MASSACHUSETTS GENERAL HOSPITAL

CENTER FOR COMMUNITY HEALTH IMPROVEMENT

2019-2020

COMMUNITY HEALTH IMPLEMENTATION PLAN

Executive Summary

Introduction

A Community Health Implementation Plan (CHIP) is a road map to address community-identified public health challenges identified through the Community Health Needs Assessment (CHNA), (www.massgeneral.org/cchi/), both conducted triennially. This report is the 2019-2022 CHIP for Massachusetts General Hospital.

The Mass General 2019 CHNA and CHIP are based on our participation in two first ever collaborative processes in Boston and North Suffolk (Chelsea, Revere, and Winthrop). In each collaborative, participants engaged community organizations, local officials, schools, health care providers, the business and faith communities, residents, and others in an approximately year-long process. The process was tailored to unique local conditions, to better understand the health issues that most affect communities and the assets available to address them.

Boston and North Suffolk have conducted their own CHNAs and CHIPs that can be found here: www.BostonCHNA.org and www.northsouffolkassessment.org. Hospitals are required by regulators (MA Attorney General, IRS) to produce their own CHNA and CHIP, approved by a governing board of the institution. Mass General used the Boston and North Suffolk implementation plans as guidance for its own and engaged content experts to complete the CHIP.

The Priorities

The guiding principle for the Boston and North Suffolk collaboratives is to achieve racial and ethnic health equity. In all communities, social determinants of health emerged as top priorities, as up to 80% of health status is determined by the social and economic conditions where we live and work. Notably, this is the first CHNA ever in which housing and economic issues rose to the top of the list.

The health priorities that emerged across communities and have been adopted as Mass General priorities were strongly aligned and include:

- Safe, affordable, and stable housing.
- Economic and financial stability and mobility, including living wage jobs and educational pathways.
- Behavioral health, including substance use disorders (SUDs) with an emphasis on youth and families.
- Access to health, social, and child care services.

Based on past assessments and historical commitments, Mass General will also continue to address the following priorities:

- Community/intimate partner violence and safety.
- Healthy eating, Active living, and Food Insecurity.
- Elder/aging health issues.
- Chronic disease prevention and management.

The Communities and Strategies

Mass General will continue its commitment and engagement in the communities of Revere, Chelsea, Charlestown, East Boston, and the youth of Boston. Joining with other hospitals through the Conference

of Boston Teaching Hospitals (COBTH) and the Boston CHNA-CHIP Collaborative, Mass General will also engage in the neighborhoods of Boston with the greatest health disparities, notably Roxbury, Dorchester, and Mattapan.

In addition to expanding its work around improving access to care, promoting educational attainment, and partnering with communities to build a culture of health, Mass General will engage in new initiatives that get to the root causes of poor health outcomes. Notable initiatives will include:

Housing

Community-wide Approaches

- *Anchor Investments* – The Partners HealthCare system has already made an initial anchor investment of $1.5 million in partnership with the Local Initiatives Support Corporation (LISC) and the Community Economic Development Assistance Corporation (CEDAC) to preserve 32 units of affordable housing in Chelsea.
- *Permanent Supportive Housing* - The system has also made a $1 million investment in the Mayor's Boston's Way Home plan to build permanent supportive housing for chronically homeless individuals.

We will look to make additional Anchor investments and advocate for public policies that preserve and create affordable housing, such as those in the Massachusetts Principles for Healthy and Affordable Housing.

Patient Approaches

- *Health Starts at Home* – MGH Chelsea participated in an initiative funded by the Boston Foundation to test novel approaches for increasing housing stability and evaluating the impact on health. We screened families in our pediatric practice and referred those who were housing unstable to CONNECT, a partnership of six agencies that works on housing and financial stability. We found that mothers reported significantly less depression and anxiety as a result of the intervention, both connected to better health outcomes for the child. Our partnership recently received a grant from the Kresge Foundation for $320,000 to continue this work.
- *Medical/Legal Partnership* – For 15 years, MGH Chelsea has partnered with the Lawyers for Civil Rights. A lawyer sits in the community health department two days a week and provides services for patients referred by physicians for housing and benefits issues. Each year, the attorney has assisted approximately 100 people to gain, maintain, or improve the quality of their housing.

Our goal is to extend both Health Starts at Home and our Medical Legal Partnership programs to all MGH health center patients.

Economic Security and Mobility

Community-wide Approaches

- *Anchor Institution* – Mass General, along with the Partners HealthCare system, is committed to becoming an Anchor Institution which means we will harness our economic activity in hiring, purchasing, building and investing to benefit low-resourced communities and communities of

color. This is a powerful tool for addressing social and economic determinants of health, such as jobs and economic development.

- *Community Coalitions* – Revere CARES has partnered with the City of Revere, CONNECT, and the Chelsea Collaborative to form the Good Jobs Coalition, and they are receiving technical assistance from the Catapult Lab. Through this coalition, they will develop a comprehensive regional workforce development plan. The Catapult Lab is an initiative of The Boston Foundation, Jewish Vocational Services, and SkillWorks to build the next generation of workforce development solutions.

Patient Approaches

- Partner with Financial Opportunity Centers – CONNECT helps people obtain sustainable living wage jobs and achieve financial health, offering services like financial education and credit building, tax preparation, housing assistance, job search, public benefits, and adult basic education in one location. CONNECT and other organizations like it achieve real results for patients and community members.

