violence and poverty in Chelsea, MA.	http://rocainc.org/work/young-mothers-program/
Metropolitan Boston Housing Partnership, housing services	http://www.metrohousingboston.org/

Contact Information	Danelle Marable, dmarable@partners.org Nequiel Reyes, NEREYES@mgh.harvard.edu

Healthy Families America at MGH Chelsea

Program Type	Community Education, Direct Services, Health Screening, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The Healthy Families America (HFA) at MGH Chelsea builds secure parent-child attachment, enriches child development, fosters empathetic parents, supports families to reduce their stress, and builds protective buffers for their children. Healthy Families America is a nationally- recognized, evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. HFA at MGH Chelsea is a home visitor service provided to first-time parents including those newly arrived in this country. The program runs from pregnancy through the child's third birthday. Bi-cultural home visitors go to the homes of high-risk pregnant women and new mothers and provide emotional and concrete support for the participants and families who are adjusting to a new culture and health care system. We aim to empower mothers in a culturally appropriate manner to help them find effective solutions and reduce parental stress. HFA served 88 families in FY2018.
Target Population	• **Regions Served:** Boston- East Boston, Chelsea, Everett, Lynn, Revere • **Health Indicator:** Access to Health Care, Other: Child Care, Other: Parenting Skills

- **Sex:** Female
- **Age Group:** Adult
- **Ethnic Group:** All
- **Language:** All

Goal Description	Goal Status
Work with at-risk families at MGH Chelsea.	Home visitors made 1148 home visits to 88 families in FY18.
Breastfeeding.	78% of the moms in the program are still breastfeeding at baby's sixth month.
Promotion of healthy childhood growth and development.	68% of families were educated about the importance of safe sleep for children under 1 year; 82% of children were screened for appropriate physical development; 95% were screened for behavioral concerns; 8 children were referred to Early Intervention for developmental concerns.
Enhancement of family functioning.	58% of the moms are screened for depression (4 depressed); 82% of families report having continual insurance coverage; 84% screened for DV (6 positive).

Partners

Partner Name, Description	Partner Web Address
CAPIC Headstart	http://www.capicinc.org/
Chelsea/Revere Family Network	http://www.capicinc.org/
Raising a Reader	http://www.raisingareader.org/
Early Learning Center- Adult Literacy English Classes	http://www.bu.edu/sed/community-outreach/programs/intergenerational-literacy/
Early Learning Center- Harbor Area early Intervention	http://www.talkreadplay.org/?q=content/har bor-area-early-intervention-program
Cradles to Crayon	http://cradlestocrayons.org/

Contact Information Maria Yolanda Parra, Healthy Families America Clinical Supervisor and Manager , myparra@partners.org

Refugee Health Assessments

Program Type	Direct Services, Outreach to Underserved
Statewide Priority	Address Unmet Health Needs of the Uninsured, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	Massachusetts General Hospital is a designated refugee health assessment site since 2001, and the program receives funding from the Massachusetts Department of Public Health. The health status of new arrivals is monitored through the initial refugee health assessment (RHA). The assessment provides the opportunity for early identification of communicable and other conditions which, if undetected, can negatively impact on the public health as well as on the refugee's wellbeing and ability to achieve self-sufficiency.
Target Population	• **Regions Served:** Chelsea, surrounding communities • **Health Indicator:** Access to Health Care, Other: Uninsured / Underinsured • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Conduct refugee health assessments with refugees and asylees in Chelsea.	In FY18, 31 new refugees and asylees had refugee health assessments at MGH Chelsea. Countries of origin: 77% El Salvador, 10% Congo, 10% Guatemala, 3% Cameroon.
90% of patients will complete their two Refugee Health Assessment visits within 90 days of arrival in US.	In FY18, 84% of the 31 refugee and asylee patients completed their two Refugee Health Assessment visits within 90 days of arrival. The average number of days from US entry to initial visit is 60.
Integrate patients into MGH Chelsea Complex Patient Population (CPP) Program to connect to services.	See CPP AG Report.

