BRIGHAM AND WOMEN'S HOSPITAL

Introduction

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

Mission Statement

The BWH Board of Trustees approved the following community benefit mission statement:

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

Internal Structure of Community Benefit Programs

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

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

Community Health Programs

Jamaica Plain

Boston Asthma Initiative (BAI)

In 1997, the Jamaica Plain community identified asthma and related environmental issues as a problem in their community. To address this problem, residents of Jamaica Plain, representatives from community-based organizations, and representatives from Brigham and Women's, Children's, and Faulkner Hospitals collaborated to develop this initiative. From the inception of the program, the initiative has sought to address asthma in the schools and in homes, while examining access to and quality of health care for children and adults living with asthma. In recent years, the program has begun to expand its services to other Boston communities neighboring Jamaica Plain. These communities include Dorchester, Mattapan, and Roxbury.

An Executive Director oversees the programs of the Boston Asthma Initiative with direction from the Board of Directors. The Board of Directors includes community residents and representatives from the health centers, hospitals, and community-based organizations. In addition to providing general direction, the Board of Directors helps to maintain community involvement in the initiative by playing an active role in strategic planning and fundraising. The program staff also includes a Home Visitor/Health Educator, who is supervised by the Executive Director.

The goals of the BAI are to:

- Identify school children and other household members with asthma and increase their understanding of asthma management
- Identify and address environmental issues contributing to asthma in schools and households
- Increase access to quality health care for asthma treatment and management, and
- Increase awareness of asthma as a community health problem.

The Boston Asthma Initiative targets:

- Boston elementary school children
- Household members of children with asthma
- Parents, teachers, and school administrators in Boston elementary schools
- Asthma care providers
- Communities impacted by asthma

The Boston Asthma Initiative provides bilingual, asthma education services to children and families living with asthma. Services include: home visits; classroom education; assistance to schools in identifying and addressing environmental concerns; public health education; resource guides; and referrals to housing, environmental, and legal agencies.

All of these services are provided free of charge in a culturally competent manner to people living in Jamaica Plain and in the surrounding communities of Dorchester, Mattapan, and Roxbury. These neighborhoods have been identified as having the highest rates of asthma in Boston, disproportionately affecting minorities and children living in an urban environment. BAI maintains strong ties with community partners (such as the Boston Urban Asthma Coalition, MassCOSH, and the Legal Services Center), health centers, and the Boston Public Schools to sustain a comprehensive health network for children and families living with asthma.

In the past eight years, BAI has educated approximately 600 children and more than 200 families through school education, home visits, community forums, and workshops. BAI works across all sectors of a child's life, including the school, home, health center, and community to link services to improve asthma management for all of the families it serves. With a strong emphasis on preventive care, BAI provides families with the knowledge and skills to better manage their child's asthma and to avoid unnecessary and costly trips to the emergency room. BAI does this by increasing families' knowledge of asthma and by empowering them with tools for advocacy and health care decision making.

Through the broad support of Brigham and Women's Hospital's Office for Women, Family, and Community Programs, BAI has been able to both sustain and expand its services. The hospital's contribution is not only financial but also comes in the form of services, programmatic support, and collaboration. For example, the assistance of the OWCFP evaluation team has helped sustain and improve a comprehensive database for assessment of the program. This database assists BAI in evaluation of the services provided and highlights areas for improvement. Additionally, the presence of an evaluation team ensures consistency in program data, as well as, in the use of current evaluation methods.

Home Visiting

BAI conducted 83 intake home visits, 75 six-month follow-up visits, and 51 one-year follow-up visits during FY2005. Ninety-two percent of the individuals who received a home visit were covered under MassHealth or Neighborhood Health Plan (NHP).

Seventy-six percent of the families served were Latinos, and nineteen percent were African American. Fifty-four percent of the families speak Spanish as their primary language at home, 22 percent speak English, and 24 percent speak both English and Spanish in the home. Sixty-four percent of BAI's intake home visits were conducted in Spanish.

During the home visits, clients are educated about how to reduce or eliminate asthma triggers. For example, at the intake home visits, the BAI home health educator found that only seven percent of clients were using bed and pillow covers to reduce asthma triggers. After receiving detailed instructions about how and why to use bed and pillow covers, almost 50 percent of clients were using them by the six-month and one-year follow-up visits.

The Asthma Leader Program

The Asthma Leader Program is one of BAI's school-based initiatives. The program seeks to improve the school environment for children by working closely with an identified "asthma leader" in each school. The asthma leader is usually a school nurse or a physical education instructor. The asthma leader's primary responsibilities are to conduct asthma education with students in kindergarten through second grade and to work collaboratively with school administrators, teachers, custodians, and other key players to form an environmental committee in each school.

