MASSACHUSETTS GENERAL HOSPITAL

Center for Community Health Improvement

Joan Quinlan, MPA, Director
Jeffrey Collins, MD, MA, Medical Director

This year, the Community Benefit Program was renamed the MGH Center for Community Health Improvement (CCHI), to recognize its significant charge to implement the new mission of the hospital which for the first time explicitly adds responsibility for improving the health of the community to the hospital's traditional mission of patient care, teaching, and research. The new mission statement is:

> ***Guided by the needs of our patients and their families, we deliver the very best health care in a safe, compassionate environment, we advance that care through innovative research and education, and we improve the health and well-being of the diverse communities we serve.***

To celebrate the renaming, CCHI sponsored an event on June 3rd attended by more than 300 people and at which former Surgeon General Dr. David Satcher was keynote speaker.

To implement this new component of the mission, MGH's President, Peter L. Slavin, MD, has asked every one of the 19 academic clinical departments to partner with the CCHI to develop a community-oriented initiative of significant scope and impact. Dr. Slavin is holding service chiefs accountable for this at annual performance reviews. At least three departments are already working toward this goal with very exciting projects.

- The MassGeneral Hospital for Children is partnering with CCHI, Revere CARES, and MGH Revere to develop an "environmental" approach to childhood obesity. This means that all of the key stakeholders in the community will work together to develop and implement a plan that incorporates multiple strategies across multiple domains (schools, recreation, after school, groceries, etc.).
- The Cancer Center is working to expand programs that offer screening at MGH Chelsea with a focus on engaging underserved and multicultural women through navigators. The expansion will include the creation of a community cancer physician leader who will work across breast, cervical, and colon cancer screenings.
- Psychiatry has already developed desperately needed substance abuse treatment services for adolescents, including those with limited ability to pay. The Addiction Recovery Management Service (ARMS) program will provide assessment and case management services and the department is working to develop an adolescent detox and stabilization unit.

Background on the MGH Center for Community Health Improvement

The mission of the MGH Center for Community Health Improvement, originally founded in 1995 as the Community Benefit Program, is:

> *Guided by the needs and strengths of the diverse communities we serve, the MGH Center for Community Health Improvement collaborates to*
> - *improve and sustain the health and well-being of communities, and to*
> - *enhance responsiveness to patients and their families through innovative approaches, programs and research that advance the field of community health.*

The Center is guided by the following principles:
- Commitment to the underserved and to reducing health care disparities
- Broad definition of health including social determinants
- Population approach
- Build on community strengths and assets
- Prevention, early intervention and health promotion, as well as, equal access to care
- Hospital and communities listen to, collaborate with, and learn from each other
- Sustainability through systemic change
- Evidence-based and culturally appropriate initiatives
- Community-based participatory evaluation
- Dissemination
- Commitment to eliminating disparities

Today, the MGH CCHI has more than 30 partnerships and programs that seek to:
- Prevent and reduce substance abuse and violence
- Increase educational and career opportunities for Boston students
- Eliminate racial and ethnic disparities in health care
- Improve access to care for vulnerable populations

The Center carries out this work in MGH's three historic health center communities of Chelsea, Revere, and Charlestown, and in Boston with hospital and community partners and public schools.

Center for Community Health Improvement Management

The community health improvement, or community benefit plan, is carried out through the hospital's Center for Community Health Improvement. The Director of this program reports to the Chief Medical Officer of the hospital, and has a matrixed reporting relationship to the Vice President for Community Health at Partners HealthCare. The Director and Medical Director also meet periodically to review strategic direction with the hospital President. Last year, the hospital created the CCHI Advisory Committee,

comprising hospital and community leaders. Annual presentations of CCHI activities are made to the hospital's General Executive Committee, the senior leadership and decision-making body of the hospital. Working groups of hospital and community partners guide each major priority. Finally, the local work is guided through coalitions and regular contact with all partners on the community level.

Evaluation, Research and Assessment

Leslie Aldrich, MPH, Director

The MGH Center for Community Health Improvement (CCHI) is committed to measuring outcomes for continuous quality improvement and program development. In order to assess if programs are making a difference, meeting the needs of communities, and efficiently and effectively carrying out goals and objectives, the CCHI Evaluation and Research Team evaluates programming and community wide initiatives. Four team members work with CCHI programs and produced much of the data in this report.

Evaluation and research methods are guided by principles of community-based participatory research (CBPR). These principles are founded on the belief that the people who live in communities where research is conducted have the right to participate in the process of defining community problems, designing and implementing interventions and solutions, and evaluating outcomes. In the ideal case, the process is interactive, with information gained from research benefiting the community through program quality improvement or as data that leads to policy change. In turn, experience with the interventions informs subsequent research and evaluation activities. These research and evaluation methods truly define CCHI's approach to addressing public health issues in the communities. Key principles for CBPR include: building on a community's strengths and resources, collaborating and creating partnerships, ensuring all partners benefit mutually, co-learning, empowerment, and dissemination of knowledge to all involved.

At the end of 2008, MGH CCHI began a strategic planning process. To begin, CCHI is conducting community health assessment processes in Charlestown, Chelsea, Revere, Boston, and surrounding neighborhoods. The assessment includes review of both primary data from focus groups, health center surveys, interviews with key community stakeholders/residents and health center leadership, as well as, secondary data collected from national, state and local agencies. Outcomes will be reviewed and analyzed with community stakeholders and the assessment will be completed in the first half of 2009.

In addition to assessing community needs, CCHI has developed a new program evaluation plan which will require quarterly evaluation meetings and written program narratives, logic model, and mid- and end-of-year report focusing on measurable outcomes. This new evaluation plan is essential for continuous quality improvement purposes and will help to ensure program sustainability and to disseminate program results to larger audiences.

Abstracts were submitted and accepted by the Eastern Evaluation Research Society (EERS), Ethiopian Community Development Council (ECDC), and the International

Family Violence and Child Victimization Research Conference, resulting in four panel discussions and one poster presentation featuring a large variety of Community Benefit work.

Circle of Care

Danelle Marable, MA

The MGH Center for Community Health Improvement Evaluation and Research Team evaluates the Circle of Care (COC) project, a partnership between ROCA, a community-based youth development organization, and MGH. COC provides services to pregnant and parenting teens in Chelsea and Revere. The Circle of Care project is in its fourth year of a five-year demonstration grant awarded by the Office of Adolescent Pregnancy Programs, an office of US Health and Human Services. Services provided include home visiting, parenting skills development, family support, accessible adolescent-focused clinical care, mental health, education, employment training and placement, and referrals to other services. The goals of the project are to reduce the number of rapid (within two years) repeat pregnancies, support teens to finish their education, and provide opportunities for teens to increase their connectedness to peers and family. The evaluation aims to measure the impact of the Circle of Care project on a range of social and clinical variables, and to assess how wrap-around services and coordinated care and tracking contribute to the overall success and health of young parents and their children.

The evaluation is a quasi-experimental design, with a comparison group from a neighboring community. Participants of the evaluation (intervention and control) are asked a series of questions when they enter the evaluation, and then again at six, 12, and 24 months in order to determine the effectiveness of the Circle of Care project. In addition, participants in the intervention group are interviewed after 12 months to gather their feedback on the Circle of Care project, including what they would like to see added to the project.

There are currently 64 young pregnant and parenting teens involved with the Circle of Care and its evaluation, ten of whom are fathers. The average age of the mother is 17 years, while fathers tend to be older, averaging 19 years of age. Most continue their education, with 56 percent either in school or completed school or a GED program. Less than half (44 percent) are working. Half of the fathers and 74 percent of mothers have had a physical in the past year. Six repeat pregnancies were reported this past year.

Those Circle of Care participants who were interviewed after 12 months indicated high satisfaction with the project, especially with their home visitor and the groups they attend. Participants at 12 months showed improvement in parenting attitudes, as measured by the Adult-Adolescent Parenting Inventory.

Goal 1: Increase educational and career opportunities for Boston youth

Boston School Partnerships

Christyanna Egun. Director, MGH Partnership Programs

Operating on the belief that there's a direct correlation between educational attainment, economic potential, and overall health status, MGH has been committed for more than 20 years to engaging underserved and underrepresented youth. In 2008, the Center for Community Health Improvement's Partnerships team embarked on a strategic planning process that would expand academic programming and outreach efforts to engage more Boston youth in the areas of STEM (science, technology, engineering, and math) education and provide more exposure and education about careers and opportunities in healthcare and life science fields.

Concurrently, while working on the strategic planning process, the team continued to manage its existing partnerships at the James P. Timilty Middle School in Roxbury, East Boston High School, and the Health Careers Academy in Boston.

MGH/James P. Timilty Middle School Partnership

Valeria Lowe-Barehmi, Principal
Susan Berglund, Manager, Mass General Hospital, Center for Community Health Improvement, Youth Partnerships

The Timilty, one of three middle schools in the Boston Public Schools (BPS) system to receive a state Expanded Learning Time grant, has 656 students, 46 percent Black, 47 percent Latino, 3 percent White, 1 percent Asian, 1 percent Native American and .8 percent Multi-Race, Non-Hispanic, 18 percent Limited English Proficient (for 38 percent of the students their first language is not English), and 23 percent of the students receive special education. Approximately 81 percent of Timilty families are low income and meet the federal guidelines for the subsidized lunch program.

The **Science Connection Program** engages students in scientific inquiry with the long-term goals of increasing science literacy, enhancing student interest in science/health careers, and creating opportunities for students to interact with positive adults and mentors. The key elements of the program include, *Science Fair Mentoring, Teacher Professional Development, Science in the Classroom Science Family Activity Nights,* and *SummerWorks*:

- During the 2007-2008 academic year, **MGH/Timilty Science Fair Mentoring** successfully matched 27 students with 31 mentors and co-mentors. Mentors, hailed from a variety of departments including nursing, pharmacy, environmental services, respiratory care, nutrition, biomedical engineering and research. MGH mentors and Timilty mentees met at Mass General Hospital every other Friday from October to February. Students and mentors worked together to decide on a question that could be answered through scientific investigation. Mentors guided students in setting up

experiments, documenting observations, collecting and analyzing data, and preparing for various oral presentations that would defend their investigation.

- Additionally, MGH assisted in organizing Timilty's week-long **school-wide science fair** effort. MGH managed and placed 56 volunteers who judged more than 600 projects, 30 judges were MGH/Partners employees, and the remaining judges were Northeastern University, Retirees Enhancing Science Education through Experiments and Demonstrations (RE-SEED) volunteers, CityYear students, Boston Teacher Residents, Boston Public Schools employees, or community volunteers.

***Science Fair Results*:**

- Nine students were finalists at the school-wide fair
- Four won awards at the Regional Science Fair.
- Five students competed at the state level, where one student won a second place award.

The Science Connection program continued its collaboration with the MGH Institute of Health Professions (IHP) through the **Science in the Classroom** initiative**.** The MGH program manager worked with the IHP Physical Therapy Department to design a curriculum that addressed health concerns for Timilty students and aligned this with the Boston Public School science curriculum standards. The issue of obesity was identified by the school as a health problem. According to data collected by the school nurse, 38 percent of sixth grade students were referred for having BMI's (Body Mass Index) over 25 (above the 90^{th} percentile according to the CDC growth charts). The numbers for students referred in grades seven and eight were 32 percent and 30 percent, respectively. As a result of this data, 12 students in the Doctor of Physical Therapy program at the MGH Institute of Health Professions designed and implemented an obesity prevention program called **"We are S.T.R.O. N.G"** for 200 Timilty sixth graders for a period for four weeks that included the **"STEP UP"** program.

S.T.R.O.N.G. stood for smart, trained, ready, organized, nutritious, and growing. The main goal of the STRONG program was to raise participants' awareness about the benefits of staying healthy. The goal of "STEP UP" was to raise participants' awareness about the benefits of staying physically active, and to provide them with some practical and accessible ways to start thinking about the impact of their individual choices on their health and well being. The in-class portion included lessons on goal setting, the importance of balancing energy intake with energy expenditure, and basic physiology, including measuring heart rate. The gym portion consisted of several exercise stations where participants were instructed in exercises and monitored as they performed. Formative and summative evaluation of "STEP UP" encompassed four major themes, including active participation of the students, learning of topics taught during classroom sessions, optimal utilization of class and gym space, and changes in overall health beliefs concerning self-efficacy, locus of control, and the benefits of exercise.

Pre- and Post-Science in the Classroom Data

- Prior to the beginning of the program, nine percent of students reported not eating any fruits or vegetables while at the post-test, only two percent reported not eating fruits or vegetables.
- Prior to the program four percent of students reported not doing any physical activity, this dropped to one percent after the program.
- 39 percent of the students reported they were active at least 45 minutes per day, this increased to 58 percent after the program.

A new addition to the Science Connection Program's **Teacher Professional Development** effort was the Boston Teacher Residency Program (BTR). BTR is a four-year district-based, teacher education program which, building on the medical residency model, combines a full year teacher residency in a school with three years of new teacher support. Four Boston Teacher Residents joined the staff to work with four science teacher mentors in grades seven and eight. The MGH program manager, at the request of the school principal, assumed the role of BTR Site Director. In addition to supporting the nine science teachers, she also directed the mentoring and training of the new science teacher residents. The program manager conducted *Grand Rounds* to expose the residents to a variety of teaching strategies being implemented in classes, to build capacity in the group of experienced mentor/teachers and to foster an environment of collaboration in the science department.

The Science Connection Program held two **Science Family Activity** events this year at the Museum of Science. A Science Family Activity Day was held on a Thursday in January and hosted 200 sixth grade students and about 25 parents/family members who enjoyed the Sea Monsters Omni movie, a special presentation in Cahner's Theater, and the hands on activities in the Human Body exhibit. A Science Family Activity Night held in May attracted more than 270 parents, students, and staff members. Families enjoyed a variety of exhibits with math and science themes presented by the Timilty teachers.

SummerWorks a seven-week career exploration initiative for graduating Timilty eighth graders, provides summer internships at MGH. In addition to being aligned with the Science Connections goals of increasing science literacy, enhancing student interest in science/health careers and creating opportunities for students to interact with positive adults and mentors, SummerWorks also provides students with real-life work opportunities, and increases students' self esteem and sense of personal responsibility. During the 2007-2008 academic year, SummerWorks selected 17 interns, three of who had participated with the Science Mentoring effort.

East Boston High School and Health Careers Academy Partnerships
Michael Rubin, East Boston High, Headmaster
Christy Zarella, East Boston High, Health and Human Service Pathway
Caren S. Walker Gregory, Ed.D., Health Careers Academy, Headmaster
Galia Wise, Manager, Mass General Hospital, Center for Community Health Improvement, Youth Partnerships

ProTech Internship Program

Entering its 17th year, ProTech is a School-to-Career program, in collaboration with the Boston Private Industry Council (PIC) that provides work-based career exploration and preparation for high school juniors and seniors interested in pursing careers in health care.

Through a competitive selection process, MGH works with its partner schools, East Boston High and Health Careers Academy, to identify and recruit 12 new prospective ProTech candidates, annually. Generally, there are a total of 24 ProTech interns at any one time. Interns are employed for 20 months in a variety of MGH departments which include, Patient Care Services, Pharmacy, Radiology, Nursing, Research, Pathology, and the Department of Medicine. To complement the interns' work experience, the ProTech Program also offers trainings, professional development seminars, and shadowship opportunities.

MGH and the MGH Center for Community Health Improvement established the **Edward M. Kennedy Health Career Scholarship** to support and encourage outstanding ProTech graduate's entry into post-secondary institutions, particularly in the areas of health care. Four 2008 ProTech graduates received the Edward M. Kennedy Health Career Scholarship.

A collaboration effort of MGH, Brigham and Women's Hospital, and the Boston Private Industry Council, **Boston's Health Care Post-Secondary Support Initiative** provides post-secondary transitional support to Boston Public School graduates who demonstrate interest in health care careers, and who are pursuing post-secondary certificates or degrees in the Boston area. The initiative addresses the decreasing supply of such workers in the Boston labor market, as well as, the increasing demand for culturally competent health care professionals. The program provides coaching, financial planning, and support, and helps students to successfully apply to and complete post-secondary health care certificate and degree programs.

2008 Protech Program Results

Seven seniors graduated from the ProTech program and were all accepted into post-secondary institutions; one these students enrolled in the US Army.

- One ProTech graduate was the recipient of the prestigious POSSE scholarship.
- One ProTech graduate was admitted to the nursing program at the University of Massachusetts Amherst.
- Through the Boston Science Partnership, nine ProTech juniors participated in the Advanced Placement Summer Bridge program on Harvard University's campus.
- Six ProTech students participated in shadowship opportunities with MGH physicians and hospital administrators.
- Since its inception, Boston's Health Care Post-Secondary Support Initiative has worked with and supported 55 students (20 students from East Boston High)
- Currently, a total of 19 students are enrolled in the Boston's Health Care Post-Secondary Support Initiative and 36 students identify themselves as program alumni.

Additional Commitments to Boston Youth

National Groundhog Job Shadow Day

Job Shadow Day allows students to visit a worksite and "shadow" an employee for several hours, observing, and assisting them with their work. This structured worksite experience provides students with truly an experiential glimpse into the world of work and the range of career opportunities available to them in the world of health care. Job shadowing is integral to making the connection between school and work. Job Shadow Day helps students gain awareness of the skills needed for certain jobs, identify possible career interests, understand the relevance of school to work and careers, apply and develop the skill of interacting with adults. MGH hosted 52 students during the 2008 Job Shadow Day, 44 MGH volunteers participated and of these, six were MGPO physicians.

Summer Jobs for Youth

As the city's largest health care employer, MGH recognizes its responsibility to provide meaningful employment opportunities to Boston's youth, and is the city's largest health care summer employer of Boston youth. Since 1991, MGH has employed students from East Boston High School, Timilty Middle School, and the Health Careers Academy. Revere, Charlestown and Chelsea HealthCare Centers also participate in this program. Students go through a rigorous hiring process, and participate in professional development workshops focused on college and career planning. Supervisors attend a program orientation and training on how to work with, and maximize their experience with young people. In 2008, MGH employed 174 youth from Massachusetts, 127 of whom were from Boston and included students participating in ProTech and SummerWorks. Approximately 100 MGH volunteers served as supervisors to these students.

Classroom at the Workplace Program

MGH has participated in the Boston Private Industries' **Classroom at the Workplace Program** (CWP) for the past seven summers. MGH provides jobs, including paid time to attend academic instruction for those who have not yet passed the Math and/or English portions of the MCAS, the state's standardized test required for high school graduation.

2008 Classroom at the Workplace Results

- Six East Boston High School juniors and seniors participated in the 2008 Classroom in the Workplace summer program with an average attendance rate of 88 percent and a retention rate of 66 percent.
- Three students in the Classroom in the Workplace completed the program pre- and post-tests and increased their score an average of 27 points.
- Overall, Classroom in the Workplace students increased their Math scores an average of 13 points and English scores an average of four points between the pre- and post-test.

- Historical program success (2001-2006): 73 percent of Classroom in the Workplace participants passed both the English and Math MCAS tests, and an additional 21 percent passed either the English or the Math test.

Goal 2: Intervene to prevent and reduce violence

Child Protection Consultation Team

Susan Lipton, LICSW, Program Director
Alice Newton, MD, Medical Director
Debra Drumm, LICSW

The mission of the Child Protection Consultation Team (the Team) is:

> *To provide the highest standard of care to children who may have experienced or are suspected of experiencing abuse or neglect and their families; and to provide all clinicians who care for children with the basic skills and knowledge necessary to provide the full range of appropriate support and service to children and their families: i.e., screen, identify, assess, intervene, refer, and follow-up on suspected cases of child abuse and neglect.*

The Child Protection Consultation Team provides leadership to the MGH's response to issues of child abuse and neglect. The Team is comprised of a program director, medical director, and a part time clinical social worker. Consultation from the Team is available to providers throughout MGH, 24 hours a day, seven days a week, to assist with the assessment and management of suspected cases of child maltreatment. Requests for consultations come from Pediatrics, the Emergency Department, Obstetrics, HAVEN, Adult Medicine, Mental Health, MGH health centers in Charlestown, Chelsea and Revere, the West End Clinic, and other MGH and community providers.

The Team works closely with many disciplines and departments within MGH, including physicians, nurses, clinical social workers, HAVEN advocates, psychiatrists, Police and Security, and attorneys. In addition, the Team interfaces with multiple community agencies including the Massachusetts Department of Children and Families (DCF), Suffolk County Children's Advocacy Center, local police departments, district attorney offices, and the courts.

In 2008, the Team participated in a variety of multidisciplinary interagency committees, including the Suffolk County Children's Advocacy Center's Case Review, and Advisory Board; Suffolk County Child Fatality Review Board; statewide Shaken Baby Syndrome Prevention committee; and a statewide training initiative for the implementation by DCF staff and community providers of new *Guidelines for Mandated Reporters Responding to the Co-occurrence of Domestic Violence and Child Abuse*.

In addition, the medical director participates in the Violence Committee of the Massachusetts Medical Society; the American Academy of Pediatrics Massachusetts SCAN team; a statewide

community education program, *Babies Cry: Have a Plan*; and also provides medical consultation and review to the Massachusetts Pediatric SANE program

The Team provides interdisciplinary training to staff and community providers on the medical and psychosocial aspects of child maltreatment, in a variety of educational forums throughout MGH and the community. Outreach and training to staff of all disciplines continues to be a major priority for the Child Protection Consultation Team.

2008 Program Data

- The Team provided consultations to clinicians in 590 possible cases of child abuse and neglect.
- Reports of suspected child abuse and neglect were filed with the Massachusetts Department of Families and Children on behalf of children in fewer than 50 percent of these cases.

HAVEN

Ann Daniels, MSW, PhD, Executive Director, Social Service Department
Elizabeth Speakman, LICSW, Interim Director, HAVEN

Mission and Goal

> *HAVEN works as part of the broader movement to end intimate partner abuse by improving and enhancing our health care response to MGH patients, employees, and community members who have been impacted by abuse.*

HAVEN's goal is to reduce the immediate impact of violence on survivors and their families, and to help individuals and families seek lives free of violence and abuse. MGH HAVEN serves patients and employees of MGH, including the MGH health centers. HAVEN also trains and consults with MGH providers and other caregivers to screen, identify, and respond empathically to survivors of abuse. In addition, HAVEN advises the hospital on the development of domestic violence policy and protocols, in keeping with guidelines set forth by the Joint Commission.

HAVEN Services and Activities

Advocacy

HAVEN provides welcoming, affirming advocacy and supportive services to all survivors, beginning in the dating years through later life, through a culturally diverse and linguistically appropriate array of supportive services.

HAVEN provides ongoing individual counseling and advocacy services to survivors identified by MGH and health center providers, or who self-identify. HAVEN helps survivors understand that they are not at fault for the abuse they suffer, that they are not alone but rather are joined by many others who share similar experiences, and that there is help available both at MGH and in their communities. HAVEN helps connect survivors

to needed services, provides information and referrals relating to the legal aspects of domestic violence and, if needed, accompanies survivors to health care, legal, or other appointments. In order to respond to an especially urgent and violent trend of increased sexual assault and trafficking in our communities, HAVEN has broadened its framework of domestic violence to include and be able to respond to victims in these complex circumstances.

HAVEN is committed to delivering culturally and linguistically appropriate services. Four of the six HAVEN staff are multilingual and provide services in French, Spanish, Haitian Creole and English. Printed program materials are available in English, Spanish, and Khmer.

Support Groups

HAVEN is especially proud of its comprehensive support group programming. Groups are offered in English at MGH, Seacoast Academy and MGH Revere, and in Spanish at MGH Chelsea. In HAVEN groups, women who have survived abuse come together to share resources, learn about abuse and its impacts, and encourage and inspire one another in their journey towards safety and healing. HAVEN at Revere offered a support group for women impacted by intimate partner abuse this year. The group was a combination of mutual aid support and skills building to cope with trauma. HAVEN at MGH recently began offering two part workshops to survivors of domestic violence on various topics such as building self-esteem and mindfulness. The groups and workshops play an important role in enabling survivors to move forward with their lives.

Specialized Adolescent Services

Consultation to the School Based Health Center at MGH Revere is offered during the 20 hours a week that an Advocate is at the Revere Health Center. HAVEN offered outreach in May 2008 to five sections of high school students at Revere High through their health classes on healthy and unhealthy relationships.

Health Professions Education

HAVEN helps prepare new health care providers through its active internship programs with graduate programs in the Boston area. Interns assist with client work, facilitate support groups, and conduct research initiatives and other individually designed projects. In the 2008-2009 academic year, HAVEN has a MSW Intern from Simmons School of Social Work for 24 hours a week.

Research and Evaluation

The findings from HAVEN's work with the MGH Gillette Center for Women's Cancer on a study assessing the impact of domestic violence on cancer treatment have been analyzed and are starting to be disseminated this year. The study, funded by the National Cancer Institute, involved in-depth interviews in English and Spanish with patients who have faced cancer while in an abusive relationship. HAVEN Advocates and Oncology

social workers have begun to use the data to educate oncology providers about the intersection of domestic violence and cancer. Through collaboration between HAVEN and MGH Gillette Center for Women's Cancer, a booklet will be developed addressing the issues described by the study participants. In addition, HAVEN will be working with a Wellesley researcher to examine how advocates' use of motivational interviewing impacts client's utilization of health care and report of safety at home.

Partnerships

HAVEN maintains numerous partnerships in the service of clients. The Hospital Project of Greater Boston Legal Services, funded through the U.S. Department of Justice, provides legal services to eligible HAVEN clients. HAVEN is an active member of the Conference of Boston Teaching Hospital's Domestic Violence Advisory Council, the Chelsea and Revere Domestic Violence Task Forces, and SAGE-Boston. HAVEN is also represented on the NASW Committee on Domestic Violence and Sexual Assault, and the Revere School-based Health Center Advisory Committee. HAVEN is an active member of Jane Doe, Inc., the Massachusetts Coalition against Sexual Assault and Domestic Violence.