We plan to expand our partnerships with financial opportunity centers similar to CONNECT in Chelsea.

Behavioral Health/Substance Use Disorder

Community-wide and Patient Approaches

- We will partner with others to Invest in increasing the pipeline of behavioral health workers who reflect the diversity of the community and in increasing community-based peer support and services to connect residents to behavioral health care. We will build capacity in community-based organizations by training community health workers to provide peer support and we will improve access to existing services.

Conclusion

We are excited to implement this improvement plan with our community and health care partners over the next 3 years and to use our collective voices, resources, and strategies to make lasting and positive health improvements.

Safe, Affordable and Stable Housing

Rationale: Data from the American Community Survey show that at least 50% of renters in Boston and North Suffolk are cost burdened, defined as spending at least 30% of their income on housing. The stresses and pressures created by housing instability and lack of affordability are associated with poor physical and mental health outcomes, as well as disruptions in work, school, and day care arrangements. Poor housing quality can have direct negative health impacts including respiratory conditions such as asthma due to poor indoor air quality, cognitive delays in children from exposure to neurotoxins (e.g., lead), and accidents and injuries because of structural deficiencies.

These effects are experienced most powerfully by people with low or fixed incomes, such as seniors and residents who work low-wage jobs, and those who are undocumented and non-English-speaking.

Goal: Ensure safe, stable, healthy, equitable, affordable housing solutions.				
Objective 1: Advocate for policies and make investments that increase and preserve affordable housing across Greater Boston.				
		Strategy 1		**Strategy 2**
		Direct resources, including but not limited to investments, grant, loans, and other financial instruments, towards community development corporations and other non-profit developers to construct or preserve affordable housing.		**Advocate and support policies that protect tenants, offer rental support, and preserve and increase affordable housing at the local and state level. This includes supporting the Massachusetts Principles for Healthy and Affordable Housing.**
Population(s):		Those experiencing housing instability		People experiencing housing instability or homelessness
Potential New Resources:		• Anchor Investment • Determination of Need Community Health Improvement Funds (DoN CHI)		
Current Initiatives:		• Anchor Investment in Chelsea with local community development corporations to preserve affordable housing • Contribution to Boston's Way Home, the Mayor's initiative to end veteran and chronic homelessness in Boston by creating permanent supportive housing		• Charlestown Coalition advocacy with Boston Housing Authority around status of current Bunker Hill Housing residents during and after redevelopment • Healthy Chelsea advocacy and support for local public and affordable housing projects • Revere CARES advocacy and support for local public and affordable housing projects
Collaborations:		• Local Initiatives Support Corporation (LISC) • Community Development Corporations • Healthy Neighborhood Equity Fund • Boston teaching hospitals		• Other Area Hospitals/Health Systems • Massachusetts Public Health Association
Expected Outcomes:		Increased/preserved affordable housing units		Policies that support safe, affordable housing
Data Source:		Investment/grantee reports		Local and state reports

Objective 2: Implement and expand programs that stabilize or create access to affordable housing for Mass General health center patients.				
	Strategy 1	**Strategy 2**	**Strategy 3**
	Support Medical-Legal Partnerships within the Mass General HealthCare Centers.	**Screen and assess Mass General health center primary care patients for housing instability and connect to partners who provide services including financial and housing counseling.**	**Invest in housing navigation to support MGH inpatients who are chronically homeless to connect with housing resources.**
Population(s):	Patients needing legal advocacy to obtain housing/preserve tenancy	Patients experiencing housing instability	Patients who are chronically homeless or at risk of homelessness
Potential New Resources	Philanthropy	Hospital Investment/philanthropy	Hospital investment
Current Initiatives:	• MGH Chelsea Legal Initiative for Care (LINC), partnership with Lawyers for Civil Rights for housing and benefits • Partnerships with Harvard Law students for immigration status at MGH Chelsea	• Early Childhood Home Visitors • Health Starts at Home (originally funded by The Boston Foundation and now Kresge in partnership with The Neighborhood Developers) • Medicaid ACO Flexible Services • Charlestown Family Support Circle • Healthy Chelsea Family Navigator	ED navigator
Collaborations:	• Lawyers for Civil Rights • Harvard Law School	• The Neighborhood Developers, a community development corporation • CONNECT, a financial services center • CAPIC, an anti-poverty agency	• City of Boston, Mayor's Initiative to End Chronic Homelessness • Housing and shelter providers
Expected Outcomes:	Increased housing stability/access	• Increased housing stability • Improved health outcomes for Health Starts at Home participants	• Increased housing stability • Decreased inappropriate health care utilization • Improved health outcomes
Data Source:	Program data	Program data	Program data

Economic and Financial Stability and Mobility

Rationale: There is significant income inequality in Boston. The median income in Boston is $62,021, but the range is wide— $27,952 in Dorchester to $170,152 in South Boston, and the disparities are significant. Whites have the highest median income ($98,317) while Latinos the lowest ($36,998). In four

neighborhoods—Dorchester, Fenway, Roxbury, and the South End—25-37% of residents live below the federal poverty level. One interviewee summarized, "Real wages have been going down for low income people [for decades]. This is at the heart of all of it: people have no time because they are working four jobs to get the same salary they used to get from one [job]. If you can't rest, how can you be healthy? Some people have to work 70 hours to make ends meet."