These committees work to identify the environmental triggers of asthma that are present in the school and to create a plan for action and remediation of the triggers. BAI partners with MassCOSH's Healthy Schools Initiative to coordinate and facilitate these committees. During FY2005, BAI worked with four schools, educating a total of 268 school children, and forming four environmental committees. One environmental committee oversaw a complete cleaning of a school. Another committee successfully advocated for the repair of a heating system and the cleaning of air vents and floors throughout the school.

Open Airways for Schools

Another component of BAI's school-based initiatives is the Open Airways for Schools asthma curriculum developed by the American Lung Association. The curriculum is multicultural and targeted at third through fifth graders. The components of this curriculum include a review of medications, asthma management, physical activity, and asthma trigger modification. Using this curriculum in FY2005, the Health Educator/Home Visitor provided asthma education to eighteen children in the third through fifth grades at the James M. Curley Elementary School in Jamaica Plain.

South Street Peer Leadership Program

The South Street Peer Leadership Program develops youth leadership skills through peer-led community health improvement initiatives. During FY2005, Team Mita, a project of the South Street Peer Leadership Program, provided interactive, youth-led health education workshops, while also engaging in youth-led anti-violence organizing. Team Mita was comprised of six peer leaders between the ages of fourteen and eighteen who reside in the South Street Housing Development. Since December 2003, a total of twelve youth have been Team Mita peer leaders.

The Team Mita peer leaders receive extensive training on a number of topics such as sexual health, emotional wellness, nutrition, asthma, job readiness, resume writing, communication, mediation and other violence prevention techniques, environmental justice, and community organizing. They also receive weekly training in media literacy and documentary filmmaking in which they explore image making and decoding for community development and social change. The media production component of this training involves instruction in storyboarding, digital photography, digital video, and editing.

The peer leaders are expected to do outreach to a minimum of twelve youth groups annually. Their job-related skills are evaluated using the Massachusetts Work-Based Learning Plan, and the teens must progress from a rating of "needs improvement" to a rating of "competent" or "proficient" in at least five skill areas. The peer leaders are also expected to participate in a minimum of two community-wide initiatives each year, which require them to work both locally and at the state level.

The South Street Peer Leadership Program empowers the peer leaders to make healthy choices for themselves, while they educate others their age on how to make healthy choices. During FY2005, all six of the peer leaders reported that they:

- Engaged in healthy behaviors because of their increased understanding of health topics
- Promoted and supported the healthy choices of others as measured by their ability to lead health education workshops for their peers
- Were able to resolve conflicts as measured by their participation in mediation training
- Used community organizing skills as measured by their participation in community-wide initiatives
- Learned about cultural competency as measured by their participation in ongoing diversity trainings.

In FY2004, the peer leaders began developing four of their own workshops on gender roles, STD prevention, teen pregnancy and contraceptive methods, and healthy and unhealthy relationships. Each workshop was accompanied by a short video clip, developed and edited by the peer leaders, and intended to encourage provocative discussions and insights. In September 2005, the peer leaders developed three additional workshops on domestic violence prevention and one on the prevention of sexual harassment.

The peer leaders offered these workshops to at-risk youth in Boston, including other peer leadership programs and community centers. Thus far, Team Mita has reached over 150 young people and conducted 26 trainings.

The Team Mita peer leaders also participate in a number of community organizing efforts. Some of these efforts include advocating for reductions in youth violence and for increases in funding for summer jobs and after-school youth programming, as well as, for improved access to reproductive health services. The peer leaders participate in the monthly Jamaica Plain Youth Affairs Committee meetings that report directly to the Jamaica Plain Neighborhood Council. They are currently engaged in supporting a bill to make health education a core competency in the public school system, and they have helped to develop a strategy to address sexual harassment in Jamaica Plain.

Mission Hill

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

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

The overall goal of the partnership is to support the academic mission of the school by increasing parent, family, community, and hospital involvement in students' learning. Since individuals with higher educational status also have improved health status, this goal is linked to the hospital's mission of improving the health status of the community.

