BRIGHAM AND WOMEN'S HOSPITAL

Introduction

Brigham and Women's Hospital (BWH) has a long-standing commitment to improving the health status of Boston women and their families, with a focus on Boston neighborhoods with disproportionately poor health and social indicators and documented need for comprehensive health and social services. BWH works in collaboration with many community organizations and government agencies to identify and address barriers to access and to mobilize community resources to help improve health status. BWH and its licensed and affiliated health centers provide primary and specialty ambulatory services to a culturally diverse group of people, and its broad array of community service programs are designed to have a measurable, positive effect on the health status of underserved women and their families.

Mission Statement

The following community benefit mission statement was adopted by the BWH Board of Trustees:

> *Brigham and Women's Hospital (BWH) is committed to serving the health care needs of persons from diverse communities. The hospital, however, makes a unique commitment to the neighboring residents of* ***Jamaica Plain*** *and* ***Mission Hill****, who have some of the most pressing health problems in the state. The hospital, along with its two licensed community health centers, is committed to developing integrated care networks to provide and assure appropriate access to high quality, cost-effective primary care to members of these communities regardless of their insurance status. The hospital also commits to meeting the needs of* ***low-income pregnant women and their families from the communities of Roxbury and Dorchester.***
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> *In order to address the health needs of its target communities, the hospital must look beyond its walls and seek guidance from the community to implement programs that recognize and address the relationships between health and social problems, including economic and educational issues. The hospital is committed to collaborating with community groups and organizations to develop comprehensive programs that respond to the needs of the communities, as identified by the communities themselves, and as suggested by public health and other data. The hospital seeks to improve the health status of residents of the communities by offering health services, continuing and expanding innovative community and school-based programs, and by serving as a resource to the community as a liaison to health careers education and as a possible employer of community residents.*

Internal Structure of Community Benefit Programs

The Office for Women, Family, and Community Programs (OWFCP) at Brigham and Women's Hospital serves as a coordinating department for community health programs and acts as a liaison for community-based organizations and the hospital. Established in 1991 as the Center for Perinatal and Family Health, the OWFCP expanded its focus beyond the needs of pregnant women and thus changed its name in 1997. The OWFCP supports initiatives related to improving the health of underserved women and their families. It collaborates with many hospital departments and clinical areas and works in partnership with other organizations and community-based groups in addressing increased access to care, offering provider training about the needs of underserved women, and developing culturally appropriate models of care.

The hospital, its health centers, and the OWFCP are dedicated to working with community residents and organizations to meet the needs of women and their families. Programs focus on addressing disparities in infant mortality, providing comprehensive care for women, fostering social and family support systems, enhancing educational and career opportunities, improving knowledge of healthy behaviors, and working with women who are victims of domestic violence. These programs reach out to disadvantaged women and their families and break down many of the barriers to accessing quality, affordable health care and social services.

Community Health Programs

Jamaica Plain

Jamaica Plain Asthma/Environmental Initiative (JPAEI)

In 1997, the Jamaica Plain community identified asthma and related environmental issues as one of its community health problems. Residents of Jamaica Plain, representatives from community-based organizations, and representatives of Brigham and Women's, Children's, and Faulkner Hospitals collaborated to develop this initiative to address asthma and related environmental issues in the schools and homes, and to examine access to and quality of health care for children and adults with asthma.

The initiative targets:

- Jamaica Plain school children attending Jamaica Plain elementary schools
- Household members of the children with asthma
- Parents, teachers, and school administrators in Jamaica Plain elementary schools
- Asthma care providers

The project director, employed by Community Cares, the parent organization of the Jamaica Plain Tree of Life, manages the Jamaica Plain Asthma/Environmental Initiative. The project director receives general direction from the Project Advisory Board which includes residents of Jamaica Plain, representatives from the health centers, hospitals and community-based organizations, parents of school children, and representatives from the Boston Public Schools Cluster 6. The purpose of the Advisory Committee is to provide direction to and maintain

community involvement in the initiative. The project staff includes a school health educator, a health educator for homes or home visitor, and an administrative assistant, all of whom are supervised by the project director.

Asthma Education and Monitoring Among School Children

Working with school nurses, program staff identifies children with asthma in the elementary public schools in Jamaica Plain. Once children are identified, program staff work with the schools to coordinate age appropriate asthma education for all children identified with asthma. A bilingual asthma educator provides education to children about the underlying process of asthma as an illness, the signs and symptoms of asthma, their role in managing asthma, and factors that trigger asthma.

School-based Environmental Assessment

Schools may harbor environmental problems that trigger asthma. Thus the school environment can contribute to the difficulty in keeping children with asthma as symptom free as possible. The Jamaica Plain Asthma/Environmental Initiative works with the Massachusetts Coalition for Occupational Safety and Health (MassCOSH) to form school environmental committees in each public elementary school in Jamaica Plain. The committees, made up of parents, teachers, school health personnel, school administrators, MassCOSH, and project staff, identify environmental triggers and methods for correcting them.

Home Environment and Family Assessment

The home may also harbor conditions that make it difficult for asthmatics to control their symptoms. School children with asthma are likely to come from homes where others have asthma. In order to address issues in the homes of Jamaica Plain school children and to identify adult and other household members with asthma, project staff work with the parents/guardians of children with asthma. The project staff offers the parent/guardian a home visit that includes one or more of the following:

- An asthma education session for the parent/guardian so they can better manage their children's asthma
- An assessment of asthma triggers in the home that may exacerbate their children's asthma, and the development of a plan for correcting selected environmental concerns
- An assessment of access to health care and the impact that asthma has on the child and family
- Referrals to resources and community agencies to address identified concerns

The household assessments are conducted by a home visitor who is trained to complete a standardized questionnaire to assess the home for asthma triggers, identify other members of the household with asthma, determine access to health care, and assess the impact asthma is having in the child's life (e.g., school absences). The home visitor has the skills to develop a plan with the family to correct selected environmental concerns, connect family members to health care, identify sources of health care coverage, identify ways to access medications and other items (such as peak flow meters, mattress covers, etc.), refer people for assistance with smoking cessation, identify the need for housing advocacy from City Life/Vida Urbana to correct code

violations and address other major housing issues, and identify other issues that come up in the home visit or interviews. Project staff identify the health care providers and usual place of health care for children and members of their household identified with asthma. Asthmatics and other family members without a primary care provider or usual source of health care will be referred to one of the three health centers in Jamaica Plain or to appropriate providers in one of the three hospitals participating in this project. Providers in the health centers refer families to the program for asthma education and home assessments. Parents and families in need and willing to be referred receive advocacy services and remedial action from City Life/Vida Urbana. The JPAEI also works in collaboration with the BWH Community Asthma Program health educator who provides education for adults with asthma and assists with community outreach.

Progress to Date

The Jamaica Plain Asthma/Environmental Initiative began in October, 1998. The project is physically located on Centre Street, a main street in Jamaica Plain that is highly visible and is easily accessible by public transportation. The Advisory Committee meets each month.

School-based activities. ***Asthma Education in Jamaica Plain Schools***. Students in the Kennedy, Curley, Fuller, Hennigan, Manning, and Agassiz elementary schools participate in asthma educational sessions. All kindergarten students in the Jamaica Plain public schools receive basic asthma education. Asthma education sessions have also been provided to students in the Curley Middle School, at the English High School summer camp, the Jamaica Plain Head Start program, and the Agassiz summer camp. JPAEI began a process in September, 2002 to expand asthma education to the middle schools in Jamaica Plain.

School Environmental Committees. The first school environmental committee was established at the Fuller School at the end of the 1999-2000 school year. Three other school environmental committees were formed by the end of the 2000-2001 school year.

At the start of the 2002-2003 school year, principals from seven schools (Agassiz, Fuller, Hennigan, Kennedy, Manning, James Curley, and Mendell) agreed to identify one person in the school to be responsible for coordinating asthma education and establishing the school environmental committees. The coordinator works closely with the JPAEI staff.

Working with School Nurses. JPAEI staff meet with school nurses to provide education and support. JPAEI created laminated Asthma Action Plans for all nurses for reference and to encourage them to obtain these for all asthmatic children.

Home visits. All school children with asthma are offered home visits. Through October, 2001, program staff had conducted more than 65 home visits. Forty-six percent of the households had other household members with asthma. The home assessments revealed dust (70 percent), bedding (58 percent), poor ventilation (44 percent), rodents (40 percent), carpets (40 percent), and pets (24 percent) as the most important potential environmental conditions contributing to asthma.

The staff are tracking the impact of asthma education and advocacy on improving conditions in the home. A small sample of 12 families received a follow-up visit by the home visitor and many had been able to make the necessary changes in their homes to get rid of identified asthma triggers. For example, 25 percent (3) of the homes that received a follow-up visit had been identified as having a ventilation issue. Out of these three homes, two had resolved the ventilation issue before the follow-up visit.

Community Education. JPAEI conducts community education through forums, fairs, outreach on the Boston Public Health Commission Health Van, and parent support groups organized under the IMPACT program.

South Street Development Initiative

The South Street Development Initiative was developed in 1998 by the Jamaica Plain Tree of Life in conjunction with Southern Jamaica Plain Health Center and the Boston Housing Authority Youth on the Rise Program. The South Street Development is owned by the state but managed by the Boston Housing Authority. There are approximately 340 mostly low-income individuals living in the development. The South Street Development Initiative aims to counter the isolation of residents, improve the health and well-being of the residents, and foster leadership among adult and teen residents of the development through several focused initiatives: peer leadership training for adolescents, adult socializing and wellness activities, and community building/leadership development. Since September, 2001, the South Street Development Initiative has focused on the peer leadership for adolescents.