In the 2019 North Suffolk Community Survey, 23% of all respondents selected poverty as a top health concern, a marked change from the 2014 and 2015 surveys when poverty was not in the top five. In 2019, 38% of Chelsea survey respondents and 28% of Revere survey respondents identified poverty among their most important health issues. People living in poverty are more likely to have worse health outcomes.

Goal: Promote economic stability and mobility and reduce the wealth gap among residents, staff, and youth.				
Objective 1: Collaborate with and convene organizations to address workforce development, maximize income and benefits, and increase financial literacy and asset building.				
		Strategy 1		**Strategy 2**
		Work with community partners in North Suffolk to develop and implement a community-wide workforce development initiative to increase job stability.		**Partner with and support financial and economic mobility programs to increase financial stability for patients and residents.**
Population(s):		People who are low-income, immigrants and refugees, and/or low-skilled		People who are low-income, immigrants and refugees, and/or low-skilled
Potential New Resources		• Hospital Anchor Investments • DoN CHI • MGH Center for Community Health Improvement		• Hospital Anchor Investments • DoN CHI • CCHI
Current Initiatives:		• Revere CARES is engaged in a workforce development initiative with CONNECT and the City of Revere, with technical assistance through Project Catapult at the Boston Foundation		• Partnership with CONNECT to build economic security • Volunteer Income Tax Assistance (VITA) • Early Childhood Home Visitors using the EMPATH model of financial mobility
Collaborations:		• CONNECT • Jewish Vocational Services • The Neighborhood Developers • Cities of Chelsea and Revere • Chelsea Collaborative		• CONNECT • Budget Buddies • Compass • EMPATH • Other Economic Stability programs
Expected Outcomes:		• Increased income • Increased full-time, benefitted employment		• Increased income • Increased savings
Data Source:		Census Bureau Department of Labor Statistics		Program Data

Objective 2: Develop anchor programs and partnerships to hire, train and promote low to moderate income residents of Boston, North Suffolk and support local businesses.				
		Strategy 1		**Strategy 2**
		Adopt innovative workforce development strategies at MGH to train and develop low-and moderate-income Boston residents.		**Adopt innovative procurement strategies at MGH using Anchor Institution principles to support local minority and women-owned businesses.**
Population(s):		New and Current Mass General Staff who are low and moderate-income residents of Boston and North Suffolk		Local Minority/Women-owned Business Enterprises from Anchor communities
Potential New Resources		Cambridge Street Building Linkage dollars ($1.3M)		Hospital Anchor Investments
Current Initiatives:		• Incumbent worker training (ESOL, GED, etc.) • Partners in Career and Workforce Development		• Partners Purchasing Diversity Initiative • Anchor strategies
Collaborations:		• Cities of Boston, Chelsea, and Revere • Job training agencies		Chamber of Commerce
Expected Outcomes:		Increased employment		Increased revenue into minority/anchor communities through purchasing for locally owned businesses
Data Source:		Program Data		Program Data

Objective 3: Build on existing youth programs to offer opportunities to promote educational attainment, develop leadership skills, and gain career exposure and experience.						
		Strategy 1		**Strategy 2**		**Strategy 3**
		Expand the Mass General Youth Programs (3rd grade through college) to more youth residing in our target communities to support college readiness and explore partnership opportunities for youth not college-bound.		**Provide summer jobs to at least 250 youth every year at Mass General and assist 40 youth in Chelsea, Revere, and Charlestown to find employment with other employers.**		**Strengthen Mass General's Coalition Youth Groups to provide paid internships to develop leadership and advocacy skills to at least 100 youth.**
Population(s):		Youth		Youth		Youth
Potential New Resources		• Philanthropy • Hospital Investments		• Philanthropy • Hospital Investments		• Philanthropy • Hospital Investments
Current Initiatives:		• Mass General Youth Scholars, a program that exposes 1,000 youth grades 3 through college to careers in science and medicine.		• Mass General Youth Summer Jobs Program • Revere Youth Leadership Council • Revere Power of Know Youth Group		• Revere Youth Leadership Council • Revere Power of Know Youth Group • Healthy Chelsea Youth Food Movement Group

				• Healthy Chelsea Youth Food Movement Group • Healthy Chelsea Teen Action Project • Charlestown Turn it Around Youth Group		• Healthy Chelsea Teen Action Project • Charlestown Turn it Around Youth Group
Collaborations:		• Boys and Girls Clubs of Boston • Becoming A Man (BAM) • Accelerated College Experience (ACE)		• Private Industry Council • Cities of Chelsea and Revere		• Revere Public Schools • Chelsea Public Schools • Boston Public Schools
Expected Outcomes:		• Increased college persistence and graduation • Increased career exposure • Increased leadership and advocacy skills		Increased job readiness skills		• Increased career exposure • Increased leadership and advocacy skills • Increased resiliency
Data Sources:		Program Data		Program Data		Program Data

Behavioral Health, including Substance Use

Rationale: The CHNA identified widespread concern about behavioral health challenges among families, friends, and neighbors. Stress, anxiety, and depression were the most frequently-cited behavioral health issues among Boston and North Suffolk residents, especially those who identify as LGBTQ, low-income, women, renters, seniors, children, immigrants, communities of color, and the unemployed. Many community organizations mentioned the need to increase resiliency and healthy coping mechanisms in youth.

