Community Health Needs Assessment & Implementation Strategy

October, 2015

Massachusetts General Hospital
Prepared by the Center for Community Health Improvement

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Executive Summary

MGH is committed to engaging in deep and transformative relationships with local communities to address the social determinants of health and increase access to high-quality health care. The MGH Center for Community Health Improvement (CCHI) conducted its first community health needs assessments (CHNA) in 1995 and has done so periodically in Revere, Chelsea and Charlestown, where MGH has had health centers for more than 40 years. As a result of these assessments conducted in partnership with local communities, we have made substantial progress on preventing and reducing substance use disorders, improving access to care for vulnerable populations, expanding opportunities for youth and more.

2015 Community Health Needs Assessment

2015 Community Involvement
1737 Quality of Life Surveys returned
123 individuals reached through 12 focus groups
More than 100 people attended community meetings

The 2015 CHNA is the second assessment since the Patient Protection and Affordable Care Act of 2010 required hospitals to conduct CHNA's every three years. The guidelines require diverse community participation to identify health priorities and develop strategic implementation plans. In the 2012 assessment, CCHI used a planning process called MAPP, Mobilizing for Action through Planning and Partnerships. This intensive process included several phases with extensive community outreach and engagement and primary data collection. The work of the community assessment committees in 2012 provided the strong foundation for 2015.

The 2015 CHNA included engaging new and existing community partners who collected and reviewed primary and secondary data. More than 2,000 people participated in this process. The goals of the 2015 CCHI CHNA were to:

1) Identify the health needs, assets and forces of change in Revere, Chelsea and Charlestown
2) Engage community members through the process
3) Gauge the communities' progress on addressing the 2012 CHNA priorities
4) Determine 2015 priorities and implementation strategy

Priorities & Strategies

Substance use and **public safety/crime and violence** remain the top two health issues for our communities, with 80% of survey respondents choosing substance use as their top health concern, up from 70% in 2012. **Obesity/poor diet and inactivity** continue to be important community priorities followed closely by **mental health** as an emerging health concern. **Education, the environment and housing**, all of which are social determinants of health, are also of concern for many residents. Many of these issues will be CCHI's priorities for the next few years.

To address these health issues, we will strengthen and focus our community coalition strategies to prevent and reduce substance use, improve healthy eating and active living and reduce the effects of trauma and violence. We will work to screen patients for food and housing insecurity and strengthen our community health worker model to improve access to care and help those most in need. Finally, we will broaden the horizons of and promote educational attainment for youth through strengthening and expanding our Science, Technology, Engineering, and Math (STEM) programs.

MGH: A Tradition of Caring

Massachusetts General Hospital (MGH) has a long legacy of caring for the underserved in the local community. Founded in 1811 to care for the "sick poor," today that commitment is demonstrated through caring for all regardless of ability to pay, supporting three community health centers for more than 40 years and a comprehensive approach to addressing social determinants of health. MGH Trustees affirmed this commitment in 2007 by expanding the hospital's mission to include "…improve the health and well-being of the diverse communities we serve."

MGH recognizes that access to high-quality health care is necessary, but by no means sufficient to improving health status. We must also engage in deep and transformative relationships with local communities to address the social determinants of health. Thus, MGH created the Center for Community Health Improvement (CCHI) in 1995, with the mission of collaborating with communities to achieve measurable, sustainable improvements to key indicators of the community's health and well-being. Since 1995 MGH has partnered with the low-income neighboring communities of Revere, Chelsea and Charlestown to identify and make measurable improvements in health. We have done this by routinely conducting health needs assessments in these communities. We convene leaders of local government, public health, schools, police, community-based nonprofits, faith-based organizations, community development corporations, and community residents. Today, our work is focused on addressing social determinants of health along the Health Impact Pyramid developed by the U.S. Centers for Disease Control & Prevention, using the following three approaches.

- ***Building and Sustaining Multi-Sector Coalitions to Change Policies and Systems***
- ***STEM: Developing the Assets of Youth***
- ***Addressing Social Determinants/Improving Access to Care for Vulnerable Populations***

Our investment in this work runs deep. MGH invests more than $15 million in community programs, not accounting for the new substance use disorder initiative (annualized at about $2 million) or the contributions of clinical departments. In total and according to the Massachusetts Attorney General's definition, MGH's investment in community benefits is 5.4% of patient care related expenses. An additional $2 million in grants and gifts is also raised to supplement, never supplant, our ongoing investment to the community. The investment of MGH has leveraged millions in federal and state grants into communities; police, schools, fire departments, housing authorities, mental health providers and others have all received grants as a result of their engagement in the community coalitions. The work is designed to build community capacity and leadership and to change policies and systems, all of which lead to sustainability.

Progress to Date on 2012 CHNA Implementation Plan

Community Initiatives

CCHI is the "backbone organization" using a "collective impact" (*Stanford Social Innovation Review*) framework for four multi-sector coalitions that seek to prevent and reduce substance use and obesity. This means we act as convener and provide staff, best practices, evaluation support and access to a range of additional resources. As example, our Revere CARES Coalition, founded in 1997, has engaged city leaders, police, schools, parents, health and human service providers,

youth, and many more in advocating for policies and systems that build protective factors and reduce risk factors for unhealthy behaviors, including substance use and healthy eating/active living. Similar approaches are used by the Charlestown Substance Abuse Coalition and the Healthy Chelsea Coalition which employ multiple strategies in multiple domains to change social norms and attitudes.

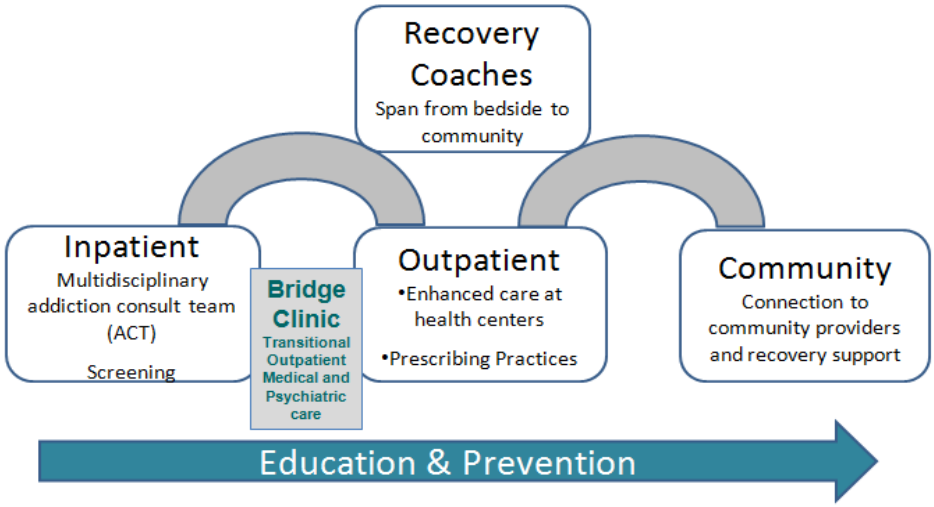
Among the coalitions accomplishments are: after-school programs to provide positive alternative activities; successful advocacy before the liquor licensing commission to limit licenses; social marketing campaigns and parent pledge drive (the Power of KNOW – Know where your kids are going, with whom, when they will be home, etc); successfully advocating for artificial trans fat bans, walking and bike trails, community gardens, farmers' markets, Complete Streets, Safe Routes to Schools and more.

As a result of the 2012 assessment, the MGH leveraged this approach to collaborate with new community partners and individuals to address the priorities identified in each community. Some of the new collaborations that were promoted and developed include:

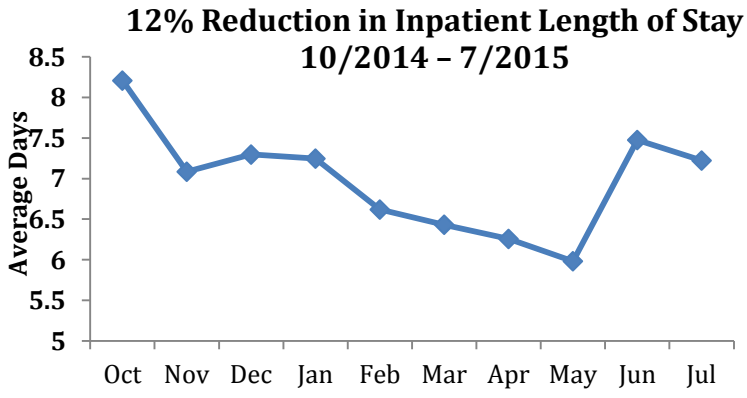
- A "Family Support Circle" to provide support to families and enhance communication and collaboration among Charlestown providers;
- CAPE/CHANGE, a partnership with Whole Foods of Charlestown; Kids Cooking Green; the Kennedy Center, the local anti-poverty agency; and the Charlestown YMCA to promote and improve health, fitness and quality of life and to reduce chronic disease risk through the consumption of healthy diets and daily physical activity;
- Boston Housing Authority Charlestown Adult Education (CAEP), Mishawum & CharlesNewtown Housing, Smart from the Start and the Charlestown Substance Abuse Coalition partnered to develop a culture of life-long learning by providing high quality high school equivalency preparation and ESOL classes and by facilitating college and career readiness skills. In 2015, 19 of 25 students in the FastTrack class passed their HiSET exams, and eight students obtained employment;
- Chelsea Leadership Team formed to respond to substance use disorders and worked to improve public safety through neighborhood revitalization, increasing access to care and education. The team engaged in neighborhood revitalization efforts to improve public safety, and provided education to the community through Narcan trainings and distribution.
- Revere's Healthy Relationships Task Force formed to address individual and family violence identified in the assessment. The task force worked with Revere Youth in Action and released a comprehensive report on status and needs in Revere regarding out-of-school activities.