Peer Leadership/Mentoring

The peer leadership/mentoring program is aimed at teens residing in the South Street Development. In order to participate, teens must be in school and make a commitment to regularly attend the activities related to the program. Adolescents receive peer leadership training and participate in activities to enhance their ability to develop leadership skills. The training focuses on the broad array of health concerns facing adolescents, conflict-resolution, and resume writing and interviewing skills. They lead workshops and outreach events covering topics such as peer pressure, school harassment, domestic violence, and drug awareness. They provide homework assistance on other afternoons for a group of approximately 15 to 20 other children. The adolescents also participate as staff on activities related to this initiative such as performing childcare, leafleting the development, and helping coordinate events. The peer leaders, according to their own self-assessment of the program, have set high expectations for themselves and see opportunities for improving their skills and the program. The teens participated in a photography project with the JPAEI to document the impact of asthma in the community.

Community Building/Leadership Development

The South Street Development Initiative plans and coordinates dinner discussion groups to bring the entire development community together to discuss issues that residents determine are important to their health and well being. Topics are broad and include domestic violence, stress reduction, nutrition, AIDS, addiction, and breast health. The Initiative also provides leadership training programs that are open to all residents. Finally, through consultation and technical

assistance, the Initiative continues to foster the development's Task Force in their inclusiveness and effectiveness.

The South Street Development Initiative also holds community meetings twice a year to obtain residents' feedback on what worked well and what changes they would like to see in the future.

Mission Hill

Brigham and Women's Hospital - Maurice J. Tobin School Partnership

For over a decade, Brigham and Women's Hospital and the Maurice J. Tobin School in Mission Hill have been working in close partnership. This unusual relationship between an academic medical center and an urban public elementary and middle school began in response to the school principal's request for specific assistance from the hospital, including, for example, improvements to the physical plant and providing nutrition education to students. Today, strong connections between the two organizations have influenced the environments of both, and are impacting the learning of Tobin students.

The overall goal of the partnership is to support the academic mission of the school by increasing parent, family, community, and hospital involvement in students' learning. Since individuals with higher educational status also have improved health status, this goal is linked to the hospital's mission of improving the health status of the community. Family involvement has been demonstrated as a critical element in student achievement, so the joint programming aims to reach out to families and assist them in becoming active participants in their children's education. Other elements of the program are designed to engage hospital employees in students' education. The partnership's activities fall into three broad program areas:

- The Tobin Fund
- The Tobin-Brigham Family Support Program
- The Tobin Middle School Transition Project

The Tobin Fund

Since 1992, the Tobin Fund has been one expression of the hospital-school partnership. Through this unique employee-giving model, BWH employees donate funds annually to the school, either through one-time contributions or through payroll deductions. Since its inception, employees have donated over $404,000 to the school. These funds go directly to the school and support, at the school's discretion, important activities. These include:

- Summer camp experience for approximately 100 students annually, who would otherwise miss the recreation, physical activity, new learning, and friendships camp offers
- Field trips and extracurricular activities
- Professional development for Tobin faculty and staff, enabling them to better respond to the many issues which impact students' ability to learn in the classroom
- Books that enrich classroom libraries and student learning and that are used for the Take Home Library and Brigham Book Buddy programs
- Essentials such as winter clothing, eyeglasses, books, food, and household necessities for families in crisis

The Tobin-Brigham Family Support Program

The Tobin-Brigham Family Support Program (TBFSP) is staffed by three "Parenting Partners"; Tobin parents who are employed by BWH and work at the school under the supervision of the school's Director of Instruction. The Parenting Partners design and implement literacy-related initiatives to involve families in their children's education and build relationships between students and adults. The school and hospital share oversight of the program, with the hospital taking responsibility, through the Office for Women, Family, and Community Programs, for gathering data to inform program development, conducting program evaluation, and fundraising. The components of the Family Support Program include the *Family Center*, the *Take-Home Library Program*, the *Brigham Book Buddies*, *Boston Builds*, and the *Tobin School-Family Communications Project.*

The Family Center. The Family Center provides a central and highly visible place in the school where parents know they are welcome, where they can receive information about the school and community resources, and where they can make connections with other parents. Two of the Parenting Partners, one of whom is bilingual, have office space in the Family Center. A second bilingual Parenting Partner is based in the school's main office, where she is easily available to families entering or calling the school. Spanish language capacity is very important, as approximately 65 percent of Tobin students are Latino, and many live in families where Spanish is the primary language.

The three Parenting Partners maintain strong relationships with other parents through their formal roles in the school and as neighbors and community members. As a result, Parenting Partners are a trusted resource and are able to effectively communicate school matters or changes in policy to other parents. They also maintain information in the Family Center about academic matters, including upcoming standardized testing dates and related details. Their participation in training given by Tobin teachers, as well as at external conferences, further integrates them into key roles bridging families and the school, and at the same time provides the Parenting Partners with additional skills.

Beyond academic issues, Parenting Partners are often aware of difficulties facing families long before other helping networks are contacted. Parenting Partners assist families with accessing teachers and other school or community resources, sometimes preventing more serious problems with potentially larger impact on families' lives and student learning. For example, Parenting Partners accompany several students each year to optometry appointments. Teachers report that having Parenting Partners in the school as part of the school staff helps other parents overcome language barriers and makes the school, as a whole, seem less intimidating. They also indicate that Parenting Partners are especially effective at communicating with other parents about school policies or the needs of individual students. Tobin School administrators appreciate the increased family involvement they attribute to the Parenting Partners' efforts. The Parenting Partners have facilitated the delivery of additional resources in the school, including Boston University's Build after-school tutoring program (described below), and food for approximately 24 needy families each month from the Greater Boston Food Bank. Also, Parenting Partners distribute

Thanksgiving and Christmas dinners from the Food Bank to Tobin families. During the 2001-2002 school year they were able to distribute food to 200 families at each holiday.

The Take Home Library Program (THL). An integral component of the school's literacy focus, the THL was created by a Parenting Partner in response to the need to increase access to books for younger students, and to increase the number of parents and other adults reading together with students. Books are provided through the Tobin Fund, and shared student-family reading occurs through a structured and documented approach. The program involves kindergarten through second graders, reaches approximately 187 students in ten classrooms, and has added a total of 30 books per year to classroom libraries over the past six years.

Brigham Book Buddies. Each month, hospital employees volunteer their time to the *Brigham Book Buddies Program* by visiting Tobin School kindergarten through fifth grade classrooms and reading aloud to students. The Brigham Book Buddies read books selected by the classroom teachers and at the conclusion of the reading session present the books to the students for their classroom libraries. The Book Buddies program is coordinated by the Parenting Partners, and promotes the literacy goals of the school. During the 2001-2002 school year, 25 Book Buddies read to 422 students in 20 classrooms. Book Buddies have responded that they thrive on the connection with the children, they love reading to the children, and they enjoy giving back to the community.

Boston University Initiative for Literacy Development (Boston Builds). The Tobin School is a site for an after-school program promoting literacy skills among elementary school students. Funded by an America Reads grant, the program brings Boston University students to the school as tutors who work with students for two hours, two afternoons a week. During the 2001-2002 school year, Build students tutored 50 Tobin students during the first semester, and 33 students during the second semester. The program also includes students from grades six and seven to provide additional academic help to students who received low scores on the MCAS test.

Success of Boston Builds depends on support and coordination from within the school. Parenting Partners arrange for space for tutoring, help tutors resolve challenges faced while managing students, and resolve the inevitable organizational issues that arise in implementing such a program. The Parenting Partners also play a critical role facilitating communication between classroom teachers and tutors about student progress. The school's Director of Instruction reports that the relationships the Parenting Partners develop with the tutors and the Build program promote the ongoing involvement of this program at the school, and thus much needed tutoring help for students. Teachers have confidence in the Parenting Partners' ability to manage the program, and so allow their classrooms to be used for this important and valued initiative.

Tobin School-Family Communications Project. The goal of the Tobin School-Family Communications Project is to support the planning, design, and implementation of a menu of communication mechanisms in Spanish and English which will build a learning community of students, staff, and parents, as well as support instructional improvement at the Tobin School.

Information gathered through program evaluation of the Tobin-Brigham Family Support Program and the Student Success Partnership indicates that:

- Family members identify themselves as an important factor in their child's success

- Family members have many stresses in their lives, which can make it difficult to help their children
- Family members often feel that they do not have the knowledge or skills to help their children with their homework
- Family members do not know the proper way to interact with their child's school
- Teachers acknowledge the importance of family member involvement, but may not have effective mechanisms for reaching families

To help increase parent/guardian involvement and to facilitate communication between family members and the school, the Tobin School created the Tobin School Family Communications Project. Several focus groups were held with parents/guardians, staff, and administrators to learn about what was working, what was not, and what could be improved to increase communication between the school and the students' families. Based on what was learned from the focus groups, new methods of communication to improve the flow of communication between the parents/guardians and the teachers, administration, and staff have been adopted. Future plans include creating a monthly newsletter, career day, having a school web site, and providing parents with videos of classroom instruction.