Participants discussed the co-occurrence of behavioral health issues with SUDs, including opioid use disorder (OUD) and trauma. Together these challenges are among the leading causes of disability in the U.S. In 2016, unintentional opioid overdose accounted for 69% of all accidental deaths, with rates highest among Latinos, followed by Whites.

CHNA respondents report that access to help is limited by stigma, culture, language, cost, and provider competency in treating communities of color, particularly immigrant communities. They recommended investing in more behavioral health support in public schools, reducing cultural stigma linked to behavioral health services, creating community-based access through peer support, and recruiting behavioral health clinicians who reflect the diversity of the communities. One key informant illustrated these barriers by sharing, "There is far too little access to treatment programs, and those that do exist are not linguistically and culturally competent."

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.						
Objective 1: Increase the pipeline of culturally appropriate behavioral health workers (licensed and community-based) and increase services in traditional and non-traditional settings.						
		Strategy 1		**Strategy 2**		**Strategy 3**
		Establishing scholarship opportunities for racially, ethnically & linguistically diverse students to obtain education and training for behavioral health roles and recruit behavioral health clinicians who reflect the diversity of the community.		**Pilot programs or partner with existing organizations that train community health workers in community-based settings to provide support and connect community members to behavioral health care.**		**Partner with school systems, health centers, and youth- and family-focused programs to provide resiliency curriculum and behavioral health support.**
Population(s):		Culturally and linguistically diverse students seeking behavioral health careers		Residents of Roxbury, Dorchester, Mattapan, Chelsea, Revere, Charlestown, East Boston		Boston, Chelsea, Revere, Winthrop public school students, parents, faculty
Potential New Resources		• System Investment • Governor's health care legislation • DoN CHI		• System Investment • DoN CHI • IRIS Database		• System Investment • Philanthropy • DoN CHI

Current Initiatives:						Chelsea and Revere School-Based Health Centers
Collaborations:		Local colleges		• Massachusetts Department of Mental Health • North Suffolk Mental Health Association • Other behavioral health agencies		• Public schools • Community organizations • Mass League of Community Health Centers
Expected Outcomes:		Increased number of diverse behavioral health workforce in Boston		• Increased alternative pathways to an array of community based BH services • Increased access to services • Increased knowledge on trauma and resources available		• Improved access to care • Increased resilient communities and youth
Data Sources:		Program Data		Program Data		Youth Risk Behavior Survey
Objective 2: Support multi-sector community coalitons to convene stakeholders to identify and advocate for policy, systems, and environmental changes to increase resiliency, reduce youth substance use, and prevent opioid overdoses and deaths.						
		Strategy 1		**Strategy 2**		**Strategy 3**
		Building Community and Organizational Capacity - Increase the capacity of communities and organizations to respond to the behavioral health needs of youth and families by convening municipalities, organizations, and residents to identify opportunities to support a culture of health.		**Advocate for policies - Create or amend policies that support youth resiliency and decrease or mitigate factors that lead to substance use.**		**Educate - Continue to provide opioid overdose prevention and harm reduction education to those struggling with addiction, families, and medical providers in Greater Boston and provide substance use prevention education and early intervention, particularly around marijuana, vaping, and opioids to parents and youth.**
Population(s):		Community residents Community organizations		Community youth and families		People with substance use disorders Community youth and families
Potential New Resources		Philanthropy		• Philanthropy • Grants		Philanthropy
Current Initiatives:		• Healthy Chelsea Coalition • The Charlestown Coalition • EASTIE Coalition • Revere CARES Coalition		• Healthy Chelsea Coalition • The Charlestown Coalition • EASTIE Coalition • Revere CARES Coalition		• Healthy Chelsea Coalition • The Charlestown Coalition • Revere CARES Coalition • MGH Vaping initiative

		• SAPC Regional Grant • Boston Substance Use Prevention Collaborative		• MGH Vaping initiative • Boston Substance Use Prevention Collaborative		• EASTIE Coalition • Boston Substance Use Prevention Collaborative
Collaborations:		Multiple community and municipal agencies		Multiple community and municipal agencies		Multiple community and municipal agencies
Expected Outcomes:		• Increased resources received in the communities • Increased stakeholders involved • Increased policy or system changes		• Increased youth resiliency • Decreased substance use • Increased mental health indicators		• Reduction in opioid overdoses and deaths • Reduction in hospitalizations • Increase in treatment admissions
Data Sources:		Program Data		Youth Risk Behavioral Survey		Program Data Data from Mass DPH on opioid deaths, treatment admissions, hospitalizations
Objective 3: Reducing stigma for those with substance use disorder and support the MGH chronic disease management model of care that spans the continuum of care from inpatient to the community.						
		Strategy 1				**Strategy 2**
		Sustain and expand Substance Use Disorders initiative across the hospital and MGH health centers.				**Sustain and expand mobile addiction program, identify areas at high risk for overdose, provide harm reduction services and initiate MAT for people with SUDs.**
Population(s):		MGH patients with SUDS				Those with a substance use disorder on the streets with a focus on opioids
Potential New Resources		Philanthropy/grants				MA DPH RFP to spread to 2 to 3 additional communities
Current Initiatives:		• Mass General SUDs Initiative – ACT (inpatient), Bridge, Hope (pregnant and new moms), Primary Care SBIRT screening, SUDs screening in Behavioral Health, jails				Kraft Center for Community Health mobile addiction services van
Collaborations:		• City of Boston • Nashua Street Jail • Boston Health Care for the Homeless Program • South Bay House of Corrections				• Boston Health Care for the Homeless Program • Boston Public Health Commission's AHOPE Program • Grayken Center for Addiction Medicine at Boston Medical Center • GE Foundation • Bridge Over Troubled Waters • RIZE Massachusetts