New Projects and Initiatives

This year, HAVEN became a referring partner to Tailored for Success (TFS), a non-profit organization dedicated to helping economically disadvantaged women return to the workforce. TFS distributes free interview appropriate business suits and career clothing, provides interview coaching and professional image consulting, and gives women the opportunity to participate in career development workshops. In addition, HAVEN and the Domestic Violence Working Group at MGH coordinated a suit drive for TFS which resulted in over 1,500 clothing items donated to TFS by employees of the main campus, as well as, the community health centers. The suit drive was an enormous and overwhelming success.

HAVEN has seen an increase in Arabic-speaking Muslim women seeking domestic violence services over the past year. In order to better understand the particular needs of this new immigrant patient population, HAVEN has begun collaboration with faith based community organizations. This collaboration has led to plans for a conference called "Peaceful Families" which will provide education about Muslim women's experience of domestic violence. Within the hospital, HAVEN continues to partner with interpreter services to provide ongoing support and advocacy to Arabic speaking women.

Program Data

- Since 1997, HAVEN has provided services to 4,479 patients, employees and MGH visitors.
- During this time, HAVEN has offered over 3,800 consultations to clinicians.
- 34 percent of overall program clients identify as Latina, ten percent Black, 52 percent White, and four percent other. 46 percent of HAVEN clients are between the ages of

20-39, 43 percent between 40-59, three percent under the age of 20, and eight percent over the age of 60. 96 percent of clients served were female.
- 70 percent of HAVEN clients have children.

HAVEN at MGH Chelsea

Marisol Coreas, HAVEN Advocate
Niza Troncoso, HAVEN Advocate

HAVEN at MGH Chelsea, part of the hospital-wide HAVEN program, works as part of the broader movement to end intimate partner abuse by improving and enhancing health care response to patients, employees, and community members who have been impacted by abuse. HAVEN's goal is to reduce the immediate impact of violence on survivors and their families, and to help individuals and families seek lives free of violence and abuse. HAVEN participates in the Chelsea community-wide Domestic Violence Task Force, multidisciplinary assessment team meetings at DSS, and in a community faith-based initiative. HAVEN is an active member of MGH Chelsea's Safe Start Program and the Family Violence Team.

Two bi-cultural HAVEN advocates train health care providers to ask patients about partner abuse sensitively and effectively. If a patient discloses abuse, the provider offers the services of a HAVEN Advocate, who works to empower survivors to better understand the dynamics and impact of abuse, increase their safety, review options, and heal from the abuse in their and their children's lives.

2008 HAVEN Accomplishments in Chelsea

- HAVEN offered two cycles of *De Mujer a Mujer*, a ten-week curriculum-based support group for Latinas confronting violence, including sessions about traditional roles within a family, STDs, and domestic violence.
- A HAVEN advocate co-facilitated a mother-child group with a clinician from the Safe Start Initiative.

2008 Data

- Since its inception in 1997, HAVEN at MGH Chelsea has provided services to more than 835 clients, 73 percent of whom are Latina.
- 72 percent of patients have been physically abused by their partner. 49 percent of their abusers are active users of alcohol or drugs, 37 percent have threatened to kill the patient, 11 percent have threatened the patient with weapons.
- Over 50 patients have participated in De Mujer a Mujer since the group began.

HAVEN at MGH Revere

Patti Rosell, HAVEN Advocate

HAVEN at MGH Revere, part of the hospital-wide HAVEN program, works as part of the broader movement to end intimate partner abuse by improving and enhancing health care response to patients, employees, and community members who have been impacted

by abuse. HAVEN's goal is to reduce the immediate impact of violence on survivors and their families, and to help individuals and families seek lives free of violence and abuse. HAVEN at MGH Revere participates in the Revere community-wide Domestic Violence Task Force, the Advisory Group for the School Based Health Clinic at Revere High School, and the Healthy Relationships Working Group.

One Advocate trains health care providers to ask patients about partner abuse sensitively and effectively. If a patient discloses abuse, the provider offers the services of a HAVEN advocate, who works to empower survivors to better understand the dynamics and impact of abuse, increase safety, review options, and heal from the abuse in their and their children's lives.

2008 Data

- Since its inception in 1997, HAVEN at MGH Revere has provided services to more than 588 clients, 45 percent of whom are Latina.
- 78 percent of patients have been physically abused by their partner. 27 percent of their abusers are active users of alcohol or drugs, seven percent have threatened to kill the patient, 11 percent have threatened the patient with weapons and seven percent have actually harmed the patient with weapons
- 67 percent of patients reported economic abuse by their partner and 55 percent reported surveillance.

Goal 3: Increase Access to Care for Vulnerable Populations

Boston Health Care for the Homeless Program at MGH

James J. O'Connell, MD

Background

The Boston Health Care for the Homeless Program (BHCHP), founded in 1985 with a Robert Wood Johnson Foundation grant to the City of Boston, delivered health care to 11,200 homeless persons in 2008**.** BHCHP's mission is to assure the highest quality health care to all homeless men, women, and children in the Greater Boston area. A major objective has been to identify and address the marked disparities in morbidity and mortality suffered by the homeless poor.

A trusting and enduring relationship between patient and doctor/clinician is the cornerstone of BHCHP's model of care. Continuity, consistency and coordination are integral to the delivery of high quality care to this itinerant and impoverished population. Multidisciplinary teams of doctors, nurse practitioners, physician assistants, social workers, and nurses offer daily clinics at two academic teaching hospitals, MGH and Boston Medical Center (BMC). These teams also venture out to deliver direct care services in over 75 sites throughout metropolitan Boston, including adults and family shelters, soup kitchens and day centers, detoxification units and treatment programs, a local racetrack, as well as, directly on the streets and most recently to chronically homeless persons who have been placed in housing. These teams provide the continuity that has been so elusive, following patients from the shelters and streets to primary care

and specialty clinics to emergency departments and inpatient care to BHCHP's 104-bed medical respite care unit at Barbara McInnis House. House calls to those who have found housing after years in the shelters and on the streets have now become integral to BHCHP's service delivery model.

2008 proved exciting for BHCHP, as the renovation of the former Mallory Institute of Pathology was completed and dedicated as Jean Yawkey Place. This new facility now houses the program's administrative offices, an expanded 104-bed Barbara McInnis House, and the BMC Clinic that integrates comprehensive medical and mental health care with a state-of-the-art dental clinic and a pharmacy. This renovation was accomplished with funding from varied national, state, and city sources, including $2.5 million from Partners HealthCare.

MGH was among the original three hospital sites for BHCHP, and the first private academic medical center in the nation to create and support an on-site health care for the homeless clinic. This relationship has flourished for almost 24 years. BHCHP at MGH offers primary care each weekday in the Medical Walk-In Unit (MWIU) and coordinates care delivered to homeless patients throughout MGH, especially in the specialty clinics, the ED, and inpatient medical and surgical services.

Medical Walk-in Unit Clinic

- BHCHP practitioners see homeless patients five days at week in the MWIU. With more than 2500 visits in 2008**,** BHCHP accounts for almost ten percent of all care delivered. Two exam rooms have proven insufficient to meet the growing need for primary care for homeless persons seen in the ED, and securing additional space is again a goal for this coming year.
- BHCHP at MGH clinicians also deliver care at community-based locations, including the Pine Street Inn, Overnight Van, Boston Night Center, St. Francis House, Pilgrim Shelter, New England Center for Homeless Veterans, and St. John's Church on Beacon Hill.

Barbara McInnis House

- BHCHP's Barbara McInnis House (BMH) expanded in 2008 from 90 beds to 104 beds in the new Jean Yawkey Place. BMH is a medical respite program that offers a cost-effective alternative to acute care hospitalization. BMH provides acute and sub-acute, pre- and post-operative, recuperative and rehabilitative, palliative and end-of-life care to homeless persons who are too ill or injured to withstand the rigors of life on the streets and in the shelters. This innovative model fills a widening gap in the health care system for those without the safety and support of a home and family.

The Street Team

BHCHP's Street Team provides care to Boston's "rough sleepers," including a high-risk cohort of people with acute and chronic medical problems who avoid shelters and sleep regularly on the streets. The Street Team provides direct care in a variety of unconventional settings: under bridges, down back alleys, in abandoned cars, on park benches and street corners, in soup kitchens, overnight drop-in centers, emergency departments, detox units, and nursing homes. These itinerant homeless persons face overwhelming obstacles to health and health care, including exposure to the extremes of heat and cold, trauma, violence, complex and chronic medical illnesses, persistent mental illness, and substance abuse. In partnership with MGH and the Massachusetts Department of Mental Health, the Street Team has developed an innovative approach to the integration of medical and mental health care (see program accomplishments). These dedicated professionals are a consistent and trusting presence on the streets, allowing a continuum of care from street corner to ICU to respite care, while fully integrating care into Boston's mainstream health care system.

- A Thursday "Street Clinic" in the MWIU at MGH was initiated in 2000 and remains the only hospital-based clinic in the country dedicated to those who live on the streets.
- In April 2008, the team began a special "Wednesday Housing Clinic," to serve former street patients who have been housed. Over 70 patients have been served through 206 visits at this innovative clinic, which has served as the foundation for the Street Team's novel approach to providing supportive health and social services through "house calls" to the new homes of almost 130 former rough sleepers.

Boston's ability to follow such a peripatetic urban cohort over time has not been duplicated in any other large urban city. This is an extraordinary testament to the collaborative network of community partners who share in the care of this disenfranchised population, including: the outreach teams from Pine Street Inn, hopeFound, and Elliott/Tri-City Mental Health Center; the academic teaching hospitals (especially the EDs of Boston Medical Center and MGH); the Area A Police Department; the Emergency Shelter Commission and the Emergency Medical Services of the City of Boston; and the Massachusetts Departments of Public Health, Mental Health, and Transitional Assistance.

Emergency Department Task Force

BHCHP participates in a MGH Emergency Department (ED) Task Force with a goal of improving the care of homeless individuals with high utilization rates. This multidisciplinary team of health care providers, case managers, social workers, and staff meets quarterly and develops and implements practical treatment plans which are kept updated in the ED for reference whenever homeless patients present for care.

Medical Education

BHCHP is actively preparing future physicians in the art and skill of caring for homeless persons. The program developed and implemented a lecture series on health care and

homelessness that is a required component of the MGH medical residency curriculum. During the ambulatory block, MGH residents learn about the history, epidemiology, and clinical issues of homelessness as well as the obstacles to access and continuity of care. Primary care residents join BHCHP staff for community and street clinics during their ambulatory rotations. Five of the team's physicians serve as faculty members in Harvard Medical School's Primary Care Clerkship, and four of BHCHP's 16 current fulltime physicians are graduates of the MGH Internal Medicine Residency Program.

2008 Program Accomplishments

- As a result of MGH's longstanding relationship with BHCHP, Partners HealthCare gave a gift of $2.5 million in 2007, their largest gift yet given, to support the renovation of the former Mallory Institute of Pathology on the corner of Massachusetts Avenue and Albany Street. Renovation of this former city morgue was completed in May 2008, and BHCHP's administrative offices, Barbara McInnis House, the outpatient clinic formerly at BMC, and a new dental clinic all successfully moved and are operating at full capacity.
- BHCHP at MGH physicians Patrick Perri, Elizabeth Cuevas, Monica Bharel and James O'Connell spent a total of two months attending on the inpatient medical service at MGH.
- To better understand the utilization patterns and numbers of homeless individuals served, the Community Benefit Program of Partners HealthCare compared the BHCHP patient database with the PHC database and found that more than 3,000 homeless individuals were served each year by MGH and Brigham and Women's Hospital. Utilization rates of ED, laboratory, and specialty services were high, as were lengths of stay when these homeless patients were compared to housed patients.
- BHCHP and HomeStart have collaborated for the past three years in an innovative "housing first" pilot program to house medically frail homeless persons who have been living on the streets of Boston for over five years. BHCHP's Street Team follows each of these individuals closely, providing 24 hour medical and supportive care seven days a week.
    - 36 individuals have been housed through this program. Only one person has been evicted during this period, although six (17 percent) have died and one suffered a fall and is permanently disabled and now living in a nursing home.
- BHCHP has continued a robust involvement with inpatient care in collaboration with the MGH and BWH nurse case managers. The goals have been to identify all homeless inpatients, assure each patient has a PCP, work together on practical treatment plans, and minimize length of stay (LOS) by fostering safe discharge dispositions and timely access to BHCHP's Barbara McInnis House.
    - 313 homeless inpatient consults were performed, with McInnis House as the most frequent discharge dispositions (72 referrals, or 23 percent).
    - Of the 307 consults still alive at discharge, BHCHP was identified as the PCP for 60 percent.
    - 61 homeless inpatients (20 percent) were "new" to BHCHP; 11 of these patients were discharged to BMH (15 percent of all discharges to BMH)
- MGH has funded an innovative collaboration between BHCHP and the Massachusetts Department of Mental Health (DMH) and its hospital, Massachusetts Mental Health

Center, to pilot two multidisciplinary teams that offer homeless persons a "medical home" that fully integrates medical and psychiatric care. MGH has funded two fulltime BHCHP psychiatrists (one a recent graduate of the MGH Psychiatry Program) to join these teams, as well as, a fulltime case manager. A fourth-year psychiatry resident "fellowship" has also been funded by MGH, and Dr. Lee Bulgin has joined the Street Team and is now supervised by the team's psychiatrist, Dr. James Bonnar. All these clinicians are also fully credentialed within DMH with full access to the array of DMH's mainstream services. These psychiatrists work side-by-side with the team's internists, nurse practitioners/physician assistants, nurses and social workers. Direct care medical and psychiatric services are offered in a host of venues in an effort to reach vulnerable individuals who have been unable to access mental health care in the past. The teams see patients on the streets, in shelters and soup kitchens, in the MGH and BMC clinics, and in McInnis House, offering continuity of high quality care to this hard-to-reach sub-group of the homeless population. This innovative pilot program has become a catalyst for systemic changes in the delivery of medical and behavioral health services at both BHCHP and DMH.

2008 Program Data

- BHCHP at MGH had 2,634 primary care visits in the MWIU during 2008.
- The Thursday Street Clinic at MGH continues to bustle with 1,886 encounters in 2008. Comprehensive care is offered, including medical and mental health care, social services, meals, clothing, and assistance with benefits and housing.
- Of 1,531 total admissions to BMH in 2008, 202 (13 percent) came directly from MGH, including 21 from the ED, 92 from inpatient services, and 89 from outpatient clinics and day surgery.
- BHCHP at MGH doctors and nurse practitioners provided 313 consults on the inpatient service. Consultations were spread among the following services: medicine (72 percent); surgery (17 percent); ED (five percent); neurology/neurosurgery (five percent); psychiatry (one percent); and OB/GYN (one percent).
- Mary Jo Cappucelli, an MGH psychiatric RN, works for BHCHP two afternoons each week, visiting homeless inpatients at MGH (and BWH) and serving as a liaison to the nurse case managers. This effort has a goal of reducing ED and hospital lengths of stay through timely and efficient admissions to BMH. During 2008, 1,021 inpatient and ED individuals were screened and reviewed.
- BHCHP's Street Team has conducted the first-ever prospective study of chronic "rough sleepers," the results of which have been instrumental in the shift in public policy toward ending chronic homelessness through creative "housing first" programs. A cohort of 119 chronic street individuals was identified in 2000. During the five-year period from 1999-2003, Massachusetts Medicaid data revealed a total of 18,384 ED visits by this group, yet the crude mortality rate of this group is 40 percent despite an average age at enrollment of 46 and only very few individuals without insurance. This has focused attention on a dire public health crisis in the shadows of our academic medical centers in cities throughout the country. The dispositions of these 119 individuals after nine years are as follows:

- Deceased 47 (40 percent)
- Housed 44 (37 percent)
- Nursing Home 10 (eight percent)
- Living on streets 9 (eight percent)
- Shelter 2 (two percent)
- Incarcerated 2 (two percent)

Only five persons (four percent) have been lost-to-follow-up during this nine-year study period, a testament to the community partnerships of BHCHP's Street Team.

- The Street Team cared for 1,271 patients in 8,753 visits in 2008 (compared to 1,385 patients in 5,239 visits in 2007). The number of unique individuals decreased by eight percent, while the number of encounters increased by 67 percent. This increase in encounters is a result of the Street Team's direct care of patients at McInnis House, an innovation this year designed to improved coordination and continuity of care.
- An active "high risk" cohort of 121 individuals was identified in 2008. The severity and complexity of the medical, mental health and substance abuse problems of this sub-group are predictors of poor health outcomes and high mortality rates. Primary and preventive health care benchmarks have been targeted by the Street Team in an effort to continually improve the quality of care. For example, among eligible female patients, 25 percent had Pap smears and 46 percent had mammograms.
- 63 individuals in this "high risk" cohort accounted for 174 admissions to McInnis House (BMH) in 2008. The number of admissions per patient ranged from one to eight, while the length of stay (LOS) ranged from one to 270 days, with a mean of 25 days. This cohort accounted for a total of 3,895 inpatient days at BMH.

MGH Senior HealthWISE

Barbara E. Moscowitz, MSW,LICSW Program Director

The mission of MGH Senior HealthWISE (Wellness,Involvement, Support, Education) is to enhance the health and well being of older adults in Boston's West End and Beacon Hill neighborhoods. The chief components of HealthWISE are weekly health and wellness clinics for residents of three neighborhood housing developments, and educational and wellness programs for all older adults in the community, held at MGH and at community sites in both the West End and Beacon Hill neighborhoods. All programs, both within MGH and in the community, are available at no cost.

Partnerships and Activities

Senior HealthWISE collaborates with numerous partners within MGH to deliver its program and services, including the MGH Senior Health, and the Departments of Social Services, Patient Care Services, Patient Financial Services, the Volunteer Department, and the Institute of Health Professions. The MGH General Store and Department of Nutrition and Food Service lend strong support to HealthWISE by providing discounts to members at all MGH and Yawkey gift shops and food sites. The MGH Transportation and Shuttle service has provided transportation to and from volunteer sites such as the Pine Street Inn.

As the needs of frail older adults increase, HealthWISE community partnerships are becoming more structured in order to maximize the effectiveness and delivery of support services. Older adults are frequently lost in the maze of services and programs, and HealthWISE is committed to active outreach and partnership with Boston Senior Home Care, ABCD (Action for Boston Community Development), the Boston Commission for Elder Affairs, the SHINE program, and Match-Up Interfaith Volunteers. Participation in local community efforts and planning is a priority for the program, and staff regularly attend committee and program meetings at local social service agencies.

Wellness Centers

Many frail adults become disconnected from available health care services because they are overwhelmed, confused, or intimidated by complicated systems. The goal of the Wellness Centers is to improve an individual's self-care and health management. This is done through education and support, and by strengthening the connection between the resident and their available resources including their physician, social worker, mental health worker, and any other significant community resource. In addition, social connections and community based activities are encouraged as necessary components of wellness. Successful interventions might include the clarification of an individual's medication regimen, treatment recommendations prescribed by the primary care provider, or referral to social or support groups.

The Wellness Centers are active in The Amy Lowell, Blackstone and Beacon House residences. HealthWISE provides each building with appropriate medical equipment and supplies, and the service is free of charge to residents and building staff. Individuals are registered and required to provide consent for communication between Senior HealthWISE staff and other designated health care providers. Residents receive care at Brigham and Women's Hospital, the Veterans Hospital, New England Medical Center, Boston Medical Center, and others, in addition to MGH. An equally important function of the Wellness staff is to provide consultation to the building managers as they manage the daily challenges of their residents.

Nursing visits include, but are not limited to:

- Screenings: Memory loss, blood pressure, blood glucose, depression
- Chronic Disease Management: Diabetes, hypertension, arthritis
- Education: Explanation of lab results, medication issues, nutrition questions, exercise
- Acute Management: Anxiety, chest pain, cellulitis, gait instability, fall, wound evaluation, flu, fever. Post hospitalization coordination and support

Resident at Risk Program/Illustrations of Team Involvement

The Resident at Risk (RAR) program targets residents who face serious obstacles and challenges to their independence. All members of the team (RN, SW, Resource Coordinator) typically become involved and maintain frequent and continuous

involvement via Wellness Center appointment, Home Visits and coordination with building management and community providers.

Of note is that the general population of residents in the three buildings is becoming increasingly frail, and more are in need of a new level of continuous involvement as their chronic illnesses present ongoing and complex levels of management. The RAR program has grown to include large populations of each building.

Illustrations of Intervention by HealthWISE team

- Residents who are discharged from hospital to home without food, medication or coordination of care. Team contacts agencies, often orders Emergency Food Packs from MGH Nutrition and Food Service, and will assist in obtaining medications from local pharmacies or MGH.
- Resident referred by building manager because of dementia, isolation and refusal to accept services. Initial incident involved stove top fire due to memory lapse. Team maintains weekly in home contact to monitor vital signs, safety, and establish relationship of trust with resident**.**
- Resident referred by building manager because of no medical care, isolation and psychiatric illness. Resident disclosed that prescriptions were unfilled due to lack of adequate health insurance. Team linked resident to a new physician, facilitated MassHealth application through MGH Patient Financial Services, obtained Emergency Food Pack and slowly connected resident to home supports from Senior Homecare.
- Resident referred by building manager because of physical frailty, isolation, hoarding and confusion. The resident had failed housing inspection and was at risk for eviction. HealthWISE team coordinated efforts to help patient accept standards of cleanliness to avoid eviction. Process was very slow and required weekly meetings for many months.
- Resident referred for needs associated with untreated health conditions such as hypertension and diabetes, schizophrenia and isolation. Team involvement required slow, deliberate and ongoing visits to establish trust with resident and assist in linking resident to health and support services. The involvement will be ongoing.
- Resident referred by management for care needs related to dementia, anxiety, isolation and frailty. Resident decompensated when her brother was hospitalized and unable to provide stability and support. HealthWISE team assisted resident in maintaining lifesaving contact with brother while in hospital, provided home visits to ensure safety, and eventually introduced homecare services.

Community Programming

In an effort to respond to the ever growing request from older adults in the community who do not have access to the Wellness Centers in the three sites, HealthWISE has expanded its health and wellness lectures, workshops, exercise classes, and social opportunities to all in the community.

Established services include:

- Monthly Hypertension Screening: 3 sites
- Health and Wellness Lectures at MGH campus
- Monthly Exercise and lunch at The Clubs at Charles River Park
- Monthly Tai Chi class at The Clubs at Charles River Park
- Film Series: MGH campus
- Monthly Community Newsletter

Flu Vaccine Program

- Flu vaccines given in three buildings and in three community sites.
- Total vaccines distributed: 296

2008 Program Accomplishments

New community programming included:

- Monthly Book Discussion Group in collaboration with West End Public Library
- Health and Wellness talks at the new West End Senior Center
- CareWISE: Opportunities for community service
- Episodic volunteering through MGH Volunteer Services
- Tour to the Museum of Fine Arts: Program that encourages healing through viewing and discussing art
- Visits to West End Museum, Museum of African American History (Beacon Hill)
- Complementary Health Fair: in collaboration with Beacon Hill Village, fair held at MGH campus

Major Accomplishments and Growth 2008

- Senior HealthWISE moved to its own site, within close vicinity of membership community. Site provides offices for staff, conference rooms for education and groups.
- **Chronic Disease Self Management Programs**: HealthWISE team received training and certification to provide CDSM programs in the residences and community. The Wellness Nurse, Diane Connor is a Master Trainer and will be able to train colleagues to assist in growing the program. Program is evidence based and originates from Stanford University.
- **Matter of Balance Training and Certification**: Evidence Based exercise program to be provided in residences
- **Falls Prevention Program**: Risk assessment and intervention program for residents of buildings, in partnership with IHP Physical Therapy Doctoral students.
- **Hoarding Training** and Interventions for residents at risk of eviction
- **Food Stamp Intervention**: Concentrated effort to penetrate the fear and shame of many in order to benefit from the program.
- **Bereavement Groups**: For residents and management staff
- **Care to Chinese Residents** of Beacon House and Blackstone: MGH NP provides monthly health and wellness talk to growing Mandarin speaking population.

- **Supportive Housing Initiative:** In collaboration with Boston Senior Homecare, developing new interventions to meet the needs of the increasingly frail population

2008 Data
- Total HealthWISE membership grew to 592 members (including Buildings)
- HealthWISE Members in Buildings: Amy Lowell - 49, Blackstone - 57, Beacon House - 35

Goal 4: Eliminating Racial and Ethnic Disparities In Health Care

The MGH Committee on Racial and Ethnic Disparities in Health Care

Joseph R. Betancourt, MD, MPH
Joan Quinlan, MPA

In late 2002, Mayor Thomas Menino convened the Boston teaching hospitals to explore their role in eliminating disparities in health and health care among racial and ethnic minorities in the city. As part of that effort, Peter Slavin, MD, President of MGH, created the MGH Committee on Racial and Ethnic Disparities in Health Care (the Disparities Committee) in the spring of 2003, and charged it to: (1) identify key areas where racial disparities in health care may exist at MGH; (2) develop solutions to address disparities found at MGH; and (3) coordinate efforts with Boston Mayor Menino's city-wide initiative on disparities.

The Committee divided itself into three subcommittees — Quality, Patient Experience and Access to Care, and Education and Awareness. Over the course of the last few years, the Committee has developed a diverse portfolio of activities (www.mghdisparities.org).

This past year, the Committee has focused its efforts in four areas:
- Capturing the experiences of racial and ethnic minority patients
- Improving and expanding cultural competency and diversity training for staff
- Conducting an organizational self-assessment using the CLAS standards
- Developing of disparity-specific core quality measures

Capturing Patient Experiences

Although standard reporting mechanisms are in place to assess patient satisfaction, racial and ethnic minority patients' experiences are often not accurately captured using these methods. The Disparities Committee convened all senior people within the hospital with responsibilities around collecting patient experience data with the goal of identifying opportunities to increase data collection. The opportunities identified include:
- Including questions on patient satisfaction surveys about issues of cross cultural communication and disparities;
- Conducting semi-annual focus groups of minority patients;

- Because many racial and ethnic minority patients often report their experiences informally and anecdotally to staff from a variety of departments, create a mechanism for capturing these experiences. A pilot project with Medical Interpreter Services has recently been implemented to help achieve the goal of the Summit.