Family involvement has been shown to be a critical element in student achievement, so the joint programming aims to reach out to families and assist them in becoming active participants in their children's education. Other elements of the program are designed to engage hospital employees in students' education. The partnership's activities fall into two broad program areas:

- The Tobin Fund
- The Tobin-Brigham Family Support Program

The Tobin Fund

Since 1992, the Tobin Fund has been one expression of the hospital-school partnership. Through this unique employee-giving model, BWH employees donate funds annually to the school, either through one-time contributions or through payroll deductions. Since its inception, employees have donated more than $465,000 to the school. These funds go directly to the school and support, at the school's discretion, important activities, which include:

- Summer camp experiences for approximately 50 students annually, who would otherwise miss the recreation, physical activity, new learning, and friendships camp offers
- Field trips and extracurricular activities

- Professional development for Tobin faculty and staff, enabling them to better respond to the many issues which impact students' ability to learn in the classroom
- Books that enrich classroom libraries and student learning and that are used for the Take Home Library and Brigham Book Buddy programs
- Essentials such as winter clothing, eyeglasses, books, food, and household necessities for families in crisis

The Tobin-Brigham Family Support Program

Three Parenting Partners and the Tobin/Brigham Partnership Manager staff the Tobin-Brigham Family Support Program (TBFSP). The Parenting Partners are employed by BWH and work at the school under the supervision of the Tobin/Brigham Partnership Manager. With guidance from the Tobin/Brigham Partnership Manager, the Parenting Partners design and implement literacy initiatives to involve families in their children's education and build relationships between students and adults. The school and hospital share oversight of the program, with the hospital taking responsibility, through the Office for Women, Family, and Community Programs, for facilitating regular planning meetings, gathering data to inform program development, and conducting program evaluation. The components of the Family Support Program include the *Full-Service School Planning Process, Family Support Center, Parent Council, School Newsletter, Take Home Library Program, Brigham Book Buddy Program, Boston Builds After-School Tutoring Program, Future Physicians Club, Health Career Day, and Middle School Summer Jobs Program.*

Full-Service School Planning Process. In January 2005, the Tobin School and Brigham and Women's Hospital began to explore the feasibility of developing a full-service school model, which would enable the Tobin School to offer a broader, more coordinated network of after-school programs for children and parents. As a result of these initial discussions, a task force was convened to undertake a more thorough planning process. The task force was comprised of the Principal, three teachers, the Student Support Services Coordinator, the school psychologist, the Tobin/Brigham Partnership Manager, a Parenting Partner, two representatives from the OWFCP, and two representatives from after-school programs.

The goal of the first task force meeting, which was held in March 2005, was to develop a comprehensive list of the after-school programs that are currently being delivered at the Tobin School, identify specific needs for additional after-school programs, and begin to understand the structural and communication challenges of maintaining a full-service school. In the months that followed, three more task force meetings were held. Task force meetings are expected to continue during the 2005-2006 school year.

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

capacity is very important, since approximately 65 percent of Tobin students are Latino, and many live in families where Spanish is the primary language.

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

Beyond academic issues, the Parenting Partners are often aware of difficulties facing families long before other helping networks are contacted. The Parenting Partners assist families with accessing teachers and other school or community resources, sometimes preventing more serious problems with potentially larger impact on families' lives and students' learning. Teachers report that having the Parenting Partners in the school as part of the school staff helps other parents overcome language barriers and makes the school, as a whole, seem less intimidating. They also indicate that the Parenting Partners are especially effective at communicating with other parents about school policies or the needs of individual students. Tobin School administrators appreciate the increased family involvement they attribute to the Parenting Partners' efforts.

The Parenting Partners hold coffee hours on Friday mornings to welcome parents into the school and introduce them to the Family Support Center. The coffee hours offer a relaxed, casual atmosphere in which the Parenting Partners can interact with parents.

The Parenting Partners have facilitated the delivery of additional resources in the school, including Boston University's Build after-school tutoring program (described below) and food for approximately 50 needy families each month from the Greater Boston Food Bank. The Parenting Partners also distribute Thanksgiving and Christmas dinners from the Food Bank to Tobin School families. During the 2004-2005 school year, they were able to distribute food to 210 families during the holiday season.

The Parenting Partners serve as liaisons between parents and the school staff. At the beginning of the year, the Parenting Partners offer a school orientation for parents/guardians of kindergarten students and new students from other grades to familiarize them with the school. One of the Parenting Partners provides interpreter services and translation services daily in the front office of the school.

Throughout FY2005, parents visited the Family Support Center to find information about school and community activities and to learn about available social service resources. From September 2004 through June 2005, there were 197 visitors to the Family Support Center. In an effort to be more responsive to the most frequent requests from parents, the Parenting Partners created special displays on education and employment resources.