Hospital Initiative

Since all communities identified substance use, including opioids, prescription drugs and heroin, as their number one issue, CCHI redoubled its community-based prevention efforts and **MGH launched a new clinical initiative on substance use disorders (SUDS)**. This initiative became the leading clinical priority in the most recent hospital strategic plan, the first time MGH's clinical priorities were community driven. This comprehensive new initiative was developed jointly by the Population Health Management and Community Health strategic planning committees, to transform the design of clinical care for patients with substance use disorders. The plan's goal is to advance care from treatment of the acute medical complications of substance use to management of the chronic disease of addiction, in much the same way that other chronic conditions like diabetes and hypertension are managed. This model includes recovery coaches, a specialized inpatient consultation team, outpatient services and connection to community supports. This change in the system of care marks the first time that MGH is addressing an issue along all levels of the Health Impact Pyramid--from primary community-based prevention, to early intervention and treatment, to chronic disease management. This was a milestone in integrating community health and clinical care. As we improve community health, MGH is working to transform hospital culture.



Preliminary findings of this initiative are promising. Since October, 2014, there has been a 12% reduction in average length of stay for patients receiving a consult.



Community Health Needs Assessment

Objectives

In 2015, CCHI planned and implemented a community health needs assessment (CHNA) in the cities of Revere and Chelsea and the Boston neighborhood of Charlestown using a participatory, collaborative approach. Assessing a community's health needs is an important step in helping communities mobilize to address health issues. CCHI conducted its first CHNA in these communities in 1995, which established the foundation of its work. CCHI has long-standing commitments to address complex health problems identified through community health data.

The goals of the 2015 CCHI CHNA were to:

1. Identify the health needs, assets and forces of change in Revere, Chelsea and Charlestown
2. Engage community members through the process
3. Gauge the communities progress on addressing the 2012 CHNA priorities
4. Determine 2015 priorities and implementation strategy

Target Population

In line with our community commitments and per the IRS Community Health Needs Assessment regulation, MGH addresses the health needs of the area's most underserved populations.

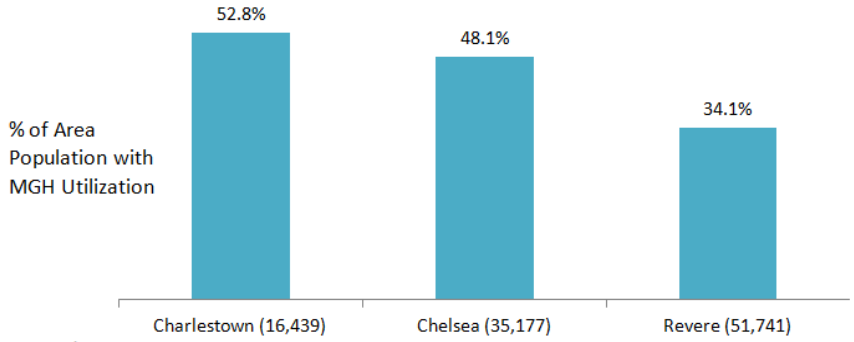
Population Characteristics

	Chelsea	Revere	Charlestown	Massachusetts
Population	36,168 62% Hispanic	52,588 25% Hispanic	17,454 7.7% Hispanic	6.6 mil. 9.6% Hispanic
Per Capita Income	$19,246	$24,873	$54,971	$35,763
Children living below 100% poverty	33.7%	22.5%	46%	14.9%
Those living below 100% poverty	23.7%	25.4%	19%	11.4%
High School Graduation Rate	58%	77%	66%	84%
Percent Population Age 5+ with Limited English Proficiency	53%	22.6%	11.5%	8.9%
Foreign born	43%	31%	17%	15%

Data Source: 2010 US Census Bureau, US Department of Education EdFacts

The focus on the communities of Revere, Chelsea and Charlestown aligns with the established MGH health centers located in each of these communities, which provide comprehensive primary and specialty care to more than 63,000 primarily low-income individuals and families annually. These patients make up much of MGH's most vulnerable populations that include non-English speaking residents and low-income families.

Percent of Community with FY14 MGH Utilization



Area (Census 2010 Pop.)			
# Patients from Area Zip Code	8,688	16,903	17,636
% Pedi Pts	21.8%	37.2%	25.7%
% of All MGH Pts	2.2%	4.3%	4.5%

Data Source: Denominators based on Census 2010 population counts and MGH utilization based on EPSi inpatient and outpatient data for FY14.

The primary barriers to care for the region are language, health insurance status, and poverty. The region has had rapidly changing shifts in population with the influx of non-English speaking individuals and families, which has challenged the health systems capacity to serve patients.

Assessment Process

The 2015 CHNA was the second assessment process conducted since the Patient Protection and Affordable Care Act began requiring hospitals to conduct CHNA's every three years. The guidelines require diverse community participation with the goal of identifying health priorities and developing strategic implementation plans. In 2012, CCHI successfully conducted the CHNA using MAPP, Mobilizing for Action through Planning and Partnerships, an assessment and strategic planning process. It was an intensive 10-month process that included several phases with extensive community outreach and engagement and primary data collection. The work of the community assessment committees in the 2012 CHNA provided the strong foundation of community engagement for future assessments and participation in CCHI's community coalitions.

The 2015 CHNA included engaging new and existing community partners and committee members through two community assessment meetings in each community. The committee meetings were well attended, and considerable effort was made to re-engage 2012 participants and outreach to new community partners. More than 100 individuals participated across the six meetings in the three communities. Committee members represented multiple sectors in the community, such as local government, police, schools, religious organizations, volunteer organizations and social service agencies. Approximately 30 individuals were present at each meeting to provide input and interpretation of data.

Primary data collection consisted of the administration of the Quality of Life survey, a tool within MAPP, focus groups targeting populations less likely to respond to surveys, and a review of available public health and hospital data. See the timeline below describing the community engagement and data collection periods. The following sections describe the CHNA process in more detail.

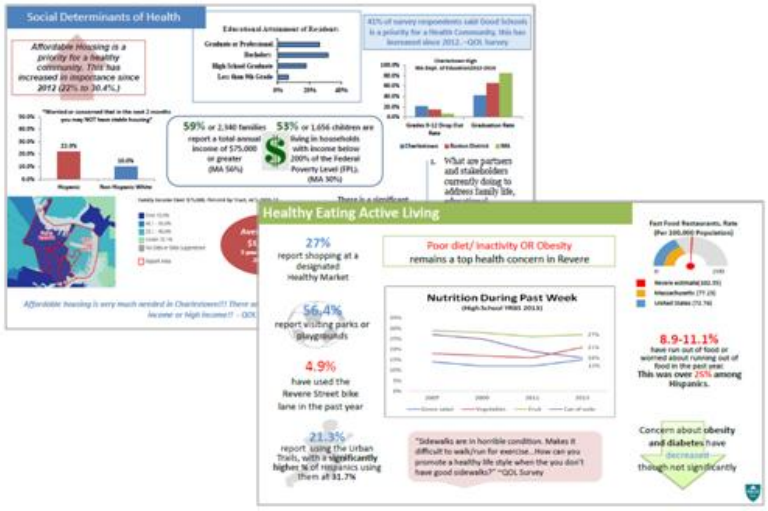
2015 CHNA Timetable (All Communities) Activity	Months
Re-engaged assessment committee members and recruited new members	Nov – Dec. 2015
Convened Assessment Meeting 1	January 2015
Quality of Life Survey Distributed	Feb - April 2015
Quality of Life Survey Analyzed	May - June 2015
Focus Groups Conducted	May - June 2015
Focus Group Data Analyzed	July 2015
Public Health Data Updated	Jan - June 2015
Convened Assessment Meeting 2	July - Aug 2015
Committees/Coalitions Work Plan Development	July - Oct 2015
MGH Board of Trustees Reviews & Approves CHNA and Hospital Response	September 18, 2015

CCHI employed a strong community participatory approach, consistent with past community assessments and the Center's guiding principles. Community assessment meetings were convened with the support of CCHI's local community coalitions and community partners. At the first of two assessment meetings, the group reviewed the 2012 CHNA process and progress made by the community, and provided extensive input on the methods for the 2015 CHNA. For example, the community assessment committees determined the distribution plan for the Quality of Life survey and identified the groups/populations to participate in the focus groups.

CCHI analyzed all of the data and presented this at the second assessment committee meeting. Participants identified priorities and discussed how or if they were addressed, what additional resources, if any, were needed, and recommended strategies for the future. The MGH Board of Trustees approved the CHNA on September 18, 2015. An overview of methodology used for this assessment is below. For more detailed information, including samples of the tools used and analysis, please contact CCHI at cchieval@partners.org.

Methodology

1. **Community Assessment Committee Participation/Contribution**: As described above, the community assessment committees guided the assessment process. During two meetings in each community, they provided important guidance on assessment methods and first hand data on community conditions, assets and the forces of change that affect health. The committee members provided important data interpretation by reviewing the data in round-table groups using community-specific data "placemats" *(see exhibit).* Data placemats are a tool to communicate with stakeholders the key data themes and engage them in data interpretation (Pankaj, Veena**.** (October 2014). "Data Placemats: A DataViz Technique to Improve Stakeholder Understanding of Evaluation Results." Paper presented at the American Evaluation Association Annual Conference, Denver, CO).



2. **Quality of Life Survey**: The anonymous survey assessed community perceptions of quality of life, health problems in the community, safety, community changes and demographic information (including perceptions of personal health, food and housing stability, gambling activity, and utilization of select local resources). The survey was translated into Spanish, Arabic, and Cantonese, and was distributed widely via the web and in-person within each community. A total of 2,015 individuals across Revere Chelsea, and Charlestown responded to the survey. After cleaning the data, an average of 86% of the responses were useable, yielding 1,737surveys.
3. **Focus Groups**: Twelve focus groups engaged individuals underrepresented in the survey response. The groups were co-facilitated by CCHI evaluators and local coalition staff. There were a total of 123 participants (42 in Charlestown, 54 in Revere, 27 in Chelsea) who participated in a one-hour session and received $20 gift card as compensation for their time. Focus groups were conducted in English, Spanish and Arabic (with the help of an interpreter).
4. **Public Health Data**: Public health data were gathered from the U.S. Census, MA Department of Education, Boston Public Health Commission, MA Department of Public Health, local police departments and community-based organizations.
5. **MGH Patient Data**: Aggregate patient data was pulled by zip code and analyzed to better understand the needs of patients who live in Revere, Chelsea and Charlestown. Once the community health priorities were identified from other data sources, data were reviewed to determine the prevalence of these health issues within MGH's patient population. This analysis confirmed that community perception was consistent with disease prevalence in the health center's patient population.