Improving and Expanding Cultural Competency and Training for all Staff

Everyone engaged in training at the hospital has attended two "summits" to coordinate a hospital-wide cultural competency training strategic plan. The Summit aims to develop uniform goals and objectives for training in the area of disparities and cross-cultural care. Currently, many departments within MGH engage in a variety of educational/training endeavors across the hospital, but the teachings, content, and methods vary. The goal of the Summit is to develop a set of core learning objectives and unifying principles that can provide the foundation for training in the area of cross-cultural care for hospital staff from all backgrounds (clinicians, non-clinical staff, service staff, etc.). A preliminary review of goals/objectives from current trainings offered has been assessed, and Summit members are currently drafting core goals and learning objectives.

CLAS Self-Assessment – Culturally and Linguistically Appropriate Services (CLAS) at MGH

In March 2001, the U.S. Department of Health and Human Services and its Office of Minority Health released national standards on Culturally and Linguistically Appropriate Services (CLAS). The CLAS standards are a set of 14 principles designed to correct inequities that currently exist in the provision of health services. These principles are intended to make health care organizations and individual providers more responsive to the individual needs of all patients and consumers. A preliminary self-assessment of MGH's services in relation to the CLAS standards is currently being conducted. Information about departmental services in relation to the requirements of each CLAS standard is being collected. An assessment of strengths, weaknesses, and areas of improvement will be presented to Committee members and other hospital leaders.

Quality Measures – Development of Disparities-Specific Core Measures

To expand current efforts of race/ethnicity stratification of National Hospital Core measures (see Quality Subcommittee below), the Committee is working with executive leaders to explore the possibility of developing a set of disparities-specific core quality measures, which are reflective of the areas in health care delivery that disparities have previously been documented in the literature.

***Quality Subcommittee*:** To develop methods for ongoing quality measurement of outcomes stratified by race and ethnicity and to design quality improvement initiatives to address when issues are identified.

- **Disparities Dashboard** - provides patient demographics and utilization data regarding interpreter services, clinical quality measures for both inpatient and

outpatient services by race/ethnicity, and patient experiences with care for different racial and ethnic groups. The Disparities Dashboard is updated on an annual basis.

- **Quality Rounds** - a doctor-nurse team routinely visits an inpatient floor and meets with multi-disciplinary members of the care team to identify key issues that could jeopardize patient safety or lead to medical errors. A specific question on disparities was incorporated into the Quality and Safety Rounds in 2006. To date, the issue of language barriers has been identified with greatest frequency, but other issues raised in response to this question also include issues of understanding and acceptance of varying cultural traditions (particularly around gender issues, religion, and visiting policies and issues of access, particularly in the ambulatory settings). The process alone has raised awareness and sensitivity on the part of the staff.

Patient Experience and Access Subcommittee- Projects and accomplishments: to assess the experience of care at MGH for patients of color, develop and implement action plan to address disparities.

- **Patient Survey** – a 400 patient telephone survey of minority patients (including 136 cross-sectional) was conducted in two languages (English and Spanish) to determine minority patients' experiences of care at MGH. While the perception of equal quality of care for minorities is better at MGH than in society in general, there is still a significant gap, and almost ten percent of minorities could cite a specific example of unfair treatment, which they believed was based on race or ethnicity. The survey was developed and analyzed by Karen Donelan, ScD., and Nakela Cook, MD, MPH. There are plans under consideration to conduct the survey routinely once a year or once every other year.

- **Multicultural Advisory Committee is** comprised of leaders, patients and their families from various minority communities, and is charged with advising MGH on minority patients' experience of care and perception of the hospital in minority communities. As a result of MAC recommendations, the MGH began a lecture series targeted at improving the service of front-line staff.

Education and Awareness Subcommittee - Projects and accomplishments: to develop plans to educate/raise awareness among the entire MGH community of disparities and the factors that contribute to disparities.

- **Awareness**. The Education and Awareness Subcommittee has created a comprehensive communication strategy that focuses on increasing internal awareness of the issue of racial and ethnic disparities and the work of the MGH Committee using the *MGH Hotline* weekly newsletter, the *Fruit Street Physician* (a newsletter for MGH physicians), and posters displayed throughout campus.
- **Continuing Education.** Committee leadership or membership is responsible for at least four presentations at grand rounds and leadership meetings per year and a semi-annual Disparities Forum.

- **New Employee Orientation.** Information about the activities of the Committee and The Disparities Solutions Center are integrated into presentations attended by all new MGH employees as a part of the mandatory employee orientation. Information about general health and health care disparities are also included in this orientation.

The Disparities Solutions Center

Joseph L. Betancourt, MD, MPH, Director
Alexander R. Green, MD, MPH, Associate Director

MGH launched the Disparities Solutions Center (DSC) in 2005, under the direction of Dr. Joseph Betancourt. The DSC is dedicated to the development and implementation of strategies that advance policy and practice to eliminate racial and ethnic disparities in health care. The Disparities Solutions Center achieves this mission by:

- Serving as a change agent by developing new research and translating innovative research findings into policy and practice.
- Developing and evaluating customized policy and practice solutions for health care providers, insurers, educators, community organizations, and other stakeholders.
- Providing education and leadership training to expand the community of skilled individuals dedicated to eliminating health care disparities.

The Disparities Solutions Center is the first center of its kind in the United States. While other disparities centers exist, the Disparities Solutions Center is the first to be based in a hospital, with a focus on moving the issue of disparities in health care beyond research and into the arenas of policy and practice. The Center serves as a national, regional, and local resource for hospitals, physician practices, community health centers, medical schools, other health professions schools, health plans and insurers, consumer organizations, and state and local governments.

The Disparities Solutions Center received an initial funding commitment of $3 million from MGH and Partners HealthCare, as well as, $1 million from the Robert Wood Johnson Foundation. Housed within the MGH/Partners Institute for Health Policy, the Center is affiliated with Harvard Medical School's Department of Medicine and Health Care Policy and the MGH Division of General Medicine.

Now in its third year, the Disparities Solutions Center has many significant accomplishments to report:

- Continuing to build a diverse, talented team of faculty and staff
- Continuing a DSC Associates Program, now with 18 area researchers and clinicians with a broad set of interests and experiences all dedicated to addressing racial and ethnic disparities
- Providing leadership to MGH projects focused on identifying and addressing disparities, especially in diabetes, colorectal cancer screening, and mental health
- Conducting the second Disparities Leadership Program, a year long executive training program targeting leaders from hospitals, health plans, and community health centers from around the country

- Advancing partnerships to address disparities across the country, including in Puerto Rico and New Orleans
- Leading several web seminars on prominent, timely technical issues and research findings
- Welcoming the second Aetna/DSC HealthCare Disparities Fellow
- Launching of the DSC/Multicultural Affairs Office Film Series, with the goal of generating discussion and interest on various topics related to inequities and disparities in health care
- Receiving the Health Care for All "Community Leader Award" for the Center's efforts to end racial and ethnic disparities in health care, as well as a distinction as a 2008 Program of Excellence from the Diabetes Coalition of Massachusetts for the Chelsea Diabetes Quality Improvement Program, co-sponsored by the Massachusetts General Physician Organization, the MGH Center for Community Health Improvement and the MGH Chelsea HealthCare Center.
- The Disparities Solutions Center (DSC), in collaboration with the MGH Revere HealthCare Center, has begun a pilot project to explore barriers to care for Cambodian patients with diabetes. Phase one of the project used focus groups with Cambodian patients, health care providers, and Cambodian interpreters/health center staff to gather information about barriers to treatment and self-care for Cambodian patients with diabetes at MGH Revere. This information will inform the development of a culturally competent diabetes management program (similar to the MGH Chelsea Diabetes Management Program) funded by Tufts Health Plan. Analysis of the focus groups are currently being conducted and phase two of the project will include a bilingual Khmer-speaking diabetes coach to work individually with patients to identify specific barriers to care and group education sessions on diabetes self-care and management.

MGH HealthCenter Communities - Charlestown

Background

Lorenzo Lewis, MD, Medical Director, MGH Charlestown
Peggy Carolan-Bolognese, Administrative Director, MGH Charlestown

In 1968, MGH worked with the City of Boston's Department of Health and Hospitals, Harvard Medical School and other community partners to develop one of the first hospital licensed, multidisciplinary community health centers, originally known as the Bunker Hill Health Center, or the MGH Charlestown HealthCare Center, as it is known today.

In 2008, the MGH Charlestown offered comprehensive services to 8,900 people in approximately 54,000 visits. Charlestown, with a population of about 15,000 residents has the greatest range in income and socioeconomic status of all Boston neighborhoods, with very wealthy, very poor, and middle income residents. Its rates of heart disease, diabetes, breast cancer and substance abuse are higher other Boston neighborhoods. MGH Charlestown's community health improvement goals include preventing and

reducing substance abuse, improving mental health and health education and physical activity

Goal 1. Preventing and Reducing Substance Abuse in Charlestown

Charlestown Substance Abuse Coalition
Beth Rosenshein, MSW, Director

In response to alarming levels of substance abuse, community leaders, the police, social service agencies, MGH Charlestown, residents, and others came together in the winter of 2004 to form the Charlestown Substance Abuse Coalition (CSAC). CSAC was further galvanized to action by the tragic overdose of two prominent youth in April of 2004, one of whom died. The mission of the Coalition is:

> *"We are a community-based Coalition of residents businesses, organizations, professionals, and advocates who work together to reduce substance abuse among youth, adults, and families. Through a unified collaborative approach, we utilize existing community resources, organize programs to respond to identified needs and harness the energy and commitment of all to provide a safe, healthy environment in Charlestown."*

CSAC's guiding principles are as follows: "CSAC believes that to be successful, it needs to identify, assess, organize, and maximize the assets and successes of our community. We value a collaborative approach that is inclusive of everyone who lives/works in Charlestown. We are committed to these values:

- Honesty and integrity in working together towards our mission
- Listening to one another and learning from our successes and failures
- Calling our community to action through outreach, awareness, and a commitment to our mission
- Including youth and parents in the entire process
- Being respectful of and accountable to our community"

Partnerships and Activities

CSAC works to achieve its goal through four strategies:

1. Changing community norms, attitudes and behaviors about alcohol and other substance abuse.
2. Increasing the safety of the neighborhood and quality of life for all by decreasing the supply of drugs, levels of crime, violence, and other consequences of substance abuse through collaboration with the law enforcement and judicial systems.
3. Increasing access to and resources for successful treatment and recovery from substance abuse for Charlestown residents and families afflicted with addiction.
4. Strengthening protective factors and decreasing risk factors for families, youth, and young adults through education, prevention, and intervention strategies.

CSAC includes a wide collaboration of MGH Charlestown, the Boston Police Community Service Office, Charlestown Court House, representatives of elected

officials, the Charlestown Boys & Girls Club, the John F. Kennedy Center, Charlestown Community Centers, Charlestown Against Drugs, the Charlestown Recovery House, Youth Service Providers Network, Charlestown MissionSafe, Charlestown Neighborhood Council, Charlestown Neighborhood Watch Coalition, Charlestown Business Association, Student Support Team Leaders and Principals from local Boston Public Schools, property managers from public housing developments, the Boston Housing Authority Residents' Association, street workers, local parishes, the Dennis McLaughlin House of Charlestown, Charlestown Mother's Association, Boston Public Health Commission, the MA Organization for Addiction and Recovery, the Greater Boston Regional Center for Healthy Communities, and many individual residents.

2008 Program Accomplishments

- CSAC is in its third year of a five year, $500,000 Drug Free Communities grant from the Substance Abuse and Mental Health Services Administration to focus on youth. Funding supports 1.5 FTE for Coalition operations, grant implementation and oversight, implementation of evidence based prevention curriculums in local public middle schools, as well as, survey design, administration, and all program evaluation.
    - The AllStars curriculum, in its second year, was administered to 87 fifth and sixth graders, while the Life Skills program was initiated this year with 58 eighth graders.
- CSAC continues to receive annual funding from the Boston Public Health Commission, retaining its designation as a NoDrug Coalition for the fifth year.
    - Funds support quarterly community-wide forums.
- CSAC received a grant from the Massachusetts Department of Public Health, in collaboration with the Boston Public Health Commission, to reduce and prevent unintentional fatal and non-fatal opioid overdoses.
- As part of this grant, CSAC conducted a comprehensive assessment of the causes of overdoses, and opportunities to intervene, and developed a three-year strategic plan.
- The plan includes the creation of a community health worker position, to create linkages, as well as, community education to decrease barriers to contacting 911, in particular, fears of police involvement and eviction.
- A new Boston Police Department Area A-1 Charlestown Police Station opened on December 3, 2008. Previously, Police resources for Charlestown had increased 40 percent, including an additional anti-crime car and a beat cop.
- CSAC created an academic internship position with Suffolk University to work with and support Boston Police Department Crime Watch Department, Charlestown Neighborhood Watch Coalition and the Charlestown Neighborhood Council Public Safety Committee. The internship was filled in September 2008 and resides in the new Police Station, Crime Watch Unit.
- Charlestown Recovery House, a 25 bed transitional housing program for men in recovery, held opening ceremonies on June 30, 2008. Since doors opened on July 23, 2008 the CRH, into early December 2008, has served 74 men, 18 of who are from the local community.

2008 Data

(All data by the Massachusetts Department of Public Health and the Boston Public Health Commission.)

- Publicly-funded substance abuse treatment admissions during 2005 indicate that 73 percent of admissions by Charlestown residents were for heroin and other opiates, 19 percent for alcohol related treatment, 7 percent for crack or cocaine and 1 percent for marijuana and other drugs, compared to 70 percent for heroin and other opiates in 2004 admission statistics.
- More Charlestown residents are accessing treatment. Admission rates to publicly funded substance abuse treatment programs for Charlestown residents were 25.9 (per 1,000) in FY2004 and increased to 37.1 (per 1,000) in FY2006.
- Emergency Medical Service responses to heroin overdose calls in Charlestown declined 17.7 percent between calendar year 2003 and FY2006.
- While overdoses increased across the City of Boston by 29 percent from FY2005 to FY2006, Charlestown's overdose numbers decreased by 11 percent during the same period.
- Between calendar years 2002 and 2005, Charlestown's drug abuse mortality rates decreased by 41 percent from 63.8 to 37.7 (deaths per 100,000).
- The assessment conducted for the opiate overdose grant revealed the following.
    - Emergency Department (ED) Discharge Database, in FY2006 among residents in the Charlestown zip code (02129), there were 95 ED visits associated with opioid abuse, dependence and/or poisoning; 51 of these had opioid abuse, dependence or poisoning as the principal diagnosis.
    - MDPH BSAS data indicates that from 2004-2006, of the seven reported fatalities due to opioid overdoses in Charlestown, six individuals were White. In addition, of Charlestown's nonfatal opioid poisonings from 2004-2006, 92 percent occurred to Whites (based on hospital discharge diagnosis data). Whites comprised 85 percent of Charlestown residents discharged from acute care facilities with diagnoses related to opioid abuse or dependence during that same time period.
    - Charlestown opiate users are more evenly split by gender than in the city as a whole (56 percent vs. 75 percent male in Greater Boston) based on public substance abuse treatment admissions (MDPH, FY2006).
    - Charlestown opiate users are younger (48 percent under 30 years old) than opioid users in Boston overall (28 percent under age 30), (MDPH, 2006).
    - The 23 individuals and four focus group participants all reported similar demographics of opiate users and expressed significant concerns about the unique challenges and lack of treatment services for women, particularly those with children.

MGH Charlestown Addiction Services

Suboxone Services. In response to a growing trend of opiate-addicted patients, Mark Eisenberg, MD, Unit Chief of Adult Medicine and William Schmitt, MD, of the MGH Charlestown Health Center and most recently Jim Morrill, MD, became certified Suboxone providers and began a Hepatitis C clinic. Suboxone has been a significant addition to the successful chemical treatment of opiate addiction. Unlike methadone, it

can be prescribed by primary care physicians who undergo a special FDA approved training course. Drs. Schmitt and Eisenberg advocated to Congress to expand the number of patients providers permitted to treat from 30 per practice to 30 per provider (the number has subsequently increased to 100 per provider). The law was enacted in 2005.

In 2004, the MGH Charlestown Health Center committed a full time substance abuse clinician to complete the team, in association with the MGH West End Clinic. In 2008 the number of Primary Care Adult Medicine Doctors who are Certified Suboxone providers rose to six. The Suboxone program at the Charlestown Health Center currently provides Suboxone treatment to 79 patients who are also involved in therapy or other supportive services.

Additional Mental Health and Substance Abuse Counseling
Rick Hall, MA, MSW, LICSW, Clinical Director

MGH committed one million dollars over five years to expand mental health and substance abuse services to Charlestown's neediest population. The new MGH Charlestown Monument Street Counseling Center - a satellite of the MGH Charlestown HealthCare Center - addresses community substance abuse and mental health concerns with expanded services in the Charlestown BHA Housing Development.

Evaluation and treatment of both substance abuse and psychiatric disorders are provided by licensed clinical social workers and a psychiatric nurse practitioner. Medication is also provided by the center's psychiatric nurse practitioner. Concrete social services and patient advocacy is also provided by the center's resource specialist.

The effort is a collaboration between the MGH Charlestown Health Center, The City of Boston, and the Boston Housing Authority. Renovation of the site was conducted through 2007 and 2008. The center officially opened its doors in April 2008 after being licensed by the Department of Public Health.

Currently, the center provides clinical services to approximately 85 patients, as well as, concrete social services to another 16-20 patients. Overall, the center has served the needs of hundreds of individuals in the community since its inception and receives referrals both from the community and primary care physicians at the Charlestown HealthCare Center.

Goal 2: Mental Health

YouthCare
Scott McLeod, PhD, Executive Director

Background

YouthCare was founded more than 30 years ago when an MGH clinician began taking disadvantaged urban children with behavioral and learning disabilities to the country for

weekend wilderness excursions. Through these brief adventures, youngsters discovered that they were capable of overcoming obstacles, taking risks, and developing group trust and cohesiveness. These excursions became Camp Bunker Hill, now called YouthCare. Today, YouthCare serves children ages 5-17 with social-cognitive deficits including Asperger's Syndrome, Nonverbal Learning Disorders, High Functioning Autism and related challenges. YouthCare's goal is to help these children to develop the social skills necessary for success at home, in school, and beyond.

YouthCare works to improve the lives of 180 children through its therapeutic after school program, summer day camp programs, teen program, social skill groups, parenting support, as well as, additional children through its school-based trainings and consultations. YouthCare offers therapeutic support through group participation in recreational, social and educational activities. Its services focus on children's educational and behavioral needs. YouthCare believes that children are best able to learn social skills within natural group settings. It also recognizes and values the need to collaborate with community service providers such as teachers, professionals, and parents.

2008 Program Accomplishments

- With the help of Partners and MGH Community Benefits, YouthCare's summer camp cabin at Hale Reservation underwent substantial renovations. This support will also enable YouthCare to expand to an adjacent site at the reservation and to increase its summer enrollment by 18 campers in 2009.
- YouthCare offered a new teen program focused on career skills development for youth on the autism spectrum. Due to its success, three teen-focused programs will be offered in 2009 expanding from 12 to 35 teens.
- Two additional full-time staff were hired to meet increased demand for social skill groups and school-based consultations.
- YouthCare offered over $70,000 in financial aid to children in its summer camp and social skills groups. Financial aid slots are targeted to low income children from Charlestown and surrounding communities who fall at or below federal poverty levels.
- YouthCare initiated a research collaboration with the Massachusetts Institute of Technology's Media Lab. The research will evaluate new treatment tools to regulate physiological anxiety of children and teens with autism.
- YouthCare staff continued its pro-bono consultation and training services to three Boston Public Schools during 2008 designating 20 percent of one full-time staff person's time to provide pro-bono services at BPS. These services focus on the delivery and improved coordination of services for students on the autism spectrum.

2008 Program Data

- YouthCare's summer program received a 4.5 average (on a five-point scale) from parents on the program's effectiveness at meeting their children's behavioral goals and a 4.4 average response on their child's overall camp experience.
- Based on YouthCare's Summer Progress Reports, over 75 percent of the children at its summer camp achieved at least one of the two social goals set by parents and staff at the start of the program. Almost 60 percent achieved both social goals set for the

summer, and several children achieved goals beyond the original two that were set. Some sample goals include:

- To engage in a reciprocal (back-and-forth) conversation for at least two exchanges
- To talk about interests of his peers, even if they are not his interests
- To take a break when prompted as a way of dealing with anger.
- To make positive comments about his role in the camp group (e.g., to gain self-confidence)
- To use a friendly tone of voice (e.g., to not use a monotonous tone of voice typical of children with autism spectrum disorders)

Goal 3: Health Education and Physical Activity

The Roger Sweet Patient and Family Learning Center
Eileen McAdams, RN

In response to statistics from the Boston Public Health Commission's Health of Boston Report (2008) concerning growing rates of diabetes and childhood obesity, the Charlestown Health Center expanded health education.

The Health Education Program comprises The Roger Sweet Patient and Family Learning Center, interpreter services and community-based health education activities.

The Learning Center provided on site education and drop-in hours for individual patient information encounters. Education sessions at the Learning Center have included: "Living with Diabetes," Latino health classes, Teen "Health Corps," health literacy, hepatitis C, addiction issues, and Boston Medical Reserves trainings. The Learning Center has also organized multiple health fairs. Additionally, interpreter services had over 1500 encounters with MGH Charlestown Health Center patients. Half of the encounters were in person and half were conducted over the phone

Leaning Center Staff have collaborated with professionals from the MGH Institute of Health Professions, seniors at the Zelma Lacey House, local housing developments-Boston Housing Authority and Mishawum Park, and youth serving organizations including Mission Safe, Boys & Girls Clubs and the Warren Prescott School.

Finally, the Learning Center staff coordinated a monthly health education program on Boston Neighborhood Network News in an effort to bring health education and information into people's homes. Presentations are part of Charlestown Live, a weekly series that focuses on events pertinent to the Charlestown community. Topics have included: Skin cancer prevention, Diabetes Risks, Hepatitis C, Addiction and Recovery, Healthy Eating, Flu Prevention/Holiday Safety, Brain Health, and Emergency Preparation for the Charlestown Community.

Northeastern University Sport In Society
Linda Keefe, Executive Director
Steven Tower, Charlestown Youth Sports Heath Coordinator

Sport In Society is partnered with MGH Charlestown Health Center through the Health Connection program which helps urban youth make the connection between being physically active and living a healthy lifestyle. Programs highlight nutrition, physical activity and healthy lifestyle choices. Youth sports health coordinator, placed in the Charlestown HealthCare Center, collaborates with health care providers, community leaders, and parents to identify youth and design programming. Standard practice incorporates: conducting baseline need assessments, designing and creating programs that incorporate physical activity, family engagement, nutrition education and practice and additional information sessions on high risk behaviors such as substance abuse. Programming and activities are constructed based on individual need, familial strengths and community resources. One prime goal of all programming is to expose the target population, young people, to new and different activities that can be translated and continued in everyday routines. Karate lessons, for example, were conducted last summer for 25 youth, a primary benefit of learning stress relieving and strength building exercises was that each participant could continue the routine after the program ended.

The primary program of the Sport In Society's Health Connection is working in collaboration with Health Center pediatricians and Child and Family Mental Health Unit. Working with referrals, the Youth sports health coordinator creates programming that addresses the specific needs and challenges of the youth referred and their families.

Since the inception of this collaboration over 200 youth ages 8-12 were identified through the referral program with pediatrics and mental health units. An additional 200 youth ages 6-16 were served through community based programming and collaborations such as Karate, surfing, “summer sports challenge” and Community Center basketball leagues

MGH HealthCenter Communities - Chelsea

Jeannette McWilliams, Administrative Director, MGH Chelsea
Sarah Abernethy Oo, MSW, Director, Community Health Programs

Background

Located two miles north of Boston, Chelsea is a city of three square miles and just over 35,000 residents (U.S. Census, 2000). Chelsea has been a gateway for refugees and immigrants entering the U.S. since the Industrial Revolution. In the past decade, Chelsea has become home to refugees fleeing countries devastated by war and poverty including Bosnia, Somalia, Afghanistan, Iraq, Northern and Western Africa, and countries in Central America. Latinos comprise more than 48 percent of the population, and 77 percent of Chelsea public school students. (U.S. Census, 2000, MA Department of

Education, 2007). Just over 58 percent of residents speak a language other than English, and nearly 44 percent of residents speak Spanish (U.S. Census, 2000).

Indicators of poverty and violence in Chelsea are numerous and severe. Poverty levels are more than twice the statewide average. More than 27 percent of Chelsea households survive on less than $15,000 annually, and 47.7 percent of residents live at or below 200 percent of poverty. Nearly 30 percent of children under age 18 live below the poverty line compared to the 11.6 percent statewide (U.S. Census, 2000).

Chelsea has a disproportionate number of young people; just over 27 percent of residents are 18 years of age or younger, (U. S. Census, 2000). Yet Chelsea's ability to keep children and families safe is strained by high levels of violence. Chelsea has the second highest rate of child abuse and child neglect reports in Massachusetts (DSS, 2000), and violence-related injuries are six times the statewide rate (MA Department of Public Health, 2000).