Parent Council. Beginning in September 2004, the Tobin School Parent Council was organized. The Parent Council is an important way that parents can be consistently involved in the school,

make their voices heard, and influence school policy. A total of nine Parent Council meetings were held over the course of the year. Eight to twenty parents attended each meeting.

One of the Parenting Partners, whose daughter is a middle school student, took a leading role in the Parent Council and served as the Co-Chairperson. Each month, the Tobin/Brigham Partnership Manager and the Parenting Partners coordinated the meetings, including the creation of the agenda, outreach to parents, childcare during meetings, and facilitation of the meetings.

Highlights of the Parent Council meetings included the organization of a fundraising event in which parents set up a concession stand at the Tobin School Talent Show and raised over $200 for student basketball uniforms. The parents formed a committee to discuss school uniforms, and the committee met with the Principal about the school's uniform policy. The parents also toured the school library, discussed the school's grading policy, and participated in a workshop on the MCAS.

School Newsletter. Beginning in December 2004, the Parenting Partners began to produce a Tobin School newsletter. The newsletter included a regular column by the Principal and articles and photos by students and teachers. Two issues of the newsletter were assembled and distributed to all students, teachers, administrators, and parents, as well as, community organizations that partner with the school. The newsletter was an effective means by which to communicate with parents who had difficulty attending school events and Parent Council meetings.

The Take Home Library Program (THL). An integral component of the school's literacy focus, the THL was created by a Parenting Partner in response to the need to increase access to books for younger students and to increase the number of parents and other adults reading together with students. Books are provided through the Tobin Fund, and shared student-family reading occurs through a structured and documented approach. The program involves kindergarten through second graders, reaches approximately 150 students in eight classrooms, and has added a total of 30 books per year to classroom libraries over the past nine years.

Brigham Book Buddy Program. Each month, hospital employees volunteer their time to the Brigham Book Buddy Program by visiting Tobin School kindergarten through fifth grade classrooms and reading aloud to students. The Brigham Book Buddies read books selected by the classroom teachers and, at the conclusion of each reading session, they present the books to the students for their classroom libraries. The Book Buddy Program is coordinated by the Parenting Partners and promotes the literacy goals of the school. During the 2004-2005 school year, the Book Buddies read to 303 students in 25 classrooms.

Boston University Initiative for Literacy Development (Boston Builds). The Tobin School is a site for an after-school program promoting literacy skills among elementary school students. Funded by an America Reads grant, the program brings Boston University students to the school as tutors who work with students for two hours, two afternoons a week. The Build tutors work with 30 Tobin students each semester.

The success of Boston Builds depends on support and coordination from within the school. The Parenting Partners arrange for space for tutoring, help the tutors to resolve challenges faced

while managing students, and address the inevitable organizational issues that arise in implementing such a program. The Parenting Partners also play a critical role facilitating communication between classroom teachers and tutors about student progress.

Future Physicians Club. Beginning in December 2004, Tobin School administrators offered participation in Monday morning clubs to middle school students. The OWFCP was invited to facilitate a club relating to health and science. Seven middle school students signed up for the six-week program. The Future Physicians Club familiarized the students with the educational requirements of health careers, introduced them to a wide variety of jobs within the field of health care, and took them on tours of hospital departments where they saw health care professionals in action.

Health Career Day. In June 2005, the OWFCP sponsored a Health Career Day for the third, fourth, and fifth grades at the Tobin School. Seven health care professionals, including doctors and nurses, spoke to several classrooms about their professions and roles at BWH. The day concluded with a pizza party for over 200 students.

Other Mission Hill Activities

In addition to the activities with the Tobin School, BWH is an active collaborator with several other Mission Hill groups and initiatives. BWH serves as the "corporate buddy" for Mission Hill Main Streets (MHMS). BWH holds a seat on the board of directors of MHMS and in 2000 made a four-year commitment to provide $10,000 annually. In FY2004, that commitment was extended for two years, and the annual contribution was increased to $15,000. The partnership also assists MHMS in other ways, such as providing technical assistance, contributions to support their wide range of community projects, and promotional support for all of the organization activities, as well as, meeting any other responsibilities of being a "corporate buddy."

BWH continues to play an active role in the Mission Hill/Fenway Food Project. As a founding member of this collaboration in 1984, BWH sponsors biannual canned food drives that benefit the emergency food pantry at the Parker Hill/Fenway ABCD office. In FY2005, BWH provided $10,000 to the Parker Hill/Fenway ABCD to support their annual Summer Jobs for Youth campaign. This contribution allowed ABCD to employ additional youth who otherwise would not have had summer jobs.