The Tobin Middle School Transition Project

The Tobin Middle School Transition Project provides support to Tobin sixth, seventh, and eighth grade students as they enter middle school, transition through their middle school years, and prepare for high school. In addition, fifth graders receive support as they transition to middle school. The project coordinator works under the direction of the school's student support service coordinator. The project goals are to:

- Promote success in middle school for all students
- Enable eighth graders to make a successful transition to high school
- Build health careers knowledge and to promote core job skills for eighth graders
- Enable fifth graders to make a successful transition to middle school

Transition to Middle School. The project coordinator identifies and uses effective mechanisms to orient and prepare fifth graders for their transition to middle school. He meets with fifth graders to explain expectations of sixth grade, and current middle school students meet with fifth graders to answer questions about being a middle school student. The project coordinator works with the school to plan and host an orientation meeting for incoming sixth grade students and their families. Nineteen enrolled sixth grade students and their families attended the orientation in August 2001, and 13 students and their families attended the August, 2002 orientation. These meetings proved to be an effective and efficient way to transmit information, introduce students and families to teachers, and begin utilization of the school agenda -- a tool for organizing homework, facilitating home-school communication, and long-range planning. All of these approaches helped allay concerns through direct contact and conversation between families and the school.

During middle school, students must meet increasingly complex and rigorous academic expectations. The project coordinator helps students develop the skills needed to juggle

assignments, classes, manage their time effectively, successfully negotiate more classes and teachers, keep track of multiple assignments, and plan for their transition to high school.

High School Choices. Making an informed choice about high school has critical implications for students' continued successful academic careers. Eighth graders must carefully consider which high schools provide the best environment for their own talents and interests, and complete all required paperwork on time. Additionally, students consider the possibility of applying to a pilot school or sitting for the Independent Schools Entrance Exam (ISEE) to qualify for entrance to the city's exam schools. Students often do not consider these options because of lack of knowledge about them or lack of confidence in taking the ISEE exam. During the 2001-2002 school year, the project coordinator arranged presentations for the students to provide information about the exam. Fifty-four students attended two presentations. He also invited interested students to participate in an after-school ISEE preparation course offered by the school.

The project coordinator surveyed each eighth grade student to help him or her identify priorities for high school, including his or her skills, interests and talents, as well as implications for long-term goals. High school representatives and guidance counselors came to the school to speak with eighth grade students, and the project coordinator took interested students to visit three high schools. The project coordinator gave 33 classroom presentations providing general information about high schools and the application process. He also hosted two parent nights so that family members could learn about the selection process and then receive assistance in completing the applications themselves. He maintained contact with parents throughout the process. Parent reaction to this assistance was extremely positive. This year, the project coordinator required every eighth grader to apply to at least one pilot, exam, or charter school, or if interested, to a private school. He and several middle school teachers helped them with the application essays and other requirements. By the end of the 2001-2002 school year, 11 out of 26 students who applied to one or more of these schools, had been accepted to at least one pilot, exam, charter, or private school. Nine of these students decided to attend one of these schools and the remainder decided to attend a traditional Boston Public School.

Improving School Attendance. The Transition Project supports the Boston Public Schools' Attendance Initiative. The coordinator calls the families of every middle school student who is absent or tardy to find out why the student is late or missing school, reviews the district's attendance policy, and helps problem solve about the underlying cause of the absence. In the 2001-2002 school year, the coordinator made 198 calls to middle school students' families regarding attendance. He provides documentation of absences and follow-through to assure increased attendance. In addition, he recognizes students with excellent attendance through classroom presentations.

Each year, the attendance of students in the Middle School is compared with the previous year's attendance rates. Comparing data on attendance of the 2001-2002 school year to that of the 2000-2001 school year demonstrates that there have been no significant changes in the average number of absences in the eighth grade (5.5 mean number of absences vs. 5.1) The seventh grade is maintaining its high attendance rate (5.2 mean absences in 2001-2002 vs. 5.5 in 2000-2001). Compared to 2000-2001, sixth graders in the 2001-2002 school year had a decrease in the mean

number of absences (4.7 mean absences vs. 7.5 in the prior year). Compared to the Boston citywide average daily school attendance (ADA),the Tobin Middle School's ADA for the 2001-2002 was 97.5 percent, much higher than the citywide Middle School ADA which was 91.7 percent. Even though the Tobin Elementary School does not have staff who can call parents/guardians each time a child is late or absent, its ADA is on a par with the citywide ADA (both ADAs for 2001-2002 were 95.1 percent). In fact, the Tobin Elementary School's ADA is lower than the Tobin Middle School's ADA (typically it is the other way around, with lower grades having better attendance than higher grades). This data strongly suggest that the Tobin Transition Project, with its high emphasis on attendance, has helped increase attendance among Middle School students.

The approach to tracking and intervening in absences provides another opportunity to build relationships with parents and is a critical aspect of supporting students. These relationships are important in other aspects of the project, such as helping students select a high school, finding social services for students or families having personal difficulties, and bringing families into school to discuss academic issues with teachers.

Individual Case Management. Throughout the year the project coordinator provides individual therapy for students in need, as well as case management services and follow-through. He meets with students to discuss social concerns or address behavioral issues, and provides crisis intervention and mediation. The principal reports that since mediation was introduced, the number of suspensions is the lowest it has been in several years. In the 2001-2002 school year, the project coordinator provided over 368 interventions with students.

Summer Jobs. Since its inception, the Middle School Transition Project has offered summer jobs at BWH to Tobin eighth grade graduates. Now in its seventh year, the summer jobs component has employed approximately ten to 20 students each summer for eight weeks, in more than 26 hospital departments. During the summer of 2002, 13 students held summer positions in a variety of departments including four clinical areas, the vascular lab, the transport office, the mailroom, the operating room supply department, and office services. Each week, students spend an afternoon exploring health careers through visits to areas of the hospital and talking with hospital health care professionals.

Based on the success of the summer jobs component of the Middle School Transition Project, students are now offered the opportunity to do volunteer work during the spring term of their eighth grade year. Students explore potential summer work sites and begin to learn job skills and prepare for their summer work assignments.

Skills gained by students through their paid and volunteer work include punctuality, professional dress and behavior, ability to complete tasks, organizational, verbal and written communication skills, problem solving, and using technology. The students' supervisors reported progress in achieving many of these skills.

Roxbury Tenants of Harvard – BWH Community Health Initiative

As a result of an historic agreement between BWH and the Roxbury Tenants of Harvard (RTH), the hospital and the neighborhood participated in a land swap which resulted the relocation of six

homes located on Francis Street and Fenwood Road, and other locations in the neighborhood. This agreement insured that no affordable housing units were lost on Mission Hill. BWH is exploring using the land they received in the swap as a site for a new building to meet the ever-increasing space demands of the hospital.

As part of the agreement with the neighborhood, BWH and the RTH entered into an extensive Community Health agreement that requires BWH to contribute financial resources and expertise. The resources will be used to develop or expand programs related to health, job training and education in the RTH community. With this agreement BWH and RTH established a Community Health Advisory Committee. The committee, which meets regularly, has four members from RTH, including residents, and four members from BWH.

The committee agreed to carry out an assessment of the assets and needs in the community and will use the results to decide upon priorities for new or expanded programs. The assessment is still in progress. The Advisory Committee agreed to recruit and train residents from the community to serve as community liaisons to assist with the assessment. The liaisons receive a stipend and are representative of the diverse RTH community. They include elders; Spanish, Russian, and Chinese speakers; members of diverse racial groups; and adolescents. The liaisons received formal training about how to conduct a needs assessment, strategies for community outreach, and cultural competency. They participated in workshops on how to conduct focus groups and perform key informant interviews.

Under supervision by a staff person from BWH's Office for Women Family and Community programs the liaisons, RTH staff and consultants developed and conducted a multi-pronged assessment by conducting key informant interviews with over 30 residents and staff, holding ten focus groups in English, Spanish, Russian, and Chinese, and mapping community assets. Early results demonstrates the need for programs to assist the elderly access health care, ESL and GED programs, teen mentoring, and community health education on substance abuse, drug abuse, asthma, and depression. The Advisory Committee will hold community forums to share the final results with the community before developing specific programs.

Other Mission Hill Activities

In addition to the activities with the Tobin school and the Roxbury Tenants of Harvard, BWH is an active collaborator with several other Mission Hill groups and initiatives. BWH serves as the "corporate buddy" for Mission Hill Main Streets (MHMS). In addition to committing to a $10,000 contribution for four years that started in 2000, BWH holds a seat on the board of directors of MHMS. The partnership also assists them in other ways, such as providing contributions to support their wide range of community activities, technical assistance, and promotional support for all of the organization activities as well as meeting any other responsibilities of the "corporate buddy."

BWH continues to play an active role in the Mission Hill/Fenway Food Project. As a founding member of this collaboration in 1984, BWH continues to sponsor biannual canned food drives that benefit the emergency food pantry at the Parker Hill/Fenway ABCD office.

BWH is also on the board of directors of Mission Safe, a community based organization that provides a myriad of services to the youth of Mission Hill. In addition to maintaining a seat on the board, BWH also provides cash and in-kind contributions.

BWH is also committed to supporting new and up and coming groups such as the Mission Hill Youth Collaborative. This is a group of organizations and community groups in Mission Hill that serve the youth of Mission Hill. BWH, as an original member of this group, is committed to working with this collaborative as it attempts to plan and develop job training opportunities for the youth of Mission Hill, in addition to establishing a seamless network of shared information and programs among those agencies serving youth.