Chelsea Community Health Improvement Goals

Since 1996, the Center for Community Health Improvement has collaborated with community partners in Chelsea to design and implement numerous programs with the following three primary goals:

1. To prevent and reduce family, intimate partner, and community violence
2. To improve access to health care and health status for all residents of Chelsea, including newly arrived immigrants and refugees who may face language and cultural barriers to seeking care
3. To reduce racial and ethnic disparities in health care among those receiving care at MGH Chelsea

Community based health care in Chelsea is delivered through the MGH Chelsea HealthCare Center (MGH Chelsea), which in 2008 provided comprehensive primary and specialty health care services to more than 37,500 individuals in over 160,000 visits. Working with MGH Chelsea, schools, community organizations, and residents, the MGH Center for Community Health Improvement led comprehensive community health assessments in 1996 and again in 2001 and is presently engaged in a third assessment. As a result of the 1996 assessment, MGH Chelsea established a Community Health Team to reduce the impact of violence – especially on children - increase access to health care, and reduce disparities in health status. Today, this team has grown to over 30 outreach workers and community health specialists, who implement 25 programs. The team relies on strong working partnerships with every unit in the health center to accomplish its goals.

Goal 1: Reducing the Impact of Family and Community Violence

Child, youth, family, and community violence threaten the safety of children and families, interfere with their ability to do well in school and in the workplace, and impact health status. Working with the health center, particularly the Mental Health

Unit, the MGH Center for Community Health Improvement (CCHI) has developed four programs that are intended to reduce the immediate impact of violence on children and families, and to interrupt the cycle of violence. These programs operate as distinct initiatives that intersect and collaborate on a regular basis to meet the needs of families.

The programs intervene with families along the continuum of family violence from crisis response when the violence first occurs through to and then caring for children who have witnessed chronic domestic violence over the long term. The goals of these programs are to facilitate the healing process and to strengthen resilience among children and to teach children and their families constructive and healthy ways of forming and conducting relationships at all levels of their lives. Some, but not all, children may engage in more than one of these programs as they travel along the continuum from first exposure to treatment and healing.

Police Action Counseling Team (PACT)
Georgia Green, LICSW, MGH Chelsea
Thomas Dunn, Lieutenant, Chelsea Police Department

The goal of the Police Action Counseling Team (PACT), founded in 1998, is to reduce the immediate impact of trauma on children who witness violence. Ultimately, PACT seeks to reduce the effects of trauma on a child's ongoing development, and to interrupt the cycle of family violence. PACT is a partnership between MGH Chelsea, the Chelsea Police Department and the MA Department of Children and Families (DCF, formerly DSS). PACT clinical social workers are available by beeper 24 hours a day, seven days a week for on-the-scene response to 911 calls when children are present. Once police officers establish physical safety, social workers provide on-site developmentally appropriate interventions by helping children to express their fears, sadness, anxiety, hope and other feelings. The team provides information and answers questions so that children can feel more in control of their circumstances. The team also helps children and families to identify and undertake immediate next steps, such as getting urgent medical care, gathering belongings if they need to relocate, or arranging for transportation to school the next day.

PACT social workers help parents and other family members understand the short and long-term effects of violence on children, provide them with language-appropriate resource materials, and offer assistance in managing the symptomatic aftermath of such incidents. PACT connects families with services, such as medical and mental health care, domestic violence shelters, court advocates, and facilitates connections with school personnel, clergy, and whomever the family identifies as a support network. Weekly team meetings at the Chelsea Police station with social workers, police officers, and DCF assure that all are communicating effectively on behalf of the family.

2008 Program Accomplishments

- PACT provided training to MGH psychology and social work interns and psychiatry residents as part of their community medicine rotations. Additionally, psychiatry

residents participated in ride-alongs with police to gain exposure and insight into the crises that families face that can result in the need for medical and mental health interventions.
- In February 2008, new police officers were oriented to PACT as part of their general orientation when joining the Chelsea PD.
- The process of including patrolmen in weekly PACT meetings allows the officers to continue to be involved in the discussion and follow up on cases they have paged on. This inclusion provides ongoing officer training and assists program development.
- PACT clinicians work closely with police detectives on child sexual assault cases. This unprecedented interagency coordination allows clinicians to stay involved with child victims and their families during the investigation and trial period. As a result, children frequently remain engaged in therapy.
- PACT has developed a relationship with Project Linus, an organization that makes knitted blankets for children in need. Given to children on site during a police call, these blankets become ongoing sources of comfort.

Program Data

PACT has provided services to 770 families including 1,529 children seen since 1998.

In 2008, 214 cases – involving 335 children and 143 adult victims – were referred to PACT and reviewed by clinicians.

- PACT clinicians were able to contact 59 percent of these cases (126) either on the phone or in person, and left messages for or sent pamphlets to the remaining 88 families. Of the 126 families directly served, clinicians met personally with 58 families, and provided consultation and follow-up over the phone for the other 68 cases.

In 2008, of the 58 families directly served by PACT:

- 111 children were involved
  - 86 percent of children had witnessed violence (96)
  - Seven percent had sustained physical injuries (8), and six percent required medical attention (7)
- 52 adult victims were involved
  - 54 percent had sustained physical injuries (28), and 12 percent required medical assistance (6)
- 74 percent of cases were domestic violence related (43)
- 41 percent involved weapons (24)
- 16 percent involved strangulation (9)
- 36 percent involved substance abuse (21)
- 45 percent involved the issuing of restraining orders (26 cases – involving 34 restraining orders total, including 23 emergency restraining orders)
- 59 percent involved filing 51-As (34 cases), with PACT clinicians directly facilitating 13 of them

Children's Witness to Violence
Katherine Griffiths, LICSW, MGH Chelsea

The goal of the Children's Witness to Violence Program, funded by the Massachusetts Department of Children and Families (DCF), is to reduce the impact of family violence on families with children. The work is carried out by a multi-disciplinary team at MGH Chelsea called the Children Exposed to Violence Team (CEV). This team includes social workers, psychologists, outreach workers, domestic violence advocates and a pediatrician. The Children Exposed to Violence Team serves children ages zero to 17 and their families who have witnessed and/or experienced violence in their homes or communities. CEV patients may have previously received or are currently receiving services from PACT, Ob/Gyn, Pediatrics, the Community Health Team and other MGH Chelsea departments, or may be referred from community organizations.

The services that the CEV team provides are uniquely designed to respond to the particular needs of young children, through mental health assessments, clinical follow-up, case management, and treatment. Therapeutic groups for mothers and their children have been a particularly effective intervention for exposure to violence in the home. Groups that mothers and their preschoolers ages four to six attend simultaneously use a curriculum designed by MGH Chelsea and The Cambridge Guidance Center clinicians. Using a curriculum developed with MGH Chelsea clinicians and DCF, and implemented state-wide, MGH Chelsea clinicians have for more than two years also led groups for mothers and children ages seven to 11. Mothers and their adolescents participate in separate groups, and then meet together for dinner, both using the ARC (attachment, regulation, and competency) curriculum designed by the Trauma Center in Brookline.

Despite the large number of referrals, clinicians from the CEV team manage to see patients, if not immediately, within just a few weeks from the referral date. This is unique as many clinics and programs that serve children affected by violence have very long waiting lists. The MGH Chelsea program also provides therapy and concrete services when the abuser is still in the home, as long as the treatment does not jeopardize the safety of the child or family. This feature is also unique, as many programs require that the family be out of the abusive relationship before treatment can begin. This is also a critical component in allowing families to receive services right away.

2008 Program Data
MGH Chelsea has contracted with DCF to serve 22 children exposed to violence per year, and provided 236 therapeutic sessions with children and their families in 2008.

Safe Start Promising Approaches
Pam Miller, Ed.D, MA, MGH Chelsea

MGH Chelsea is one of 15 Safe Start Promising Approaches (Safe Start) sites nationally that are funded by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. The goals of Safe Start are to reduce the harmful effects on children of exposure to violence, as well as to enhance the delivery of services to children

and families through research driven services and effective community collaborations. The RAND Corporation is conducting a two year longitudinal study to evaluate the effectiveness of the clinical interventions.

The MGH Chelsea Safe Start program builds on the long-standing community partnerships that exist with the Chelsea Police Department and the Department of Children and Families (DCF). These collaborations provide consistent opportunities for staff across agencies to share expertise and knowledge about the impact of children's exposure to violence. Reciprocal education and training sessions are offered and staff collaborate to expand, enhance, and develop policies and procedures to improve systems and facilitate referrals and communication with community partners.

Through a multi-disciplinary group of MGH Chelsea providers, including members of the CEV team, Safe Start coordinates the extensive support, services, and resources required by children who have been exposed to violence and their caregivers. These include:

- Improved capacity to identify and refer children and families exposed to violence to services
- Linkages to needed medical care and additional health care resources
- Individual and family mental health treatment
- Group sessions for parents and children, developed with particular emphasis on attachment and affect regulation
- Home visits to assess physical safety, child supervision, and exposure to media that can contain violent content, such as TV, videogames, and music
- Services as needed through domestic violence advocates and the Child Protection Consultation Team.

The MGH Chelsea Family Violence Team, an outgrowth of Safe Start, includes multi-disciplinary health center staff and community partners from Chelsea, including DCF, the police, the schools, the court, and the Boys and Girls Club. During monthly meetings, this team brainstorms about improving family interventions and providing new systems for interagency communication. Community members are often invited to use meetings as a forum to address topics about violence exposure, and guest speakers are frequent participants.

2008 Program Accomplishments

- Safe Start trainings for MGH Chelsea staff and community partners in 2008 have included an extensive curriculum on advancing institutional change for racial equity sponsored by The People's Institute for Survival and Beyond and an extended session entitled Understanding Prostitution and Child Sexual Exploitation offered through The Home for Little Wanderers.
- The Chelsea Police Department continues to use Safe Start funding to allow officers to follow up with families exposed to violence and sexual abuse, in order to assist both children and adults with criminal prosecution issues.

Program Data

- During 2008, Safe Start received 93 family referrals for caregivers and their children (ranging in age from infancy to late adolescence).
- 22 home visits were conducted.
- The RAND evaluation in Chelsea enrolled 36 families in 2008 and has followed a total of 62 families for up to two years.
- The therapeutic groups offered to children exposed to violence have included: an on-going group for parents and their children up to age three that serves over eight families; four completed group series for adolescents and their parents that enrolled a dozen families in total; and a group series for children ages four through 12 that served more than eight families.

Pediatric Violence Prevention Program
Sara Lahaie, MSW, LCSW

The Pediatric Violence Prevention Social Worker (PVPSW) provides consultation to pediatricians and services to children and families receiving care at the MGH Chelsea when there is risk for abuse and neglect. The bi-lingual social worker is based full time in Pediatrics and provides flexible, non-productivity driven services which are critical in helping pediatricians deal with complicated systems and in helping families deal with the complex trauma that arises in child abuse cases. The PVPSW works hand in hand with pediatricians and often provides "corridor consultations" in the midst of busy patient care schedules.

The PVPSW conducts initial evaluations for children and families, provides short-term therapy until appropriate referrals for longer-term services can be made and provides short-term case management to families affected by violence. The PVPSW also follows sexual abuse and child abuse cases through the medical, legal and child protective systems as needed. The PVPSW documents all 51A reports filed by providers in all departments at MGH Chelsea. The presence of the social worker within the Pediatric Department increases providers' effectiveness with and comfort in identifying cases of child abuse and neglect. The PVPSW worker works closely with Safe Start, HAVEN, the CEV team, and PACT.

2008 Program Accomplishments

- The PVPSW conducted presentations on child abuse and filing 51-As with the Community Health Team and Adult Medicine Team.
- The PVPSW co-lead two different types of therapy groups for children exposed to domestic violence.

Program Data

- From May through December of 2008, the Chelsea PVPSW received 87 client referrals, for issues ranging from preventive needs (for mental health services, parental training, or concrete resources), to severe cases of sexual abuse.
- Among the 87 clients seen by the PVPSW from May through December of 2008:

- 49 percent were female (43)
- 51 percent were male (44)
- The average age was 8.7 years old

- From May to December of 2008, 257 total consults with the PVPSW took place, averaging 2.95 consults per client.
    - 47 percent were phone consults (120)
    - 33 percent were in-person consults at MGH Chelsea (86)
    - Five percent were consults with other providers involved in the patient's care (12)
    - 32 percent of consults resulted in referrals to other services (82), for 48 unduplicated clients (55 percent of total clients)
    - Of these 48 clients receiving referrals to other services:
        - 60 percent were referred to mental health/social work/therapy/counseling services (29)
        - 29 percent were referred to concrete resource specialists (14)
        - 19 percent were referred to the Safe Start program (9)
        - 15 percent were referred to the Department of Children and Families (formerly the Department of Social Services) (7)
        - Ten percent were referred to the Children Exposed to Violence (CEV) program (5)
        - 50 percent were to other services (HAVEN, LINK, ROCA, DA's office, Early Intervention, Chelsea Family Network, etc.) (24)

- From May to December of 2008, the PVPSW tracked 35 51-A reports, involving 53 children. Of these 35 reports:
        - 80 percent involved neglect (28)
        - 20 percent involved sexual abuse (7)
        - Six percent involved physical abuse (2)

GOAL 2: Improving Access to Health Care

Immigrant and Refugee Health Program
Eric Kamba, MSW, MPH, Refugee Health Assessment Program Manager
Chantal Kayitesi, MPH, Refugee Women's Program Manager
Ali S. Abdullahi, Refugee School Program Coordinator

The goal of the Immigrant and Refugee Health Program is to help newly arriving refugees and immigrants meet their health care needs and cope with the struggles of everyday life while managing the impact of trauma experienced in their native countries. The program goals include engaging newly arrived refugees in Chelsea and surrounding communities into primary and other health care and assisting those refugees with successful resettlement defined as placement in housing, employment, success in school for the children and addressing other concrete needs. While not a formal goal, the program has had the positive unintended consequence of transforming both the health

care and educational systems to become more culturally aware and competent to respond appropriately to the needs of the refugees.

Staff work with a team of multicultural and multilingual interpreters/outreach workers to identify individuals' and families' needs and plan interventions accordingly. The team pays close attention to patients with health issues that require close follow-up and support. Patients' needs are identified through home visits, individual encounters with patients, families and groups, and through direct communication with providers. In addition to facilitating access to primary and preventive care, families are referred to other services such as reproductive health, mental health, domestic violence prevention and intervention, chronic disease management and education, food safety programs, etc. The Immigrant and Refugee Health Program also includes a patient navigation system to make sure that patients access specialty services outside of MGH Chelsea.

Staff provide training to staff in the health center, the schools and community in identifying children and adults who may be suffering from the effects of trauma, and work with providers, school staff and outreach staff to support children and their parents individually and in groups in culturally appropriate ways.

Staff, including interpreters/outreach workers work with parents and families to adjust to their new lives in the United States, find jobs, enroll in education, engage in health and mental health services, locate and retain safe and adequate housing, obtain legal help, resolve family conflicts, and address family or community violence issues.

The most recent arrivals to Chelsea have been Iraqis and refugee groups from sub central Africa; the program has also accommodated refugee groups from Eritrea, Cuba, Burma, and Nepal. Managers continued to provide services to significant numbers of Somali, Sudanese, Afghani, Bosnian, Brazilian and others from Arabic-speaking countries. The Immigrant and Refugee Health Program provides services in multiple languages through its own staff or other members of the Community Health Team, including Bosnian, Somali, French, Arabic, Russian, Swahili, Kirundi, Dari, Haitian Creole, and Portuguese. The program works with patients to develop a comprehensive plan to assure they receive adequate care.

A Designated Refugee Health Assessment Site

Through a contract with the Massachusetts Department of Public Health (DPH), MGH Chelsea provides a comprehensive health assessment for newly arriving refugees and persons seeking asylum as required by the U.S. State Department. The assessment includes screening for issues ranging from uncorrected dental or eye problems, to the consequences of torture or malnutrition. Refugee patients may arrive with serious medical conditions including highly contagious pulmonary tuberculosis, malaria, syphilis, chronic hepatitis B and C, and intestinal parasites. Due to a history of extreme trauma for many refugees, providers screen for mental health issues such as post-traumatic stress disorder and acute psychosis, early in the patient's care.

The Immigrant and Refugee Health Program provides a continuum of care across multiple sites, including the hospital, home, schools, and early intervention programs. To reduce anxiety and provide information, the program managers make home visits to inform families about how health care services are delivered in the United States. MGH Chelsea has developed strong working relationships with Boston-area refugee resettlement agencies and the Mass. Department of Public Health Office of Refugees and Immigrants.

Refugee School Program

The school portion of the program was established to bridge the cultural and academic gap for newly arrived refugees and maintains an affable relationship with the district and the school system. The Refugee School Program Coordinator is funded jointly by MGH CCHI and the Chelsea Public School System. In 2007, a special grant was received from the MGH Ladies Visiting Committee to help support the school portion of the program.

The program coordinator assists with school registration, enrollment, problem solving, guiding students to select suitable subjects, educating teachers about different cultures, defusing classroom tensions, providing after-school help for students, and coordinating parent/school meetings and helping in those meetings with interpretation. The program also works closely with parents, raising their awareness of the importance of education, since most parents were not exposed to formal education in their homelands. The coordinator works to get parents involved in their children's schooling, facilitating their connection to the educational institutions, and persuading them to initiate meetings with school staff when necessary. The coordinator also encourages school staff to make the school environment hospitable for disinclined parents.

The coordinator explains to students their rights and responsibilities in relation to school, including educating students about the culture in the United States, the school's expectations, the importance of education, the importance of setting future goals, and possible venues to attain and accomplish these goals.

The program coordinator works with the school system to identify students at risk for gang involvement and other negative behaviors, and intervenes. The program makes referrals to the Mental Health Unit and Pediatric and Adolescent Unit at MGH Chelsea for students who experienced trauma in their country of origin. The coordinator keeps an open door policy for all refugee students and encourages them to drop in no matter how trivial the matter.

2008 Program Accomplishments

- Workshops and community events were organized to orient new refugees to MGH Chelsea and the school system. Sessions included: 1) a welcome and orientation session for 22 new Burundi, Somali and Sudanese patients, 2) a workshop on budgeting and family finances for 20 Burundi and Somali patients, and 3) a job training workshop for 11 Burundi, Iraqi and Haitian patients.

- Education groups for refugee girls and women included: 1) a presentation for 16 new female refugee patients explaining the services offered at MGH Chelsea, 2) a presentation on hygiene for 18 young African girls held at MGH Chelsea, and 3) another presentation on hygiene for 12 Somali young girls at the Chelsea Middle School.
- Multiple trainings were conducted for state and community agencies, MGH social work and psychology interns, and psychiatry residents, and new residents in Adult Medicine.
- A presentation on the Refugee Health Assessment Program was made at the ECDC's (Ethiopian Community Development Council) 14th National Conference on African Refugees and Immigrants held in Virginia in May of 2008.
- A presentation on the Refugee and Immigrant Health Program was made at the Massachusetts Department of Public Health Conference "An Ounce of Prevention" in October of 2008.
- In October of 2008, the program sponsored an “International Celebration of Cultures” event under a tent outside in the MGH Chelsea parking lot. This was a festive event that included foods, traditional clothing, music and dance from all over the world. The event was attended by over 200 patients and over 50 staff members.
- In July of 2008, the program began the Cancer Prevention Project for Refugee Women targeting breast cancer prevention among Somali, Bosnian and Arabic speaking women. (This pilot program is outlined below in further detail under Goal 3: Reducing Disparities in Health Care of this report.)
- A support group was conducted for six elementary-school aged Somali Bantu boys and their mothers that focused on social skills, anger management and self-regulation; and another group was conducted for seven Somali teen boys focusing on identity issues.
- Multiple workshops were held for parents on how they could assist their children with adjusting to a new school environment. Many of the parents have never attended school themselves and did not understand school expectations.

Program Data

- Staff had over 4,000 combined encounters with program participants where individual case management, navigation and advocacy were provided.
- Since the start of the 2008 school year, 11 students from the school system have been referred for comprehensive mental health assessments.
- The formal health assessment portion provided medical services to 73 refugees and asylees including 51 from Iraq, four from Cuba, one from Tanzania, four from Russia, six from Somalia, two from Burma, two from Uganda and three from Nepal.
- A specialized TB clinic provides follow up care for those refugees who test positive for TB. 90 percent of patients have successfully completed treatment. Almost 600 patients have been treated in this clinic since it began in 2003.

Bridging the Gap – The Refugee Family Service Project
Ali Abdullahi, Refugee School Program Coordinator
Tamara Leaf, Psy.D., MGH Chelsea

Bridging the Gap seeks to improve the cultural competence of future physicians. The program is a partnership with Harvard and Tufts Medical Schools, in which medical students are paired with immigrant/refugee families. Students support families in recognizing and addressing simple health-related needs and act as advocates, educators, mentors, and friends, while learning first-hand the cultural issues that pose challenges to the families' ability to access health care. Events and workshops are offered regarding obstacles families may face, available resources, Medicaid issues, and the resettlement process. Students have regular contact with MGH Chelsea staff and meet together in monthly reflection sessions that are designed as trainings to help facilitate their involvement in this program and share leanings from their experiences with their families.

2008 Program Accomplishments

- The Refugee School Program Coordinator has joined as the leader of the program. This provides the added benefit of closer communication about school age children and their families.
- New systems have been developed to facilitate easier administration of the program, including improved release and referral forms and the process of designating student volunteers as "non-paid employees".

Program Data

- During its eighth year, the program matched 11 Tufts Medical School students and 15 Harvard Medical School students with families from Iraq, Afghanistan, Bosnia, Morocco, Somalia, and Western and Central Africa, as well as, immigrant families from Central American countries and Brazil.

Medical Interpreter/Outreach Services

Leandro Porto, Portuguese Interpreter/Outreach Worker
Claudia Contreras, Spanish Interpreter/Outreach Worker
Cristina Bayani, Spanish Interpreter/Outreach Worker
William Ward, Spanish and Portuguese Interpreter/Outreach Worker
Franka Miletic, Bosnian Interpreter/Outreach Worker
Yahya Noor, Somali and May Maay Interpreter/Outreach Worker
Kaftun Ahmed, Somali Interpreter/Outreach Worker
Amal Ali, Arabic Interpreter/Outreach Worker
M. Javad Rajai, Dari, Arabic and Russian Interpreter/Outreach Worker

The goal of the Medical Interpreter/Outreach Services is to provide quality language services to all MGH Chelsea patients who have limited English proficiency by reducing language and cultural barriers to health care. All staff members are both interpreters and outreach workers, which allows them not only to facilitate accurate communication between patients and healthcare providers during medical encounters, but also to advocate for patients whenever necessary and help them navigate the health care system outside of the medical encounter. Staff provide a critical cultural framework that enhances understanding between patients and providers. Staff interpreters provide on-site interpretation and outreach services for patients who speak Bosnian, Spanish, Portuguese, Dari, Russian, Arabic, Somali, May Maay, and Swahili. On-call interpreters are hired as needed for other languages, including American Sign Language (which accounts for over a quarter of all on-call requests), Haitian Creole, Vietnamese, Burmese, Korean, and Amharic.

Continuous improvement is a hallmark of this program. In the winter of 2008, MGH Chelsea launched a Toyota Process Improvement Project to streamline interpreter services and ensure quicker and more efficient interpreter services for patients and providers. The initial feedback from these efforts has been positive. Given the high demand for quality language services, the speakerphone MGH has dubbed the IPOP (Interpreter Phone on a Pole) was launched in all practices, making phone interpreting a viable option when a face-to-face interpreter is not available. This has reduced the use of bilingual staff as interpreters and has ensured that a trained interpreter, even if by phone, is used for all medical encounters.

Monthly training sessions are carried out for staff to improve on the job skills such as note taking, mental health interpreting and outreach skills.

2008 Program Accomplishments

- All units in the health center staff have been trained to use the IPOP when face-to-face interpreters are not available to ensure high quality interpreting services.
- Two new Spanish interpreters, one new Bosnian and one new Somali interpreter were hired. A Haitian Creole and French speaking staff member from another department at MGH Chelsea has been identified and trained to be an on-call interpreter in those two languages.
- Two staff interpreters were given the opportunity to attend the conference of the International Medical Interpreter Association in Boston, which offered many training courses and seminars.
- Several staff interpreters are currently participating in Medical Terminology courses at MGH and the Outreach Educator Training Series at the Community Health Education Center.

Program Data

- Close to 8,500 interpreting/outreach encounters were conducted, averaging over 700 a month.
- More than 5,500 of those encounters involved interpreting at medical appointments, of which: 53 percent were in Spanish, 17 percent in Portuguese, 14 percent in Somali

and Swahili, ten percent in Middle Eastern languages (Dari and Arabic), and six percent in Bosnian and Russian.
- Staff performed nearly 3,000 outreach and support activities (also included above in the Immigrant and Refugee Health Program), including phone calls to patients (38 percent), assistance to patients with filling out forms and applications, written translations of documents (25 percent), meetings with community agencies, home visits, interpretation offsite, and patient navigation (27 percent, nearly double last year's 15 percent).
- Nearly 800 requests were placed last year for on-call interpreters, 27 percent of which were for American Sign Language.

CHAMP (Chelsea Asthma Management Program)
Susie Severino, CHAMP Program Coordinator
Eduardo Budge, MD, MGH Chelsea

The goals of CHAMP are to improve the management of asthma care for MGH Chelsea patients with the aim of reducing emergency room visits and hospitalizations. Once a pediatric or adult medicine provider identifies a patient with asthma, the program coordinator facilitates communication and follow-up between the provider and the patient. During the same provider visit, the coordinator reinforces the patient's understanding by providing education about asthma including triggers, symptoms, medications, and by reviewing the patient's individualized action plan. Barriers to follow-through are identified and strategies developed. As needed, the coordinator conducts home visits to reinforce asthma teaching and to identify potential environmental hazards in the home. The coordinator also identifies food resources, housing, domestic violence intervention and makes referrals to other programs as needed. The coordinator maintains a close relationship with the Chelsea Public Schools and nurses to identify students with asthma who are in need of services.