BWH is on the Board of Directors of Mission Safe, a community-based organization that provides myriad services to the youth of Mission Hill. In addition to maintaining a seat on the board, BWH also provides cash and in-kind contributions. In FY2005, BWH contributed $16,000 to help support Mission Safe's peer leadership programs and Stop the Violence event.

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

In FY2004, BWH provided $5,000 to Mission Hill Neighborhood Housing Services to support their planning effort to develop a parcel of land at Roxbury Crossing.

BWH continues to support programs for the young and old of the Mission Hill neighborhood. The hospital provides annual contributions to support the Mission Hill Little League. It also supports City Councilor Mike Ross's annual softball league, which draws participants who range in age from 16 to 21 years old. The softball games provide an opportunity to offer information on job assistance and health care services.

In addition, for the past ten years, BWH has maintained a discount meals program for Mission Hill seniors. This program affords seniors an opportunity to have a full meal, one Sunday a month, in the hospital cafeteria.

Since its inception eight years ago, BWH has supported the annual Harvard School of Public Health Walk For Health, which helps raise funds for Mission Hill agencies and organizations serving youth.

BWH provides a free flu vaccine program for Mission Park residents. This program has been offered for the last 17 years.

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

Other Community Programs

Division of Social Medicine and Health Inequalities

The Division of Social Medicine and Health Inequalities at Brigham and Women's Hospital is a pioneering initiative in health care that addresses health disparities in resource-poor communities through training, education, research, and service. Founded in 2001, the Division's mission is to reduce disparities in disease burden and to improve treatment outcomes both at home and abroad. It focuses on infectious diseases (including HIV and tuberculosis) and on non-infectious diseases (including coronary artery disease, diabetes, and addiction), and other health problems of major importance to society.

The Division trains doctors and other health care professionals who work both locally and globally, combining their practical experience with research interests to develop new and replicable medical intervention models that advance medical practice and standards of care. The Division functions in close collaboration with the Department of Social Medicine at Harvard Medical School and in partnership with Partners In Health (PIH), a non-profit corporation that has developed and implemented a unique health care model, which combines social justice and medicine. All three organizations work with community-based groups to foster active local involvement in the planning of efforts to maintain health, particularly in resource-poor communities.

Prevention and Access to Care and Treatment (PACT) Project

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

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

PIH recruited and trained the first band of the PACT Project's community health promoters (CHPs) from the corps of concerned citizens. These community residents, none of whom possessed any medical expertise, were enlisted, trained, and mobilized to become street-based advocates. Drawing on their acquired medical knowledge and their first hand experience as community members, PACT's CHPs have effectively accompanied PACT participants while navigating the complex maze of social and health resources to find solutions to physical and social ills. The insights and methods of the PACT health promoters in engaging "challenging" patient populations have been extremely effective and instructive to the physicians and students of the PACT Project, thereby creating an open and mutually rewarding learning community. Over the past six years, PACT has continued to grow and, in collaboration with other agencies and health clinics, has served over 250 HIV-positive individuals from across the city.

The PACT Health Promotion program relies on trained community advocates to improve marginalized HIV patients' access to and utilization of health and social resources. CHPs engage patients in health promotion and harm reduction activities, including improved medication adherence, increased use of preventive medical services, reduced emergency room visits and hospitalizations, safer drug use, and increased condom use.

Participants receive services according to three tiers of varying intensity: once monthly, once weekly, or once daily health promotion services. Patients can move between tiers depending on their needs and clinical status. The directly observed therapy (DOT) initiative is the most intensive program and employs DOT specialists to visit ill and non-adherent patients on a daily basis in order to assist them – and observe them – in taking their life-saving HIV regimen. This program is unique in the country and is a central part of a community-based HIV disease management model that is growing in reputation.

Because treatment and prevention are inextricably linked, PACT also houses an HIV and substance use harm reduction program. The Fuerza Latina program, funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a social recovery, leadership development, and community-organizing program designed to address the personal

experiences and social context of impoverished Latino men with a history of alcohol and drug abuse. Through Fuerza, these men are trained as peer prevention leaders and conduct HIV and substance abuse prevention activities to reduce drug-related harm in their communities.

In 2004, this model was expanded to include Latina women in early recovery from injection drug use, as well as, inner city youth. Partnerships with over ten schools have led to a huge demand for Fuerza youth placements, as well as, school in-services on HIV and substance use by youth leaders.