Partners

Partner Name, Description	**Partner Web Address**
MA Department of Public Health	http://www.mass.gov/dph/refugee
International Institute of Boston	www.iiboston.org
Catholic Charity Boston	www.ccab.org

MA DTA	www.mass.gov/eohhs/gov/departments/dta
CAPIC	www.capicinc.org
Roca	http://rocainc.org
REACH	http://www.reachma.org/
Chelsea School System	http://www.chelseaschools.com/cps/
Kids in Need of Defense	https://supportkind.org/
Refugee and Immigrant Assistance Center	http://www.riacboston.org/

Contact Information	Ali, Abdullahi, Manager of the Refugee and Immigrant Health Program, AABDULLAHI1@mgh.harvard.edu

Building a Healthier Charlestown: Charlestown Educational Collaborative

Program Type	Mentorship/ Career Training/ Internship, Prevention
Statewide Priority	Reducing Health Disparity
Brief Description or Objective	After a community health assessment and community health improvement planning process conducted in 2012 and updated in 2016 by the CCHI and Spaulding Hospital in partnership with the residents of Charlestown, determined that **education; substance abuse/mental health; access to care/autism and cancer prevention and access to treatment** continue to be the priority issues in Charlestown to address. The overall purpose of Building a Healthier Charlestown is to improve population health by helping local partnerships of organizations build and/or enhance their capacity to implement evidence-based approaches to impact the health of the community. MGH and Spaulding have invested financial and technical resources to aid in this effort. A collaboration between Smart from the Start (SFTS), CharlesNewtown Winn Residential, Mishawum Housing, Charlestown Coalition, and Charlestown Adult Education. The goal of the collaboration is to expand the services of the adult education program in order to reduce the number of students waiting for services and to provide additional access to ESOL and HiSet (GED) preparation classes.
Target Population	• **Regions Served:** Boston- Charlestown • **Health Indicator:** Education / Learning Issues, Stress Management, Child Care, Substance Abuse

	• **Sex:** All • **Age Group:** All Adults • **Ethnic Group:** All • **Language:** All

Goal Description	Goal Status
Increase access and availability to ESOL via Family Literacy classes and high school equivalency (HiSet) by opening additional classrooms and providing support services.	73 students had job training & 26 students got a job. 16 Students graduated with their HiSET & 85% of ESOL students advanced. 30 clients used on-site childcare to complete their degree/job training.
Provide supportive services to students who are at risk or in need of support in order to help them achieve their educational and personal goals.	30 students served by the Family Support Circle clinician & intern. Students were provided resources, behavioral therapy, case management services, psycho education, skill building workshops.

Partners

Partner Name, Description	Partner Web Address
The Charlestown Coalition	www.charlestowncoalition.org/
Winn Companies- Cooperative of CharlesNewton	www.winn.prospectportal.com/charlestown/charlesnewtown/
Mishawum Park –Peabody Properties, Inc	www.peabodyproperties.com/our-communities/view-all-communities/64-mishawum-park.html
Smart from the Start	www.smartfromthestartinc.org/locations/boston/

Contact Information	Lori D'Alleva, Director of Adult Education BHA/Charlestown Adult Education 76 Monument Street, Charlestown, MA 02129 617-635-5121, cccae@comcast.net

Building a Healthier Charlestown: Healthier Living through Good Food and Exercise

Program Type	Community Education, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity

Brief Description or Objective	After a community health assessment and community health improvement planning process conducted in 2012 and updated in 2016 by the CCHI and Spaulding Hospital in partnership with the residents of Charlestown, determined that **education; substance abuse/mental health; access to care/autism and cancer prevention and access to treatment** continue to be the priority issues in Charlestown to address. The overall purpose of Building a Healthier Charlestown is to improve population health by helping local partnerships of organizations build and/or enhance their capacity to implement evidence-based approaches to impact the health of the community. MGH and Spaulding have invested financial and technical resources to aid in this effort. The **John F. Kennedy Family Service Center** received funds to support the **Healthier Living Through Good Food and Exercise initiative in collaboration with Kids Cooking Green, the Charlestown YMCA, Cancer Prevention Awareness and Education and Whole Foods Market to** provide activities so that youth and their families become more knowledgeable about and embrace the choice to eat a healthy diet and engage in an active lifestyle that promotes positive physical and mental health.
Target Population	• **Regions Served:** Boston- Charlestown • **Health Indicator:** Nutrition, Obesity, Physical Activity • **Sex:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Teach children about foods through engagement of the preparation process and provide them the opportunity to enjoy the varying tastes, textures, and colors.	In collaboration with the Kennedy Center, Kids Cooking Green reached about 500 people with programs and activities in Charlestown. About 150 of those reached were in grades K-5.
Make healthy foods accessible, available and affordable in community through farmers' markets and youth events.	Charlestown hosted a Wellness Fair at the Harvard Kent reaching over 100 families and a Back 2 School Fair at the Charlestown Farmers' Market where 50 Kids talked nutrition under the market tent.