2008 Program Accomplishments
- Implementation of the new Asthma Action Plan developed by Partners for pediatric and adolescent patients has begun. The program goal is to provide a Custom Action Plan for 100 percent of the patients on a controller medication.
- The CHAMP coordinator participated in trainings including the annual Pediatric Asthma Update Conference. The coordinator participated in asthma awareness month and organized several training sessions during the month at MGH Chelsea for providers and support staff.
- CHAMP provided asthma literature and supplies for Urgent Care, Adult Medicine, and Pediatrics at MGH Chelsea and at 100 Everett Avenue.
- An improved database was developed by the CCHI Research and Evaluation team to better capture outcome and process measures of those receiving interventions from the program.
- The program has begun implementation of the "Fall Plan". In October of each year, a phone call will be made to asthma patients reminding them of the Flu Vaccine. The target group will be those on a controller medication and those patients who do not

have a scheduled appointment with their primary care doctor in the next three months. The ACT (asthma control test) will be conducted on those patients identified as non-compliant with medications or making frequent visits to the Urgent Care.

Program Data

- CHAMP continues to strive for 100 percent Asthma Action Plans for those pediatric patients on controller medications. It is estimated that the program has reached 75 percent of that goal.
- CHAMP now maintains a pediatric and adult asthma registry which was developed after considerable review of the patient's medical record, diagnosis and medical history in 2008. This registry has identified 1,350 active asthma patients, with 766 adults and 584 children/adolescents. This registry is important in facilitating follow-up on critical health care matters, for example assuring that all patients with asthma have regular flu shots.
- Since the program's inception in 1997, the CHAMP coordinator has seen over 915 patients through home and office visits.
- Annually, the program identifies over 70 new asthmatic patients.
- Program referrals come from Urgent Care (70 percent), adult and pediatric providers (20 percent), and Neighborhood Health Plan high-risk patient registry (ten percent).

Outcomes for CHAMP

New data collection systems were put in place in 2008. There is now the following data on 72 asthma patients (adults and children) at intake and three month follow-up:

- **Asthma Control Test (ACT) -** The score on the Asthma Control Test, a five question assessment to evaluate asthma symptoms during the past four weeks, was compared for each individual at intake and at three month follow-up. A score of less than 19 indicates poorly controlled asthma. The majority of patients (88.4 percent) had a score below 19 or less at intake. At follow-up, 47.1 percent of patients had scores of 19 or lower.
- **Visits to doctor for asthma -** At intake, 87.1 percent (61/70) of patients went to the doctor at least once in the past three months, compared to 60.6 percent (43/71) at three months.
- **Visits to Urgent Care or Emergency Department for asthma -** At intake, 73.6 percent (53/72) of patients went at least once to urgent care or the ED in the past three months. At follow-up, only 18.3 percent (13/71) of patients went at least once to urgent care or the ER in the past three months.

Food for Families

Kathleen Healey, CPNP, MSN, MGH Chelsea
Katherine L. Flaherty, Sci.D., Research Director, Project Bread

The goal of the Food for Families program is to improve health status by reducing the incidence of food insecurity and hunger among individuals and families. Food for

Families reaches families from Chelsea and surrounding communities whose children are pediatric patients at MGH Chelsea.

The program started in 2003 through a study conducted by Ronald Kleinman, MD, Chief of Mass General Hospital *for* Children, with funding from Project Bread and the Center for Community Health Improvement. Food for Families identifies families in Pediatrics at MGH Chelsea experiencing hunger or who are at risk for hunger through a single validated screening question. Once identified, patients and their families are referred to a part time outreach worker who conducts a formal interview to assess the family's hunger concerns and assist families with accessing the federal nutrition programs, including helping them complete the application for the Food Stamp Program.

The need for increased access to nutritious food, particularly among Latino residents, is urgent. A 2005 Project Bread-sponsored study surveyed households in Massachusetts with high rates of poverty. Overall, 32 percent of households surveyed in these low-income communities reported food insecurity, meaning that they were unable to buy sufficient food to meet the basic nutritional needs of households' members. Food insecurity was even higher, 37 percent, among Latino households.

Among families screened in Chelsea, 11 percent reported experiencing hunger in the past month. Of these, 40 percent carry a nutrition-related diagnosis, such as diabetes mellitus or anemia. Patients with these conditions are at higher risk for chronic health problems when they regularly lack basic nutrition. Prior to the introduction of food assistance in the health center, providers were not aware that these factors were influencing health outcomes among their patients.

In September 2007, with additional support from Partners Community Benefit and Project Bread, the project was expanded to include six additional health center sites with the goal of bringing hunger resources closer to where families can easily access them and in hopes of making a strong case to the Massachusetts State legislature that access to hunger resources should be an integral and reimbursable part of primary health care.

2008 Program Data

- From November 2007 to September 2008, Chelsea Pediatrics screened more than 3,000 patients for hunger insecurity. Approximately 11 percent were found to be food insecure.
- 146 families were interviewed.
- Of those families not receiving Food Stamps, 82 were referred for Food Stamps.
- 124 families of the 146 interviewed were referred to food pantries for assistance by the Outreach Worker.
- With program growth, the 20 hours outreach worker position will expand to a 40 hours position in 2009.

Legal Initiative for Kids (LINK)
Laura Maslow-Armand, Esq., Lawyers' Committee for Civil Rights under Law

LINK removes legal obstacles that interfere with the health status of pediatric patients, particularly immigrant families. Under a contract with the Lawyers' Committee for Civil Rights under the Law, a LINK lawyer works one day per week to assist families with maintaining or obtaining safe and secure housing, and gaining access to public entitlements and cash assistance. In the majority of cases, LINK assistance was extensive, involving several hours of consultation, document preparation and advocacy. Working closely with pediatric and mental health providers who refer the patients and their families, the LINK attorney provides assistance with eviction prevention, negotiates with utilities, facilitates applications to subsidized housing, appeals disability denials, and advocates for public benefits. The LINK program involves collaborative work between the attorney and the Community Health Team's interpreters/outreach workers, bi-cultural home visitors, and case managers.

The families that are referred to LINK are struggling to cover rent and utilities with only minimum wage earnings and transitional cash assistance. The benefit to the family's physical and emotional well-being is significant when it can move out of substandard overcrowded apartments into affordable subsidized housing. Since most of the families move into public housing in Chelsea, they remain in contact with their providers at the MGH Chelsea and, therefore, can maintain continuity of care.

2008 Program Data

- Since the beginning of the program in 2003, LINK has interviewed and assisted more than 215 families, two-thirds of whom come from Africa or the Middle East.
- The program estimates that the total number of family members who benefited from this assistance to be at least 870 persons.
- 39 families have been offered public housing units, almost all under lease from the Chelsea Housing Authority. 19 of those families are from Somalia, seven from Latin America, five from Afghanistan, three from the Sudan, two from Iraq, one from the Congo, and two are United States citizens.
- 23 families have avoided eviction.
- 25 families obtained disability benefits. All of these families are African, Afghani or Latin American.
- In its five years, LINK has successfully reversed every denial of Supplemental Security Income or Social Security Disability Income.

Chelsea High School Student Health Center
Jordan Hampton, RN MSN CPNP, Program Director
Sheila Desmond, MD, Medical Director

MGH Chelsea has operated the Student Health Center (SHC) at Chelsea High School since 1990. The goal of the SHC is to increase the number of high school students receiving primary and specialty health care.

The SHC provides confidential, comprehensive health care to teens who might otherwise not receive it, including physical exams, reproductive health care, mental health counseling, nutrition, preventive health education, and treatment for acute, episodic, and chronic illnesses. The SHC staff collaborates with health center primary care providers and specialists to ensure continuity of care and appropriate follow up. The SHC also provides classroom presentations on reproductive health, a support group for pregnant and parenting students through the Circle of Care program, and sponsorship of the Stay in Shape program, designed to address health, nutrition, and physical activity among female students.

2008 Program Accomplishments

- The Student Health Center completed its fourth year of the WK Kellogg Foundation School Based Health Care Policy Initiative.
- SHARE students (Student Health, Advocacy, Research and Education, an after school program for students at the Student Health Center, sponsored Domestic Violence Awareness Day, the Great American Smoke-out, World AIDS Day, and a nutrition policy campaign.
- SHARE students attended the 3rd annual School-Based Health Care Advocacy Day at the State House in March 2008, which featured the Program Director as emcee. Students met with legislators to discuss the importance of school-based health care.
- For the eighth year, the SHC offered two 10-week long sessions of Stay in Shape, a nutrition and exercise program for girls run by a certified health educator, a registered dietitian and a certified personal trainer. The program reached a total of 46 girls in the school year.
- The Program Director of the SHC ran the GAPPS program – Graduation and Attendance for Pregnant and Parenting Students at Chelsea High School – consisting of monthly support meetings. The group met seven times over the school year. Approximately 20 of the 35 invited students attend each session. At each session, the girls were given time to discuss challenges they were facing at the high school, as well as, at home. Each session also included an educational portion with outside speakers.
- For the fourth consecutive year, a group of five teen moms went to the State House on April 3rd with the Program Director to participate in Teen Parent Lobby Day.
- The Program Director precepted a third year nurse practitioner student from the MGH IHP
- Staff from the SHC assisted with the recruiting and hiring of five Chelsea High School students who participated in summer internships at MGH Chelsea through the Jobs 4 Youth program.

Program Data

- 415 students were patients at the SHC during the 2007-2008 school year.
- A total of 1,203 primary care visits were conducted.
- A total of 453 mental health visits were conducted.

MGH ROCA Youth Health Center
Lisa Carr, MD, MGH Chelsea
Leah Giunta, FNP-C MGH Chelsea
Teresa Grignon, MS, RNCS, MGH Chelsea
Vikki Segovia, Family Planning Counselor

MGH Chelsea operates a fully licensed satellite clinic at ROCA, a Chelsea-based youth development organization. The goals of the MGH ROCA Youth Clinic are to introduce young people to the health care system in an age-appropriate approach to care, to encourage young people to take a proactive role in making healthy life choices by providing access to culturally sensitive health information, and to improve understanding of the health needs of young people.

The clinic uses an innovative approach to engage hard to reach youth in health care by integrating health promotion into the arts, education, and leadership programming at ROCA. The clinic provides comprehensive health risk assessments, STD testing and counseling, anonymous HIV testing and counseling, and contraceptive services. A bilingual, bicultural family planning counselor provides teens with education, discusses relationship issues, and makes assessments for depression and relationship violence. The counselor also provides group education about contraceptives and sexually transmitted diseases to adolescent mothers in ROCA's Healthy Families Program and to young people at La Via, ROCA's school for high-risk youth. Those young people with identified depression / high-risk behaviors are referred to a mental health worker who works directly with the program and can provide counseling and medicine therapy to identified patients within one month of referral. The MGH ROCA clinic closely coordinates care with both the Chelsea High School Clinic and The Revere Adolescent Clinic.

2008 Program Accomplishments

- ROCA raised money during a capital campaign to create a clinic space that is twice as large as the previous space, and this new space will be operational in the next weeks.
- The clinic has been able to expand from two to four sessions per week and has a presence on site three days per week.
- The increased space will facilitate the education of medical residents, medical students, and nurse practitioner students. This will help clinic staff to fulfill their mission of educating and mentoring future health care providers.
- In addition to providing STD testing and contraceptive services, the clinic has been able to expand HIV testing to cover the test for all patients free of charge.
- The numbers of gay/bisexual/transgender patients accessing the clinic has increased in the past year as the clinic has worked to promote the environment as a safe place to seek care and advice.
- ROCA has recently been approved for a grant to improve outreach to young men to educate them around sexual health and reproduction. The clinic staff look forward to working with ROCA to develop programming around this grant.

Program Data

- In 2008, 153 patients received care at the MGH ROCA Youth Health Center. 118 of those were females and 35 of those were males.
- In 2008, despite being closed for over four months of renovation, there were a total of 271 patient visits (244 family planning visits, 24 medical visits and three patient education visits).

Prenatal Outreach Program

Adela Marquez, Outreach Worker

The Prenatal Outreach Program seeks to improve birth outcomes among at-risk pregnant women in Chelsea. A bilingual, bicultural prenatal outreach worker connects patients with hospital and community resources and assists them with planning for their unborn child and their own health care. The outreach worker helps patients complete forms (such as the birth certificates), provides family planning information, advocates for health insurance and welfare benefits, and connects patients with local food pantries, childcare programs, clothing services, WIC, and English as a Second Language programs. The program depends on many established partnerships in order to fully serve patients, including HAVEN, Mental Health and Social Services, Pediatrics, the Visiting Moms Program, the Circle of Care Project for Pregnant and Parenting Teens, the Safe Start Program, and Patient Financial Services at MGH Chelsea.

In May 2007, with the help of MGH Community Health Associates, the MGH Chelsea Obstetrical Department was awarded a grant from the Massachusetts Department of Public Health to facilitate the provision of community-based services to women of reproductive age. The goal of this project has been to ensure that all pregnant and postpartum patients of the health center, especially those identified as high risk have access to the appropriate social support services. This project includes the implementation of a standardized, valid depression-screening tool called the Edinburgh Postnatal Depression Scale. The scale is administered to pregnant and postpartum patients at their initial, 28 week and postpartum appointments. The goal is to identify, evaluate and treat women who have depression. From December of 2007 to September of this year, 714 pregnant and postpartum women have been screened using this instrument. Of the 714, 116 or 16.2 percent have screened positive for a possible depression diagnosis. Prenatal social workers project provide the evaluation and treatment services in conjunction with the Mental Health Department when the women have screened positive.

In the past year, the Immigrant and Refugee Health Program has become an intrinsic element in serving pregnant and postpartum women who are new immigrants or refugees. By connecting women directly to the Refugee Women's Program Manager all the connections, advocacy and concrete services that were traditionally provided for women who spoke English and Spanish are now available to other women as well. In the past year, the specific women served have included women from Somalia and a few other African countries as well as Arabic speaking women from countries both in Africa and parts of the Middle East.

A database has been developed to track needs of pregnant and postpartum patients and document that these patients were referred to the appropriate services. Reports are run from this database to gather additional demographic information for the possible development of future programs.

2008 Program Data

- The Prenatal Outreach Worker worked with over 300 patients.
- The majority of patients were undocumented, did not speak English and had very low literacy levels in their native languages.
- Patients ranged in age from adolescence to midlife, and most were single and unemployed.
- The Refugee Women's Program Manager worked with over 20 refugee and new immigrant mothers throughout their pregnancy and post-partum period.

Chelsea Visiting Moms Program

Amal Ali, Visiting Mom
Fadumo Hirsi, Visiting Mom
Rosa Mojica, Visiting Mom
Tania Soares, Visiting Mom

The Visiting Moms Program provides home visitors to high-risk new mothers who receive care at MGH Chelsea. The goals of the program are to help families achieve stability in order to enable healthy long-term outcomes for the child, the mother, and the family, and to reduce abuse and neglect.

Pregnant and parenting women are referred to the Visiting Moms Program from the Health Center's Prenatal, Pediatrics, and Mental Health Departments, as well as from the inpatient MGH Obstetrics and Pediatric Units. Bicultural home visitors support the new mothers, ages 21 and above, with adjusting to and caring for their children. Visiting Moms offer emotional support, concrete assistance, advocacy, referral to resources, and information about child development and guidance on the care of infants and young children. The Visiting Moms serve as role models, demonstrating ways to adapt to a new country and culture. They lend support around difficult psycho-social stressors, such as unemployment, lack of finances, language barriers, immigration problems, difficulty accessing benefits, and emotional and physical abuse. The mothers' traditional parenting techniques may be difficult to maintain within this culture so reducing isolation and providing role modeling for the mothers is of central importance to the work.

Collectively the mothers speak more than ten languages, including Spanish (52 percent), Somali, Arabic, Portuguese, Swahili, Ugandan, Dari, Haitian Creole, French, and Cantonese. The Visiting Moms speak five of these languages, thereby, increasing their ability to encourage the mothers to use available resources, some of which the Visiting Moms themselves might have accessed. The Visiting Moms are able to maintain these supportive relationships for up to three years.

2008 Program Accomplishments

- The Visiting Moms presented the program as key note speakers to an international audience at a home-visiting symposium sponsored by Jewish Children and Family Services. The symposium was entitled "Home Visiting Initiatives across Cultures and the Continents". This event was held at JFCS headquarters in Waltham, MA.

Program Data

- Since the Visiting Moms Program began in 2002, 166 cases have been opened, with 63 mothers currently enrolled in services.
- More than half of the women are new mothers; many of the children of the other women remain in their home countries with relatives.
- Over the past year, the Visiting Moms have had over 1,300 encounters with a total of 72 moms, babies, and families, for an average of 18 encounters per client.

Determination of Need Programs

Joanna Kreil, MSW, MPH, Community Initiatives Program Coordinator

In November of 2006, MGH submitted a Determination of Need (DoN) application to the Massachusetts Department of Public Health to obtain approval for the construction of a new ten-story building at the hospital in downtown Boston. DoN applications require that a percent of the total capital cost be allocated to community health improvement projects. The MGH CCHI worked with the communities and the DPH to identify community needs and as a result committed to funding the Chelsea REACH Program, an after-school program for Chelsea's seventh through tenth graders, as well as, violence prevention and/or intervention programs in Chelsea. The DoN proposal was approved in June of 2007.

Chelsea REACH (Reach. Explore. Achieve) Program

During a year-long assessment focused on youth in Chelsea, the Hyams Foundation identified the need for an intensive program for youth in grades seven through ten, focusing on the transition from middle to high school. Chelsea Public Schools is the lead agency.

The program focuses on improving academic achievement, educating students about career opportunities, and providing personal development and emotional support and seeks a mix of academic achievement among its enrolled students. REACH also comprehensively addresses the needs of students and families, with the goal of increasing the number of Chelsea youth who complete high school, go on to college, and make meaningful contributions to the community. Because the Hyams Foundation and MGH believe that increased educational opportunities are a protective factor against high-risk behaviors, this initiative is compatible with the overall objectives of the MGH Center for Community Health Improvement and the City of Chelsea to reduce violence.

2008 Program Accomplishments

- The Program Director was hired and she hired and trained group leaders.
- Technical Development Corporation (TDC) was selected as the evaluator for the program.
- A Program Oversight Committee with representatives from various sectors of the community was formed and met several times to discuss and vote on key issues related to the operation of the program.
- The program opened on March 31, 2008 and was fully enrolled (60 students) within two weeks and a wait list was created. The diverse group of enrolled students included: 47 Latino, three Black, two Bosnian, one Brazilian, five Somali, one Ugandan and three White students. Of this mix of students 20 students had been functioning below average academically, 22 had been academically average students and 20 students had been functioning above average academically.
- The Chelsea community agencies Choice Thru Education, Community Schools, HarborCOV, and ROCA were engaged to conduct some of the after school activities.
- A summer component met four days per week for five weeks and combined educational and fun activities. Average attendance during the summer was 30-35 students.
- 53 of the original REACH students returned in September, and 21 new students enrolled. Of the new students there are: 17 Latino, seven Somali, two Black, one Bosnian, one Cape Verdean and one White. 16 of the new students are female and 13 are male.

Chelsea Violence Prevention/Intervention Programs

Between September of 2007 and January of 2008, CCHI met with Chelsea community leaders to conduct an assessment of gaps in violence prevention and intervention programming. In addition, violence and demographic data were collected and reviewed from the Chelsea Police Department, the MA Department of Public Health, and the Youth Risk Behavior Survey.

Based on this assessment of both qualitative and quantitative data, CCHI issued a request for proposals for seven years for one or more innovative violence prevention or intervention programs that addressed one or more of the following areas: teen dating violence; services for immigrant and refugee populations; sexual exploitation of youth; home safety training in relation to violence and abuse; early childhood development and violence prevention for very young children; family-oriented services; quality childcare services; and/or short-term anger management and/or mental health services. MGH Chelsea received eight responsive proposals and engaged in an extensive review with both key members of the community and outside experts in the field. The funding was awarded to CAPIC Head Start, the Chelsea Police Department, and ROCA, Inc.

CAPIC Head Start received a one-time award for the purchase of Second Step, a violence prevention curriculum for children from preschool through grade eight. The curriculum is a classroom-based social skills program, designed to reduce impulsive, high-risk, and

aggressive behaviors and increase children's social-emotional competence and other protective factors.

CAPIC Head Start also received a renewable award for the Good Guys Program. This program serves fathers of children enrolled in the Head Start Program and supports the Head Start philosophy that encourages all parents to take an active role in their child's education. The goals of the Good Guys Program are to: 1) have Head Start fathers make the connection that the bridge between school and home is an important bridge to cross, and one that can be reached without extraordinary effort; 2) help fathers recognize and appreciate the importance of spending "quality" time with their child; and 3) assist fathers in their role as collaborating parents.

The Chelsea Police Department received a renewable award to hire a Newcomer Advocate. He/she will create positive relations with refugee and immigrant communities to help make these populations less susceptible to crimes such as extortion, domestic violence, burglary, robbery, and gang-related activities. The Newcomer Advocate, in collaboration with other members of the Chelsea Police Department, will develop and implement a program to strengthen the community's knowledge of the refugee populations arriving and living in the City of Chelsea, as well as increase collaboration among Chelsea's community partners.

ROCA, Inc. received a renewable award to support the organization's intervention model and demonstrate the effectiveness of this model. ROCA engages in intensive intervention work with very high-risk youth and young adults, ages 14-24 in Chelsea. In response to the growing number of disconnected and disengaged young people in Chelsea, ROCA's integrated program model creates developmental and economic opportunities for youth who: 1) are street, gang, and/or court involved; 2) have dropped out of high school; 3) are young parents facing multiple barriers; and/or 4) are refugees and immigrants struggling with language barriers, trauma, isolation, and lack of support.

Power Up
Wanda Gonzalez, MD, Pediatrician, Principal Investigator
Jennifer Vetree, MS, RD, LDN, Clinical Nutrition Specialist
Ming Sun, MPH, Community Health Educator
Sofia Devine, PT, Physical Therapist
Katherine Griffiths, LICSW, Clinical Social Worker
Joanna Kreil, MSW, MPH, Community Initiatives Program Coordinator

In childhood, a healthy body mass index (BMI) is between five percent and 85 percent of average weights of children nationwide. Children with a BMI between 85 percent and 95 percent are considered overweight, and children with a BMI greater than 95 percent are considered obese. According to a 2006 community needs assessment of preschool and elementary-school aged children in Chelsea, approximately 40 percent of Chelsea's preschool aged children are overweight or obese. Furthermore, 32 percent of Chelsea's elementary school children are overweight, and 18 percent are at-risk for becoming overweight. These figures are significantly higher than the national average ($p<.001$).

Additionally, growth exams were conducted on all Chelsea middle school children by Chelsea Public Schools during the 2007-2008 academic year, and these exams revealed that 55.8 percent of Chelsea middle school children have BMIs above 85 percent.

Power Up is a four week nutrition and exercise program for overweight and obese 10-12 year olds and their parents who get their care at MGH Chelsea. The program is supported by the Department of Pediatric Medicine in partnership with the Center for Community Health Improvement. The program was designed to be family-oriented with the understanding that while middle school students often make dietary choices for themselves, particularly during school hours, they still spend a considerable amount of time under the guidance of their parents. With increased family participation, children have greater success attaining and maintaining a healthy lifestyle, and thus, a healthy weight. Power Up addresses several major causes of obesity, including excess consumption of soft drinks and other beverages that are high in sugar, increased food consumption in general, lack of physical activity, exercise that is low cost and can be done with little space, and television viewing and advertising.

Five children and their parents participated in the first section of the four week program. Two participants achieved a decrease in BMI, and three participants achieved a stabilization of BMI. Furthermore, at the end of the program, there was an increase in the number of children who reported eating five or more fruits and vegetables per day, consuming at least three servings of dairy per day, and eating breakfast daily. There was a decrease in the number of children who reported drinking juice on a daily basis. Lastly, there was an increase in the number of children who felt they had control over their weight and what they eat, as well as, an increase in the number of parents who felt they had control over their child's weight. The Power Up series will be offered two or three times a year and a reunion for all participants will be held three months after the conclusion of the series to check in on how children and their families have been doing.

Goal 3: Reducing Disparities in Health Care

Racial and ethnic disparities in health and health care are well-documented both locally and nationally. MGH Center for Community Health Improvement, partnering with the MGH Disparities Solutions Center and the MGH Committee on Racial and Ethnic Disparities in Health Care, has prioritized reducing disparities in care throughout the hospital and its affiliated health centers as an essential component of improving the health of individuals, families, and communities. At MGH Chelsea, the Diabetes Management Program and the Cancer Care Programs have been implemented to address these issues.

Chelsea Diabetes Management Program

Barbara B. Chase, APRN, ANP, CDE, Diabetes Program Coordinator, MGH Chelsea
Sofia Devine, PT, DPT, Physical Therapist, MGH Chelsea
Teresa Grignon, RN, CNS, Support Group Facilitator, MGH Chelsea
Adilson Horta, MA, MHC, Diabetes Coach, MGH Chelsea
Maureen Marre, APRN, FNP, CDE, Diabetes Educator, MGH Chelsea
Estela Perez, LICSW, Support Group Facilitator, MGH Chelsea
Elisamuel Sanchez, RN, Diabetes Educator, MGH Chelsea
Jennifer Vetree, MS, RD, LDN, Clinical Nutrition Specialist

Diabetes mellitus type 1 and type 2 are both complex, multi-system diseases which require ongoing self-management by patients and families in collaboration with their health care providers to achieve optimal control. Although all patients with diabetes face challenges to controlling their disease through proper nutrition, adequate exercise, glucose monitoring, and medication management, minority and patients of lower socio-economic status may face additional challenges due to language barriers, cultural and socioeconomic factors, and poorer access to high quality care. Research has shown that racial/ethnic disparities in diabetes care are widely documented, both in terms of prevalence and in treatment and management.