BWH continues to support programs for the young and old of the Mission Hill neighborhood. The hospital provides annual contribution to support to the Mission Hill Little League. In addition, BWH, for the past ten years, has maintained a discount meals program for Mission Hill seniors. This program affords seniors an opportunity to have a full meal, one Sunday a month, in the hospital cafeteria. BWH has also supported, since its inception six years ago, the annual Harvard School of Public Health Walk For Health, which helps raise funds for Mission Hill agencies and organizations serving youth. In addition to financial support, BWH provides the site for both the beginning and ending of the walk. BWH also provides a free flu vaccine program for Mission Park residents. This program has been offered for the last 15 years.

In addition, BWH provides contributions to many other Mission Hill groups such as Mission Main Tenants Task Force, H.E.R.E. House on Mission Hill, Mission Main Crime Committee and the Alice Taylor Tenants Task Force. BWH also picks up the bus transportation costs for all of the Mission Church Grammar School field trips throughout the academic year.

Other Community Programs

Prevention and Access to Care and Treatment (PACT) Project

The Prevention and Access to Care and Treatment (PACT) Project, a community-based project in inner city Boston, is committed to improving health outcomes for under-served individuals with HIV disease. PACT is a joint project of the Division of Social Medicine and Health Inequalities at the Brigham and Women's Hospital and Partners In Health at Harvard Medical School.

PACT was founded in response to a 1997 Boston Globe article, which reported the growing incidence of HIV among young black women in the disadvantaged neighborhoods of Roxbury, Mattapan, Hyde Park, and Dorchester. In addition, statistics showed that a black woman living with HIV in Roxbury had a mortality rate fifteen times higher than a white man with HIV. Alarmed, a group of community residents in the Roxbury area approached Partners In Health (PIH) for help in creating a community-based program to prevent transmission of HIV and improve access to quality services for those already infected with the virus. With funding from the Office of Minority Health, the PACT Project was born.

PIH recruited and trained the first band of PACT Project's community health workers (CHWs) from the corps of concerned citizens. These community residents, none of whom possessed any

medical expertise, were enlisted, trained, and mobilized to become street-based advocates. Drawing on their acquired medical knowledge and their first hand experience as community members, PACT's CHW's have effectively accompanied PACT participants while navigating the complex maze of social and health resources to find solutions to physical and social ills. The insights and methods of the PACT health promoters in engaging "challenging" patient populations have been extremely effective and instructive to the physicians and students of the PACT project, thereby creating an open and mutually rewarding learning community. Over the past 4 years, PACT has continued to grow and, in collaboration with other agencies and health clinics, serves over 100 HIV-positive individuals from across the city.

Over the past year, the PACT Project health promoter program has been funded through The Crichton Trust and Partners In Health. PACT has two sub-projects, the DOT-HAART (Directly Observed Highly Active Anti-Retroviral Therapy) program and the Fuerza Latina program. The DOT initiative, funded through the Center for AIDS Research (CFAR), employs CHW's to visit ill and non-adherent patients on a daily basis in order to assist them – and observe them – in taking their life-saving HIV regimen. The Fuerza Latina Program, funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a social recovery, leadership-development, and community-organizing program designed to address the personal experiences and social context of impoverished Latino men with a history of alcohol and drug abuse. Through Fuerza, these men are trained as peer prevention leaders and conduct HIV and substance abuse prevention activities to reduce drug-related harm in their communities.

Goals of the Program

PACT's comprehensive community-based programming aims to achieve three primary goals:

- To provide harm reduction training and materials, prevention case management, and peer prevention services to high-risk and HIV-positive individuals, including youth, substance abusers, and young women;
- To increase access to and utilization of culturally-relevant and respectful health care and social services for those infected with HIV; and
- To mobilize the Roxbury community to advocate for its health and to address the underlying conditions and inequalities that create such vulnerability.

Program Components

PACT's Access to Care Program. CHW's provide intensive and comprehensive case management services to over 110 HIV-positive individuals, most of whom suffer from a multiplicity of problems including poverty, homelessness, substance abuse, and mental illness. The access component of PACT also includes the DOT Program where CHW's visit a cohort of non-adherent patients to assist and observe them in taking their medication.

PACT's Prevention Program. Over the past four years, the PACT Project has provided comprehensive education and prevention services to over 200 low-income African American and Latino men and women who vary widely in age and sexual orientation. The Fuerza Latina Program is a new approach to HIV and substance abuse prevention that is based on peer prevention activities. This year, Fuerza will focus on personal recovery, leadership development

and community organizing within a cohort of Latino men in early substance abuse recovery. Over the next two years, the program will be expanded to African Americans, youth, and women.

Evaluation Plan

Both qualitative and quantitative data are being collected from these studies. Quantitative data is being collected through quarterly questionnaires that assess access to care barriers, motivational readiness, risk behaviors, HIV-risk behavior knowledge, and overall program satisfaction. Medical chart reviews and physician report forms also help track clinical/biological outcomes such as recent opportunistic infections, CD4 and viral load count, as well as, utilization outcomes, such as emergency room use and hospitalization rates. Qualitative data is being collected through focus groups, interviews, and participant observation. These help instruct the design and implementation of responsive and effective interventions, as well as shed light on the barriers that the poor and marginalized face in achieving good outcomes.

Program-specific outcomes are also being tracked. Within the DOT program, for example, are adherence rates, change in CD4/ viral load, and movement toward HAART self-administration are monitored. In the Fuerza Latina program, relapse rates, outreach data (e.g., number of condoms and bleach kits distributed in the community), and the impact of community mobilization efforts are being tracked.

Health Careers Exploration Program

Student Success Jobs Partnership

In 1999, Brigham and Women's Hospital, Partners HealthCare System, several community organizations in Mission Hill and Lower Roxbury, and the former Cluster 4 of the Boston Public School System came together to explore ways that Boston public schools and community institutions could work together to support student achievement. As a result, these entities formed the Student Success Partnership (SSP) to help ensure that Cluster 4 students receive the community support they need most in order to achieve their academic potential.

Through the SSP, an in-depth needs assessment with students, parents, and school administrators was conducted. A series of common themes that transcended the circumstances and personalities of individual schools were identified. Students are almost universally eager to succeed and speak with almost one voice about the types of support they need in order to achieve their goals. Students realize the importance of their performance in the classroom. At the same time, students' views of academic success also relate to the quality of their relationships with adults and peers, opportunities for self-expression, and the ability to gain insight into the world around them and develop goals for the future. Students stated that they need consistent, positive reinforcement from adults and mentors, as well as people to offer practical help, knowledge and skills. Students clearly stated that they were able to make connections to a bright and successful future through positive experiences and environments.

In response to many of the needs identified through the SSP needs assessment, BWH launched the Student Success Jobs Partnership (SSJP) in 2000. The SSJP is an after-school work achievement program that provides meaningful learning opportunities to students in Mission Hill and Roxbury.

The goals of the SSJP are:

- To provide under-served students with unique opportunities to envision a promising future for themselves through participation in and exposure to work-sites and careers
- To increase consistent, positive adult involvement in the lives of these students through a broadened commitment of volunteerism from corporate and non-profit community
- To provide opportunities for after-school activities, including workplace environment activities that support rather than compromise the student's academic success

Approximately 7,000 students attend the former Cluster 4 schools, of which 48 percent are black, 22 percent Latino, 16 percent White, and 13 percent Asian. In September, 2000, 25 high school students from Cluster 4 Boston Public Schools were hired to work ten hours per week in after-school positions within departments and programs at Brigham and Women's Hospital. Students from Boston Latin Academy, Madison Park Technical and Vocational School, O'Bryant School of Math and Science, and New Mission High School were recruited.

The coordinator of the SSJP organized and facilitated supervisor and student recruitment and training. She established a strong collaboration with the Private Industry Council (PIC) staff in the Cluster 4 high schools to assist in recruitment of students and to serve as a direct link to the schools. The SSJP Coordinator provided guidance and direction to the students, served as a liaison between the students, schools, parents, and supervisors, and promoted the program throughout BWH. The retention rate was excellent, as 24 out of 25 students (96 percent) passed their 90-day probationary period, and 18 out of the original 25 (75 percent) completed the first year of the program.

Each SSJP student was assigned an adult mentor/supervisor who worked with him or her throughout the program. Twenty-one professional staff members at BWH were recruited and coached to become mentors/supervisors in the program. Supervisors were responsible for the students' daily assignments, including determining working hours, goal setting and achievement. In addition, supervisors offered consistent guidance and positive reinforcement, and answered job-related questions.

SSJP students worked in the following areas: Division of Preventive Medicine; Rheumatology Clinic; Women's Health Center; Health Promotion & Education Program; Bretholtz Family Library; Cardiovascular Diagnostic Intervention Center; Radiology Film Library; Central Transport Services; Office for Women, Family and Community Programs; BWH Physician Hospital Organization; General Surgical Specialties; Ultrasound; General Clinical Research Center; Brigham Dental Group; Parent/Childbirth Education; Center for Reproductive Medicine; Operating Room; Vascular Diagnostic Center; and Tobin Middle School Library and After-School Program.

A series of learning workshops were presented to SSJP students for personal and academic growth. At these meetings, SSJP students shared their experiences and connected with each other as a group. Students were encouraged to discuss their accomplishments as well as obstacles that they may have encountered during the program. Topics of the workshops included: managing personal finances, dressing for success and telephone etiquette, exploration of healthcare careers, and understanding the college preparation process. Through seminar evaluations, SSJP students indicated that the seminar workshops were useful, and the speakers were positive role models who demonstrated a clear connection between a positive after-school experience and success in the future. Students also suggested several topics for future seminars (e.g. more college preparation, computer skills), and their ideas have been incorporated into the seminar schedule for the second year.