Limitations

As with all field research, there are several data limitations to report. This assessment sought to obtain diverse participation in the community. Every effort was made to ensure broad distribution of the Quality of Life survey so that all groups in the community were well represented. The majority of survey respondents were white females despite this community outreach. However, there was a sufficient sample within each community to allow for analysis by sub-groups (e.g. male vs. female, Hispanic/Latino). Focus groups were conducted in the communities to obtain the perspectives of youth, parents and non-English speakers. Lastly, the data shared on the data placemats with the community assessment committee consisted of preliminary data organized by common themes determined by the CCHI evaluation and research team. The data placemats were used to generate discussion, which furthered the understanding of the conditions in the community. Finally, availability of data for Charlestown, which is a neighborhood of the City of Boston, is different than that for Revere and Chelsea which are independent municipalities.

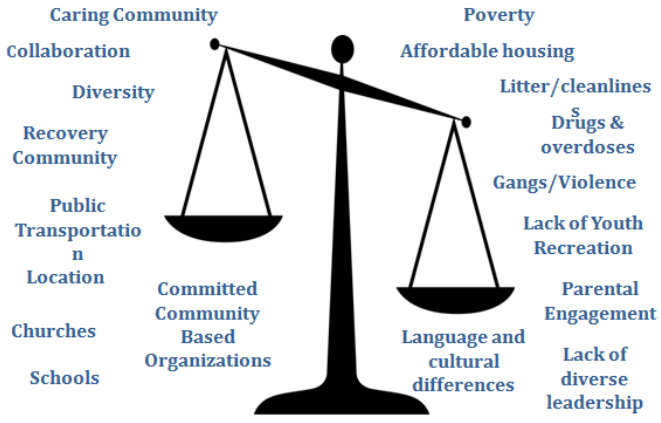
Key Findings

Community Assets, Challenges, Forces of Change & Perceptions of Health

In meetings and focus groups, communities discussed their strengths and assets, challenges, forces of change that affect public health (also called threats and opportunities) and defined the characteristics of a healthy community. In addition, community member perceptions of their community's health - current and future - also were assessed through discussion and the Quality of Life Survey. This information was important to consider in developing a common vision with committee members and in identifying obstacles or positive forces in the community and region that might impact change. This information was gathered primarily through guided discussions during community assessment committee meetings.

Community Assets & Challenges

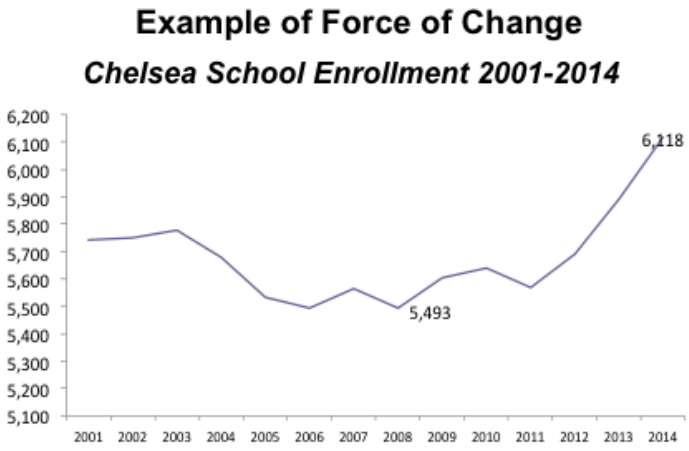
Primary Data Sources: Assessment Committees, Focus Group



Assessment Committee members and focus group participants had many positive things to say about their communities. Communities named diversity, culture, dedicated and compassionate people, committed community-based organizations, collaboration, location, public transportation, churches and schools as some of the positive attributes. The primary perceived challenges within communities included poverty, affordable housing, drug use and overdose, violence and gangs, parental engagement, lack of youth recreational activities, cleanliness of the environment, and lack of diversity in leadership. Understanding both the assets and challenges of each community was essential to developing sustainable solutions.

Forces of Change that Affect Health (Threats and Opportunities)

Primary Data Source: Assessment Committees



The forces of change are external influences occurring locally or nationally that impact the promotion and protection of the public's health. Assessment committee members were asked, "What is occurring or might occur that affects the health of your community?", and a list of threats and opportunities were identified. These issues were important to identify and discuss to select priorities and strategies that are responsive and relevant to the changing environment.

Several common forces of change across the communities were identified. The most frequently mentioned include the cost of housing, the influx of new immigrants, gentrification, local development including the planned casino in the neighboring community of Everett, the promotion and availability of new nicotine delivery devices (i.e. electronic cigarettes), the changes in laws and increased access to marijuana (e.g. decriminalization, medicinal marijuana) and changing leadership in the communities and region.

Characteristics of a Healthy Community

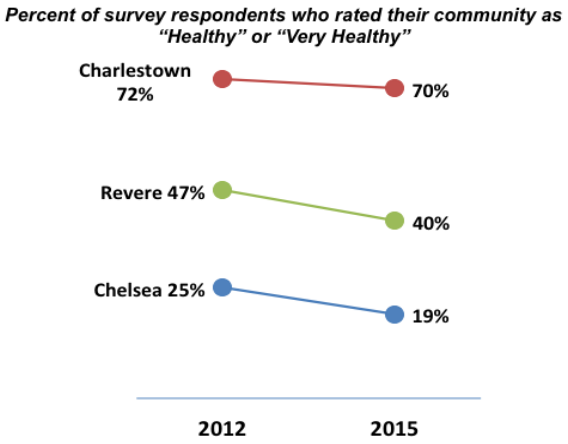
Primary Data Sources: Quality of Life Survey, Focus Groups

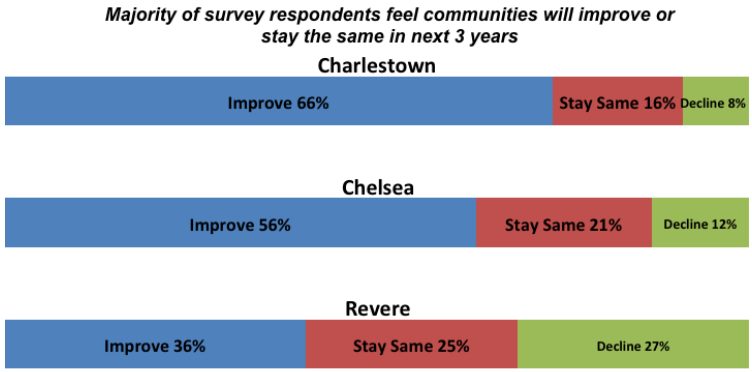
Similar to the 2012 assessment findings, residents told us that low crime/safe neighborhoods, good schools and access to health care were among the top characteristics that make a healthy community. In 2015, this list expanded to include good jobs/healthy economy, clean environment (particularly in Revere) and affordable housing (particularly in Charlestown). These themes also came through in the focus groups. Many spoke about the desire to have the streets cleaned of debris, well paying jobs and jobs/opportunities for youth. These social determinants were important to all, but were significantly more important to Latinos within the three communities. These attributes help define each community's vision and shaped their goals.

Rating the Current & Future Health of the Community

Data Source: Quality of Life Survey

While 2015 survey respondents perceive their communities as less healthy than in 2012, the majority of respondents feel that their community will improve or stay the same in the next three years (new question in 2015).



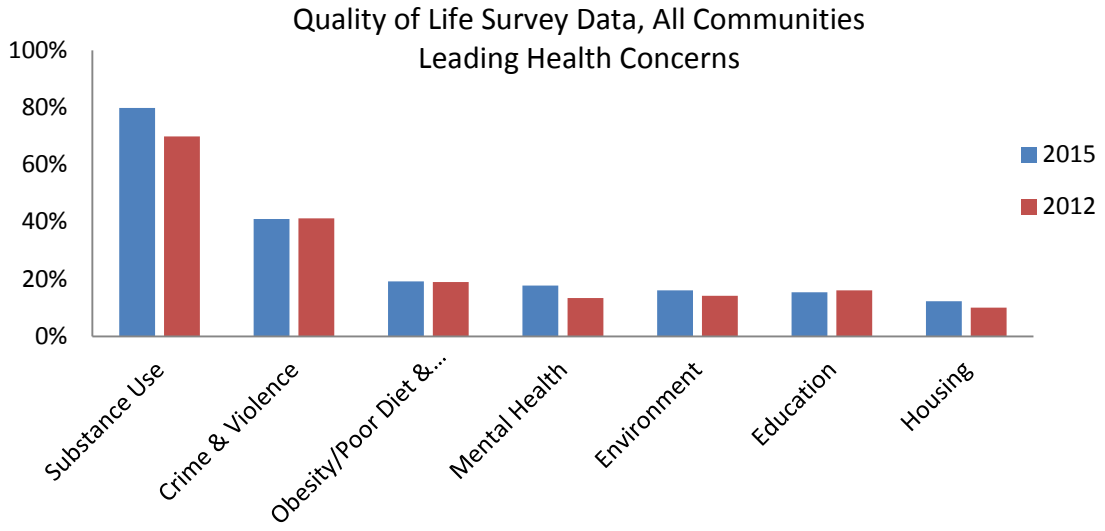


Criteria for Prioritization of Themes

Communities came together to analyze the data and determine priorities that were most relevant. Primary data along with updated secondary data were used to decide if communities were headed in the right direction from the 2012 assessment and if there were any emerging unaddressed health needs.