				• MA Department of Public Health
Expected Outcomes:		• Decreased addiction severity • Reduction in length of stay and 30-day readmission to the hospital • Decreased overdose, particularly in the post-incarceration period		• Lower mortality from opioid overdose • More engaged in treatment • Harm reduction results in fewer medical complications of addiction
Data Sources:		Program Data		Program Data City & State Overdose Data

Accessing Services (Healthcare, Childcare, Social Services)

Rationale: Across focus groups, interviews, and surveys CHNA respondents expressed satisfaction with their health care; the Boston Behavioral Health Risk Factor Surveillance System (BRFSS) survey results show that 80% of respondents identify at least one personal doctor. Nevertheless, they described barriers to care including language, navigating the health care system, understanding health care benefits, transportation, a lack of culturally sensitive approaches to care, and immigration status. In particular, CHNA participants spoke about the fear in undocumented or mixed status families that prevent family members from seeking care. CHNA respondents also cited long wait times for appointments (44%) and a lack of evening and weekend services (38%) that limit access to health care.

Goal: Ensure all Mass General patients have access to coordinated and equitable health and family support services and resources to support overall health.				
Objective 1: Increase the capacity of health services to provide culturally and linguistically relevant care and expand access to those services.				
	Strategy 1	**Strategy 2**	**Strategy 3**	**Strategy 4**
	Increase the capacity of Mass General community health centers and other health care organizations to reduce barriers to care for patients through community health workers, navigators, and other outreach programs.	**Reduce barriers to timely cancer screening and follow-up cancer care through culturally appropriate navigation and innovative programs.**	**Support families with children up to age 5 to develop nurturing relationships and healthy child development.**	**Continue to work with Partners HealthCare Center for Population Health to support implementation of community health workers across the system to support patients in the Medicaid Accountable Care Organization.**
Population(s):	Patients with complex health and social needs	High-risk community health center patients who need cancer screening or care	Families with children under 5 with complex health and social needs	ACO patients with complex health and social needs
Potential New Resources	• Hospital Investment • Grants • Philanthropy • State and Federal Funding	• Hospital Investment • Philanthropy • Grants	• Hospital Investment • Philanthropy • Grants • State and Federal Funding	• Hospital and System Investment • Medicaid ACO
Current Initiatives:	• MGH Chelsea Community Health Improvement Team Programs	• Cancer Navigation Program • Trefler Program for Cancer Care Equity • Implementation Science Center for	• MGH Revere Healthy Steps • MGH Revere Parents as Teachers • MGH Chelsea Healthy Families America	• Partners CHW Collaborative • MGH CCHI and health centers

		• Revere & Chelsea School-Based Health Centers • MGH Community Health Associates • Boston HealthCare for the Homeless Program		Cancer Control Equity (ISCCCE) • Komen Foundation Cancer Navigation Program		• MGH Chelsea Healthy Steps • Healthy Chelsea Early Childhood Network	
Collaborations:		Numerous community organizations		• Harvard T.H. Chan School of Public Health • Massachusetts League of Community Health Centers • 31 community health centers across MA		• MA Department of Public Health • Healthy Families America • Raising a Reader • EMPATH • Chelsea/Revere Family Network	MA Department of Public Health
Expected Outcomes:		• Increased arrival rates to appointments • Increased medical compliance • Increased care coordination • Increased funding to deliver equitable, culturally relevant care		• Increased arrival rates to appointments • Increased timely cancer screenings • Increased early detection of cancer • Increased follow through in cancer care • Increased adoption of proven-effective interventions for cancer screening and prevention in community health settings • Increased equity in cancer care and outcomes		• Decreased child abuse and neglect • Increased parent-child attachment • Child(ren)achieving developmental milestones • Increased connection to care and community resources • Decreased maternal depression	• Number of CHWs • Number of trainings
Data Sources:		Program Data		Program Data		Program Data	Program Data

Objective 2: Assist older and disabled adults who live in three buildings near Mass General in Boston's West End and Beacon Hill in maintaining independence as they age in place by identifying social and health related needs and providing nursing, social work, and resource intervention.		
		Strategy 1
		Ensure seniors and disabled adults in three buildings near hospital have access to coordinated health and support services and resources to support overall health and age in place.
Population(s):		Low-income older and disabled adults who live in three local buildings
Potential New Resources		Cambridge Street DoN CHI
Current Initiatives:		Connect to Wellness, an outreach team of nurse, social worker, and resource specialist who spend a day a week in each building offering individual and group services
Collaborations:		Preservation of Affordable Housing, Rogerson Communities, HallKeen
Expected Outcomes:		• Reduced inappropriate utilization for MGH patients • Better chronic disease management • Connection to supportive benefits and resources • Preserve tenancy and build social connection
Data Sources:		Program Data