In 2005, an assessment of diabetes disparities at MGH Chelsea revealed similar disparities. Spanish-speaking Latinos (37 percent) were more likely to be in poor diabetes control compared to English-speaking Whites (24 percent) and Latinos were less likley than Whites to have received a glycohemoglobin test in the past year (66 percent verus 75 percent). Improving diabetes care is an area of interest for both disparities elimination and improvement of overall quality of care.

To address patient and provider needs, improve quality overall, and reduce racial/ethnic disparities in care, an innovative, culturally competent diabetes management program was created in the spring of 2006, to serve the unique needs of patients at MGH Chelsea. This multidisciplinary program is the result of collaboration between MGH Chelsea, the Disparities Solutions Center, Massachusetts General Physician's Organization, and the Center for Community Health Improvement.

The Diabetes Management Program aims to improve diabetes self-management among all MGH Chelsea patients through education and empowerment and to reduce racial/ethnic disparities in diabetes control and testing between Latino and White non-Latino patients at MGH Chelsea. The Program also aspires to understand the barriers patients encounter that prevent optimal care and diabetes control, as well as, the factors important to reducing these obstacles. A further goal of the Diabetes Management Program is to improve and facilitate the processes of diabetes care for both providers and patients.

The Diabetes Management Program has four core program components that include:

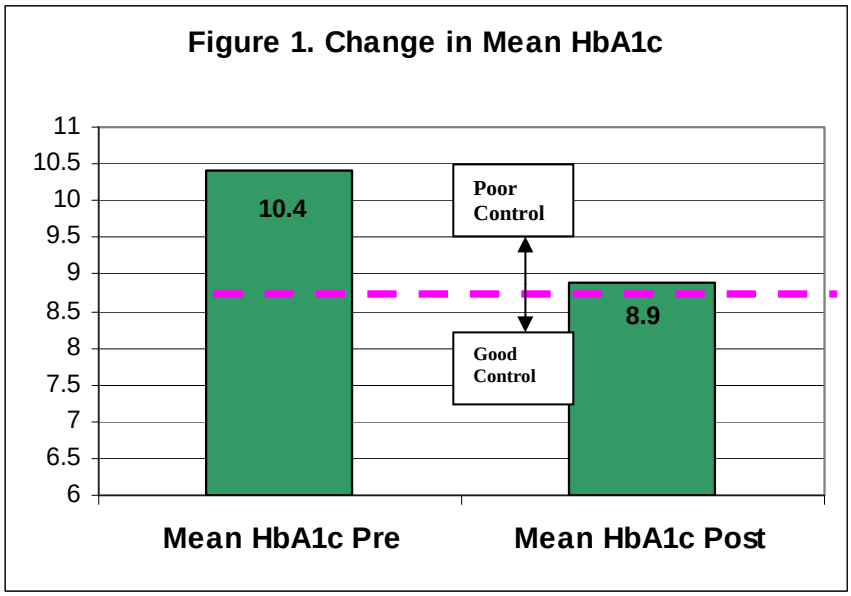
1. **Case Management**. Use of an electronic database to facilitate meeting standard of care goals, identifying patients most at-risk and improving the efficiency and cost effectiveness of care delivery,
2. **Coaching**. Ongoing outreach, using an electronic database and provider input to identify, engage and coach patients most at risk; individual bilingual (English and Spanish) coaching sessions based on a culturally competent model for chronic disease management that emphasizes working with patients to explore their barriers to achieving good diabetes control and developing a plan to help them overcome these barriers,
3. **Diabetes Self Management Education (DSME)**. Comprehensive nine hour, ADA recognized, patient education program, offered in either group or individual visits, in English or Spanish, using two nurse educators, a dietitian, a physical therapist and two mental health professionals as faculty,
4. **Support Group**.. Ongoing group visits in English and Spanish, offered to patients after completion of the DSME program, and co-facilitated by mental health professionals and the diabetes coach to reinforce DSME learning, encourage adaptation and behavior change, and promote community based peer support systems.

2008 Program Accomplishments

- In April 2008, the program received a Program of Excellence Award from the Diabetes Coalition of Massachusetts stating that the program "has led to a significant reduction in disparities between Latinos and whites at MGH Chelsea and has improved the quality of diabetes care provided to all patients with diabetes, particularly those in poor control".
- The Diabetes Self Management Education Program was featured in a Channel 7 news spot in June, highlighting how the Diabetes Nurse Educator offers diabetes education in an interactive and culturally responsive way for Latino patients.

Program Data

- As of October 2008, over 373 patients have received diabetes coaching. 66 percent of these patients speak Spanish as their primary language.
- 132 patients have completed the DSME program. 82 percent of these patients speak Spanish as their primary language.
- Preliminary results have shown that patients participating in the DSME program between January 2007 and November 2008 decreased their HbA1c levels by ten percent after successfully completing the program.
- In 2007, 85 percent and in 2008, 100 percent of participants reported that the DSME Program helped them understand how to create and follow an exercise plan.



- Preliminary results have also shown a significant reduction in HbA1c levels of 1.48 for program participants (a reduction of 0.5 is considered clinically significant).
- In terms of addressing racial/ethnic disparities, the program has seen the rates of control between White and Latino patients closing with a decrease in the percentage of Latino patients with uncontrolled diabetes from 2005-2007 (35 percent vs. 29 percent) and for White patients (24 percent vs. 20 percent).

Cancer: Early Detection and Navigation
Sanja Percac-Lima, MD, PhD, Cancer Care Physician Leader

Cancer related morbidity and mortality can be reduced with screening, early detection and treatment. Still, in low income, non-English speaking patients and minorities rates of cancer screening and early treatment are lower than in other groups. When diagnosed, these patients present in late stages and have higher mortality rates than White, English-speaking and higher income patients. Since 2001, MGH Chelsea has had programs that provide cancer care for vulnerable patients to decrease the disparities in care that exist. Currently there are four programs, outlined below that encourage early screening and detection and provide navigation to those with abnormal findings.

Avon Breast Health Outreach Program
Atala Esquilin, Avon Breast Health Coordinator
Denise Sidorowicz, ANP, MGH Chelsea

The Avon Breast Health Outreach Program aims to improve follow-up through the use of a patient navigator for women at MGH Chelsea who have had an abnormal mammogram. The program targets Latinas and is a collaboration between the Avon Comprehensive Breast Evaluation Center at MGH, MGH Center for Community Health Improvement and Partners Community Benefit. This multi-site initiative includes two other health center sites in Boston.

The Breast Health Coordinator serves as a health care navigator and liaison between patients who had an abnormal breast exam or mammogram and providers, following up when patients miss appointments, and accompanying them to appointments when needed to help navigate through the health care system. The coordinator makes referrals to other community resources, and provides emotional support to patients undergoing diagnostic work-up or breast cancer treatment, including home visits as indicated. Through a special arrangement with the Avon Breast Evaluation Center, MGH Chelsea patients receive all required care (e.g. ultrasound, mammography, pathology) in a coordinated appointment in less than a month from initial referrals. All patients have access to a Spanish interpreter through the IPOP speaker phone. The coordinator also conducts outreach to women at risk for breast cancer, and participates in community events to increase awareness about the program.

2008 Program Data

- Since its inception in May 2001, the program has served 728 patients including 88 patients diagnosed with breast cancer through the program**.**
- Since the program began, 64 percent of the patients served have been Latinas and 66 percent did not speak English.

Cervical Health Outreach Program

Diana Maldonado, Cervical Health Program Coordinator
Gloria Gamba, MA, Senior Cancer Care Coordinator
Denise Sidorowicz, ANP, MGH Chelsea

The Cervical Health Outreach Program, which began in 2004, aims to increase rates of follow-up for women, including adolescents, who have had abnormal pap smears, with the goal of preventing cervical cancer. The program is delivered to patients of MGH Chelsea in need of follow-up of abnormal pap tests, with an emphasis on reaching Latinas.

The program's Cervical Health Coordinators work closely with the Center for Colposcopy at MGH to ensure that patients from Chelsea attend initial and follow-up appointments, and to facilitate communication between MGH specialty and MGH Chelsea primary care providers. The coordinators serve as patient navigators providing emotional support, assistance with scheduling appointments, reminder calls, help accessing insurance, and accompany patients to appointments and/or conducting home visits as needed. They ensure that patients follow through in getting their second and third HPV vaccines once they have begun their vaccination schedule at the Center for Colposcopy. The coordinators also conduct outreach to inform the community about the program. The program's expansion to include adolescents presents unique challenges, since teens often require more time for education, counseling and support.

2008 Program Accomplishments

- With the help of Dr Raymond Lui, the Director of the MGH Center for Colposcopy, MGH Chelsea implemented the new guidelines for cervical cancer prevention into the

program Dr. Lui conducted trainings for medical providers in the Pediatric and Adult Medicine Units to help with this implementation.
- To further improve the quality and efficiency of the program, the Senior Cancer Care Coordinator has conducted interviews with women that have abnormal pap smears to explore their barriers to colposcopy and their satisfaction with care received.

Program Data
- Since its inception in 2004, the program has served 431 patients
- 77 percent are Latina
- ten percent are from other ethnicities (non-White and non-Latina)
- 24 percent speak English
- Six percent speak languages other than English or Spanish
- Nine percent are under 20 years old
- Only 23 percent have private insurance

Colorectal Cancer Screening Program
Gloria Gamba, MA, Senior Cancer Care Coordinator
Sanja Percac-Lima, MD, PhD, MGH Chelsea

The Colorectal Cancer Screening Program aims to increase colorectal cancer screening (CRCS) for all eligible patients at MGH Chelsea and to decrease disparities in CRCS rates that exist between Latino and White patients, as well as, in low income and non-English speaking populations in Chelsea.

The Senior Cancer Care Coordinator works closely with the Gastroenterology Department at MGH Boston and Adult Medicine providers at MGH Chelsea to facilitate communication between the MGH specialty department and the patients. The program is offered to patients of MGH between the ages of 50-79 years old. The coordinator who is bi-lingual provides education in Spanish or English on colon cancer screening options and explores the patient's barriers to colon cancer screening. The coordinator schedules and reminds patients about appointments, helps them access insurance, explains instructions for their GI prep, translates written material and provides key emotional support. The coordinator also accompanies patients to their GI appointments and interprets during the appointment if needed. Screening results and patient contacts are documented in the program data base and in the electronic medical record. Interpreters assist when appropriate. The program began with support from an MGH Clinical Innovation Award and is now supported by CCHI in partnership with the MGH Cancer Center.

2008 Program Data
- Since the beginning of the program in January 2007, the coordinator has contacted 760 patients
- 232 patients have completed their colonoscopies
- 107 patients completed and returned Fecal Occult Blood Test cards (FOBT).
- To evaluate efficiency of the program, a randomized controlled trial (RCT) was carried out from January to October of 2007:

- All 1,223 patients 52-79 years old at MGH Chelsea who were overdue for CRC screening were randomized to intervention (n=409) or usual care control (n=814) group
- Over the nine-month period, intervention patients were more likely to undergo CRC screening than control patients (27 percent vs. 12 percent). Most of the difference among intervention and control patients was attributable to significantly higher colonoscopy rates (21 percent vs. 10 percent)
- The higher screening rate resulted in the identification of 10.5 polyps and 0.24 cancers per 100 patients in the intervention group vs. 6.8 polyps and 0.12 cancers per 100 patients in the control group.
- These results were published in Journal of General Internal Medicine: Percac-Lima S, Grant RW, Green AR, Ashburner JM, Gamba G, Oo S, Richter JM, Atlas SJ. A Culturally Tailored Navigator Program for Colorectal Cancer Screening in a Community Health Center: A Randomized, Controlled Trial. J Gen Internal Med 2008 Dec 6 (Epub ahead of print)

Cancer Prevention Project for Refugee Women
Chantal Kayitesi, MPH, Refugee Women's Program Manager, MGH Chelsea
Barbara Bond, LICSW, Ed.D, Gillette Center for Breast Oncology

The Cancer Prevention Project for Refugee Women started in July 2008 and aims to improve breast cancer screening and care in refugee women from Africa and Bosnia who currently receive care at MGH Chelsea. The goal is to increase the awareness of need for and completion of breast cancer screening and to facilitate early diagnosis and treatment of cancer among refugee women.

Currently, ten outreach workers from MGH Chelsea and the refugee communities are undergoing training to become cancer care navigators for refugee women. The training is focused on breast and cervical anatomy, prevention, early detection of breast and cervical cancer and diagnostic and treatment options. Participants learn how to assess women's barriers to cancer screening and treatment and to educate them about the importance of breast self-exam, screening and early diagnosis. These trained outreach workers, who already have developed strong connections to refugee women in their communities, will be able to assist women in scheduling their primary care visits, mammograms and the follow-ups of abnormal findings.

The project objectives are:
- To increase the breast cancer screening rates in refugee women to the same level as Spanish and English speaking women receiving care at MGH Chelsea
- *T*o explore which barriers to screening are most salient for refugee women;
- To design and implement a program with interventions aimed at overcoming these barriers
- To provide timely follow-up for abnormal results and access to treatment if needed.

Revere

Background

Roger Pasinski, MD, Medical Director, MGH Revere HealthCare Center
Deborah Jacobson, Administrative Director, MGH Revere HealthCare Center
Kitty Bowman, Director, Revere CARES
Eric Weil, MD, Center for Community Health Improvement Liaison

Revere is a rapidly changing residential, coastal community of approximately 47,300, located five miles north of Boston. Revere is home to many immigrants, including natives of Cambodia, Vietnam, the Caribbean Islands and Latin America, as well as, Bosnia, and Somalia. The Massachusetts Department of Education reports an increasingly diverse student body in Revere of 47 percent White, (down from 91 percent in 1990), 36 percent Latino, eight percent Asian, four percent Black, one percent Native American, and five percent other. Forty-two percent of Revere students come from homes where the primary language is not English compared to the state average of 15 percent, and ten percent of Revere school children have limited English proficiency. More than 14 percent of the total population and 21 percent of children under 18 live below federal poverty levels. Sixty-two-percent of Revere students are eligible for free or reduced price meals. Revere's school dropout rate is substantially higher than the state rate (7.7 percent vs. 3.8 percent).

Revere Center for Community Health Improvement (CCHI) Goals

CCHI work in Revere relies on strong and effective collaborations across virtually all sectors, including Revere families and residents, and focuses on youth and supports the MGH Revere HealthCare Center's goal of creating a comprehensive continuum of adolescent care, from community based prevention efforts to direct patient services. The priorities include:

- Reducing and preventing substance abuse and violence among Revere youth and building a healthier community.
- Increasing access to health care, and promoting health and wellness among Revere adolescents.

Approach to Doing the Work

In Revere, the MGH Revere HealthCare Center (MGH Revere) serves as the base for community benefit work. First opened in 1981, the health center was relocated in 1995 to an expanded 50,000 square foot new facility directly on Revere Beach at 300 Ocean Avenue. MGH Revere offers comprehensive health and mental health care services, and in FY2008, the health center provided care through more than 114,000 patient visits.

Goal 1: Reducing and Preventing Substance Abuse Among Revere Youth

Revere Cares
Kitty Bowman, Director

Revere CARES (Community Awareness, Resources, and Education to Prevent Substance Abuse), founded in 1997, is a community coalition dedicated to reducing and preventing alcohol and drug use among youth in Revere and to building a healthier community. Revere CARES has enabled Revere to make measurable gains in reducing youth alcohol and other drug use.

Revere CARES builds on the strengths of the community to increase protective factors for youth and to decrease risk factors. Now numbering 350 members, Revere CARES includes a growing and diverse group including concerned parents and other adults, teens, Revere Public Schools, the Revere Police and Fire Departments, the Chamber of Commerce, community based providers, churches and others from the faith community, and elected and government officials. Revere CARES is changing the community norms within which Revere youth make choices about tobacco, alcohol and drug use.

The Coalition uses research-based strategies and is based on the belief that a community that works together to send clear and consistent messages about substance abuse, active living, healthy eating and violence to teens, offers positive alternative activities, and makes appropriate services available can reduce alcohol and drug use, violence, and childhood obesity among youth. The Coalition measures its success not only by indicators of substance use, violence, and childhood obesity, but also in terms of community change that is sustainable for the long term. Revere CARES Coalition focuses on four priorities:

- Advocating for public policy changes and enforcement efforts
- Conducting community awareness campaigns
- Implementing science-based prevention and early intervention programs for youth
- Building a healthier community by collaborating with others

2008 Program Accomplishments
2008 was a productive year for Revere CARES in all its priority areas. Accomplishments include:

Public policy changes and enforcement efforts

- The City of Revere received the Shannon Gang Violence grant award from the Massachusetts Executive Office of Public Safety for the third year in a row, and Revere CARES Coalition was awarded a Youth Violence Coalition Expansion grant for a second year in a row from the Massachusetts Department of Public Health.
- Revere CARES advocates at License Commission hearings to prevent issuance of new alcohol licenses in Revere and to restrict drinking hours. In 2008, Revere CARES successfully advocated for the roll back of bars' closing times from 2:00 a.m. to 1:00 a.m.

- In response to Revere CARES' advocacy, the new Revere Police Station has juvenile holding cells.

Implementing science-based programs and interventions

- Revere CARES provides technical assistance and staff support for the Revere After-school Partnership, comprised of after school providers, the City, Parks and Recreation Department, Revere Public Schools, MGH Youth Zone, and Revere CARES with the goal of expanding after school programming and improving quality of programs;
- Revere CARES also supports CASTLES, a Revere High alumni group that fundraises for after school programs.
- Revere CARES also works with the Revere After-school Partnership to support after school programming in all elementary schools and one middle school; and partially supports with MGH Determination of Needs (DoN) funds a school based program director to oversee programming and efforts to create seamless school and community based comprehensive after school and summer programming.
- Revere CARES works with MGH Youth Zone and the Police Activities League to support peer leadership efforts to reduce youth ATOD use and violence. Recent efforts include school and community Retreats on Violence.
- Revere CARES and Revere High School provide substance abuse education for athletes, freshman, and sophomores, and support the Power of Know Club, a high school peer education program.
- Revere CARES Policy Work Group and Opiates Task Force serve as the community advisory board for a grant from the Massachusetts Department of Public Health to reduce opioid overdoses. Initial activities included conducting an assessment and planning process using the strategic prevention framework.

Increasing awareness about substance abuse

- Revere CARES collaborated with the MGH Youth Zone and alcohol outlets on a Sticker Shock Campaign to place stickers reading, "Hey You! It is ILLEGAL to purchase alcohol for people under age 21" on all multi-packs of beer, wine coolers and alcopops (sweet alcohol drinks marketed to teens) in Revere liquor stores.
- Revere CARES conducted the *Power of Know*, a comprehensive media campaign designed to increase parents' awareness of their role in reducing underage substance abuse. As part of the campaign, over 500 parents pledged to ask the "who, what, where, and when questions"; to talk to their children about alcohol, tobacco and drugs; and to model responsible use of alcohol.
- Revere CARES conducted The *Parents Who Host Lose the Most* campaign. The campaign was designed to inform parents about the civil and criminal penalties associated with hosting teen parties where alcohol is served.
- Revere CARES hosted the Second Annual Revere Beach Memorial honoring people who lost their lives to alcohol and drugs at sunset, September 21stth at the William G. Reinstein Bandstand on Revere Beach. Over 100 participated in this candle light vigil.

Building a healthier community

Substance Abuse and Violence

- Revere CARES collaborates with Revere High School to support the RHS Connect Club, a violence prevention club of ten students who work to improve school climate in collaboration with the high school administration. RHS Connect conducted a school retreat to develop a better understanding of restorative justice, participated in a youth violence survey, and conducted a community retreat to identify strategies to reduce youth and community violence.
- Revere CARES provides technical, staff, and financial support for the Power of Know Club at Revere High School. The Power of Know Club members are guest lecturers on alcohol, tobacco and other drugs (ATOD), assisted the headmaster revise school ATOD policies, and worked to increase awareness of the harm of ATOD use and to expand activities in the school and the community. .
- Revere CARES identified the priority areas for 18-24 year old population and plans to fund one or more innovative sustainable employment training programs for this group.
- Revere CARES, Revere Public Schools, and Revere Parks and Recreational Department established the Education in Community Action Program (ECA). The ECA Program offers Revere High School students enrichment courses and an opportunity to apply for a related paid service-learning internship with the Revere Parks and Recreation Department during the summer following the completion of the courses. Fifteen students completed an enrichment course and were employed by the Revere Parks and Recreation Department during the summer of 2008.

Food and Fitness

- The City of Revere, Revere Beach Partnership, Revere First, Revere Beautification Group, MGH Revere HealthCare Center, WIC, and Revere CARES worked together to support a multicultural Farmer's Market on Revere Beach from July through October. Revere CARES contributions included obtaining funding for promotional activities, facilitating farmers' market meetings, and coordinating volunteers
- Revere CARES supported Revere's Police Activities League (PAL). PAL program provides community youth with a safe, positive, and structured recreational environment by offering a basketball league to youth ages ten to 16 years on Friday nights and Saturday mornings as well as during the summer months. Approximately 150 youth of diverse backgrounds, participated with an average of 85 youth per session.
- The Food and Fitness Initiative was adopted by Revere CARES in 2007 and is a collaboration with MassGeneral Hospital for Children and the City of Revere. The initiative seeks to develop an environmental approach to hunger, overweight and obesity with a strong school component. During 2008, the initiative established a representative Revere based task force; developed a partnership with Revere Public Schools (RPS); engaged in initial partnership discussions with RPS food service providers; identified priorities for and opportunities to increase healthy eating and active living and decrease hunger; and defined the Garfield Middle School Advisory Board and began recruitment efforts.

Program Data

The following data from Revere's Youth Risk and Behavior Survey show the gains made from 1999 to 2007 through community substance abuse prevention, intervention, and policy efforts. Following national and local trends, Revere students reported less tobacco, alcohol and marijuana use over time. In addition, Revere high school students have reported a decreased ease in obtaining substances, suggesting policy and community efforts may have contributed to this change.

Tobacco use is steadily declining:

- ***Among High School Students***, the percent of youth ever having smoked steadily declined from 69 percent to 54 percent (22 percent decrease). The percent currently smoking steadily declined from 37 percent to 25 percent (32 percent decrease).
- ***Among Middle School Students,*** the percent of youth ever having smoked has steadily declined from 51 percent to 28 percent representing a 45 percent decrease and the percent of youth who reported smoking in the past 30 days has steadily declined since 2001 from 20 percent to eight percent in 2007, representing a 60 percent decrease.

Some alcohol indicators are declining:

- ***Among High School Students***: Following national and local trends, the percent of students who reported ever drinking alcohol, past 30 day use and binge drinking have all decreased since 1999. The percent of youth who reported ever having been drunk has steadily declined from 66 percent to 53 percent (20 percent decrease) and the percent of youth who reported frequent binge drinking (5 or more drinks in a row on six or more occasions in the past month) has steadily dropped from 14 percent in 1999 to seven percent in 2007 (50 percent decrease).
- ***Among Middle School Students:*** The percent of youth who have ever drunk alcohol declined from 58 percent to 42 percent with a slight increase in 2005 before declining in 2007. This represents a 28 percent decrease between 1999 and 2005.

Marijuana use is declining:

- ***Among High School Students,*** the percent of youth ever having used marijuana steadily declined from 54 percent to 44 percent (19 percent decrease). The percent of past 30 day use of marijuana steadily declined from 35 percent to 26 percent (26 percent decrease).
- ***Among Middle School Students,*** the percent of youth ever having used marijuana has fluctuated between 22 percent and 21 percent over the past six years, however, this change drastically declined from 21 percent in 2005 to 14 percent in 2007, representing a 33 percent decrease between these two years.

Additional indicators:

- Among High School Students rates of perception of ease of obtaining tobacco (86 percent in 1999 to 67 percent in 2007), alcohol (83 percent in 1999 to 67 percent in 2007) and marijuana (83 percent in 2001 to 64 percent in 2007) have steadily decreased over time since 2001.

Goal 2: Increasing Access to Health Care in order to Improve Health Status and Well-being among Revere Youth

MGH Revere Adolescent Health Initiative
Debra Jacobson, Administrative Director, MGH Revere
Kerstin Oh, MD, Medical Director

The goals of the MGH Revere Adolescent Health Initiative are to increase access to comprehensive, holistic care for adolescents in Revere, improve health status, celebrate the strengths and diversity of youth, nurture social connectedness, and promote health and wellness. The Initiative links school based and confidential clinical services (the *MGH Revere Adolescent Health Program*) with an after-school program (*Youth Zone).* The components of the Revere Adolescent Health Initiative are described below.

Clinical Care: MGH Revere School-Based Health Center
Anna Berrian, RN, MSN, CPNP, Nurse Practitioner
Emily Wilcox, RN, MSN, CPNP, Nurse Practitioner

The School-Based Health Center (SBHC), located in Revere High School (RHS) and the Seacoast Academy, is in its sixth year. It is staffed by two nurse practitioners, a practice manager, a medical assistant/family planner, two mental health providers, and a patient care coordinator. The SBHC provides comprehensive health care, including management of acute illnesses, chronic disease management, immunizations, confidential care, mental health, and substance abuse counseling. The nurse practitioners also offer consultative services to the city's school nurses, health, and physical education teachers. They also coordinate coverage for RHS home football and hockey games.

Two licensed clinical social workers are on site a total of 28 hours per week to provide counseling to students. Referrals are received from teachers and counselors from within the school system. When necessary, referrals are made to MGH Revere Health Center or community-based services. A DPH funded grant has been able to provide classroom instruction with an Intervention/Prevention Specialist. All freshman and sophomores participate in classes that provide information on Life Skills and alcohol/substance abuse awareness.

SBHC staff conducts classroom and assembly presentations, and collaborate with school guidance counselors and social workers. Approximately 600 students are reached through classroom presentations on health and sexuality, by both nurse practitioners. Care for students is integrated with the MGH Revere Health Center, and includes assistance with enrolling in insurance, and follow-up, and referrals to MGH Revere physicians for primary care, mental health providers, and the OB/GYN Department.