Priorities were based on 1) community need; 2) potential for impact; 3) community interest, will and readiness, and; 4) resources.

Community Defined Priorities



According to Quality of Life Survey data that asks respondents to identify the top three health issues of concern, substance use and public safety/crime and violence remain the top two perceived health issues for our communities. Substance use has risen significantly in importance, with 80% of survey respondents choosing this as a top health concern in 2015 compared to 70% in 2012. Crime and violence are perceived similarly to 2012. Obesity/poor diet and inactivity remain on the radar; however they have decreased in importance in some communities compared to the 2012 survey.

Concern about mental health has increased significantly in all three communities since 2012, and is significantly more important to females in Revere and Chelsea. Of almost equal concern to community members are education, the environment and housing, all of which are social determinants of health.

It is important to mention that 6.6 % of community members report homelessness as a health concern, an increase since 2012. Additionally, both housing and food insecurity have increased in importance, particularly for the Latino population. Although not seen in the chart above, cancer was also a concern for many Charlestown residents (13% of respondents indicated a top health concern).

Data from the Massachusetts Department of Public Health and the Youth Risk Behavior Survey (YRBS), confirm the prevalence of these important health issues. New emphasis needs to be placed on the mental health needs of residents as well as making sure everyone has the basic necessities of food and shelter.

Substance Use Disorders

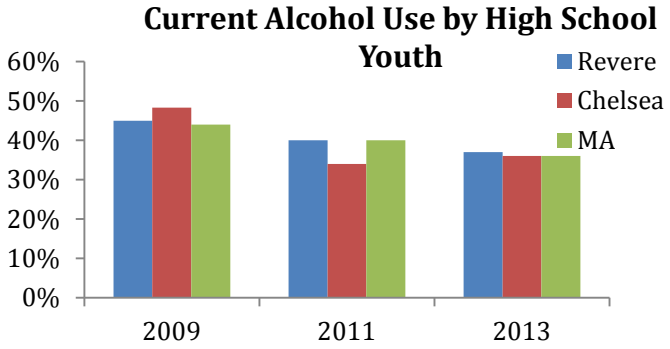
Eighty percent of survey respondents who live and work in these communities believe substance use disorders, consisting of alcohol or drug use, addiction and overdose, is the most important health problem facing their community. This has increased significantly since 2012, and is largely due to the increase in opioid use and heroin overdoses and deaths that have plagued these communities.

There are many complications and risk factors associated with substance use disorders (SUD) that affect the health of individuals and communities. A SUD is a medical condition with significant physical, behavioral, and psychosocial effects. Excessive substance use can cause health problems such as liver disease, heart disease and lung disease to name a few, as well as depression, suicide, unsafe sexual behavior and violence. According to the National Institute on Drug Abuse, prolonged drug abuse changes the brain in fundamental ways that reinforce drug taking and leads to addiction, making this a disease, not a behavior that can be cured with willpower alone. Below are some data to elucidate these findings and emerging trends in drug use.

New Nicotine Devices: The rates of tobacco use have been declining nationally and in these communities, but there has been an increase in both the concern and usage of new nicotine delivery and smoking simulating devices (i.e. e-cigarettes, e-Hookas, vaping pens) that are widely available and often marketed to youth. These devices allow young people to smoke substances more discreetly. Right now these devices are unregulated for manufacturing, product standards and marketing by the federal government. The U.S. Food and Drug Administration recently

proposed rules that would ban the sale of e-cigarettes to anyone under age 18. According to a CDC survey, the smoking of e-cigarettes by high school students overall, tripled to 4.5% in 2013 from 1.5% in 2011. A recent CDC study also found that more than a quarter million adolescents and teens who had never smoked traditional cigarettes used an electronic cigarette in 2013, a threefold increase from 2011. Local data on e-cigarette use is not available. According to focus group participants, however, these devices are perceived to be less harmful than cigarettes, despite any conclusive research data. Revere and Chelsea youth, in particular, report that they are being more widely used. E-Hookahs (colored stick-type vaping pens) are reported be popular among youth and students report seeing these used in school (easy to conceal, no smell).

***Alcohol Usage*:** Alcohol remains the most widely used drug by youth with many youth using before age 13, and many likely to binge drink. The immediate effects of alcohol misuse/abuse include unintentional injuries, violence and risky sexual behaviors as well as alcohol poisoning and death. According to the high school Youth Risk Behavior Survey, 20% of Revere and 23% of Chelsea youth report using alcohol before the age 13. Similarly, between 20% and 22% of youth report current binge drinking. Although current alcohol use has been declining over time, more than two-thirds of youth report current alcohol use.



Alcohol in general still remains a concern for the community with 39% of Quality of Life survey respondents reporting it as a health concern. In Chelsea 40% of Latinos report alcohol abuse/addiction as a problem significantly more than the White Non-Hispanic respondents at 28%.

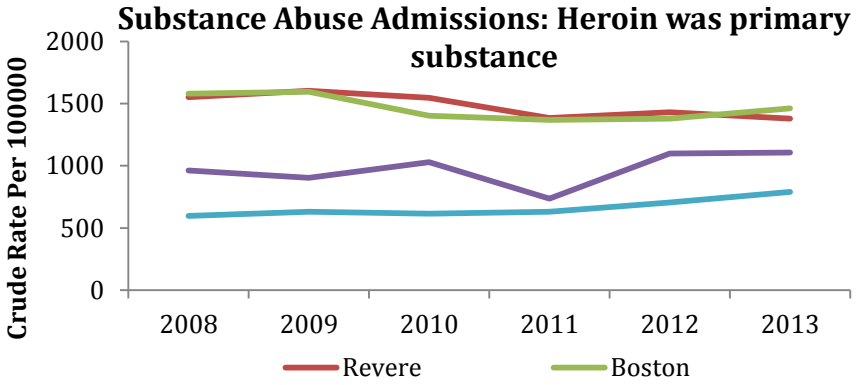
Increase in Marijuana Use Associated with Change in Law: In 2012, the mean age of first marijuana use was 12.8 years in Massachusetts. In Charlestown 5% of middle school youth report using marijuana with the average age of onset as 11.8 years. Revere and Chelsea report 9% and 13.5% using marijuana before age 13. Most focus group participants (particularly youth) agreed that marijuana is a problem in the community and very popular among teens. Teens perceive that "everybody's doing it", it is easy to get, it is affordable and many perceive that it is healthier than cigarettes, suggesting that "at least marijuana doesn't kill you". In Chelsea alone close to 50% of youth report being offered, sold or given marijuana in the past year. The decriminalization of marijuana in the Commonwealth and the establishment of medical marijuana dispensaries throughout the state send confusing messages to youth. Many think marijuana is legal and/or beneficial to use as it may help with ailments, despite research demonstrating marijuana's significant impact on brain development for youth.

"*There's no way to stop it. Maybe, but not really. It's a choice." – Teen perspective on marijuana use*

Prescription Drug Misuse & Heroin Use: The number of high school youth who report using prescription drugs for recreational purposes is on the rise. According to the 2013 Youth Risk Behavior Survey, 12% of Chelsea High School students (females13.8%; males 10.4%) reported taking drugs without a doctor's prescription in the past 30 days, which is considerably higher than the state rate of 3%. Also from the Chelsea High School 2013 YRBS, 7.5% of students (3.3% in 2011 and 2.8% in 2010) reported using opiates for the first time before age 13, with 8% reporting Oxycontin or heroin use during the past 30 days. Prescription drug misuse, including opioids, benzodiazepines, heroin, is of epidemic proportions.. Prescription drug misuse and overdose and heroin use were identified as a large problem in Chelsea, Revere and Charlestown, and participants reported that obtaining prescription drugs from friends, family, and on the street was easy.

Teen focus group participants explained that teens use substances to cope with problems and stress, because their peers use, to feel cool, for fun or that they use it out of boredom. To prevent substance use, youth expressed wanting more activities afterschool and on weekends, recreational facilities, and job and mentoring opportunities.

Adult Heroin Use: Department of Public Health data show that these communities have higher substance-related hospital discharge and treatment rates for heroin use compared to the state. This is in large part due to the rise of prescription drug misuse (misuse of medications that are used to relieve moderate to severe pain, such as Morphine, Oxycontin and Vicodin) and heroin use.



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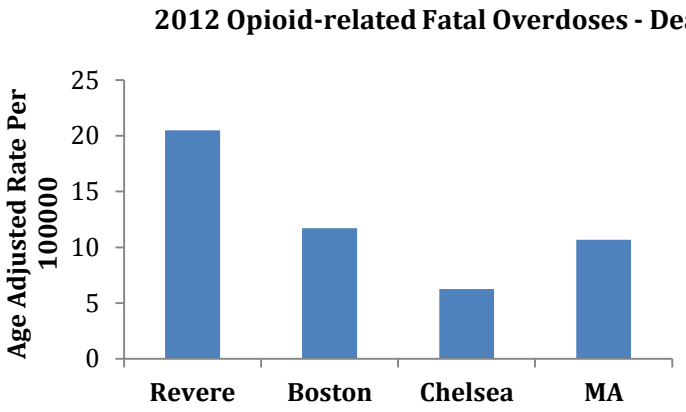
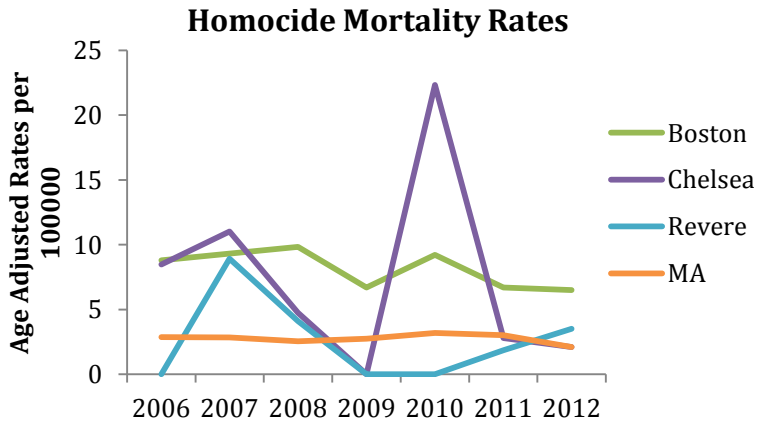
Higher usage has led to more overdoses and overdose deaths within the state. According to a 2015 Massachusetts Department of Public Health report, the rate of unintentional opioid-related overdose deaths, which includes deaths related to heroin, reached the highest levels in 2013 at 14.5 deaths per 100,000 residents representing a 273% increase from the rate of 5.3 deaths per 100,000 residents in 2000. Department of Public Health fatal and non-fatal opioid overdose data describes this population as predominantly white males between the ages of 25-64.
Opioid use and resulting deaths are a serious problem in Revere, Chelsea and Charlestown and the effects are being felt by residents both young and old. In 2014 Chelsea reported 68 overdoses in the city. From January to July of 2015 this number has been surpassed with 98 reported overdoses. Revere and Charlestown have also seen increases in both overdoses and related death. Revere reports a 20% increase in overdoses deaths from 2003 to 2013. The Massachusetts Department of Public Health has been a national leader in by implementing cutting-edge