Community/ Intimate Partner Violence and Safety

Rationale: In Boston, community violence was the most frequently discussed type of violence in focus groups, namely in the neighborhoods of Dorchester, Mattapan, Roxbury, Chinatown, and East Boston. When Boston CHNA survey respondents were asked how safe they considered their neighborhoods to be, 25% described their neighborhood as unsafe or extremely unsafe. Twice as many respondents from Roxbury (50%), Mattapan (49%), and Dorchester (45%) described their neighborhood as unsafe or extremely unsafe. One in five Boston CHNA survey respondents described gunshots in the neighborhood (22%) and feeling unsafe when alone on the street at night (19%) as serious problems.

There is very little quantitative data available on interpersonal or domestic violence. In 2018, the Boston Police Department served a total of 1,921 restraining orders, ranging from 386 in Roxbury and 368 in Mattapan to 2 in Charlestown. However, it is well known that intimate partner violence is underreported.

Goal: Promote policies, systems, and programs to achieve safety in communities and homes.				
Objective 1: Reduce injuries and deaths related to violence and promote safety in the home and in the community through clinical care and education, community engagement, advocacy, and research.				
		Strategy 1		**Strategy 2**
		Provide intimate partner and community violence intervention programs to Mass General patients and community residents.		**Prevent firearm-related violence and promote safety in the homes and communities of the patients we serve.**
Population(s):		Patients experiencing intimate partners violence (IPV) and/or community violence		Patients and communities affected by gun violence
Potential New Resources		Philanthropy		Philanthropy
Current Initiatives:		• HAVEN, for those experiencing intimate partner violence • VIAP, for survivors of community violence • PACT, for child witnesses to violence		Center for Gun Violence Prevention
Collaborations:		• Boston Police Department • Chelsea Police Department • Many other community organizations		• Boston Police Department • Chelsea Police Department • Many other community organizations
Expected Outcomes:		• Increased access to resources • Increased arrival rates to appointments • Decreased trauma • Increased resiliency		• Increase in number of physicians and other health professionals trained in screening for weapon safety in the homes and counseling in gun safety
Data Sources:		Program Data		Program Data

Healthy Eating, Active Living, and Food Insecurity

Rationale: Access to fresh and affordable healthy food is a growing problem in some neighborhoods in Boston and North Suffolk communities, with lower income neighborhoods, most commonly communities of color, having few grocery stores and a high prevalence of fast food and convenience stores. Data indicate that nearly one in five Boston residents reported being food insecure, meaning that they ran out of food and funds to purchase more over the course of the month. Experiences with food insecurity varied by population group. In aggregated 2013, 2015, and 2017 BBRFSS data, Latino (39.1%) and Black (34.5%) residents were significantly more likely than White residents (10.7%) to report food insecurity as were foreign-born residents compared to U.S. born residents. Food insecurity and lack of access to fresh and affordable healthy food is associated with obesity. At the neighborhood level, the percent of adults in Mattapan (71%), Hyde Park (65%), Dorchester (63-65%), West Roxbury (64%), East Boston (63%), and Roslindale (63%) who were obese or overweight was significantly higher than the rest of Boston.

Goal: End hunger and reduce obesity in Boston and North Suffolk.				
Objective 1: Increase healthy eating and active living by advocating for systems changes, increasing opportunities for physical activity, and providing healthy food resources to patients and community residents.				
		Strategy 1		**Strategy 2**
		Support policy, systems, programs, and environmental changes to increase access to affordable, healthy foods and physical activity in communities and school environments.		**Screen for and provide resources to patients who are struggling with food insecurity.**
Population(s):		Community residents		Patients who are experiencing food insecurity
Potential New Resources		Philanthropy DoN CHI		Philanthropy Grants
Current Initiatives:		• Healthy Chelsea Initiatives: Holiday School Food Project, School Food partnership, Hunger Network, and advocacy work • Revere on the Move Farmers Markets and Food Economy work • Stay in Shape program to educate youth on healthy eating and active living • BOKS Program, physical activity before school		• MGH Chelsea Food for Families • MGH Chelsea Food Pantry • MGH Revere Food Pantry • First 1,000 Days • Shopping Matters • Stay in Shape
Collaborations:		• Cities of Chelsea and Revere • Greater Boston Food Bank • Chelsea public schools • Other community organizations		• Greater Boston Food Bank • Other community organizations
Expected Outcomes:		• Increased healthy eating, especially among youth • Increased physical activity		Decreased food insecurity
Data Sources		Program Data Youth Risk Behavior Survey		Program Data

Chronic Disease

Rationale: Data show that cancer, SUDS, asthma, diabetes, and other chronic diseases are drivers of mortality in Boston and North Suffolk communities. There are significant racial and ethnic disparities in these conditions that result in higher mortality rates. For example, the age-adjusted mortality rate per 100,000 is higher in Chelsea (963.8), Revere (734), and Winthrop (928.7) than the Massachusetts rate (668.9). Likewise, Charlestown (758.2), Dorchester (737), East Boston (759), Hyde Park (840.4), and Roxbury (769.9) are higher than Boston's age-adjusted mortality rate per 100,000 (702.5).