The MGH Revere domestic violence advocate from the HAVEN program provides support services to the SBHC and the Adolescent Health Center. A Healthy Relationships

Working Group including the SBHC, Youth Zone, Adolescent Health Center, Revere Public Schools, Revere Police, and HarborCOV, the local domestic violence agency has been established and will resume when the HAVEN program's staff vacancies are filled. The group has conducted outreach to the middle schools, provides professional development at RHS and Seacoast Academy, and offers a relationship support group for girls. Supporting, educating and intervening with victims of intimate partner abuse remains a priority for the Revere adolescent population.

2008 Program Accomplishments

- The SBHC is one of five recipients of grants from the MA Dept. of Public Health for Mental Health/Substance Abuse services.
- Access to health insurance was facilitated by having staff from the MGH Revere Patient Financial department available at the school while immunizations were provided.

2008 Program Data

- 102 new patients were registered
- There are now 1,108 active patient charts
- During the 2007-08 school year, there were 487 visits to the SBHC

Adolescent Health Center

The MGH Revere Adolescent Health Center (AHC) is located on Broadway in Revere and provides confidential services to students from all Revere schools, their partners, and families five days a week during after-school hours, from 2:30 to 5:00 p.m. The AHC offers continuity of care for RHS and Seacoast Academy students requiring additional family planning services. The two SBHC nurse practitioners also staff the AHC, assuring coordination and continuity of care across the two sites. Services at the AHC include family planning counseling, and education. The nurse practitioners screen for domestic violence and are able to connect the patient to HAVEN advocate.

ROCA, Inc., in partnership with MGH Chelsea & Revere, received a five-year grant from the Office of Adolescent Pregnancy Programs to fund the Circle of Care (COC) project, with the goal of preventing subsequent pregnancies. Now in its third year, COC provides young parents with individual and group support. Each participant is assigned a youth worker and several different parenting group options. The Clinical Manager, a Nurse Practitioner from MGH, provides support for delaying any subsequent pregnancy and connecting each participant with a Primary Care Provider. Patients from both the AHC & SBHC have been referred to this program.

2008 Program Accomplishments

- 63 participants are receiving services
- Weekly parenting groups include cover topics such as prenatal care, parenting a new baby and a toddler, playgroups, young mothers groups at Chelsea and Revere High Schools

The Youth Zone -- After-School Youth Development Program
Linda Jeffrey, Program Director

The mission of the Youth Zone is to provide a safe place for youth to develop life skills within the context of a caring community and to prepare them to deal with challenges of adolescence. The Youth Zone provides a wide variety of preventive, educational, recreational, and vocational planning, programs and resources that facilitate the development of the innate strengths found in all youth, with a focus on younger adolescents ages 10 to17. The Youth Zone is based on building family and community networks where youth can explore and lay the foundation for positive changes in all areas of their lives.

The Youth Zone is open five afternoons a week, providing youth the opportunity to participate in a Peer Leader program during one of those afternoons. Most participants are from low-income single parent families where parents often work long hours to meet the needs of their families. Many face the complex constraints of poverty, substance abuse and domestic violence in their homes and neighborhoods. Outreach to uninvolved youth and families is a core component of the Youth Zone, which also serves as a point of access to medical, mental health, and social services provided at the SBHC and MGH Revere. A partnership with the Chelsea Boys and Girls Club continues to provide our members with a free membership to their program.

Services at the Youth Zone include health education, a six-week sports program, homework support, a six-week poetry/journal writing program, arts and crafts, exercise, music, as well as, Peer Leadership, community service, and a variety of social skills enhancement activities. This year we have partnered with a member of the Senior Wellness program at MGH Revere, to offer members a crochet club one afternoon per week. In addition to the after school program, we provide a six-week summer vacation program that is both educational and fun. The summer program offers care to 40 Revere youth.

2008 Program Accomplishments

- The Youth Zone continues to participate in MGH's Jobs 4 Youth program by hiring two RHS students as junior counselors for its six-week summer program. These students are also former members of the Youth Zone program.
- Scholarships were given to seven families for children attend the summer program, which was made possible through fundraising efforts by Caring Alumni Supporting the Learning and Enrichment of Students (C.A.S.T.L.E.S) committee.
- The Youth Zone began its first Counselor in Training (CIT) program this summer, paying a stipend to two members to participate in the planning and structure of the summer program for six weeks.
- Peer Leader program participated with intergenerational activities by connecting with pediatric patients and the Senior Wellness program at the Revere Health Center
- The local Elks continued to donate to the Youth Zone

2008 Program Data

- More than100 youth are members of the Youth Zone, and they made 3,842 visits in 2008
- 40 youth participated in summer program during a six-week period

Stay in Shape Program

Stay in Shape is an after-school program of health and nutrition education and physical activity for girls at the Chelsea High School (since November 2000) and Revere High School (since May 2005). During each school semester the program is held twice a week for ten weeks at Chelsea High and once a week for 10 weeks at Revere High. Pre and post-intervention tests are administered in each program cycle to assess the program's effectiveness and impact.

The program is supported by MGH Community Health Associates (CHA), which successfully transition program operations to the schools this year. CHA is now exploring the possibility of offering the program to Wright Middle School in Chelsea and Rumney Marsh Academy (a middle school) in Revere.

2008 Program Accomplishments

- Stay in Shape received a $22,500 Community Impact Grant from the American Heart/Stroke Associations to support the program at the four previously mentioned schools.
- Revere High School partnered with For Kids Only after School and received a *Kids in Motion Grant* from United Way. The grant will allow up to ten participants to work as healthy lifestyle mentors to younger children in the after school program in summer 2009.
- The topic of Teens' Risks for Hepatitis C was added to the program's health education curriculum for the first time.

2008 Program Data

- 25 percent of the participants reported being very confident in following a healthy lifestyle before the program. That number rose to 75 percent at the end of the program
- The program outreached to a combined total of 62 students from Chelsea and Revere High Schools. 28 of them received an award for their outstanding participation and quality performance. For Revere High School alone, the program served 20 participants and awarded ten of the 20 participants in the end.
- Nine participants at Chelsea High also earned their eligibility to receive the Extra Academic Credits.

Healthy Steps for Young Children
Harwood Egan, MD
Susan Curley, MSEd, CLC

The first three years of life are the focus of a national initiative, the Healthy Steps for Young Children Program. This family-focused approach emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of very young children from birth to age three. Healthy Steps capitalizes on "teachable moments" in which parents' concerns for their young children make them receptive to information that will challenge and change their attitudes and parenting practices for the benefit of their children.

The goals of the program include timely well child visits and immunizations, increased parental knowledge of child development, appropriate expectations, parents who read more to their young children, and suitable limit setting techniques. Recently, the specialists have spent more time focusing on healthy eating habits, good weight gain, and obesity prevention. Overall, the program also seeks to improve access to care for all patients and their families.

The program integrates Healthy Steps specialists into the pediatric team. Specialists have training in child development to enhance the information and services available to parents by addressing major behavioral and developmental issues, and giving the practice the opportunity to focus on a whole baby, whole family brand of pediatrics. As part of their well child visits, families meet with their specialist to discuss such topics as sleep, healthy eating, discipline and limit setting, and activities to promote development. Additionally, specialists assist families in need of a variety of community resources, including Early Intervention, Food for Families, HAVEN, The Family Network, Cradles to Crayons, childcare options, and others. Reach Out and Read, a successful national early literacy program, is also implemented as part of Healthy Steps.

The Healthy Steps approach is being implemented and tested in numerous pediatric practices. MGH Revere is one of 15 sites nationwide selected by the Commonwealth Fund, and supported by Partners HealthCare. The nation's first large clinical trial designed to improve delivery of developmental and behavioral services to young children has improved quality of care, enhanced communications between pediatricians and parents, and helped children receive appropriate preventive services, according to a national evaluation of the program that appeared in the December 16, 2003 issue of the *Journal of the American Medical Association*. Parents in the study reported they are more likely to read to their children, place their infant on their backs to sleep, and discuss concerns around aggressive behaviors in toddlers with their pediatric practice.

In the September 2007 edition of the journal *Pediatrics,* parents from the original research group noted several sustained benefits of the Healthy Steps program. These benefits included greater satisfaction with pediatric health care, increased odds that parent's will discuss a child's serious behavioral issue with the pediatrician, and a greater chance that children read books. Parents reported they were less likely to use severe discipline strategies such as slapping or spanking.

Program Accomplishments

- Two of the specialists have completed training to initiate a research project using the Incredible Years curriculum, which teaches parents interactive play, positive reinforcement skills, and nonviolent discipline strategies. The Incredible Years parent groups will begin later this year at MGH Revere.
- Healthy Steps has hired a new specialist who is a licensed social worker.
- One of the specialists continues to provide extensive breastfeeding support as a certified lactation counselor. This specialist continues to attend relevant conferences and other trainings to increase clinical knowledge for the benefit of the practice.
- The specialists have increased the amount of training provided to residents of the MGH Pediatric and Med/Peds departments. Residents participate in discussions and visits to learn more about behavior, development, and meeting the needs of young families.

Program Data

- Healthy Steps has 571 families enrolled, including 237 new referrals.
- Specialists had 2,078 office visits, 332 phone calls with patients, and made 26 home visits.
- Six to 13 families attend the monthly parenting group in order to network with other parents and obtain information on development and behavior.
- The specialists have collaborated with the Family Support Early Intervention program and have conducted 89 Early Intervention visits.

Other Community Health Initiatives

When a hospital builds a new building with inpatient beds, it is required to obtain a "Determination of Need" certificate from the Massachusetts Department of Public Health. In order to obtain this certificate, hospitals must set aside a percent of the maximum capital expenditure – or total cost of the building, for community health improvement initiatives. Some of these initiatives were reported on in the body of this report. Others are detailed below.

Community Against Substance Abuse

Community Against Substance Abuse (CASA) is a community-based coalition in Winthrop with the mission of bringing together concerned parents, schools, police, and

community stakeholders to address the growing problem of substance abuse among youth in Winthrop. MGH committed $500,000 over seven years to support the coalition's work. During the past year, a number of individuals were hired to address identified youth needs at the high school and middle school both during and after the school day, including, a full-time high school adjustment counselor at Winthrop High School, an after-school youth specialist for at-risk middle school age youth, and a teacher advisor to implement a Gay/Straight Alliance at Winthrop High School.

- During the first full year of funding, the high school adjustment counselor saw 77 students for a variety of reasons including substance abuse, academic issues, grief/loss, trauma, anxiety, depression, and anger management. The adjustment counselor also ran several psycho-educational support groups and facilitated drug awareness activities.
- The after-school youth specialist began a five day per week after-school program for Winthrop's middle school population at the beginning of the first year of funding. The program included academic support, social skill development, and recreation. Forty youth signed up for the program, and attendance ranged from 12-25 students per day.
- The Gay/Straight Alliance at Winthrop High School was initiated in February of 2008 with an initial membership of 33 students. By the end of the academic year, 60 students had joined the group. The group's activities included a Day of Silence, attendance at a Gay Pride Parade, and a fundraiser to support future events.

The opportunity has also arisen to open a youth center in Winthrop for youth ages 8-15. MGH funding is being used to procure equipment and supplies to outfit the youth center with the necessary tools to engage youth in many diverse and interesting projects such as arts and crafts, academic tutoring, and recreational activities.

North End Community Health Center

MGH is providing a total of $500,000 over five years to the North End Community Health Center for two services identified as community priorities:

- Transportation services to medical and other appointments for elderly and/or disabled residents of the North End
- Sliding-fee-scale access to subsidized adult day health services for Medicare beneficiaries who would otherwise not receive those services and might be forced into institutional care.

HIV/AIDS

Pathways to Wellness

Pathways to Wellness is the only public health-focused, non-profit provider of comprehensive complementary therapies in Massachusetts. MGH made a one-time grant of $250,000 to support a strategic alliance between Pathways to Wellness and the South End Community Health Center (SECHC). This alliance required the relocation of Pathways to the SECHC space, including a build-out design, programmatic reform, and construction of 2,200 square feet of open and unused space.

Boston Living Center

The Boston Living Center (BLC) provides meals and a broad range of other supportive services to its more than 2,400 members, all of whom are HIV-positive and most of whom are low-income. The BLC is the largest peer-led group in New England serving people who are HIV-positive, and is a long-standing MGH partner in caring for HIV-positive patients. Much of BLC's operating budget comes from federal funds that are being eliminated. Therefore, MGH granted $300,000 over three years to help ensure that BLC continues to operate as it identifies and transitions to new sources of funding. In the last year, MGH funds were applied to the center's operating expenses, specifically program activities and supplies, facility costs, and salaries.

Public Health Infrastructure

Massachusetts League of Community Health Centers

MGH committed $500,000 over five years to the Massachusetts League of Community Health Centers (the League) to assist in providing essential services to community health centers throughout the state. During the past year, the League provided technical assistance community health centers in the form of training, guidance, and conflict resolution with Boards, management consulting, and guidance on funding requirements. Additionally, the League played a key role in developing and implementing a career tracking curriculum and pilot program for entry level clinical and non-clinical staff as well as, programs and proposals for training and supporting incumbent workers at community health centers. At the policy level, the League tracked the impact of health care reform and related changes in financing, regulations, and programs. Efforts focused on sustaining access to primary care, information development and dissemination, and analysis of the service needs of low-income patients and community health center communities. This included assistance to community health centers as employers, as well as, providers of care.

Urban Youth Sports

MGH is providing $220,000 over three years to Sport in Society's Urban Youth Sports (UYS) program. The mission of this program is to improve the health and well-being of urban youth through physical activity and healthy development initiatives. UYS works with community health centers to fight obesity by providing health center-based workers in East Boston, Dorchester, South End, Roxbury, and Jamaica Plain. MGH funds were used to expand the program to the Charlestown Community Health Center.

Boston Public Health Commission

The Boston Disparities Project is a city-wide effort led by the Boston Public Health Commission and Mayor Thomas M. Menino to address the severity of disparities that exist among residents of color. MGH committed $500,000 over five years to fund this

initiative. Over the past three years of the project, activities have included: (a) release of two requests for proposals to provide funding to 54 pilot projects to implement blueprint recommendations in Workforce Diversity; Patient Navigation and Education; Data Collection and Quality Improvement; Neighborhood Investment; Community Institutions Raising Public Awareness; Violence Prevention and Trauma Response; and Food Access and Obesity Prevention; (b) on-going efforts around implementing the Data Collection Regulations passed in July 2006; (c) evaluation of grantees to identify promising practices, challenges, and overall performance in years one and two; and (d) using the documentary *Unnatural Causes: Is Inequality Making Us Sick?* as an opportunity to raise awareness and provide action around inequities in health and neighborhoods across the City of Boston.

Harbor Community Health Alliance

MGH committed $50,000 over five years to the Harbor Community Health Alliance (CHNA #19) to issue mini-grants to area agencies and address community health priorities. Last year, these funds were used for an annual legislative breakfast to draw attention to important health issues facing CHNA #19. The funds were also used to support five mini-grants at $3,000 each for a range of projects for young people, families, and elders, including:

- Chelsea/Revere/Winthrop Elder Services for "A Summit on Hoarding: An Opportunity to Develop a Community Response,"
- Community Action Programs Inner-City, Inc. for the CAPIC Head Start Program,
- Revere Public Schools for "The Respect Core,"
- ROCA, Inc. for "The NSMHA-Roca Health Bridge: A Community-Based Collaboration Between Roca and North Suffolk Mental Health Association to Reach High Risk Youth," and
- The Revere Parks and Recreation Department for a summer sea kayaking program for youth.

Boston Alliance

MGH committed $250,000 over five years to the Boston Alliance for Community Health to allow the Alliance to support its staff and/or issue requests for proposals for mini-grants that will address community health priorities. In FY08 the funds supported both the Alliance Coordinator's salary and the organizations mini-grant program for health improvement projects in local neighborhoods. Through the mini-grant program, 10 Boston coalitions each received $10,000, including:

- Charlestown Substance Abuse Coalition for the Charlestown Female Recovery and Support Program
- Codman Square Neighborhood Council for Reaching Out to Reduce Violence and Improve our Food and Fitness Behaviors
- Dorchester Community Services Collaborative for Dorchester Teen Violence Prevention Program
- East Boston Adult Education Coalition for the Nutrition and Exercise Project (NEP),"
- Franklin Field/Franklin Hill Healthy Boston Coalition for Keep a Future

- The Chinatown Coalition for Fall Prevention
- Jamaica Plain Coalition for Use Weights to Prevent Breaks and Beyond
- Roxbury Community Alliance for Health for Roxbury Weigh-In and Jazz in the Park for Good Health
- South Boston Collaborative Advisory Network for Youth Assets Campaign Focus Groups
- South End Healthy Boston Coalition for Substance Abuse Resource Assessment

United Way of Massachusetts Bay and Merrimack Valley

MGH committed $200,000 over five years to support United Way of Massachusetts Bay and Merrimack Valley's (UWMBMV) efforts in communities with disparate health outcomes. The first year of funding was put into the organization's Community Impact Fund and helped UWMBMV make great strides toward achieving the goals of its four "Impact Areas":

- Healthy Child Development – Children will enter school ready to learn
- Increasing Youth Opportunities – Youth will have adult guidance and positive options for the future
- Sustainable Employment – Families will have the opportunities and financial know-how to build better futures
- Affordable Housing – Families will have safe, permanent homes

Boys and Girls Clubs of Boston

Boys and Girls Clubs of Boston provide safe and alternative activities to youth, and are strong MGH community partners in Charlestown and Chelsea/Revere. MGH is providing Boys and Girls Clubs of Boston with $200,000 over five years for initiatives aimed at preventing violence and substance abuse. In FY2008, MGH's funding contributed to building the endowment funds of the Charlestown and Jordan (Chelsea) Clubs. Prior to the Clubs' Comprehensive Campaign, the endowment made up less than two percent of the budget, and it is now almost five percent. Boys and Girls Clubs of Boston is now entering a new phase of development with a more stable financial foundation.

74 Joy Street

MGH provided a one-time capital grant of $30,000 to support the renovation of the 74 Joy Street community building in Beacon Hill that houses important community organizations including Beacon Hill Nursery School, the Beacon Hill Civic Association, and the Beacon Hill Business Association. The 74 Joy Street building also houses Hill House, which holds classes for children and adults and hosts community events, and Beacon Hill Village, a virtual retirement community. The renovation and revitalization of the building included improved accessibility, updated fire protection, and modern mechanical, telecommunication, and security systems. The renewed building complies with ADA requirements, meets code standards that allow it to serve children from age

two, and allows elders and children use of the fourth floor, which was previously off-limits due to accessibility and safety constraints. Most significantly, the "new" 74 Joy Street also expands the programming capability of the building and makes possible multiple simultaneous activities and meetings in the civic space.

Statewide Community Initiatives

Critical MASS

Critical MASS for Eliminating Health Disparities seeks to mobilize a sustainable statewide effort to accelerate the elimination of racial and ethnic health disparities in Massachusetts. MGH made a commitment of $50,000 over five years to this organization. During the first year of funding, Critical MASS finished editing and printing 1,200 copies of the toolkit, *Taking Community Action on Health Disparities*, to help individuals and organizations at the community level mobilize towards the elimination of health disparities within their surrounding community. A Boston-based Toolkit "launch" took place on May 20, 2008 at Northeastern University. As of July 2008, 500 copies of the Toolkit had been distributed across the state to community organizations, public health groups, health care providers, and universities. In addition, 100 CD-ROM versions of the Toolkit were distributed to the Massachusetts Department of Public Health disparities project grantees.

Greater Boston Center for Healthy Communities

MGH committed $20,000 per year for five years for the Greater Boston Center for Healthy Communities' (Regional Center) work to promote healthy communities and reduce substance abuse in Chelsea, Revere, Winthrop, and in Boston's many neighborhoods. In FY2008, the Regional Center provided extensive technical assistance, training, and facilitation to the Charlestown Substance Abuse Coalition (CSAC) by assisting in the development of the CSAC Steering Committee; facilitating an annual retreat to review successes and challenges and plan for the upcoming year; assisting in the creation of an annual work plan; and assisting in grant development for the BSAS opioid overdose reduction application. The Regional Center was also able to assist new and struggling Substance Abuse Prevention Coalitions in Roslindale, Dorchester, East Boston, and the South End in the areas of coalition development, including outreach and recruitment, and in understanding and implementing the Strategic Prevention Framework and doing community assessments. This work helped ready coalitions to successfully apply for and receive SAMHSA and DPH funding.

Massachusetts Partnership for Healthy Communities

MGH is providing $400,000 over five years to the Massachusetts Partnership for Healthy Communities for: (1) ongoing statewide training and technical assistance to individuals and communities through the MassForum, which is a year-long educational program for community health teams from Massachusetts cities and towns, and the Department of Public Health's six Regional Centers for Healthy Communities for skill building and

strategy development; and (2) for issuing planning and implementation grants to communities across the state through an RFP process. Over the past year, the Massachusetts Partnership for Healthy Communities distributed $68,580 to seven coalitions across the state. Coalitions who received planning grants include the Wayside Youth and Family Support Network in Milford for its Juvenile Advocacy Center, Enlace de Familias in Holyoke for its Holyoke Unites/Holyoke Se Une project, Danvers Healthy Community Task Force for its Community That Cares project, the Friends of Lowell Council on Aging for its Building a Healthy Senior Community: Lowell Senior Count/Planning project, the Oak Hill Community Development Corporation in Worcester for its Green Island Neighborhood Initiative, and the Mattapan Community Development Corporation for its Mattapan Healthy Community Planning project. In addition, Bold Coalition in Fall River received an implementation grant.

Summer Alternatives for Youth

MGH provided a capital grant of $100,000 to Camp Harbor View to assist them with offering an innovative summer camp for Boston youth who live in neighborhoods with high levels of violence. The camp is located on Boston's Long Island.

MGH Community Health Associates

Anne Richmond, Director

MGH Community Health Associates'(CHA) works collaboratively with the MGH Health Centers to provide high quality, innovative health care programs and foster community based research. CHA is committed to delivering comprehensive, evidence-based preventive health services to low income, uninsured and underserved populations who live and work in the Charlestown, Chelsea, Everett, and Revere communities. To realize its mission, MGH Community Health Associates provides programmatic support, clinical supervision, fiscal grant management oversight, and technical assistance for four MGH community health centers serving more than 75,000 individuals and families annually. MGH Health Centers in Charlestown, Chelsea, Everett, and Revere provide a community based service delivery model. In addition, the health centers are committed to working in partnership with communities to improve the health status of the cities at large.

Access to Resources for Community Health (ARCH)

The goal of ARCH is to improve access to high-quality health information among patients and providers mainly through teaching in the community and processing requests for information on prevention, wellness, and disease management. Partnering with MGH Treadwell Library, ARCH manages the website www.arch-mgh.org with well-identified links to high-quality information, operates a multi-media resource room, provides hands-on training to clinicians and patients on how to use the ARCH website, and leads the

ARCH Patient Education Initiative that assists health centers to identify, organize, and distribute patient education materials.

2008 Program Accomplishments

- Partnering with MGH Treadwell Library, ARCH completed the ARCH-Head Start Project with support from the 4th Community Outreach Grant from the National Library of Medicine/New England Region. The project brought access to health information to teachers, staff, and parents of CAPIC Head Start in Chelsea through establishing the ARCH-Head Start Health Information and Resources Center onsite and training on how to use www.arch-headstart.org, as well as, www.arch-mgh.org.
- Since project completion in August 2008, the Family Advocates at CAPIC Head Start have been training more parents on how to access ARCH resources, a strategy proposed and agreed upon by the partnership to sustain the project beyond its grant period.
- ARCH Project Director received the annual CAPIC Community Service Award on behalf of the project partnership. This award recognizes the project's dedication and contribution to empowering low-income families.

2008 Program Data

ARCH processed a total of 127 requests, including:

- 16 requests for hands-on training (including eight classes for Head Start parents), reaching a total of approximately 50 community residents
- 12 requests from physicians
- 50 requests from other clinicians
- 33 requests from Revere, 27 from Chelsea, ten from Charlestown, three from Back Bay, and four from the North End

Breast and Cervical Screening Collaborative/Women's Health Network (BCSC)

The MGH CHA Breast and Cervical Screening Collaborative (BCSC) is part of the Dana Farber/Partners CancerCare Breast and Cervical Screening Collaborative, which began at MGH Chelsea in 1995 and is comprised of Dana-Farber Cancer Institute (DFCI), Partners HealthCare and 11 health centers in the Greater Boston area, including MGH Chelsea, MGH Revere, MGH Charlestown, the North End Community Health Center, MGH Everett, and MGH Back Bay. Current member health centers in the BCSC include the six MGH members, as well as, Mattapan Community Health Center, Neponset Health Center, Geiger Gibson Health Center, Harbor Family Health Center, and Martha Eliot Health Center.

The goal of BCSC is to reduce breast and cervical cancer mortality through early detection. The program offers cancer-screening services, tracking and follow-up at the health centers for uninsured and underinsured women age 40 and over, and women under age 40 when medically indicated, in the Greater Boston area. Cervical screening services are available to eligible women age 40 and over and women ages 18 to 39 if they have had a documented abnormal screening and need further diagnostic services to rule out

either breast or cervical cancer. The BCSC places emphasis on reaching special populations of women, such as linguistic, ethnic, social, and cultural minorities, and those who are medically underserved.

BCSC services include:

- Clinical breast exam
- Pelvic exam and pap testing
- Mammography at participating hospitals and health centers, as well as, mobile mammography services in neighborhoods and communities
- Patient and provider training in prevention screening and diagnostic testing
- Patient tracking system for annual recall and diagnostic follow up
- Patient navigation services to assist women in completing annual screenings and diagnostic services, if necessary
- RN Case Management for women with abnormal screening results requiring further diagnostic follow up

In 2008, the BCSC began its twelfth year as a Women's Health Network (WHN) provider through the Massachusetts Department of Public Health (MDPH). The new challenge in 2008 was to integrate the program into the changing landscape of health care reform. The role of the program navigators/enrollment coordinators has greatly shifted from enrolling women into WHN, to contacting current and past enrollees and facilitating their transition out of WHN and into Commonwealth Care, Health Safety Net or other insurance. The coordinators have been reminding these women to continue their screening plans and offering assistance in obtaining appointments where needed. Therefore, while the numbers of women enrolled in WHN have decreased, those remaining are some of the hardest to reach women who require the WHN coverage and assistance in navigating the health care system.