prevention/intervention strategies. Revere and Chelsea have participated in these efforts through the MassCALL2 and Massachusetts Opioid Abuse Prevention Collaborative Grants and the Charlestown Substance Abuse Coalition is using similar strategies within this neighborhood.



Violence & Public Safety

Forty-one percent of survey respondents perceive crime and violence as an issue in their communities. This issue was discussed extensively in focus groups, and many residents reported feeling unsafe due to the violence that they see and hear about. Both adult and youth focus group participants in all communities reported seeing or hearing about physical fights occurring in public places. Focus group participants also mentioned specific areas where they feel unsafe, particularly at night. Other types of crime that were worrisome amongst participants were gang violence, domestic violence, theft and bullying. Crime and violence is of particular concern in Chelsea. According to both state and national crime data, Chelsea is considered one of the most violent communities in the state. According to 2013 Youth Risk Behavior Survey, many youth are taking part in physical fights and many feel unsafe even at school. Thirty percent of Revere and 24.3% of Chelsea high school youth report being in a physical fight one or more times in the past year. This number has almost doubled from 2011 in Chelsea. In addition 7% of Revere and 10% of Chelsea youth report skipping school in the past month because they felt unsafe compared to the state rate of 4%.

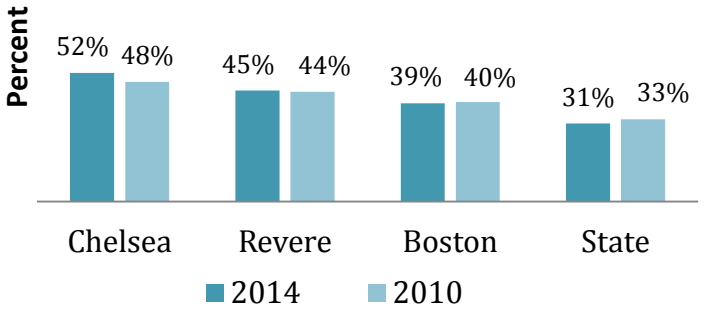


Gang violence has gained more attention in the last year, particularly within Charlestown and Chelsea, although present in Revere. Solutions to these issues suggested in the focus groups included more policing, better lighting on the streets, community watches, programming to teach conflict resolution, youth mentoring programs, and parent education/engagement in communicating with their kids.

Healthy Eating Active Living

Nineteen percent of survey respondents reported obesity or diet and/or inactivity as a concern. Although coalitions in Chelsea and Charlestown have made significant progress to change the food and physical environments so that healthy choices about eating and active living are easier to make, there is still work to be done. The percent of overweight and obese children in both Revere and Chelsea is still higher than the state and nation, with close to half of youth being overweight and obese. Both the short term and long term effects of overweight and obesity on health are of concern because of the negative psychological and health consequences (ex. heart disease, diabetes, asthma, and depression).

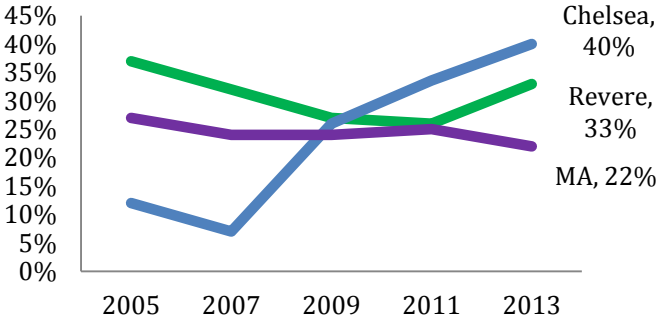
Overweight and Obese Students in Grades 1, 4, 7 and 10



Mental Health

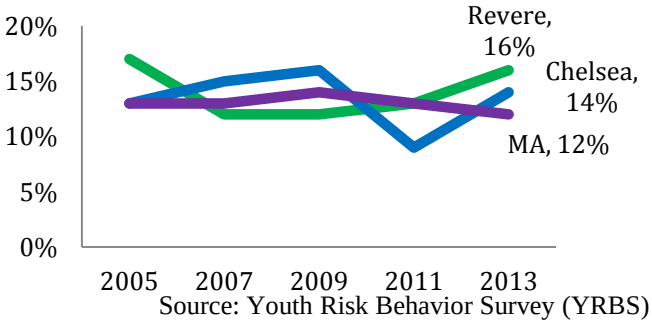
Concerns about mental health have increased significantly since 2012 with more survey respondents reporting it as a health concern. Data from the Youth Risk Behavior Survey reveal that youth are struggling. According to the 2013 High School Youth Risk Behavior Survey, more than one- third of youth from Chelsea and Revere reported feeling sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities, an indicator for depression. Although not shown in the graph below 30% of Boston youth report feeling depressed. Additionally, between 14% and 16% of youth reported that they considered suicide in the past 12 months compared to the state rate of 12%. Thirteen percent of Boston youth report considering suicide.

Revere & Chelsea Youth Report Higher Rates of Depression than the State



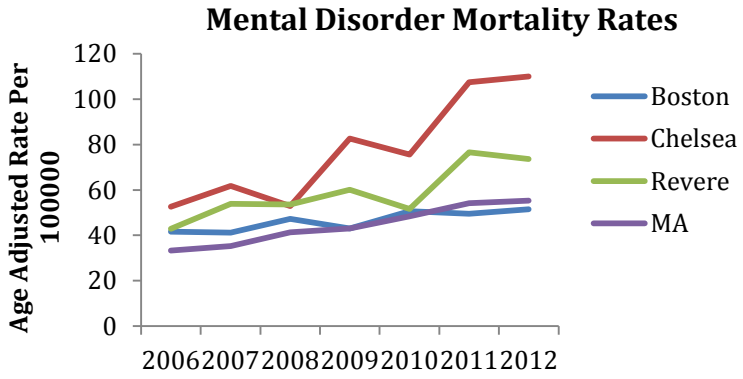
Source: High School Youth Risk Behavior Survey (YRBS)

Revere & Chelsea Youth Report Considering Suicide at Rates Higher than State



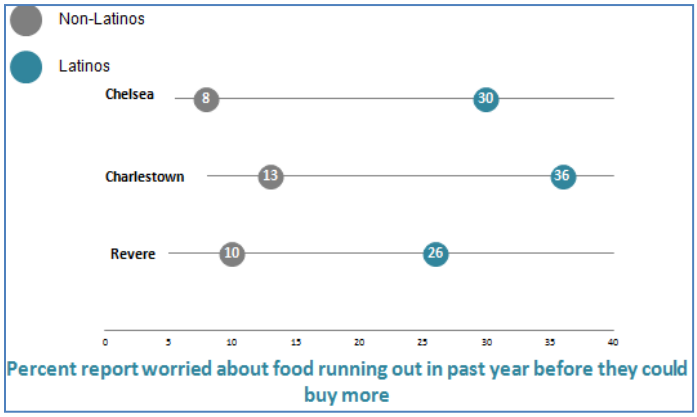
Source: Youth Risk Behavior Survey (YRBS)

Mental health is prevalent in both youth and adults and has resulted in elevated hospitalization and mortality rates in Revere and Chelsea compared to the state.

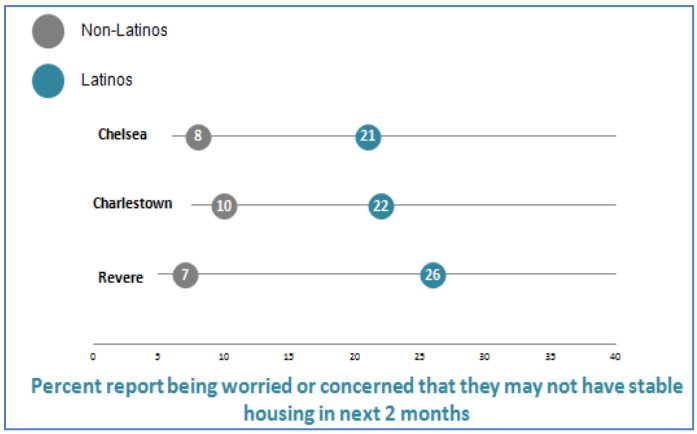


This primary and secondary data support the need to address depression and other mental health issues in our communities. Mental and physical health are intertwined and are exacerbated by community conditions such as increased substance use, violence, poverty, housing and food insecurity found in all of these communities. Both needed to be treated together.