Goal: Design strategies and programs to help improve health outcomes for those with chronic disease.		
Objective 1: Ensure high-risk patients with chronic disease (Diabetes, HIV, Hep C, Asthma, SUDs) receive access to coordinated health and support services, assistance with social determinants, medications, and other resources to better manage their disease.		
		Strategy 1
		Improve the health of high-risk patients with chronic disease through culturally appropriate navigation, resources, and supports.
Population(s):		High-risk community health center patients with diabetes, asthma, SUDS, Hep C, HIV
Potential New Resources		• Hospital Investment • Philanthropy • State and Federal Funding
Current Initiatives:		• Comprehensive Community Health Workers • MGH Chelsea Pediatric Asthma Program • Hepatitis C Navigation Program • HIV/AIDS Medical Case Management Program • Diabetes CHW pilot • Mass General SUDs Initiative (see Behavioral Health) • Adult and Pediatric integrated Care Management Programs (iCMP) • Live Tobacco Free
Collaborations:		• City of Boston • Mass League of Community Health Centers • Many other organizations
Expected Outcomes:		• Increased arrival rates to appointments • Decreased disease burden • Increased medication adherence • Increased care coordination • SDOH's addressed
Data Sources:		Program Data

Current Mass General Programming by Priority Area

Current Program	Safe & Affordable Housing	Financial & Economic Stability and Mobility	Behavioral Health, including Mental Health and Substance Use	Access to Care	Community Violence & Safety	Obesity & Food Insecurity	Elder/Aging Issues	Chronic disease with cancer, diabetes focus
Boston Health Care for the Homeless Program (BHCHP) at MGH				✓				
Boston Substance Use Prevention Collaborative			✓	✓				
Cancer Navigation Program				✓			✓	✓
Charlestown Coalition			✓		✓			
Charlestown Family Support Circle		✓	✓	✓				
Charlestown Turn it Around Youth Group		✓	✓		✓			
Chelsea High School Based Health Center			✓	✓	✓	✓		
Chelsea Immigrant and Refugee School Program			✓	✓	✓			
Chelsea Teen Action Project Youth Group		✓	✓					
Chelsea Youth Food Movement		✓				✓		
Comprehensive Community Health Worker Program	✓	✓	✓	✓		✓	✓	✓
Connect to Wellness	✓			✓			✓	
EASTIE Coalition			✓	✓	✓			
Healthy Chelsea Coalition		✓	✓	✓	✓	✓		
Healthy Chelsea Early Childhood Network				✓				
Helping Abuse and Violence End Now (HAVEN)				✓	✓			
Hepatitis C Program			✓	✓				✓
Living Tobacco Free			✓	✓				✓

Current Program	Safe & Affordable Housing	Financial & Economic Stability and Mobility	Behavioral Health, including Mental Health and Substance Use	Access to Care	Community Violence & Safety	Obesity & Food Insecurity	Elder/Aging Issues	Chronic disease with cancer, diabetes focus
Mayor's Way Home Investment	✓							
MGH Chelsea Food for Families				✓		✓		
MGH Chelsea Health Starts at Home	✓	✓	✓	✓				
MGH Chelsea Healthy Steps Program				✓				
MGH Chelsea Healthy Families America	✓	✓	✓	✓	✓			
MGH Chelsea Legal Initiatives for Care (LINC)	✓	✓		✓				
MGH Chelsea Medical Interpreter and Community Health Workers				✓				
MGH Chelsea Pediatric Asthma Program				✓				✓
MGH Chelsea Police Action Counseling Team (PACT)				✓	✓			
MGH Chelsea Refugee Health Assessments			✓	✓				
MGH Vaping Initiative				✓				
MGH Youth Programs & Youth Scholars		✓	✓					
Office Based Addiction Treatment Program			✓	✓				✓
Revere Adolescent Health Initiative			✓	✓	✓	✓		
Revere CARES Coalition		✓	✓			✓		
Revere Family Planning Program				✓				
Revere Health Leadership Council		✓	✓					
Revere Healthy Steps for Young Children	✓	✓	✓	✓	✓	✓		

Current Program	Safe & Affordable Housing	Financial & Economic Stability and Mobility	Behavioral Health, including Mental Health and Substance Use	Access to Care	Community Violence & Safety	Obesity & Food Insecurity	Elder/Aging Issues	Chronic disease with cancer, diabetes focus
Revere High School Based Health Center			✓	✓	✓	✓		
Revere on the Move		✓				✓		
Revere Parents as Teachers	✓	✓	✓	✓	✓	✓		
Revere Power of Know Afterschool Clubs		✓	✓					
Revere Youth Zone			✓	✓		✓		
SAPC Regional Substance Abuse Prevention Collaborative			✓					
Stay in Shape Program			✓	✓	✓	✓		
Trefler Cancer Care Equity Program				✓			✓	✓
Violence Intervention Advocacy Program (VIAP)				✓	✓			