2001-2002 School Year

Seventeen students participated in the second year of SSJP, including ten students from the first year of the program. Participants were again recruited from the former Cluster 4 high schools to work in offices and departments at BWH.

In addition to providing important job experience and adult mentors, SSJP also strives to improve the academic achievement of all participating students. During the 2001-2002 academic year, a Boston Public School teacher met with several of the SSJP students to help with their mathematics (the subject most requested by participating students) homework. In end-of year evaluations, students stated that the tutoring had helped them better understand their assignments and had an impact on their grade by helping complete homework and encouraging the timely completion of assignments.

During the second year, SSJP students attend a number of lectures and workshops focusing on personal and professional growth. Students found the series, which highlighted topics such as college preparation, managing personal finance and exploration of healthcare careers, to be beneficial as they planned for the years after high school.

Student Stories."*It has meant a lot to me to be a part of SSJP. I have learned and discovered many new things that have helped me make the right decisions. Through the program, I worked in the Microbiology Lab at BWH. I have learned to do a lot of the things that employees do. I have also realized the importance of the lab to the hospital, and how to work independently and cooperatively. This program has helped me aim for success."*

"After working with BWH staff and victims of domestic violence in Passageway, I realized that I want a career interacting with children. I am planning to be a pre-medical major in college and study to become a pediatric nurse."

"The Student Success internship has led me to understand different careers. I have met many people through this program and learned how to communicate with many different people. I enjoyed being a part of SSJP and hope that it continues to run so that other students may have the same opportunity."

"Completing this program means that I have succeeded. Sometimes I wanted to quit and hang out with my friends, but then I remembered that it was a privilege to participate in this program. I have done something useful with my time and have completed a successful internship at BWH. It shows people that I am not a person who gives up easily."

Evaluation. The SSJP participants are a key component in shaping the direction of the program, and the tremendous success of the program is directly related to the sense of ownership and investment felt by student participants. As such, participants are a critical component of the evaluation of SSJP.

Several evaluation materials have been developed and are being used to ensure that the SSJP program goals are being reached. Many of these methods have been used for the past two years and are instrumental in measuring student progress and student, supervisor, and parent satisfaction with the program. This information is also used to capture specific lessons learned and to upgrade program design and implementation. These methods include:

- Beginning and End of Year Student Questionnaire
- Seminar Evaluations
- Mentor/Supervisor Evaluations
- Parent/Guardian Interviews
- Massachusetts Work-Based Learning Plan (MWBLP)
- Tutor Evaluations

SSJP's first two years have provided the foundation of a successful program, prepared to grow in years to come.

Improving the Health of Women

BWH is the state's largest birthing hospital, and it plays a unique role in developing and implementing innovative women's health programs. Women's health is viewed as more than a service of primary, obstetric, and chronic care for women's reproductive and other problems, but as a way to ensure healthy families and thus healthy communities. Women from low-income neighborhoods who are also disadvantaged by their educational status, language, employment, economic status, immigrant status, language, race, or other personal characteristics face significant barriers to maintaining their health and that of their families. Promoting programs that improve the health of women through health, social support, educational opportunities, and employment fosters healthier families and thus healthier communities. Programs that extend to families also help to address the needs of women as these programs promote a woman's ability to care for her family.

The overall vision for BWH's community health initiatives is driven by a desire to equalize health status and opportunity among underserved women and their families. Concerned about alarming disparities in health among Boston's core urban population of women, BWH has focused on these women and their families, as well as the communities in which they live to guide its community health initiatives. Higher infant mortality rate for black babies, lower rates of adequate prenatal care for black and Latina women, higher rates of breast and cervical cancer

among black women, higher percentage of black and Latina adolescents who become mothers, and the impact these health concerns have on the health of families and children are the types of health disparities driving BWH's community benefit focus. The Office for Women, Family, and Community Programs (OWFCP) is responsible for carrying out several community health programs designed to improve the health of underserved and minority women as part of BWH's community health mission.

Perinatal Case Management Program

Established in 1991 as a response to the high infant mortality and low birth weight rates in certain Boston neighborhoods, the Perinatal Case Manager Program (PCMP) seeks to prevent infant deaths and poor birth outcomes by addressing the social and medical needs of pregnant women. The PCMP provides support for case managers at each of six of the hospital's licensed or affiliated health centers, (Brookside Community, Southern Jamaica Plain, Martha Eliot, South End, Mattapan Health Center, and Whittier Street health centers). The case managers provide women with comprehensive support services to complement their clinical care. By working collaboratively with hospital providers, case managers ensure that culturally responsive care continues for pregnant women through their perinatal period.

The case managers have established trusting relationships with patients and are often involved in patients' care outside of the OB arena. Case managers provide a variety of services, including risk assessment, advocacy and coordination of care. Case managers educate women about the need for preventive care and about healthy behaviors. They link women to social services in Boston, and have been instrumental in making significant improvements in indicators such as early registration in prenatal care, adequacy of prenatal care, postpartum and infant care, and immunizations.

The case managers have worked with the health centers and community organizations to develop systematic approaches to problems such as housing, immigration, domestic violence, and barriers to health care and welfare benefits. Data collected for FY2002 at six health centers (Brookside, Martha Eliot, Whittier Street, South End, Mattapan and Southern Jamaica Plain) indicate that the five most frequently provided services are in the areas of food/nutrition, education, medical support, scheduling, housing and material needs. The six health centers provided services to 1,839 women, 52 percent of the women had more than one visit, and 39 percent were new patients. Most women had an average of three visits and the average age of women served was 26. The majority (67 percent) of patients were Latina, with 17 percent African American, 7 percent Haitian, 3 percent other, 3 percent Caucasian and 1 percent Somali. Case managers requested workshops about immigration policy changes and accessing benefits for undocumented immigrants. The lack of available subsidized housing is still a challenge for many case managers. Often women who receive services from case managers cannot take care of their health before they take care of other issues in their life such as lack of housing, their immigration status or lack of income. To evaluate whether case manager's services meet the needs of women, a survey will be mailed out to randomly selected patients who have visited the case manager. OWFCP will compile reports describing the results for each health center on an annual basis.

To assist women with gaps in community resources, the PCMP provides the Perinatal Emergency Fund. Case managers can apply to the Perinatal Emergency Fund for financial assistance to help their clients with paying for items such as rent, utility bills, layettes, a stroller,

or groceries. The Infant Car Seat Program, provides car seats at minimal cost to women who are low-income. The PCMP provided 193 car seats to 183 women. Through the Perinatal Van program, women receive transportation to their medical appointments. In FY2002, 123 women made 525 van trips to health-related appointments for themselves or their children.

Outreach and Financial Support for Women with Breast Cancer

This program is a collaborative effort between the Office for Women, Family, and Community Programs and the Healing Hands Foundation. The program assists women with breast cancer who have do not have adequate financial resources or insurance to cover the services and treatment related to their breast cancer diagnosis. Women with individual incomes of $25,000 or less or with family incomes of $42,000 or less are eligible to receive up to $1,200 per year. Women who are eligible can apply for assistance to defray the cost of Tamoxifen, wigs, breast prostheses and bras, transportation and childcare related to treatment, counseling, breast compression sleeves and other related expenses.

To increase community awareness about this program, outreach is conducted over the Internet, via hotlines, at community events, with vendors, in local and national resources guides, at support groups, and in community health centers, hospitals, and churches. Referrals come from either providers or patients themselves.

Many of the women in the program travel a long distance to get to their treatment in the Boston area. Patients often rely on family and friends for transportation, because they are unable to drive after surgery or chemotherapy treatment. Although our program targets low-income women, many do not qualify for MassHealth. Medications such as Tamoxifen are expensive and often not the only medication women are taking for treatment. Many insurance companies do not cover the cost of other similar medications such as Femara. The program works with women to identify other sources of payments. Through collaboration with vendors such as Brooks Pharmacy, the program is able to refer women to the vendor for services. In return, vendors distribute information about the program through newsletters and by displaying applications and a program description at their sites.

During FY2002, 24 women with breast cancer applied for assistance, and 21 met the eligibility criteria. The average age of women is 55 years. The OWFCP distributed funds as follows: 43 percent for transportation, 21 percent for medication, 20 percent for other breast cancer expenses, eight percent for childcare, and one percent for wigs.

Passageway and the Health Center Domestic Violence Initiative

In 1997, Brigham and Women's Hospital (BWH) launched Passageway, a domestic violence intervention program developed by the OWFCP. A hospital-wide domestic violence advisory committee articulated the following goal for the program: to develop and support coordinated, safe domestic violence interventions within BWH and in the community.

The program model is based on an empowerment philosophy and has its foundation in the grassroots history of the battered women's movement. In developing Passageway, the OWFCP created a program that would both incorporate the perspectives and experiences of women and assist the hospital in integrating screening for abuse and domestic violence interventions into routine health care.

Since its inception, Passageway has responded to approximately 1,700 new requests for advocacy services and consultation and trained over 2,250 health care providers and staff. In addition to working with on-going clients, Passageway provides support groups in English and Spanish.

Passageway at BWH works collaboratively with community health centers and agencies through its four program components:

- Advocacy Services and Consultation
- Training/Education
- Community Linkages
- Evaluation

Advocacy Services and Consultation

Passageway provides free, voluntary, and confidential services to patients and employees who are experiencing domestic violence. Services include risk assessment and safety planning, crisis intervention, individual counseling, support groups, referrals, intervention with complex systems (e.g., health care, courts, employers), assistance in accessing resources and education to patients and employees in understanding their rights and options. Staff offers consultation to health care providers and hospital staff regarding screening practices, safety planning, and other issues impacting patient and employee safety.