Goals of the Program

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

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

Program Components

Prevention. PACT runs four year-long prevention programs: one for Latino men in recovery from intravenous drug use, one for Latina women recovering from substance use, and two for inner-city youth who are at risk of contracting HIV. The prevention program enrolls community members and trains them to become effective HIV and substance use prevention leaders with the objective of reducing community vulnerability to disease and other drug-related harm. The prevention model is based on harm reduction and social activism philosophies, with the goal of creating vocal, empowered, and skilled community organizers. Adult leaders conduct prevention activities in "hot zones" across the city, and youth conduct prevention activities in the schools and through mass media campaigns.

Health Promotion. Inner-city HIV/AIDS patients struggle to obtain consistent access to necessary health care and social services because of complicated institutional structures and a lack of coordinated efforts between agencies. PACT health promoters build personal relationships with HIV/AIDS patients to help them navigate this disjointed system and achieve better physical health and mental wellbeing. Health promoters visit patients weekly and accompany them to medical and social service appointments. They educate patients about HIV and antiretroviral therapy, provide social support, and collaborate with other agencies to connect patients to existing resources. Health promoters are a critical link between patients and the resources they need to be healthy and contributing members of society.

Directly Observed Therapy. Some patients are chronically non-adherent to HIV medication due to overwhelming personal and social obstacles and extreme HIV/AIDS-related illness. PACT is the only program in the country to offer these individuals its unique brand of home-based directly observed therapy (DOT) of HIV medications. Patients who receive DOT continue working with their health promoter but are also assigned a DOT specialist who visits their home

each day to observe and support them during their pill-taking routine, a complex regimen requiring timeliness and precision in the management of multiple and changing dosages. DOT specialists provide guidance and instruction to prepare patients to eventually self-administer their medicine.

PACT clients may move between the health promotion and DOT programs as their adherence to medication, health status, and social and psychological circumstances change.

Research and Evaluation

The goals of the PACT's programs are to improve the health and quality of life of participants while reducing high-risk behavior and medical costs associated with illness and poor health care. Quantitative data is being collected through questionnaires that assess access to care barriers, mental health, risk behaviors, self-efficacy, and overall program satisfaction. Medical chart reviews and physician reports help track outcomes such as recent opportunistic infections, CD4 and viral load counts, emergency room visits, and hospitalization rates.

Qualitative data is being collected through focus groups, interviews, and participant observation. These help instruct the design and implementation of responsive and effective interventions, as well as, shed light on the barriers that the poor and marginalized face in achieving good outcomes. Patient parameters prior to and after entry into health promotion and DOT programs are compared in order to demonstrate change over time.

In the prevention program, relapse rates, outreach data (e.g., number of condoms and bleach kits distributed in the community), and the impact of community mobilization efforts are being tracked. These data are compared against similar programs in the country.

Collaboration

PACT relies heavily on collaboration with existing case management, mental health, substance abuse treatment, and health care services provided by other institutions in the city of Boston. PACT health promoters and prevention leaders do not replace patients' case managers at other agencies.

Examples of organizations that PACT works with are Latin-American Health Institute, Nutrition Works, AIDS Action Committee, Habit Management, Casa Esperanza, and AHOPE. PACT also works closely with referring health care providers from such institutions as Boston Medical Center, Brigham and Women's Hospital, and Shattuck Hospital, as well as, Dimock, Codman Square, and Dorchester House Community Health Centers. Health promoters supplement the work of these health care providers by assisting with their most difficult and labor-intensive patients. To do this, health promoters and prevention leaders:

- Carry smaller case loads
- Provide services within client homes and neighborhoods
- Accompany participants to appointments and treatment centers
- Focus on health maintenance skills, including adherence, harm reduction, and effective communication with service providers

- Work within a flexible and patient-centered system of care that allows them to move from one intensity tier to another depending on their needs
- Provide services to clients citywide, regardless of institutional affiliation.

Health Careers Program

Middle School Summer Jobs Program (MSSJP)

The Middle School Summer Jobs Program is offered to fifteen eighth graders at the Tobin School and the Roxbury Preparatory Charter School. MSSJP started in May 2005 with a six-week volunteer opportunity. Students were placed in hospital departments and were expected to volunteer in those departments for six hours per week. Participating departments included radiology, orthopedics, the operating room, and inpatient floors.

Nine of the students successfully completed their 36-hour volunteer commitment and became eligible for the summer jobs portion of the program. These students worked at their summer jobs for approximately twenty hours per week during July and August.

The MSSJP students also participated in weekly seminars. At one seminar, Harvard Medical School students presented the three-part curriculum "In Touch With Teens" which educates young people about maintaining healthy relationships and avoiding dating violence. The students also took part in a workshop series facilitated by high school juniors and seniors, which focused on preparing MSSJP students for their first year of high school. Topics covered included time management, studying tips, extracurricular activities, peer pressure, and networking.