Social Determinants of Health (Housing, Education, Environment)



Percent report worried about food running out in past year before they could buy more



Percent report being worried or concerned that they may not have stable housing in next 2 months

Even when financial obstacles to health care are removed, social, cultural, linguistic, racial, and socioeconomic barriers—the social determinants of health—can prevent people from seeking care or following through on recommended treatment, and contribute to health inequities. In addition, these factors can lead to a culture and climate that fosters unhealthy behaviors and prevent people from living healthy lives.

In all of these communities, **food and housing insecurity** were reported at high rates. Approximately 12% of Massachusetts residents report being food insecure defined by the USDA as the inability to meet food needs during at least 7 months of the year. Seventeen percent of Charlestown and 14% of Chelsea Quality of Life survey respondent's report that the food they purchased did not last long enough and they could not buy more. These numbers increase to 20% and 16% respectively when asked if respondents worried about food running out in the past year. Similarly, between 13%

and 14% report being worried or concerned that they will not have a place to stay in the next two months.

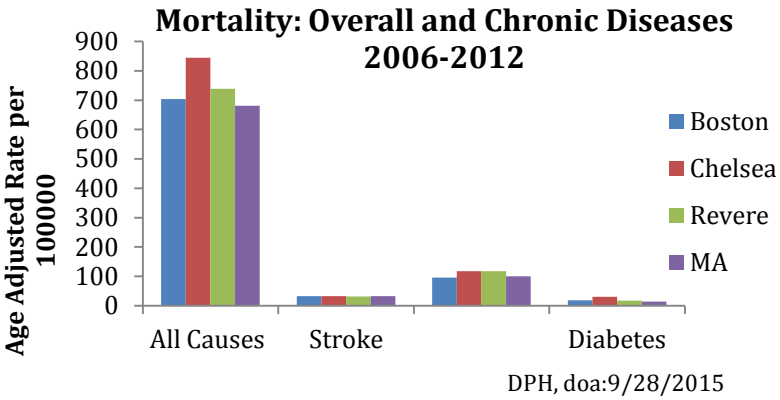
There is a disparity in this concern between Latinos and Non-Latinos, with Latinos reporting insecurity at double or triple the rates of their non-Latino counterparts.

Housing and food insecurity often go hand in hand, and the physical and emotional effects on children and adults are great. For older children poor school performance is often found in those who are housing and/or food insecure.

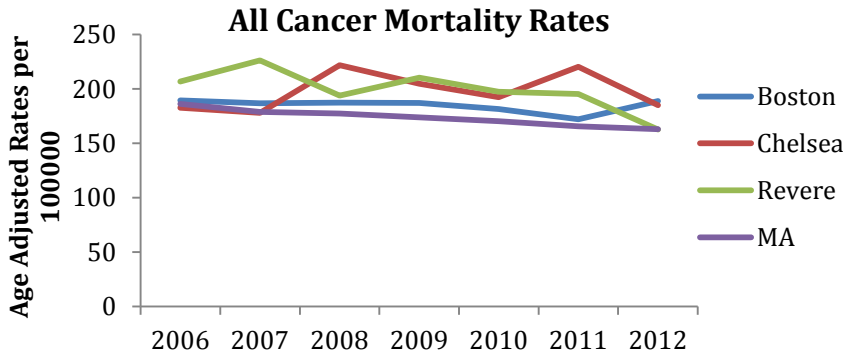
It is not surprising that **educational attainment is** also highly correlated to health status. Fifteen percent of survey respondents report education as being the most important health problem in their community. In all communities graduation rates are much lower than the state rate (see table on page 9) and school systems lack the resources to keep up with the ever-changing needs of their student population. In Chelsea, over the past 24 months, there were 1,955 students in grades 1-12 who have enrolled in school who speak little to no English. Poverty, overcrowding, mobility, language barriers and trauma, particularly for immigrants who experienced or witnessed violence to get to this country, are prevalent.

A **clean environment** was identified as an essential component of a healthy community. Sixteen percent of survey respondents report the environment as being the most important health problem in their community. Focus group participants as well as many survey respondents described many environmental health concerns including unkempt parks and public spaces, roads and buildings in disrepair, and debris on sidewalks. In Revere and Chelsea in particular, the need to improve the aesthetic feel of the community was mentioned. In addition, the lack of open spaces and places to go that felt safe were discussed.

Overall Mortality



In the communities that are faced with an increased burden of these social and physical indicators often brought on by poverty, mortality is often greater. In Boston, the difference in life expectancy by census tracts is 33 years (Joint Center for Political and Economic Studies' Place Matters reports.) The communities of Revere, Chelsea and Charlestown are no different than other communities faced with these same disparities. Mortality rates brought on by chronic disease such as diabetes, as well as from cancer, is higher in these communities compared to the state overall.



Issues Not Tackling

The MGH and the Center for Community Health Improvement are working to address the health priorities determined by the CHNA through the Center's three approaches, and hospital and health center's patient focused disease outreach programs. Our implementation report, however, is not inclusive of all patients and communities.

Violence and crime, including gang violence is not directly addressed through our health strategies and approaches. The MGH will look for opportunities to collaborate with police and other organizations to address this important health issue. The strategies and ideas that were identified by all communities to address violence will be shared with community partners.

Strategies & Implementation Plan

CCHI addresses these community priorities using the following 3 approaches:

Building and Sustaining Multi-Sector Coalitions - CCHI is the backbone organization that uses a "collective impact" framework to support four multi-sector community coalitions that work to prevent and reduce substance use and obesity. CCHI acts as a convener and provides staff, best practices, evaluation services, grant writing, and other resources to support the coalitions' community-based leadership. Each coalition works with the 12 sectors recommended by Community Anti Drug Coalitions of America (CADCA) to change policies and practices to prevent teen substance use, reduce harm from opioids, and improve physical and food environments to make healthy choices easier.

Developing the Assets of Youth - Educational attainment is one of the most important social determinants of health. MGH has partnered for 25 years with Boston, Chelsea and Revere public schools to provide educational and career opportunities for thousands of youth interested in health and science careers. In 2013-2014 MGH offered these opportunities to 650 young people in grades 3 through college, the vast majority of whom are low-income students of color.

Improving Access to Care for Vulnerable Populations - Even when financial barriers to care are removed, social, cultural, linguistic, racial, and socioeconomic barriers can prevent people from seeking care and contribute to inequities in morbidity and mortality. CCHI supports multiple programs that reduce these barriers for vulnerable patients, including through the services of community health workers and navigators, a medical-legal partnership that improves access to housing and income benefits, and outreach programs. Multicultural staff connects patients with community-based resources, acting as a bridge between health care providers and the community.

Detailed action plans for each priority area over the next 3 years are listed below. Action plans are evaluated annually and refined based on changing community needs. Topics, objectives and targets set by *Healthy* People 2020 serves as a guide to identify priorities, outcomes measures and data sources. When applicable we will use Healthy People 2020 as our benchmark.

Priority Area	Goals
Substance Use	1. Provide "backbone support" to multi-sector coalitions using a collective impact model to make policy, systems and environmental changes to reduce youth substance use and prevent opioid overdoses and deaths. 2. Transform care for those with substance use disorders by reducing stigma and developing a chronic disease management model of care that spans from the community to the bedside.
Violence and Public Safety	1. Support police departments and community organizations in their efforts to reduce violence by advocating for and collaborating on evidence-based strategies. 2. Continue to support MGH-based violence intervention programs.
Healthy Eating, Active Living, and Food Insecurity	1. Provide "backbone support" to multi-sector coalitions using a collective impact model to make policy, systems and environmental changes to increase access to affordable, healthy foods and physical activity. 2. Screen for and provide resources to patients who are struggling with food insecurity
Mental Health & Trauma	1. Create and support existing community-wide learning collaboratives with agencies and leaders to build trauma-informed communities that promote resiliency in young children and families. 2. Train MGH staff on understanding the effects and recognizing the symptoms of trauma, and ensure staff do not re-traumatize patients. Additionally, ensure that staff are supported to avoid secondary trauma or re-traumatization themselves. 3. Work with MGH Psychiatry and organizations to intervene early to prevent mental health problems and build resilience in youth, and strengthen mental health delivery systems.
Social Determinants of Health (Housing, Education, Environment)	1. Continue to screen and provide connections to resources for MGH patients. 2. Build and strengthen partnerships with community agencies that address the social determinants of health and work towards solutions. 3. Continue to expose and inspire youth to Science, Technology, Engineering, and Math (STEM) subjects, health and wellness, college readiness, and careers by strengthening and growing the MGH Youth Programs.

Priority: Substance Use	
Goal	**Partners**
1. Provide "backbone support" to multi-sector coalitions using a collective impact model to make policy, systems and environmental changes to reduce youth substance use and prevent opioid overdoses and deaths.	MGH Community Health Centers, Cities of Revere and Chelsea; Boston neighborhood of Charlestown Revere, Chelsea, Charlestown Schools, Revere, Chelsea, Charlestown Police Departments, Local community agencies, parents, residents, and youth in Revere, Chelsea, Charlestown.
Strategy	**Actions**
Education: Continue to provide substance use prevention education, particularly around marijuana, nicotine devices, and opioids to parents and youth.	Work with schools, organizations, and medical providers to develop materials and educate youth and parents on the dangers of substance use, nicotine devises, the laws around medical marijuana, and removing unnecessary access to prescription medications. Provide evidence-based curriculum in schools and with community agencies Consult with media experts in the delivery and creation of web portals. Distribute resources in various languages through various media such as newspaper and social networks Disseminate health educational materials by participating in community events Organize community-wide events such as memorials to increase awareness and reduce stigma.
Education: Continue to provide opioid overdose prevention and harm reduction education to those struggling with addiction, families, and medical providers.	Partner with community organizations to regularly provide workshops on recognizing the signs and symptoms of an overdose and what to do if one occurs. Work with MGH and community partners to distribute Narcan to users, their families, and bystanders and advocate that first responders, who do not yet carry Narcan, do so. Advocate for recovery drop-in centers in each community.
Social Marketing: Implement additional community and school-wide social marketing campaigns to increase education and change social norms.	Review and adapt social marketing campaigns already implemented in other communities or nationally. Contract with professional consultants for the development of local campaigns. Identify common community strategy to be implemented across all MGH communities.