The WHN provides funding for breast and cervical health services for uninsured women to promote and enhance the early detection of breast and cervical cancer. In 2006, North Shore Medical Center was spun off from the Collaborative and contracted with the MDPH on their own to oversee the WHN at three heath centers, Salem Family Health, Peabody Family Health, and Lynn Community Health Center. This left the current member health centers in the BCSC to include the six MGH members, as well as, Mattapan Community Health Center, Neponset Health Center, Geiger Gibson Health Center, Harbor Family Health Center, and Martha Eliot Health Center. DFCI and Partners have provided significant supplemental funding to support the Collaborative central administration and outreach activities.

Beginning in January of 2004, the Massachusetts Division of Medical Assistance implemented the Breast and Cervical Cancer Treatment Program (BCCTP). Through this program women who meet WHN eligibility, and are diagnosed with either breast or cervical cancer, or a precancerous cervical lesion requiring further diagnostic evaluation, or who are in treatment, are enrolled in Mass Health Standard. This was an added benefit for women diagnosed and needing added coverage during treatment.

Outreach, education, and building awareness about breast and cervical cancer screening in our communities are incorporated in our work at local health fairs and presentations to local groups of teens and women in the community. In addition, for the past 13 years CHA has sponsored American Cancer Society Making Strides Teams at the six MGH Health Centers, which provide a month of increased breast health education. CHA is the program and fiscal administrator for BCSC**,** providing programmatic support, clinical supervision, fiscal grant management and oversight, and technical assistance.

2008 Program Data

- 348 women were served.
- 89 percent were between the ages of 40-64.
- Program participants included 25 percent White, 25 percent Black, and five percent Asian; 44 percent chose not to respond to this question.
- 59 percent self report as Spanish, Hispanic, or Latina.
- 76 percent reported a primary language other than English.
- Languages reported: 54 percent Spanish, 12 percent Haitian, ten percent Vietnamese, 23 percent English and the remainder made up of Arabic, Cape Verdean, Chinese, French, Italian, Polish, Portuguese, and other.
- Nine percent had a screening mammogram or Clinical Breast exam that required further evaluation.
- 48 percent of the total number of women enrolled needed case management.
- Four women were diagnosed with breast cancer.
- Two women were diagnosed with cervical cancer and 19 with precancerous cervical lesions.
- Of the 348 women enrolled into the Collaborative, 197 were enrolled at MGH WHN sites, and when needed, received case management services from the program's nurse case manager.
- Since the inception of the BCCTP, the BCSC has enrolled 135 WHN women into Mass Health Standard coverage, of those; 35 were from MGH WHN sites.
- For the 14th year MGH CHA and the BCSC organized six MGH HealthCenter Making Strides teams that together encouraged 90 participants to walk for our team and raised funds for the American Cancer Society's Walk Against Breast Cancer.

CPR Training

CHA provides CPR training and re-certification to professionals and residents of Charlestown, Chelsea, Revere, and Everett, including MGH HealthCare Center staff, The MGH Community Health Associates (CHA) staff, community nurses, teachers, students, parents, grandparents, coaches, day care providers, Department of Social Services workers, Cub Scouts, and other youth groups.

2008 Program Data

- In 2008, the program issued more than 80 CPR certification cards
- Trainings were conducted at MGH CHA, MGH Health Centers in Charlestown, Chelsea, Revere, and Everett as well as for community members who work with youth, elders, and in day care facilities.

Celebrating Women, Living A Vibrant Healthy Life!

CHA, in collaboration with the MGH Community Health Centers of Back Bay, Charlestown, Chelsea, Everett, North End, and Revere, sponsored the seventh annual "Celebrating Women, Living a Healthy Vibrant Life!" The theme of this year's event was Women's Heart Health. A multidisciplinary team of staff from across the health centers and main MGH campus work to plan this event. Mallika Marshall, MD, CBS health reporter and MGH Chelsea Physician was Mistress of ceremonies and Malissa Wood, MD ,MGH Cardiology presented the keynote address, "Follow Your Heart To a Healthier You". The goal of this exciting event is to increase access among girls and women of all ages to health information and health care services.

Held at MGH in the Charlestown Navy Yard on May 1, 2008, the event reached 1,000 women from communities served by the MGH health centers, as well as, the North End and Winthrop. Designed as "one stop shopping" for vital health information, activities include a community health fair with lectures and discussions, health screenings, health prevention and education, and community awards for women who exemplify living a healthy, vibrant life. Topics presented during the event included: breast and cervical cancer prevention and screening; osteoporosis, nutrition, exercise, diabetes, cardiovascular disease, domestic violence, substance abuse, massage, menopause and hormone replacement, smoking cessation, stress reduction, teen issues, healthy cooking demonstrations, brain health and alternative therapies, as well as, information and resources for career opportunities.

A very touching part of the program each year is the presentation of awards to one woman from each community who serves as a role model for other women by living a healthy, vibrant life. These women were selected by their community health center and then interviewed by young women from their own community who also write a biography about the woman. The teen then introduced the woman during the award ceremony and presented her biography.

Child Passenger Safety Program

The Child Passenger Safety Program was created to provide toddler car seats and car seat training to children and their families who would otherwise be unable to afford this safety restraint. In conjunction with the MGH community health centers in Charlestown, Chelsea, Everett, and Revere, CHA coordinates the distribution of car seats to clients who cannot afford to purchase one. Many patients served by the health centers are new immigrants who are not aware of safety regulations and/or how to appropriately protect their children in the family car. Pediatricians, nurse practitioners, and social workers in each of the health centers ask parents or guardians about the status of their child's car seat during routine well child and sick visits. The cost of the car seats to program participants is subsidized by the program. Each client is offered prevention education on how to install and use the car seat appropriately to provide maximum protection for his or her

child. With a referral from health center primary care providers or social workers, those patients who need car seats for their children can get them from CHA or the health centers regardless of their ability to pay.

Each health center participating in the program designates an on-site contact person. This individual is trained in appropriate use of car safety restraints by attending a four-hour program.

Program Highlights

- In FY2008, MGH CHA distributed 34 car seats to clients of the MGH Health Centers.
- Each Health Center has a site coordinator who attended the training in on the proper installation of child safety seats.
- Car seats were distributed to clients and proper installation education was provided in English and Spanish.

Family Planning Program

Through a contract with ABCD, the Family Planning Program operates at the MGH Chelsea and MGH Revere Health Center satellite sites: Chelsea School-Based Health Center, Chelsea ROCA Clinic, Revere School-Based Health Center, and Revere Adolescent Health Center. The program serves at-risk youth in need of confidential and comprehensive reproductive health care. Patients, mostly adolescents, can access care without parental consent or notification, regardless of their insurance status. Clinical services provided by the program include counseling, physical exams, STD and HIV/AIDS screening, pregnancy testing, and contraceptive methods dispensed at point of a clinical visit and free of charge.

2008 Program Accomplishments

- 2009 Family Planning Grant Renewal Application for MGH Chelsea and MGH Revere was completed and submitted to Boston ABCD.
- CHA worked with MGH Charlestown and included Charlestown for the first time in the MGH 2009 Application for Family Planning funding from Boston ABCD.

2008 Program Data

- A total of 2,550 family planning visits were made across all our Family Planning sites.

Heart Awareness and Primary Prevention in Your (HAPPY) Neighborhood Heart Trial

Hepatitis C Education Program

The Hepatitis C Virus (HCV) Program began at the MGH Revere HealthCare Center in 2001 when primary care staff identified a growing number of patients infected with HCV. In 2004, the project was extended to include the MGH Chelsea and Charlestown

HealthCare Centers. In 2005, the HCV Project launched a HCV treatment clinic at the MGH Charlestown HealthCare Center. James Morrill, MD continues to lead the HCV Project and has created the first community-based program within the MGH system for treatment of patients with Hepatitis C. In 2007, the project was awarded a three-year DPH Chronic Disease Management Grant to allow hiring a full-time and a part-time Community Health Worker to advocate and educate Hep C patients with co-morbid conditions and to outreach to high- risk residents in Charlestown, Revere and Chelsea.

The project includes the following goals and objectives:

- Improved clinical care:
  - Development of registries of HCV patients at the Revere, Chelsea, and Charlestown HealthCare Centers.
  - Identification of potential HCV treatment providers.
  - Standardization of HCV prevention, screening and management strategies.
  - Coordination of care between primary care and HCV treatment providers.
  - Development of health center-based, multidisciplinary HCV treatment clinics at all three MGH community health centers.
  - Integration of the Community Health Worker in the clinic setting to assist with appointment setting and reminders, referrals to internal and external supportive services and treatment follow up.
  - Collaboration with MGH Institute for the Health Professions (Patricia Duynstee, RN, PhD) to help develop health center databases.
- Provider and patient education:
  - CME programs for health center staff.
  - Seminars for patients and their families.
  - Creation and dissemination of patient and provider education materials.
  - Individual patient education sessions.
- o Research to improve the understanding of HCV and inform patient care:
  - Analysis of disparities in populations and practice patterns among health centers.
  - Measurement of changes in the quality of care over time.
  - Analysis of HCV screening rates.
  - Investigation of the growing population of young opioid users (age 18-24) with newly diagnosed HCV infection.
  - Collaboration with basic researchers to allow access to cutting-edge studies and provide a community focus.
- Community Outreach
  - Provide community-based HCV presentations.
  - Creating greater community awareness of HCV through advocacy work with the MA Hepatitis C Coalition and the MA Department of Public Health and other community based organizations.
  - Outreach to youth at local schools and youth organizations.

2008 Program Accomplishments

- Health center databases were updated and analyzed using the Partners Research Patient Data Repository (RPDR). IRB approval to study the epidemiology of HCV at the MGH Health Centers renewed in 6/08.
- Continued growth of the MGH Charlestown HCV Clinic, with over 60 patients evaluated and ten patients enrolled in treatment as of October 2008.
- Educational efforts continued, including presentations to youth organizations in Charlestown; a CME lecture at the South Boston Health Center; and participation in a MA DPH panel discussion on Hepatitis C in Youth; a cable television presentation highlighting Hepatitis C basics; a community wide Hepatitis C forum in Charlestown; and a four-part Hepatitis C Circle of support and information in Charlestown for individuals and families affected by Hepatitis C.
- The PCOI primary care Hepatitis C guideline was updated.
- Awarded an MGH Department of Medicine three-month fellowship to study the characteristics of young adult patients with HCV infection.
- Increased community awareness of Hepatitis C education through participation in health fairs, community meetings and political forums.

"Pack It In": Tobacco Treatment, Outreach, and Referral Program

The *Pack It In* program has provided tobacco treatment, outreach and referral services to residents in the communities served by the MGH Community Health Centers including Charlestown, Chelsea, Everett, Revere, and Winthrop.

As the only tobacco treatment service in most of these communities, the *Pack It In* program fills an important need. Building on existing services provided in MGH's health centers, *Pack It In* enhances the ability of providers and staff to identify, encourage, and help smokers to quit. The need for services is apparent: nearly 75,000 unduplicated clients are seen annually in the health centers serving the target communities. There are an estimated 7,805 smokers who currently utilize health center services within these communities. Available to ***all*** community residents, *Pack It In* targets new immigrant, minority, low-income and working class populations.

Program Highlights
Since 1994, **more than 3,600** clients have received services from tobacco cessation programs implemented by MGH Community Health Associates.

In FY2008, Pack It In:

- Reached more than 167 individuals through individual and group counseling, lectures, nicotine replacement therapy, and referral services.
- Received 112 referrals into the program for services from the MGH Health Centers.
- Provided 65 individual and group visits to program participants.
- Outreached to 620 individuals in the targeted communities.

- Coordinated the health centers' observance of the Great American Smokeout and World No Tobacco Day.
- Conducted two daytime and evening tobacco treatment support groups serving a total of 16 individuals.

Next Steps

- The program in the upcoming year will begin to measure quit rates of program participants at six month, one year, and two year intervals.
- Develop a plan to seek additional resources for the program to support additional outreach efforts, the marketing of the program, nicotine replacement therapy, and staff support.
- To support the current services offered, alternative and complementary therapies are offered to support program participants in relapse prevention. This includes stress management, yoga, relaxation, and Tai Chi.

Pediatric Asthma Quality Initiative

The Pediatric Asthma Quality Initiative continues to implement programs this year in all of the MGH health centers and to MGH Pediatrics with the Massachusetts General Physicians' Organization (MGPO). The goals of the Pediatric Asthma Program are to decrease ED visits and improve the quality of patient care.

Each participating practice has an identified physician champion and an asthma coordinator. After pediatric asthma patients are identified, the asthma coordinator reviews data with the physicians on all patients, lists and classifies asthma on the electronic medical record (LMR) problem list, and develops an asthma action plan with the primary care physician. Asthma coordinators also complete and update this information on the newly implemented web-based MGH asthma registry. The web-based registry is available to all the MGH pediatric practices.

Every MGH pediatric practice had access to Pediatric Asthma Action Plan in LMR allowing providers to generate printed guidelines to help manage a pediatric patient's asthma. The Pediatric Asthma Action Plan is saved as a note in LMR. The printed documents are provided to the patient's parent or guardian, and can be based on any of the following:

- Symptoms
- Predicted peak flow
- Personal best peak flow

Each Pediatric Asthma Action Plan includes details on medications and is given to the patient and the family based on the severity of his or her condition (indicated by the green, yellow, or red zones). Providers can also select to include a Student Medication Administration Authorization form with the printing of the MGH LMR Pediatric Asthma

Action Plan. This form indicates that a primary care physician consents to have either the student or school nurse, as indicated, administer medications in the Asthma Action Plan. A pilot translating the English Pediatric Asthma Action plan into Spanish will be scheduled in November 2008.

The asthma coordinators in each practice continue to conduct ED and inpatient post discharge telephone interview assessments to improve the follow up care of discharged patients. The asthma coordinators discuss the discharge medication instructions with families, follow-up on the discharge plans, clarify any questions and assist families in making a follow-up appointment with their pediatric primary care physician (PCP).

The MGPO provided funding for aerochambers for prescribed inhaled prescription administration for patients whose families could not afford them. The MGPO also funded hypoallergenic pillowcases and mattress encasements to assist families with limited funding resources.

Stay in Shape Program

In response to chronic levels of youth inactivity and poor eating habits, Stay in Shape offers an after-school program of health and nutrition education and physical activities to girls at Chelsea High School (since November 2000) and Revere High School (since May 2005). During each school semester the program is held twice a week for ten weeks at Chelsea High and once a week for ten weeks at Revere High. Pre and Post-intervention tests are administered in each program cycle to assess the program's effectiveness and impact.

CHA made an important transition this year to support schools' involvement in Stay in Shape. Instead of playing the role of running the program for the schools, CHA now helps each of the schools identify program staff from existing school human resources who can take on day-to-day operation of the program. The transition has been successful at both Chelsea and Revere High Schools. CHA is now exploring the possibility to offer the program to Wright Middle School in Chelsea and Rumney Marsh Academy (a middle school) in Revere.

2008 Program Accomplishments (School Year 2007-08)

- Program successfully underwent an operational transition
- Program prepared proposal to apply for the first round of the Community Impact Grant at the American Heart/Stroke Associations and received funding in September of 2008. The grant will support Stay in Shape at the four schools mentioned above through 2009.
- Program at Revere High School partnered with For Kids Only Afterschool in their successful proposal to *Kids in Motion Grant* at United Way. The grant will allow up to ten participants to work as mentors of healthy lifestyle to younger kids attending For Kids Only Afterschool in summer 2009.

2008 Program Data (School Year 2007-08)

- A new question about participants' level of confidence was added to the pre- and post-intervention questionnaires. 25 percent of the participants reported being very confident in following a healthy lifestyle before the program. That number rose to 75 percent at the end of the program.
- The topic of Teens' Risks for Hepatitis C was added to the program's health education curriculum for the first time.
- In spring semester 2008, the fitness curriculum at Chelsea High School also taught Exercise Safety, Fitness for Life, Fitness All Year Long, Monthly, Weekly, and Daily Fitness Planning, Flexibility, Heart Rate, Bone Strength, and Have Fun with Fitness Activities, as recent studies report on more success in sustaining behavior change among participants if a fitness program also incorporates teaching.
- Program reached a combined total of 62 students from Chelsea and Revere High Schools. Among them, 28 received an award for their outstanding participation and quality performance.
- Nine participants at Chelsea High also earned their eligibility to receive the Extra Academic Credits.
- Program at Chelsea High School began to work with Dr. Emily Gregory from MGH Chelsea Pediatric Unit to prepare for an IRB-approved Focus Group Study on teen girls' perception of childhood obesity, what kind of lifestyle programs they want to have at their school, how they want their health care providers to address the issues of body weight and obesity, among other study measures. The Focus Group Study is expected to complete in spring 2009.
- Program began to explore expansion plans with two middle schools.

Wellness Center

MGH-Community Health Associates' new Wellness Center opened in spring 2007. Located on the fifth floor of MGH Revere, and serving all MGH HealthCare Centers, the center features a large activities room with ocean views for Yoga, Tai Chi, and other classes and workshops, a private treatment room for acupuncture and massage, and a comfortable counseling room. Additionally, some of the wellness and health promotion services are offered on-site at the community health centers serving Charlestown and Chelsea.

Patients are referred to the Wellness Center by their PCP, or they self refer, and can obtain medical clearance if needed for program participation.

The goal is to enhance the well-being and quality of life for patients served through MGH community health centers, by providing culturally appropriate, easily accessible, and affordable wellness and health promotion programs that are integrated into their medical care.

Services offered in 2008 included:

- ***Yoga*** - *Chair Yoga* and *Gentle Yoga* classes continued to be offered in Revere during 2008, The yoga program will be expanded to Charlestown and Chelsea in 2009. *The Chair Yoga* classes are geared for people dealing with other chronic health issues, and include patients in wheelchairs/scooters. *The Gentle Yoga* classes focus on gentle stretching for greater flexibility, and relaxation tools for stress management.
- ***Tai Chi*** –Tai Chi classes are offered in Revere for patients seeking a stress management tool that enhances balance as well. Additionally, in 2008 we partnered with the Osher Center to host a Tai Chi study for Heart Failure patients in Revere.
- ***Acupuncture*** - The Acupuncture Clinic opened in fall of 2007, for four hours a week, and in 2008 was expanded to 13 hours per week, due to an enthusiastic response from the MGH HealthCare Center patients and physicians. Although DPH Guidelines do not require a physician's order for acupuncture, Medical Clearance is obtained for patients requesting acupuncture, as part of providing integrative services in concert with the PCP's at the MGH HealthCare Centers. The Acupuncturist also documents all clinic visits on the patient's electronic medical record (LMR). 85-90 percent of patients reported that this is the first time they received acupuncture, and they tried it because it is affordable and accessible. Most patients come for treatment of chronic pain and fatigue and for stress management, although patients have been seen for a myriad of issues.
- ***Therapeutic Massage*** - Therapeutic Massage was offered to patients in 2008, starting with a four hour-a-week clinic. Due to the enthusiastic response from patients, doubled clinic hours have been doubled.
- ***Walking Club*** -The Wellness Center sponsors a walking club that walks one day a week for a mile along Revere Beach, from August to October. It will resume in April 2009.
- ***Community-Based Research –*** MGH Community Health Associates/Wellness Center initiated working partnerships with the MGH Benson-Henry Institute for Mind/Body Medicine, and the MGH Women's Heart Health Center, to implement two studies in the MGH community health care centers.

Stress Reduction Pilot Study for Patients with Depression

This study is conducted in partnership with the MGH CHA Wellness Center, the Benson-Henry Institute for Mind-Body Medicine, and the Mental Health Centers at MGH Revere and Charlestown.

The 12 week Medical Symptom Reduction Program, developed by the Benson-Henry Institute for Mind/Body Medicine, was re-formatted to an eight-week program for use in community health settings, with the direct input of social workers from the MGH Revere and Charlestown HealthCare Centers, and from patients themselves. Study participants will continue to be asked for their input in further modifying the program content.

Preliminary analysis of pilot study data, showed that patients completing the program had significant decrease in their depressive symptoms, with a mean depression score change

from 17.74 to 12.50, a significant improvement in spiritual growth from 2.05 to 2.44 , and significant improvement in mental health from 35.56 to 52.86.

In summary, the pilot study showed that the RR based Medical Symptom Reduction Program was effective in decreasing depression symptoms, enhancing spiritual growth and mental health among depressed patients with diverse social and ethnic backgrounds at the MGH community health centers.

We are continuing to provide the Mind-Body groups for patient with depression in Revere and Charlestown, and plan to begin providing the groups in Chelsea in 2009 (in both English and Spanish).

Heart Awareness and Primary Prevention in Your (HAPPY) Neighborhood Heart Trial

A personalized program "HAPPY Heart Trial" (**H**eart **A**wareness and **P**rimary **P**revention in **Y**our neighborhood) for women aged 40-60 years, is designed to help incorporate preventive strategies. This is a pilot project, developed and directed by Malissa Wood, MD, FACC, from the MGH Division of Cardiology and Women's Heart Center. Patients are asked to participate in an aggressive lifestyle based cardiovascular risk reduction program for two years. Recruitment of female subjects started in April 2008 and enrollment was completed in November 2008. Enrolled participants are women between the ages of 40 and 60, with a household income of less than 200 percent of the poverty level, and with at least two risk factors for the development of coronary artery disease. Enrolled subjects receive their primary adult medical care at MGH Revere HealthCare Center or MGH Chelsea HealthCare Center. Risk factors include hypertension, obesity, hyperlipidemia, positive family history, cigarette smoking, or diabetes. The multi-disciplinary team (Principal Investigator, Physicians, Registered Nurses, Physical Therapist, Registered Dietician, ECHO technicians, Biostatistician, and Research Assistant) meet on a regular basis to review and evaluate the program.

Patients meet with a RN Health Coach one to two times a week for coaching and intensive counseling regarding their risk factors, and meet on an on-going basis to track progress and to identify problems with compliance. There is an aggressive start-up when women enroll in the program (and tailoring, as needed, to meet individualized planning needs):

- Coaching visits one to two times per week, then meet monthly for the remaining 21 months, or as needed.
- Participation in a program of integrated relaxation.
- Individually (initially taught and reviewed with the RN Health Coach and reinforced in the monthly group sessions),
- Tai Chi
- Yoga
- Exercise regimen to be replicated at the MGH CHA Wellness Center, MGH Revere HealthCare Center, or outdoors. Exercise interventions include:

    - Walking
    - Aerobic exercise classes
    - DVD/tapes
    - Design of individual exercise program
- Nutrition Consultation including development of a family nutrition plan, food shopping consultation, special interest will be paid to family and cultural preferences.
- Smoking Cessation (group and or individual counseling).

The program is offered in English and Spanish with a bilingual Research Assistant available to translate and accompany Spanish speaking women to program components that require Spanish translation. To date, none of the women enrolled have elected to withdrawn from the trial. Baseline data is being evaluated using a web based data collection tool. In September 2008, educational and exercise programs began meeting three to four times a month to support women that have met the initial goals set by the Principal Investigator and RN Health Coach. The meetings continue to reinforce the program goals and provide group, as well as, individual educational and coaching sessions.

Technical Support and Assistance

The professionals at MGH Community Health Associates are resources to staff and colleagues throughout the MGH and Partners communities. In addition to administering the programs included in this report, each year CHA's professional staff provides technical assistance and support to the staff of the MGH community health centers.

Access to Care

MGH is among the largest providers of Health Safety Net care to people without means to pay in the Commonwealth. In FY2008, more than $62 million worth of care was provided to nearly 7,000 patients. Almost half of those patients came from MGH priority communities. At the same time, the hospital treated nearly 6,500 patients insured under Commonwealth Care.

MGH is also a major provider of health care for patients on Medicaid, providing more than $231 million worth of care to more than 36,000 patients in FY2008, at a loss to the hospital and its doctors of nearly $58 million. Nearly half of MGH Medicaid patients were from priority communities.

Measuring The Commitment

One way to measure MGH'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 FY2008 Community Commitment
(in $ Millions)
Compiled According to the Attorney General Guidelines

Community Benefit Programs		
Direct Expenses		
	Program Expenses	6.5
	Health Center Subsidies (Net of HSN Care)	26.3
	Grants for Community Health Centers	4.2
Associated Expenses		N/A
DoN Expenses		3.4
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	4.5
	Doctors Free Care	7.0
Hospital Health Safety Net (HSN) Care		17.6
Corporate Sponsorships		0.5
Total per AG Guidelines		70.0

Components of FY2008 Community Commitment
(in $ Millions)
Compiled According to a Broader Definition

Community Benefit Programs		
Direct Expenses		
	Program Expenses	6.5
	Health Center Subsidies(net of HSN and Payer Losses)	9.6
	Grants for Community Health Centers	4.2
Associated Expenses		N/A
DoN Expenses		3.4
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	4.5
	Doctors Free Care	7.0
Hospital Health Safety Net (HSN) Care		29.3
Bad Debt (at Cost)		
	Hospitals	7.6
	Doctors	5.8
Medicaid Loss (at Cost)		
	Hospitals	39.1
	Doctors	18.7
Medicare Loss (at Cost)		
	Hospitals	117.0
	Doctors	62.4
Unreimbursed Expenses for Graduate Medical Education		4.1
Corporate Sponsorships		0.5
Linkage/In Lieu/Tax Payments		8.4
Total Broader Definition		328.1

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, MGH contributed between more than four percent and more than 15 percent of patient care-related expenses to the community in FY2008.

Contact Information

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