Collaborators

Name	Description	Communities
Accelerated College Experience (ACE)	Teaches students to take ownership of their academic experience by setting their own high standard of personal and academic excellence as measured by achieving a GPA of 3.0 or higher in college.	Greater Boston
Becoming a Man	Helps young men of color navigate difficult circumstances that threaten their future.	Boston
Boston Health Care for the Homeless Program	Provides or assures access to the highest quality health care for all homeless individuals and families in the Greater Boston area.	Greater Boston
Boston Private Industry Council (PIC)	An organization that strengthens Boston's communities and its workforce by connecting youth and adults with education and employment opportunities that align with the needs of area employers.	Boston
Boston Public Health Commission's AHOPE Program	City of Boston's harm reduction program offering needle exchange and naloxone education and distribution.	Boston
Boston's Way Home	A City of Boston initiative to end chronic homelessness.	Boston
Boys and Girls Clubs of Boston	Provides safe and affordable places for children and teens during out-of-school time.	Greater Boston
Bridge Over Troubled Waters	Provides effective and innovative services to runaway, homeless and high-risk youth, helps youth avoid a lifetime of dependency on social services, guides youth towards self-sufficiency, and enables youth to transform their lives and build fulfilling, meaningful futures.	State-wide
Budget Buddies	Provides financial coaching for women with low-income.	Greater Boston
Chelsea/Revere Family Network	A state funded child and family support program serving families with children from the prenatal stage up to eight (0-8) years old.	Chelsea, Revere
Chelsea Collaborative	Empowers residents to enhance the social and economic health of the community and its people; and to hold institutional decision makers accountable to the community.	Chelsea, Revere
Community Action Programs, Inter City (CAPIC)	A private, non-profit corporation designated to identify and eradicate the root causes of poverty in Chelsea, Revere and Winthrop.	Chelsea, Revere, Winthrop
Compass Working Capital	Provides financial coaching for people with low-income.	Greater Boston
CONNECT	CONNECT offers the services of five agencies working to improve the financial mobility of low-income families.	Chelsea, Revere
EMPATH	Provides financial coaching for people with low-income.	Greater Boston
GE Foundation	The philanthropic organization of GE committed to transforming communities and shaping the diverse workforce of tomorrow.	State-wide

Name	Description	Communities
Grayken Center for Addiction Medicine at Boston Medical Center	Offers innovative treatment, education, and research programs.	State-wide
Greater Boston Food Bank	The largest hunger-relief organization in New England and among the largest food banks in the country.	Greater Boston
HallKeen Management	Property management company for affordable multi-family, assisted living, and mixed-use properties	Greater Boston
Harvard Law School	Provides volunteer law students to fight discrimination through legal action, education, and advocacy.	Greater Boston
Harvard T.H. Chan School of Public Health	Brings together dedicated experts from many disciplines to educate new generations of global health leaders and produce powerful ideas that improve the lives and health of people everywhere.	State-wide
Healthy Families America	One of the leading family support and evidence-based home visiting programs in the United States. We believe early, nurturing relationships are the foundation for healthy development.	Nation-wide
Healthy Neighborhood Equity Fund	Provides capital and strategy to invest in affordable housing.	State-wide
Jewish Vocational Services (JVS)	Empowers individuals from diverse communities to find employment and build careers, while partnering with employers to hire, develop, and retain productive workforces.	Greater Boston
Lawyers for Civil Rights	Fosters equal opportunity and fights discrimination on behalf of people of color and immigrants through legal action, education, and advocacy.	State-wide
Local Initiatives Support Corporation (LISC)	Provides capital and strategy to invest in affordable housing.	Nation-wide
MA Department of Public Health	Promotes the health and well-being of all residents by ensuring access to high-quality public health and healthcare services, and by focusing on prevention, wellness, and health equity in all people.	State-wide
Mass League of Community Health Centers	Promotes population health equity for all through leadership and programs supporting community health centers and members in achieving their goals of accessible, quality, comprehensive, and community responsive health care.	State-wide
Massachusetts Department of Mental Health	The State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages; enabling them to live, work and participate in their communities.	State-wide
Massachusetts Public Health Association	A statewide membership organization that promotes a healthy Massachusetts through advocacy, education, community organizing, and coalition building.	State-wide
Nashua Street Jail	Jail located in Boston for pre-trial detainees.	Suffolk County

Name	Description	Communities
North Suffolk Mental health Association	Providing mental health services to individuals, and especially children, in relatively under-served communities.	Revere, Chelsea, Winthrop, Boston
Preservation of Affordable Housing	A national nonprofit organization whose mission is to preserve, create and sustain affordable, healthy homes that support economic security and access to opportunity for all.	Nation-wide
Raising a Reader	Helping families with children from birth to age eight develop, practice and maintain home literacy habits essential for school and life success.	Nation-wide
RIZE Massachusetts	An independent nonprofit foundation working to end the opioid epidemic in Massachusetts and reduce its devastating impact on people, communities, and economy.	State-wide
Rogerson Communities	Provides housing and health care for elders and low-income individuals and families.	Greater Boston
South Bay House of Corrections	A jail in Suffolk County.	Suffolk County
The Neighborhood Developers	A community development corporation that preserves and builds affordable housing and builds the social connectedness of residents.	Chelsea, Revere, Everett

MASSACHUSETTS GENERAL HOSPITAL

CENTER FOR COMMUNITY HEALTH IMPROVEMENT

Massachusetts General Hospital
Center for Community Health Improvement
101 Merrimac Street, Suite 620
Boston, MA 02114
Phone: 617-726-8197
Email: mghcchi@partners.org
https://www.massgeneral.org/community-health/cchi/