Collaboration: Increase engagement, communication, and access to programs and services between community members, providers, patients, CCHI staff and other professionals, and build capacity within outside agencies.	Partner with the schools to Increase number of youth, parents; partner with other community sectors engaging in coalitions, partnerships, and attending events such as departments of parks and recreation, community-based immigrant or ethnic organizations, faith groups, youth centers, and state-run programs and services. Work with partners to expand initiatives though grants, programs, and policies. Support the expansion of service learning & community service for youth, and peer leadership programs.
Policy: Monitor, educate, advocate, support and assist in the changing of policies of cities, schools, organizations, local and state that regulate all aspects of substance use from its legality status to those influencing social behavior.	Identify partners and opportunities to create or amend policies that support youth resiliency and decrease factors that lead to substance use. (Examples include advocating for local e-cig regulations; smoking bans in public housing and Narcan with all first responders)
Environmental: Continue to support programs to reduce access to prescription drugs and unclean needles.	Organize and participate in Medication Take Back Events and needle clean-up. Promote the local Medication Disposal program. Monitor parks and open spaces for issues associated with ATOD use.
Goal	**Partners**
2. Transform care for those with substance use disorders by reducing stigma and developing a chronic disease management model of care that spans from the community to the bedside.	MGH General Medicine, MGH Psychiatry, MGH Community Health Centers, Community-based treatment providers, Boston Health Care for the Homeless Program
Strategy	**Action**
Clinical Interventions: Continue and work to expand Substance Use Disorders initiative across the hospital and MGH health centers.	Components of the plan include a specialized inpatient multi-disciplinary addiction consult team (medicine psychiatry, nursing social work, recovery coaches), a post-discharge clinic, enhanced outpatient care at health centers including expanding access to medication assisted treatment, and recovery coaches, peers in recovery who help patients make the connections between inpatient, outpatient and community-based recovery treatment and support services.

<u>Expected Long Term Outcomes associated with this priority:</u>

- → Decrease current use of alcohol & tobacco among youth and adults.
  - Source: Youth Risk Behavior Survey; Behavior Risk Factor Surveillance System
- → Decrease the percent of current marijuana usage among youth.
  - Source: Youth Risk Behavior Survey
- → Decrease the percent of prescription drug usage among youth.
  - Source: Youth Risk Behavior Survey
- → Increase the percent of youth who perceive great risk associated with substance abuse.
  - Source: Youth Risk Behavior Survey
- → Decrease opioid overdoses and deaths.
  - Source: Police Data, Mass. Department of Health Bureau of Substance Abuse Services
- → Decrease length of stay and addiction severity and readmission rates for inpatients with a SUD
  - Source: Hospital medical data

Priority: Violence and Public Safety	
Goal	**Partners**
1. Support police departments and community organizations in their efforts to reduce violence by advocating for and collaborating on evidence-based strategies.	MGH Community Health Centers Cities of Revere and Chelsea; Boston neighborhood of Charlestown Revere, Chelsea, Charlestown Schools Revere, Chelsea, Charlestown Police Departments Local community agencies in Revere, Chelsea, Charlestown
Strategy	**Action**
Collaboration: Collaborate with agencies that are working on violence and public safety as needed and as work intersects	Participate in and ensure communication between coalitions and other community collaborative initiatives, such as police departments, Chelsea Thrives, an initiative funded by the Working Cities Program of the Federal Reserve, and Hub and COR, an evidence-based approach for agencies to collaborate on those at risk for violence. Collaborate on grants to build capacity as they arise. Support the expansion of after school programming and
Environmental: Collaborate with environmental enhancements that contribute to the safety of open spaces.	Collaborate with mobilizing community residents to clean-up activities of the environment including at parks and open spaces.
Goal	**Partners**
2. Continue to support MGH-based violence intervention programs.	MGH Social Services Department MGH Emergency Department
Strategy	**Action**
Education: Support and connect victims of domestic and community violence to needed resources	Support access to HAVEN, the domestic violence advocacy program for MGH patients and community members who have experienced domestic violence. Support access to the Violence Intervention Advocacy Program, the violence intervention program for patients brought to the MGH Emergency Department as a result of their violence-related injuries

<u>Expected Long Term Outcomes associated with this priority:</u>

- → Increase the feelings of safety in one's community and home.
  - Sources: Community Survey & Focus Groups; program data

Priority: Healthy Eating, Active Living, and Food Insecurity	
Goal	**Partners**
1. Provide "backbone support" to multi-sector coalitions using a collective impact model to make policy, systems and environmental changes to increase access to affordable, healthy foods and physical activity.	MGH Community Health Centers, Cities of Revere and Chelsea; Boston neighborhood of Charlestown Revere, Chelsea, Charlestown Schools, Local community agencies, parents, residents, and youth in Revere, Chelsea, Charlestown
Strategy	**Action**
Outreach and Communication: Work with partners to provide education, and resources around healthy eating and active living to youth and adults by participating in community-wide events, promoting events with similar goals, and communicating through various media channels such as Facebook and websites.	Communication specialist and/or contracted firm will maintain website and social media pages. Staff will attend and host tables at community events Staff will organize community-wide events that educate and promote healthy eating and active living.
Collaboration: Reach out to organized neighborhood groups or engage neighborhoods to organize groups to implement activities that will increase access to healthy eating and active living.	Facilitate an organizing process to create new neighborhood groups and help build their capacity. Visit organized neighborhood group meetings and invite them to adopt HEAL goals.
Collaboration: Work in partnership with the schools to: increase physical activity through a walk to school program, and through the support of classroom activity breaks, and increase access to healthy foods through the engagement of the school food service and student activities to bring palatable, healthy foods to students	Work with youth to educate them on healthy eating & active living and to learn how to advocate for healthier school food. Implement walkability audits, trace routes and organize walk to school events. Offer support and ideas for in-classroom fitness breaks.
Physical Environment: Work with municipalities, neighborhood groups, local and regional planning organizations, local pedestrian and bicycle advocate organizations and park organizations and funders of parks to change community design standards to make streets and open spaces safe for all users.	Collaborate with Walk Boston for walkability audits to mark urban trails, safe routes to schools and wayfinding signage strategies. Work with MassBike and facilitate local conversations for the striping of bike lanes and bike safety education and work with Bike to the Sea for the completion of bike trails. Secure grants and organize community builds to restore playgrounds
Physical Environment: Work with inspectional services, board of health, residents and local businesses to make healthy foods accessible, available, and affordable in corner stores, restaurants and farmers markets and neighborhoods.	Engage the board of health and inspectional services to support healthy corner stores and healthy dining initiatives. Recruit corners stores and restaurants to participate in healthy eating initiatives. Organize, support and facilitate school and community gardens. Support and organize a Farmers Market with an incentive program for the use of WIC and senior

	coupons and electronic benefit transfer program.
Policy: Monitor, educate, advocate, support and assist in the changing of policies of cities, schools, organizations, local and state that regulate all aspects of healthy eating and active living from its legality status to those influencing social behavior.	Engage city officials to adopt a "Complete Streets" policy that takes into account automobiles, pedestrians, bicyclists and users of public transit. Monitor federal artificial transfat policy changes. Monitor school food policies. Influence local inspectional office policies and practices for the support of healthy corner store and healthy dining initiatives.
Goal	**Partners**
2. Screen patients who are struggling with food insecurity and provide resources	MGH Community Health Centers Local community agencies in Revere, Chelsea, Charlestown
Strategy	**Action**
Clinical Intervention: Provide community health workers to work with food insecure patients	Screen for food insecurity in all departments of the health centers. Ensure community health workers reach out to food insecure patients and provide resources to patients, such as SNAP (food stamps) application assistance, list of food pantries, and emergency food vouchers. Implement grant-funded partnership with local community development corporation to refer food insecure patients to their resources and measure impact on health.

<u>Expected Long Term Outcomes associated with this priority:</u>

- → Increase contribution of fruits and vegetables to the diets of the population (adults and youth).
  - Source: Youth Risk Behavior Survey; Behavior Risk Factor Surveillance System
- → Increase the proportion of adults and children who meet current federal physical activity guidelines for aerobic physical activity. (Youth: 1 hour per day, 5+ days a week/Adults: 30 minutes a day, 5+ days a week adults).
  - Source: Youth Risk Behavior Survey; Behavior Risk Factor Surveillance System
- → In Chelsea and Revere, reduce the proportion of public school children who are overweight or obese.
  - Source: School Nurse Data
- → Decrease the proportion of households experiencing food insecurity.
  - Source: U.S. Census Bureau

Priority: Mental Health & Trauma	
Goal	**Partners**
1. Create and support existing community-wide learning collaboratives with agencies and leaders to build trauma-informed communities that promote resiliency in young children and families.	MGH Community Health Centers,, Cities of Revere and Chelsea; Boston neighborhood of Charlestown, Revere, Chelsea, Charlestown Schools, Local community agencies, parents, residents, and youth in Revere, Chelsea, Charlestown
Strategy	**Action**
Outreach and Communication: Work with partners to provide education, knowledge, and promote events around trauma informed care, mental health, and healthy development	Host meetings and support community agencies to implement plan-do-study-act cycles to increase the number of trauma-informed policies Leverage current CCHI outreach and communication to stress the connections between mental health and substance use
Collaboration: Support the expansion of after school programming and activities to provide youth with healthy activities that develop social skills, resilience, and other core developmental assets	Support a positive youth development initiative with both school and community components; work with schools towards implementation and evaluation of curriculum based in positive youth development practices
Goal	**Partners**
2. Train MGH health center staff on understanding the effects and recognizing the symptoms of trauma, and ensure staff do not re-traumatize patients. Additionally, ensure that staff are supported to avoid secondary trauma or re-traumatization themselves.	MGH Community Health Centers, Local community agencies in Revere, Chelsea, Charlestown
Strategy	**Action**
Education: Advocate for a trauma-informed approach across the hospital	Continue to participate in the Partners-wide Trauma-Informed Care (TIC) committee Ensure CCHI staff are trained in TIC Implement reflective supervision across CCHI staff
Goal	**Action**
3. Work with MGH Psychiatry and local organizations to assess opportunities to implement evidence-based prevention strategies build resilience in youth, and strengthen mental health delivery systems.	Identify and meet with partners to assess critical need and identify best practices for community mental health resources Work with partners to seek support for resources to provide resources and services.