During FY2002, Passageway responded to 464 Brigham and Women's Hospital patients and employees experiencing domestic violence. There were 345 new requests for advocacy and consultation. There were 6,203 service contacts provided on behalf of victims of domestic violence. Staff facilitated 14 support group sessions, with an average of five participants at each session.

Training/Education

Health care providers and staff are trained to understand the issue of domestic violence, how it relates to health care and its impact on women's health and access to health care. Training in prioritized clinical departments is preceded by comprehensive protocol development with the goal of universal screening of female patients. Passageway provides training sessions and technical assistance on safe screening practices and domestic violence interventions. Disguised case vignettes of women's experiences are presented in training sessions to illustrate the impact of domestic violence on women's health. Brigham and Women's Hospital has an institution-wide Domestic Abuse Protocol developed by Passageway and serves as the basic content for clinical training. Pocketsize screening and intervention cards are available to providers. The

hospital's Nursing Department has adopted a self-learning packet developed by Passageway that is included in mandatory competencies for all nursing staff.

Community Linkages

Recognizing that the hospital's response is only a part of the larger continuum of domestic violence services, Passageway staff develops and strengthens collaborative relationships with a variety of agencies and institutions, such as sexual assault programs, shelters, police, courts, and state-certified batterer intervention programs. Staff participates in projects that help facilitate smoother referrals and coordination of services between the hospital and community agencies. Listening to the obstacles that women face in accessing community services, advocates align program priorities in community linkage projects. Addressing gaps in services becomes the first priority for Passageway projects. Current community linkages include:

- Greater Boston Legal Services - a collaborative with renewed funding from the Department of Justice to provide legal assistance to low-income women experiencing domestic violence
- SAGE Boston - a collaboration of over 40 Boston health care, elder protective service and community-based agencies and programs working together to address the needs of women over 60 who have traditionally been under-served by domestic violence and sexual assault services
- NASW Committee on Domestic Violence and Sexual Assault - working group to improve the responses by mental health providers to abused women and perpetrators of domestic violence

Evaluation

To develop effective advocacy, training, and community linkages, staff conduct quality improvement projects and extensive evaluation to assess needs and determine program priorities. Evaluation projects inform service delivery, protocol development, training content, and community partnerships. In addition to review of service utilization, current evaluation activities include finalizing the analysis of 30 in-depth interviews with abused women, standardizing data collection throughout the hospital and health centers and conducting a review of screening rates in the hospital's Emergency Department. Passageway is working to develop an assessment tool to better measure outcomes in hospital-based domestic violence programs.

Health Center Domestic Violence Initiative

Established in 1999, the Health Center Domestic Violence Initiative is a collaborative between Brookside, Whittier Street and Martha Eliot health centers. Each health center has a full-time advocate supported by community benefits and administered through Passageway. Currently, advocates from the health centers and Passageway meet quarterly to improve communication and continuity of care for patients and participate in resource sharing and trainings. The Initiative's aim is to ensure consistent and safe domestic violence interventions across the health care system and increase access to support for women experiencing domestic violence.

Domestic violence advocates at Brookside Community Health Center, Martha Eliot, and Whittier Street health centers, responded to an additional 201 patients seeking services, with a total of 1,153 service contacts. In addition, the health center advocates offered 47 support group

sessions for patients and community residents and participated in six health fairs and community awareness events.

Harvard Medical School's (HMS) Center of Excellence (CoE) in Women's Health

The HMS CoE was created to establish and evaluate a new model health care system that unites women's health research, medical training, clinical care, public health education, community outreach, and the promotion of women in health professions around a common mission to improve the heath status of diverse women across the life span. The HMS CoE has a major focus on the health of minority women. The OWFCP has taken the lead in developing programs and initiatives to address these issues in the CoE. The OWFCP has developed health journals that focus on the health needs of women of color. The journals contain important health education information, a section for women to track their own health history, and resources. The journals offer recommendations for questions women should ask their providers and provide suggestions for routine health screenings. The goal is for women to use the journals to advocate for high quality care for themselves. The journals have been reviewed in focus groups by women in the community and have been well received. The journals will be distributed to women and evaluated for their effectiveness in increasing knowledge and their satisfaction with health interactions.

Health of Women and Infants Working Group, Boston Public Health Commission

The OWFCP has taken a lead in co-chairing this group and developing and evaluating a model of care that is designed to improve the health outcomes of women in Boston who have a history of fragmented care. Through funding from the Boston Foundation and the Centers for Disease Control, BWH is participating in a demonstration project to reduce discontinuity of care, systematically identify medical and social risk among women, increase access to appropriate services, and improve women's satisfaction with the process of care. The implementation of this model includes: provider education, designing and testing a health assessment tool, and using a case management model to identify and link women to health care and social services. This project is ongoing, and enrollment of women will continue over the next three years.

Access to Care

BWH is one of the largest providers of free care to people without means to pay for health care in the Commonwealth. In FY2002, more than $16 million worth of care was provided to nearly 7,000 patients. Almost half of these free care patients came from the communities of Dorchester, Mattapan, Jamaica Plain, and Roxbury.

BWH is also a major provider of health care for patients on Medicaid, providing more than $55 million worth of care to almost 27,000 patients in FY2002. Almost one-third of those patients were from Dorchester and Mattapan.

Measuring the Commitment

One way to measure BWH's commitment to the community is by the amount spent on health care services and programs. The following table calculates this in two different ways: first, according to the guidelines promulgated by the Attorney General's office and second, according to a broader definition which considers additional components of spending or revenue loss.

Components of FY2002 Community Commitment
(in $ Millions)
Compiled According to the Attorney General Guidelines

Community Benefit Programs		
Direct Expenses		
	Program Expenses	3.4
	Health Center Subsidies (Net of Uncompensated Care)	5.6
	Grants for Community Health Centers	0.8
Associated Expenses		N/A
DoN Expenses		N/A
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	2.1
	Doctors Free Care	2.2
Net Charity Care (Shortfall plus Assessment)		17.8
Corporate Sponsorships		N/A
Total per AG Guidelines		31.9

Components of FY2002 Community Commitment
(in $ Millions)
Compiled According to a Broader Definition

Community Benefit Programs		
Direct Expenses		
	Program Expenses	3.4
	Health Center Subsidies(net of UC and Medicaid Loss)	4.4
	Grants for Community Health Centers	0.8
Associated Expenses		N/A
DoN Expenses		N/A
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	2.1
	Doctors Free Care	2.2
Net Uncompensated Care – Hospitals		12.0
(Shortfall plus assessment net of Insurer Contributions)		
Bad Debt (at Cost)		
	Hospitals	6.4
	Doctors	9.8
Medicaid Loss (at Cost)		
	Hospitals	13.9
	Doctors	5.2
Unreimbursed Expenses for Graduate Medical Education		27.0
Linkage/In Lieu/Tax Payments		1.0
Total Broader Definition		88.2

Note: Where N/A is reported, it should be noted that although amounts are not available for reporting, Partners hospitals, health centers, and physicians provide substantial contributions.

Depending upon the definition used, BWH contributed between approximately four and almost ten percent of patient-care related expenses to the community in FY2002.

Health Centers

Brookside Community Health Center

Background

Brookside Community Health Center was originally established as the Brookside Park Family Life Center in 1970, a "grass roots" program with a five-year funding grant through the Model Cities Program. This grant was made in response to a proposal drafted and developed by a group of community residents, organized to address the health care needs of Jamaica Plain. The proposal clearly expressed a defined set of needs, identified in a community needs assessment,

for accessible affordable health care that addressed the social and medical needs of families.

A group of local residents established itself as the center's Consumer Policy Board functioning under a set of by-laws drafted to govern the Board and its actions. The Board took action to plan and organize the health center and hire the first staff members. The Board continues to function as an engaged set of consumers and advisors who work directly with the health center's Executive Director and staff. The 16-seat board requires that 12 of the seats be filled by consumers who are elected at-large annually by health center clients.

Throughout its 32-year history, the health center has evolved and grown in order to meet the needs of its patients and improve the health status of the community. In 1970, after initially opening for business in a school classroom, the health center moved to four house trailers and then into a renovated parish hall basement. Within 5 years the health center had settled into its current location, a manufacturing building leased by BWH from the City of Boston. The building, a one story, 27,700 square foot space, was renovated in 1975 with funding from a federal government program to meet the health center needs. The building is fully handicapped accessible and on public transportation routes. The health center occupied the building with N.I.C.E, a community-run day care program, until the summer of 1999. At that time, the Day Care relocated to a new building of its own, allowing it to increase its capacity and offer services in an updated and fully refurbished space.

In December of 2000, BWH purchased the building from the City of Boston. Long-planned renovations, which will result in a complete overhaul of the building's infrastructure systems, were initiated in June, 2001. This work has taken longer than planned and is expected to be completed by late January, 2003. Once completed the renovations will allow the health center to occupy the full building. This increase in space will support improved working conditions for staff and the delivery of care available to serve clients.