Partners

Partner Name, Description	Partner Web Address
Charlestown YMCA	www.ymcaboston.org
Kids Cooking Green	www.kidscookinggreen.com
Women, Infant's & Children's Nutrition Program (WIC)/ MGH Charlestown Health Center	www.massgeneral.org/charlestown/services/
Harvard Kent Elementary School	www.bostonpublicschools.org/school/harvardkent-elementary-school
The Art of Healthy Living	www.artofhealthyeating.com
North End Waterfront Health Center	www.northendwaterfronthealth.org
Fresh Truck	www.freshtruck.org
New England Aquarium	www.neaq.org

Contact Information	Crystal Galvin Director of Community Services John F. Kennedy Family Service Center, Inc. 55 Bunker Hill St. Charlestown, MA 02129 P: 617-241-8866 x.1352 C: 857-417-8054 cgalvin@kennedycenter.org www.kennedycenter.org

Healthy Families	
Program Type	Community Education, Direct Services, Health Screening, Prevention
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The Healthy Families program at MGH Chelsea builds secure parent-child attachment, enriches child development, fosters empathetic parents, supports families to reduce their stress, and builds protective buffers for their children. Healthy Families America is a nationally- recognized, evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. Healthy Families America at MGH Chelsea is a home visitor service provided to first-time parents including those newly arrived in this country. The program runs from pregnancy through the child's third

	birthday. Bi-cultural home visitors go to the homes of high-risk pregnant women and new mothers and provide emotional and concrete support for the participants and families who are adjusting to a new culture and health care system. We aim to empower mothers in a culturally appropriate manner to help them find effective solutions and reduce parental stress. In FY18, a total of 70 participants were served.
Target Population	• **Regions Served:** Boston-East Boston, Chelsea, Everett, Revere • **Health Indicator:** Access to Health Care, Other: Child Care, Other: Parenting Skills • **Sex:** All • **Age Group:** Adult • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Breastfeeding.	78% of the moms in the program are still breastfeeding at baby's sixth month.
Promotion of positive parent-child interaction.	A new tool was used to observe, assess and promote positive interactions between parent and baby with 85% of the families.
Promotion of healthy childhood growth and development.	82% of the children were assessed at 9, 12, 18, 24, 30 and 36 months with the Ages and Stages Questionnaire. Activities to enhance child development were provided at home visits.
Enhancement of family functioning.	82% of families report having insurance continuity; 100% children connected to medical home; 84% screened for DV.
Increase role of fathers in children's lives.	A new fatherhood coordinator will be hired to provide support to those single fathers raising children on their own; and to lead quarterly activities for dads.

Partners

Partner Name, Description	**Partner Web Address**
Chelsea/Revere Family Network	http://www.capicinc.org/
Raising a Reader	http://www.raisingareader.org/
Early Learning Center- Adult Literacy English Classes	http://www.bu.edu/sed/community-outreach/programs/intergenerational-literacy/
Early Learning Center- Harbor Area	http://www.talkreadplay.org/?q=content/harbor-area-

Early Intervention	early-intervention-program
Harbor Area Healthy Families Program- Roca	http://www.rocainc.org/services_programs.php
Cradles to Crayons	http://cradlestocrayons.org/

Contact Information	Sarah Oo; soo@partners.org Maria Yolanda Parra; myparra@partners.org