<u>Expected Long Term Outcomes associated with this priority:</u>
This is a newly identified community priority and over the next year we will meet with internal and external partners to develop strategies and identify measures of progress.]

Priority: Social Determinants of Health (Housing, Education, Environment)	
Goal	**Partners**
1. Continue to screen and provide connections to resources for MGH patients.	MGH Community Health Centers, Cities of Revere and Chelsea, Boston neighborhood of Charlestown, Community agencies in Revere, Chelsea, Charlestown
Strategy	**Action**
Clinical Intervention: Screen for the social determinants of health (SDH) at all primary care visits.	Educate providers on the SDH and how they can affect health outcomes Work with IT systems to include the SDH questionnaire in patient medical records Advocate for increased services to address the SDH
Clinical Intervention: Provide all medically and psycho-socially complex MGH health center patients with Community Health Worker.	Train all Complex Patient Population Community Health Worker (CPP CHWs) to work with patients to address barriers to care, and support patients to achieve goals. Implement SDH questionnaire as part of the CPP CHW initiative. Institute pathways of referrals to internal programs and outside agencies to address the SDH.
Goal	**Partners**
2. Build and strengthen partnerships with community agencies that address the social determinants of health and work towards solutions.	MGH Community Health Centers, Local community agencies in Revere, Chelsea, Charlestown, The Neighborhood Developers, CAPIC, Public Schools
Strategy	**Action**
Collaboration: Work with partners to expand initiatives though grants, programs, and policies that tackle the social determinants of health.	Actively seek opportunities to engage MGH providers and community partners to address housing, education, and the environment. Implement grant-funded partnership with local community development corporation to refer housing insecure patients to their resources and measure impact on health. Collaborate with city on Working Cities, Plan Revere, and other key efforts in addressing economic development, equity, housing, and environmental improvements. Collaborate with public schools to collect, analyze, and disseminate YRBS; inform schools of positive and negative trends among student population regarding quality of life and behavior. Collaborate with public schools to address health issues that affect educational attainment and support programs that increase educational and social equity among students and their families.

Goal	Partners
3. Continue to inspire an interest in youth in Science, Technology, Engineering, and Math (STEM) subjects, health and wellness, college readiness, and careers by strengthening and growing the MGH Youth Programs.	MGH - Internal Departments and Community Health Centers; Boston, Chelsea and Revere students, their families, schools, and community-based organizations.
Strategy	**Action**
Education: Continue to offer youth in grades 3 – 12 and beyond, with STEM exploration, hands-on experiences, health and wellness education, mentoring, academic &summer employment, college readiness, and high level internships.	Partner with schools and local Boys and Girls Clubs of Boston branches to provide an after school curriculum to stimulate an interest in STEM in grades 3-8. Continue to provide science fair mentors to 7th and 8th graders at the Timilty Middle School. Provide programming for all four years of high school students that exposes them to health careers, provides college readiness and jobs in the junior and senior years Provide opportunities for about 200 young public school students in the City of Boston at MGH for the summer Support graduates of MGH high school programs to succeed in college with scholarship, as well as mentoring, tutoring and other support.

Expected Long Term Outcomes associated with this priority:

- → Patients report increased Health-related Quality of Life and Wellbeing
  - Source: PROMIS10 questionnaire
- → Patients report decreased food and housing insecurity
  - Source: Social Determinants of Health questionnaire
- → Increase educational achievement for youth participating in CCHI programs, including high school and college graduation.
  - Source: Program data
- → Youth who are exposed to STEM careers will choose to follow a STEM career path
  - Source: Program data

Appendix

Community Health Needs Assessment Committee Members

Revere

Name	Organization/Affiliation
Fanny Araque	Early Childcare Provider
Elle Baker	City of Revere/Revere on the Move
Barbara Bishop	Speaker DeLeo's Office
Kitty Bowman	Revere CARES Coalition
Tania Buck	FKO Afterschool
Diane Colella	City of Revere
Julie Demauro	City of Revere/Revere on the Move
Carol Donovan	City of Revere Health Department
Selene Erazo	Resident
Megan Fidler Carey	Revere Public Schools
Jonina Gorenstein	MGH CCHI/CHA
Carol Haney	Revere Beautification Committee
Kim Hanton	North Suffolk Mental Health Association
Ann Houston	The Neighborhood Developers
Vanny Huot	The Neighborhood Developers
Andie Janota	City of Revere/Revere on the Move
Gurpal Kaur	Youth
Andy Lafontant	Youth
Miles Lang Kennedy	City of Revere Mayor's Office
Judy Lawler	Chelsea District Court
Kenia Maldonado	Youth
Chris Malone	Revere Public Schools
Eileen Manning	MGH CCHI/CHA
Leandro Montoya	Youth
Julia Newhall	City of Revere/WROC/MOAPC
Ira Novoselsky	City Council
Amy O'Hara	Revere Poice Department
Roger Pasinski, MD	MGH Revere HealthCare Center
Dimple Rana	City of Revere/Revere on the Move
George Reuter	The Neighborhood Developers
Ervin Rivera	City of Revere/Revere on the Move
CarrieAnn Salemme	WROC/MOAPC, North Suffolk Mental Heath Association
Ming Sun	MGH CCHI/CHA
Michael Try	City of Revere/Revere on the Move
Carol Tye	Revere Public Schools, School Committee
Joshua Ward	Youth
Joseph Ward	Youth

Chelsea

Name	Organization
Tom Ambrosino	City of Chelsea
Dave Betz	Chelsea Police Department
Roseann Bongiovanni	Chelsea Collaborative
Mary Bourque	Chelsea Public Schools
Michelle Camiel	Cooking Matters
Nancy Ellen Capistran	MGH Chelsea
Margaret Carsley	Chelsea Community Garden
Jim Cunningham	Chelsea Revere Winthrop Elder Services
Jennifer DeCourcey	Soldiers' Home
John DePriest	City of Chelsea Department of Planning and Development
Arlan Dobson	North Suffolk Mental Health Association
Judith Dyer	Resident and CAPIC Board of Directors
Al Ewing	Chelsea Housing Authority
Bonnie Fishman	MGH Chelsea
Ron Fishman	MGH Chelsea/CCHI
Sharon Fosbury	The Neighborhood Developers
Tracie Gillespie	UMass Extension
Kim Hanton	North Suffolk Mental Health Association
Madelyn Herzog	Food Corps
Mary Lyons Hunter	MGH Chelsea
Katie Kalina	Community Substance Abuse Centers
Phyllis Kinson	Chelsea Revere Winthrop Elder Services
Molly Lawrence	Cataldo Ambulance
Tara McCarthy	MGH WIC
Mary McKenzie	City of Chelsea Health Department
Yanya Noor	MGH Chelsea
Paul Nowicki	Chelsea Housing Authority
Sarah Oo	MGH Chelsea Community Health
Ana Perez	MGH Chelsea
Cheryl Poppe	Soliders' Home
Luis Prado	Chelsea Health and Human Services Department
Sylvia Ramirez	Chelsea Collaborative
Toby Raybould	MGH Trauma, Emergency Surgery and Surgical Critical Care
Dan Reindeau	Cataldo Ambulance
Bob Repucci	CAPIC, Inc.
George Reuter	The Neighborhood Developers
Scott Richardson	Project Bread
Ruben Rodriguez	North Suffolk Mental Health Association
Joanne Stone-Libon	CAPIC Head Start
Ming Sun	MGH CCHI/CHA
Francisco Toro	City of Chelsea Veteran's Services
Melissa Walsh	The Neighborhood Developers / Chelsea Thrives
Maryanne Winship	Salvation Army

Charlestown

Name	Organization
Jean Bernhardt	MGH Charlestown HealthCare Center
Miles Byrne	Resident / Corcoran Realty
Peggy Carolan	Charlestown New Health
Sarah Coughlin	Charlestown Substance Abuse Coalition
Lori D'Alluva	Charlestown Adult Education
Johan de Besche	MGH Institute for Health Professions
Lori Deliso	Kids Cooking Green
Crystal Galvin	John F. Kennedy Family Center, Inc./Resident
Sean Getchell	Aid to Rep Daniel Ryan
Tommy Howard	Charlestown Recovery House/Resident
Deborah Hughes	Special Townies Organization/Resident
Rebecca Kaiser	Spaulding Rehabilitation Hospital
Terry Kennedy	John F. Kennedy Family Center, Inc./Resident
John Killoran	Charlestown Boys and Girls Club
Shannon Lundin	Charlestown Substance Abuse Coalition
John McGahan	The Gavin Foundation
William McNicholas	Charlestown Division of Boston Municipal Court
Paul Murphey	MGH Institute for Health Professions
Pete Nash	Charlestown Boys & Girls Club
James Ronan	St. Mary's Catherine of Siena Parish
Jessica Rubin	Charlestown Boys and Girls Club
Kevin Smith	Charlestown Recovery House/Resident
Steve Telesmanick	YMCA
Jim Travers	Charlestown Recovery House/Resident
Gretchen Wagner	Charlestown Substance Abuse Coalition
Rosie Wall	Kids Cooking Green
Rosanne Spinali Walsh	CAPE (Cancer Awareness, Prevention & Education)
Dave Whelan	Charlestown Neighborhood Council/Resident
Phenice Zawatsky	Charlestown Family Support Circle