The program concluded with a graduation ceremony that included students' families and their BWH department supervisors. The Assistant Principals from the Tobin School and the Roxbury Preparatory Charter School spoke during the ceremony. Two students also spoke about their experiences in the program.

The MSSJP students were asked to complete a pre-questionnaire upon entering the program and a post-questionnaire when they completed the program. Eighty-three percent of the students reported that their relationship with their supervisor was either excellent or very good. The students also listed specific skills that they had acquired through participation in MSSJP. Those skills included how to: talk to a patient, respect patients' privacy, help new mothers with infants, be a good listener, stock a room before a patient is admitted, stock an operating room cart, and discharge patients. Ninety-two percent of the students said that they would recommend MSSJP to a friend.

Student Success Jobs Program

In response to many of the issues identified through a comprehensive needs assessment, BWH launched the Student Success Jobs Program (SSJP) in 2000. SSJP is an after-school and summer work achievement program that provides internships to underserved students from five Boston public high schools in Roxbury. SSJP matches students with a mentor within the medical field,

provides them with hands-on work experience in the hospital, and enhances their interest in higher education in health fields.

The goals of SSJP are to enable participating students to:

- Build both the interpersonal and technological skills that are integral to success in the workplace and that support academic achievement
- Develop a sophisticated understanding of the multiple functions of an academic medical center
- Engage in an in-depth exploration of health care professions and science-related career paths
- Establish stable, trusting relationships with their BWH mentors
- Forge friendships with peers from other neighborhoods and high schools
- Receive tutoring to improve academic performance
- Successfully embark on the college application process

Each academic year, a total of 25 students are selected for participation in SSJP from Boston Latin Academy, Madison Park Technical and Vocational School, John D. O'Bryant School of Math and Science, Health Careers Academy, and New Mission High School. In the summer, the students also receive six-week internships in the hospital. All of these students have the unique opportunity to take part in an innovative learning initiative that establishes tangible links between work and school.

Each high school that participates in SSJP has an on-site Career Specialist from the Boston Private Industry Council (PIC) who works with students to both explore their emerging career interests and connect them with employment opportunities. In conjunction with the Office for Women, Family, and Community Program's (OWFCP) Youth Programs Manager, the school-based PIC Career Specialists target a pool of interested and qualified students and refer them to SSJP. Each year, approximately 75 students are interviewed for the 25 available SSJP slots. The criteria for selection are:

- Presently enrolled in a partnering high school
- Interested in pursuing a health-related career after graduation from high school
- Capable of maintaining a grade point average of 2.5 or better
- Completion of an essay explaining their interest in working at BWH
- Submission of two letters of recommendation
- Demonstration of responsibility, maturity, and strong communication skills while in high school
- Commitment to working ten hours per week during the academic year (summer internships require a 25-hour per week commitment)

In FY2005, the students worked in the following departments: Allergy Lab, Blood Control Unit, Burn and Trauma Unit, Department of Medicine, Emergency Department, Investigational Pharmacy Lab, Kessler Health Library, Microbiology Lab, Neonatal Intensive Care Unit, Neurology Lab, Orthopedics Clinic, Podiatry Clinic, Radiology, and the Spine Center.

In the five years of the program, 100 students participated in SSJP. Forty-two percent of these students have been African American, 23 percent Latino/a, eighteen percent Asian, sixteen percent African/Caribbean, and one percent Caucasian. Eighty-five percent were female, and

fifteen percent male. Thirty-five percent attended Madison Park High School, 25 percent Boston Latin Academy, sixteen percent John D. O'Bryant High School, fourteen percent New Mission High School, and ten percent Health Careers Academy.

Since 2003, 30 SSJP students have graduated from high school:
- 93 percent of them are enrolled in college
- 70 percent of them are majoring in a science or health field

In addition, three SSJP graduates are working part-time and one SSJP graduate is working full-time at the hospital.

2004-2005 Academic Year Program Components

Program Components. In October 2004, the SSJP students went on an overnight retreat to Thompson Island Outward Bound. Retreat activities included team-building games, an outdoor challenge course, trust activities, and a 60-foot alpine tower climb. The students also engaged in academic and career goal setting and in small group discussions about establishing and maintaining priorities. The retreat strengthened the students' interpersonal relationships, gave them the chance to challenge themselves physically and mentally, and was an exciting way to embark on the new school year.