Brookside's board and staff continue to remain committed to its mission,

> ***To provide high quality, family-oriented, comprehensive health care, with a focus on serving the low income population of our community, regardless of ability to pay.***

With this mission, the health center has always strived to provide comprehensive, family-oriented, multi-discipline services, in a public health model. Services are provided through four direct care departments, Medical, Dental, Family Services and WIC/Nutrition. Each of these departments is made up of a multidisciplinary team of staff. The Medical department provides primary care in pediatrics and adult medicine, OB/GYN care and family planning services. The Dental department provides preventive and restorative services as well as endodontic, periodontic and orthodontic services to adult and pediatric patients. The Family Services department provides mental health, social services, HIV health education/ prevention, Substance Abuse services, and Parenting Education and Domestic Violence Advocacy Support services. The WIC/Nutrition department provides nutritional assessment and counseling to adults and pediatric patients, a supplemental food support program and a Smoking Cessation program. An on-site laboratory, managed by Brigham and Women's Hospital's Laboratory Administration, provides services to all departments. Brookside has 123 staff members for a total of 94.6 full

time equivalents (FTEs) positions, including physician staff.

Over the past 32 years of service, Brookside has reached out and served approximately 30,069 residents from the community. In FY02 alone, there were 1,484 new clients registered for services at the health center. This number represents an increase of 8 percent over the number of new registrants in FY01, and a 28 percent increase over FY00. This continued steady increase of new clients seeking enrollment at Brookside clearly reflects a strong public recognition of the services offered.

Of these new users, 30 percent came directly from Jamaica Plain. This indicates strong, continuing support from the community for the health center. A review of the ethnicity of new registrants found that 62 percent reported their ethnicity as Latino, 13 percent as African-American, and 13 percent as White. These trends are a continuation of those seen over the past few years. It clearly establishes the support of the growing Latino population in the City of Boston for Brookside services, while maintaining a level of diversity in Brookside patients. In another important area, over 60 percent of the new registrants came to the health center already enrolled in insurance and/or entitlement programs. This is a 13 percent increase over FY2001 and reflects the trend that an increasing number of new patients are those who have multiple options for health care are choosing Brookside for their care. Although there has been a decrease in the number of new patients who report income levels below $100/week, (22 percent in FY2002 compared to 31 percent in FY2001), Brookside continues to serve those who may be less fortunate with a continuing ability to attract the most vulnerable members of the community while meeting the needs of others

FY2002 Accomplishments

FY2002 was one of change and adjustment. Due to the on-going renovations and construction, staff and patients alike were challenged in their day-to-day efforts to get needs met and maintain the high quality of care that is Brookside's legacy. This project has had an impact on all but despite the stress it presented, staff continued to demonstrate a commitment and dedication that is unique valuable. This was a busy and demanding yet productive and rewarding year for all involved in the health center.

Some of the highlights of our accomplishments include:

- Conducted 60,777 patient visits, recruiting 1,484 new clients and reaching a total of 10,247 unduplicated users, maintaining all hours of operations and providing high quality care with a continued focus on coordination and collaboration to achieve successful patient outcomes, despite the renovations.

- Successfully recruited a halftime OB/Gyn MD, stabilizing the services available and increasing capacity to better meet patient demand.

- Managed to keep most grant-funded programs in place despite cuts to most and substantial reductions in others. Programs that continued despite funding cuts included the Jamaica

Plain WIC Program, along with the CHC Support and Enhancement Project and the Primary Care Program. The very successful Smoking Cessation Program was selected for a 45 percent increase in funding allowing for greater outreach and increased number of clients served. Unfortunately, both grants to support HIV work were reduced by 50 percent and resulted in the closure of these services for a period of time.

- Continued important projects to support the work and mission of the health center. These include: Urban Youth Connection Project, offering the increased resource of a on-site coordinator working with providers to increase information on physical fitness programs and develop programs to address issues of obesity in youth; the Partners In Asthma Care Program, which offers the services of an on-site RN Case Manager to support the needs of asthmatic patients; Reach Out and Read Program, providing free, age-appropriate books for all children seen for well-child visits; and the REACH 2010 Project, a research project focusing on increasing access to cancer screen programs for women of African descent.

- Once again, Brookside staff were selected for recognition and honors in the Partners HealthCare Systems, "Partners in Excellence" awards program.

- Dr. Barbara Gottlieb, a primary care provider in the Internal Medicine practice, was selected as a recipient of the Community Clinical Award by the Brigham and Women's Physician Organization at their annual physician recognition banquet and appointed "The Academy" of Harvard Medical School.

- Staff continued to increase number of patients receiving financial and administrative assistance with applications for Medicaid and Free Care, and decreased the percent of uninsured. Staff assisted close to 700 families in successfully in obtaining healthcare coverage under MassHealth.

- Completed credentialing of Nurse Practitioners and Nurse Midwives in the Medicare program as well as with other payers such as Blue Cross, etc. to increase access to reimbursement and allow all patients the options of seeking care from this highly qualified and committed group of clinicians.

- Participated in BWH/Faulkner and Partners Psychiatry Department's Substance Abuse Team working to identify initiatives and develop programs to meet the needs of patients.

- The Consumer Policy Board continued the work of their very successful efforts for community outreach, increasing the Jamaica Plain awareness of the health center.

- Jamaica Plain WIC Program was once again recognized by the Department of Public Health for having one of the highest breastfeeding rates in the State as well as one of the highest rate of immunizations for WIC enrolled children and highest Early Prenatal Enrollment rates among Massachusetts WIC Programs.

- Continued to take leadership role in health planning projects such as:
  - City-wide Alliance for Health

- Boston Conference for Community Health Centers
- J.P. Asthma Initiative
- J.P. Tree of Life
- JP Health Planning Committee
- Neighborhood Health Plan (NHP) Advisory Board

- Maintained extended service hours of Medical and Dental department, offered evening hours to WIC clients at Brookside and Martha Eliot and increased utilization of services by offering increased access to the working families of the community.

- Conducted center-wide Patient Satisfaction Survey as well as a Staff Satisfaction Survey with excellent findings.

- Brookside was selected as a site for the City Year-sponsored Serve-a-thon for the seventh year in a row.

- In collaboration with NHP's Campaign for Excellence developed a plan that resulted in funding to support the following essential staff: Pediatric Team Leader, Diabetes Case Manager/RN, Women's Health Counselor and a Data Collection Clerk to meet the needs for updating immunizations.

Southern Jamaica Plain Health Center

Background

One of the health centers operating through the license of BWH, Southern Jamaica Plain Health Center (SJPHC) has been serving the community for over 30 years. Starting as a well-child clinic in Jamaica Plain's Curtis Hall, the health center now serves close to 9,000 patients with its comprehensive services of adult medicine, pediatrics, women's health, mental health/substance abuse services, cardiology, nutrition and podiatry. SJPHC's mission is to provide personal, high quality health care with compassion and respect to a diverse community. Health center providers include six internists, four pediatricians, midwives and nurse practitioners in women's health, a podiatrist and cardiologist, and social workers, psychologists and psychiatrists in the mental health/substance abuse department. Sick calls are screened by the bilingual triage nursing staff. Patients made 40,000 sick and health maintenance visits last year, taking advantage of the health center's accessible schedule and 24-hour on-call service.

The health center augments its medical and mental health services with health education, case management, screening programs (blood pressure, diabetes, mammography, cholesterol), a Mind/Body Center that includes T'ai Chi and yoga, and a child literacy program. In addition, the health center has a long history of providing substance abuse treatment services to patients, families and the community. Health center staff also works collaboratively with residents of the local South Street public housing development.

The patient population of the health center is quite diverse, both ethnically and economically, reflecting the community in which it is situated. Approximately 50 percent of the patient population is Latino, 11 percent African American and 39 percent white. The health center is beginning to attract patients who have recently immigrated from the African continent, Asia and the Caribbean Islands. Seventy-five percent of the health center staff is bilingual in Spanish to serve the patient population.

All of SJPHC's physicians are on staff at Brigham and Women's Hospital and are on the faculty of Harvard Medical School. All SJPHC providers are credentialed with the major managed care companies; financial assistance is available in the form of MassHealth, Children's Medical Security and Free Care/Sliding Fee.

In December, 1998, SJPHC moved a few blocks down the street to a brand new facility. This building is a welcome addition to the business district of Jamaica Plain and provides SJPHC's patients and staff with a quiet, welcoming, private and spacious location in which to receive health care services.

FY2002 Accomplishments

- The health center's patient population continues to grow rapidly, and SJPHC remains a major resource for access to care for the populations most at need in Jamaica Plain and surrounding communities- immigrant, Spanish-speaking, and low-income residents. The patient population has grown from 4,600 patients to almost 9,000 patients since the move to the new facility in December, 1998, a growth of 96 percent in four years.

- Collaborating with JP Tree of Life and residents of South Street public housing development, the fifth year of a community-building project was successfully completed, and funding obtained for the next year of the project, with Brigham and Women's Community Benefits as the lead funder. SJPHC is providing supervision to the Teen Peer Leadership Program.

- The Pediatric Department continued its participation in the Reach Out and Read program and was very successful in securing over 1,000 books for SJP's pediatric patients. Young patients receive a book each time they come for their well-child visits.

- The Pediatric Department ran a bicycle helmet program in collaboration with Children's Hospital.

- SJPHC participated in major community activities such as the Jamaica Plain World's Fair and the Wake Up the Earth Festival, where SJPHC also provided the First Aid Station.

- SJPHC received staff grants for health education from the Massachusetts Department of Public Health and for case management from the Boston Public Health Commission.

- During the holidays, the health center participated in the Globe Santa program.

- Collaborating with Pfizer Pharmaceuticals and Partners, SJPHC provided three heart parties to the local community. These "parties" include screening for cholesterol and glucose levels and checking blood pressures. Over l00 women participated.