The Kraft Center for Community Health at Massachusetts General Hospital	
Program Type	Community Participation/Capacity Building Initiative, Direct Services, Health Professional/Staff Training, Outreach to Underserved
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity
Brief Description or Objective	The **Kraft Center for Community Health** aims to catalyze innovative solutions to real world community health problems, execute solutions locally, and make them scalable and ready to spread nationally to improve health outcomes for disadvantaged populations throughout the Massachusetts and nationally. Current programming addresses addiction, cancer care inequities, obesity, and training initiatives in primary care and community health. The Center's mobile health program combines harm reduction, clinical services including medication-assisted treatment (MAT), data hot-spotting, and mobility to bring addiction services to Boston's most vulnerable residents living with substance use disorder (SUD). The Center supports several cancer care equity projects, including a pilot funding opportunity for Greater Boston community health centers to implement innovative, sustainable programs to combat inequities in cancer care and

	outcomes. The Center's programming also addresses childhood obesity, where the First 1,000 Days program supports mother-father-infant triads from early pregnancy until the child's second birthday providing counseling to reduce risk of obesity and other chronic diseases. Finally, the Center continues its work in training initiatives in primary care and community health, supporting both a primary care fellow as well as a local intern.
Target Population	• **Regions Served:** Boston, Boston-Brighton, Boston-Dorchester, Boston-Downtown, Boston-Fenway Kenmore, Boston-Roxbury, Chelsea, Revere. • **Health Indicator:** Alcohol & Substance Abuse, Cancer, Overweight & Obesity, Substance Abuse • **Sex:** All • **Age Group:** All Adults, Child-Infant • **Ethnic Group:** All • **Language:** All

Goal Description	**Goal Status**
Launch a mobile addiction program, identify areas at high risk for overdose, and provide harm reduction services and initiate MAT for people with SUD.	Van was launched on 1/9/18. The mobile team made 3457 contacts with drug users, had 248 patient encounters, wrote 131 prescriptions for MAT, and distributed 1257 naloxone kits and 36510 syringes.
Bring innovative programming to community-based settings to reduce inequities in cancer care and outcomes in Greater Boston.	Provided pilot funding to 3 community health centers to launch innovative, sustainable programs to increase cancer screening and facilitate rapid connections to cancer care.
Deliver evidence-based childhood obesity interventions to high risk populations.	The First 1000 Days program has engaged and supported 1088 families. Dr. Taveras & her team also awarded PCORI grant to disseminate and implement *Connect for Health* program across 3 states.

Continue to promote community health leadership through training.	Provided mentorship and community health training to 1 primary care fellow. Also hired and provided guidance to a local intern.

Partners

Partner Name, Description	Partner Web Address
Boston Health Care for the Homeless Program, clinical partner for the Kraft Center mobile health program, provides high quality care for homeless individuals and families in Greater Boston.	https://www.bhchp.org/
Boston Public Health Commission – AHOPE, harm reduction partner for mobile health program, is a harm reduction and needle exchange site providing a range of service to active injection drug users.	http://www.bphc.org/whatwedo/Recovery-Services/services-for-active-users/Pages/Services-for-Active-Users-AHOPE.aspx
Trefler Foundation, sponsor and thought partner for cancer care equity work, supports experimentation and innovation in health care, healthy lifestyle, and education and workforce development.	https://treflerfoundation.org/
GE Foundation, sponsor and thought partner for mobile health program, is committed to transforming our communities and shaping the diverse workforce of tomorrow by leveraging the power of GE.	https://www.ge.com/sustainability/philanthropy

Contact Information	Dr. Elsie Taveras, 617-726-8555, elsie.taveras@mgh.harvard.edu

Expenditures

Community Benefits Programs

Expenditures	Amount
Direct Expenses	$70,865,718
Associated Expenses	N/A
Determination of Need Expenditures	$422,365
Employee Volunteerism	N/A
Other Leveraged Resources	$10,446,698

Net Charity Care

Expenditures	Amount
HSN Assessment	$27,015,146
HSN Denied Claims	$1,198,346
Free/Discount Care	$3,214,145
Total Net Charity Care	**$31,427,637**

Corporate Sponsorships	$1,010,004
Total Expenditures	**$114,172,422**
Total Revenue for 2018	**$2,903,878,656**
Total Patient Care-related expenses for 2018	**$2,464,668,924**
Approved Program Budget for 2019 (*Excluding expenditures that cannot be projected at the time of the report.)	$114,172,422