- SJPHC held the annual SJPHC Health and Safety Fair featuring a bicycle helmet and safety program.

- The health center was a site for an important cardiac research study conducted by Dr. Paul Ridker of Brigham and Women's Hospital, looking at aspirin and c-reactive protein.

- Access to the health center's women's services continued to improve. The health center provided prenatal care to 150 women, and continues to be a major source of care in the community, particularly for Latinas.

- Support for pregnant and breastfeeding women is provided at the health center through a series of prenatal classes presented by the health center ob/gyn, midwives and pediatrician. In addition, a breastfeeding support program is available in collaboration between the SJPHC midwives and La Leche League.

- SJPHC, with funding from Blue Cross/Blue Shield, ran an exercise program for girls six to 12 years old who are overweight or have a sedentary lifestyle. Participating girls were introduced to lifelong exercise activities such as walking, jogging, dance, and yoga.

- Along with SJPHC's two sister health centers in Jamaica Plain (Brookside and Martha Eliot), SJPHC participated in the planning and implementation of the Mayor's Health Van's visits in the Jamaica Plain community.

- SJPHC played a key role in increasing dialogue and cross-referral among a variety of asthma providers who serve the Jamaica Plain community.

- The SJPHC Community Advisory Board, made up of ten members, continued to provide input from patients and community members about SJPHC's services and programs.

- SJPHC awarded two $500 Martin Leber Scholarships to health center patients going on to college or post-high school training programs. Established in honor of SJPHC's longtime pediatrician, the awards went to students in nursing and medical assistant programs.

BWH-Affiliated Community Health Centers

In addition to its licensed health centers, BWH works in partnership with a number of area community health centers. A description of specific collaborations follows.

Codman Square/Dorchester House

Asthma Disease Management

Codman Square and Dorchester House participate as pilot sites in the Partners in Asthma Care program, a collaborative effort including Partners and Neighborhood Health Plan. The program provides an asthma case manager at each health center, as well as enhanced patient education materials and provider training. Other asthma performance improvement efforts include the development of clinical guidelines, culturally and linguistically appropriate patient education materials, and clinical tracking measures. One measurable result of these efforts is a decline in hospitalizations and visits to the emergency room for patients with asthma in these community health centers over the past three years.

Health Services Partnership

Partners provides funding for Health Services Partnership (HSP), which is the medical services organization (MSO) founded by Codman Square and Dorchester House. HSP has brought strong care coordination programs to the health centers, sophisticated information services network and data reporting capacity, the implementation of a coding and organizational compliance program, and improvements in behavioral health care. Recently, Codman and Dorchester merged their public health, youth, and technology programs as part of the DotWell Initiative. HSP works to further the health centers' goals to provide the highest quality care and to improve patient access and satisfaction. Two current major initiatives to achieve these goals include reengineering of the patient visit and advanced access scheduling.

Martha Eliot Health Center

Brigham and Women's Hospital has had a relationship with Martha Eliot Health Center for more than 25 years. The relationship is based on the desire to meet the obstetrical, medical, and surgical needs of Martha Eliot patients and to partner with them to improve the health of Jamaica plain's most vulnerable residents. Partners supports a number of key positions at Martha Eliot Health Center that improve medical management prevention efforts and care for underserved patients. These positions include:

Prevention Nurse

The nurse is a certified diabetes educator who is bilingual in Spanish. Since her arrival, screening rates for diabetic patients have increased dramatically. She has also helped to improve mammography and pap smear rates. This position also serves as a continuity nurse, working with physicians to coordinate home services and visiting nurse functions after hospital discharge, as well as follow-up visits with the patient's PCP. Currently, the prevention nurse is working to

expand preventive services and health education to all patients seen in the Adult Medicine practice.

Patient Liaison

The majority of Martha Eliot patients are Latino, with almost two thirds reporting Spanish as their primary language. The Spanish-speaking patient liaison in the Adult Clinic plays an important role in helping these patients access subspecialty care and improving communication between referring physicians and subspecialty providers.

Advanced Practice Nurse

The nurse practitioner in the Adult Triage/Walk-In practice supports both Adult and Women's Health Services patients with urgent medical issues, as well as adolescent youth with urgent medical issues. Shifting less complicated urgent visits to the advanced practice nurse has resulted in increased access to primary care physicians and preventive services within the Adult Clinic.

Case Manager

The case manager is indispensable in assisting providers and patients with many of the social issues impacting the health of the patients. The case manager assists patients with insurance applications, transitional public assistance and housing. She also assists with billing issues, transportation and accompanies patients with limited English proficiency to appointments at subspecialty clinics, courts and immigration hearings. This role meets the patient's social needs, allowing physicians to concentrate on the patient's medical issues.

Whittier Street Community Health Center

Cervical Cancer Screening

Several years ago, Simmons College faculty and students, Dana-Farber/Partners CancerCare, and Whittier staff participated in a series of meetings to develop an improved tracking system for cervical cancer screening services. Faculty from Simmons conducted Continuous Quality Improvement (CQI) training to provide staff with process tools for system and organization development, including mapping, measurement techniques, and evaluation approaches. As a result of this work, Whittier Street has implemented a computerized tracking system for cervical screening services. The system has enhanced communication between clinical staff and departments. More recently, Whittier is reviewing the case management component of cervical screening and the Whittier/Simmons collaborative has conducted studies on caring for diabetes patients, controlling infections from invasive procedures, screening and follow-up for breast cancer. In addition, Whittier has been participating in the Breast and Cervical Cancer Collaborative. The collaborative comprises17 health centers that work together to provide breast and cervical screening and diagnostic to underinsured and uninsured women.

For the past three years, Partners has provided support for an obstetrician at Whittier Street. BWH and Whittier Street staff have engaged in an evaluation and design effort to build a more

effective case management model.

Mattapan Community Health Center

Breast and Cervical Cancer

Mattapan and Dana-Farber/Partners CancerCare have been collaborating to increase the number of women in the Mattapan area who are screened for breast and cervical cancer. Through this effort, women are provided with better access to mammography services including a mobile mammography van in the community. In addition, Mattapan is participating in the MGH Breast Cancer Program to assist patients who are diagnosed with breast cancer, or who require additional follow-up after a screening mammogram. The program provides funding for a breast health nurse and a patient navigator to help patients access care at academic medical centers and to connect patients with the services they may need to access care (such as transportation and childcare). These efforts are particularly important in Mattapan, where data from the Boston Public Health Commission indicate that Mattapan has a higher breast cancer mortality rate than the overall Boston breast cancer mortality rate.

Health Care Report Card

Partners funded the creation of a Community Health Report Card for the Mattapan and Hyde Park areas of Boston. Created in association with the Mattapan Community Health Center, Boston Public Health Commission, and Simmons College, the Report Card was presented to the community at the annual Health Care Revival meeting. The Report Card brings together key community health data and shows some of the important work that is being done by the Health Center in collaboration with community partners. The data assists the community in better understanding the health trends for Mattapan and Hyde Park in relation to the other 14 Boston neighborhoods.

Upham's Corner Health Center

Clinical Trials

Partners has been working to bring clinical trials focusing on chronic diseases to community health center populations. The Upham's Corner Health Center in Dorchester is the first site to participate in this pilot. The first clinical trial, tentatively scheduled to start January, 2003, is the Navigator trial, which will focus on the prevention of diabetes and cardiovascular outcomes in subjects with impaired glucose tolerance (IGT).

Asthma Management

Upham's Corner Health Center (UCHC) continues to develop and refine its asthma case management program. A full-time Asthma Nurse Educator/Case Manager case is responsible for the asthma clinic. She collaborates with the pharmacist and primary care providers to provide a multidisciplinary approach to the care of asthmatic patients. In addition to preventing crisis

visits, the team works with families to minimize exposure to triggers and to put Asthma Action Plans in to place.

Access Management

Many barriers to health care exist for people who have little resources including lack of insurance or knowledge about how to access it. For this reason, UCHC's Benefits Office provides outreach, assessment, enrollment and post-enrollment services for appropriate health insurance options, including Medicaid, Medicare, Children's Medical Security Plan, Centercare, Senior Pharmacy program, and Free Care. UCHC staff also assists uninsured people over 65 to access the Senior Pharmacy Program. Partners helped fund UCHC's Benefits Office staff, which are all bilingual/bicultural and thus able to assist patients in a culturally competent manner.

Adolescent Health

Partners funding helps to support UCHC's provision of comprehensive care for adolescent patients. The interdisciplinary care team includes a teen clinic coordinator, adolescent social worker, and adolescent health educator.

Other key public health positions that Partners helps to support include a lead specialist, a QA coordinator, a MCH/HIV health educator, and a community health advocate.

Neponset/Geiger-Gibson/Mary Ellen McCormack (Harbor Health)

Harbor Health and BWH/Partners continue to focus on improving the rates of breast cancer and cervical cancer screening. In addition, there are new programmatic efforts focused on addressing abnormal pap smear results and improving follow-up care. Harbor Health and BWH/Partners also have worked to successfully improve pediatric immunization rates. Programs that are aimed at the reduction of unhealthy behaviors such as smoking, substance abuse, STDs, and teen pregnancy continue.

More recently, Geiger Gibson/Mary Ellen McCormack became part of the MGH/Avon Breast Care Program. The goal of the Avon program is to help patients with abnormal findings access state of the art care at MGH and other academic medical centers. The Avon program provides funding for a breast health nurse who can work directly with the patients.

Contact Information

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