In FY2005, the SSJP students helped to produce a monthly newsletter called the *SSJP Visionary*. The newsletter featured articles written by the students and was distributed to over 200 individuals, including BWH staff, SSJP families, and organizations that have partnered with SSJP. The newsletter proved to be an effective way of sharing program updates and activities.

Throughout the year, the SSJP participants attended monthly workshops on a variety of topics, including personal finances, job interviewing skills, nutrition, medical careers, college applications, and readiness for college life. The students were also expected to submit journal entries every other month. One journal-writing assignment required them to imagine what their lives would be like ten years from now and to write a letter to the OWFCP's Youth Programs Manager describing their personal, educational, and professional accomplishments.

In February 2005, the SSJP students were given the opportunity to shadow physicians during their patient consults and to observe an actual surgery in the operating room. While in the operating room, students were required to wear scrubs and a mask, and they learned about basic operating room protocols.

2004-2005 Evaluation Results

SSJP evaluation results for FY2005 show that students were introduced to numerous health careers, including Cardiologist, Lab Technician, Nursing Assistant, Nurse Practitioner, Patient Care Assistant, Physical Therapist, Research Scientist, Radiologist, Surgeon, and Unit Coordinator. When students were asked about what they learned in their SSJP internships, they reported that they had learned about arthritis, cancer, Down's Syndrome, heart disease, and lupus. They also reported that they had acquired the following science-related skills: how to grow and keep cells alive, make infections with various viruses, count cells, spin a spinal fluid

specimen, harvest cells, identify if a cell is alive or not under a microscope, identify cell colonies, and understand the functions of various pieces of medical equipment.

The students were also asked about their satisfaction with their mentors and with SSJP.

Students' Ratings of Their BWH Mentors and Their Satisfaction with SSJP

	Excellent/Very Satisfied	Very Good/Satisfied	Good	Fair
Ratings of BWH Mentors	66%	22%	6%	6%
Satisfaction with SSJP	82%	18%	-	-

SSJP participants said the following about their experiences in the program:

> *"My goal is to become an obstetrician and work within community health clinics to provide services and resources for pregnant women of color in other countries. Being in SSJP for three years has inspired me because I have met peers with the same interests in medicine and similar goals in life."*
>
> *"As a child, I watched my uncle struggle with heart disease. I began to research and learn about the heart and became fascinated with cardiology, which is why I want to be a cardiac surgeon. Through SSJP, I have learned about medicine, had opportunities to shadow surgeons, and have a clear path of what my future holds."*
>
> *"SSJP provides me with hands-on experience in the Renal Pathology Lab. I help to analyze the functions and diseases of the kidney through biopsies and electron microscopy. I am interested in public health as a career and the study of diseases relating to groups of people is fascinating to me. Ultimately, I want to study racial disparities in health care."*

At the conclusion of the 2004-2005 school year, fourteen of the eighteen SSJP students who completed both a pre- and post-questionnaire indicated their intention to major in a science or health field. Those fields included biology, nursing, nutrition, physical therapy, pre-med, psychology, and public health.

In FY2005, there were eight seniors among the 23 high school students who graduated from SSJP. All eight of the seniors now attend college. Five of these eight students are planning to major in a health or science field. One of these students attends a local college and is working full-time at BWH.

Improving the Health of Women

BWH is the state's largest birthing hospital, and it plays a unique role in developing and implementing innovative women's health programs. Women's health is viewed as more than a service of primary, obstetric, and chronic care for women's reproductive and other problems. It is also seen as a way to ensure healthy families and thus healthy communities.

Women from low-income neighborhoods who are disadvantaged by their educational status, language, employment, economic status, immigrant status, race, or other personal characteristics face significant barriers to maintaining their health and that of their families. Promoting programs that improve the health of women through health, social support, educational opportunities, and employment reduces these barriers and helps women to care for themselves and their families.

The overall vision for BWH's community health initiatives is driven by a desire to equalize health status and opportunity among underserved women and their families. Concerned about alarming disparities in health among Boston's core urban population of women, the Office for Women, Family, and Community Programs' (OWFCP) community health initiatives have focused on these women and their families. Higher infant mortality rates for African American babies, lower rates of adequate prenatal care for African American and Latina women, higher rates of breast and cervical cancer among African American women, higher percentages of African American and Latina adolescents who become mothers, and the impact these health concerns have on the health of families and children are the types of health disparities driving the OWFCP's community benefit focus.

Perinatal Case Manager Program

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

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

The case managers have worked with the health centers and community organizations to develop systematic approaches to issues such as housing, immigration, domestic violence, and barriers to health care and welfare benefits. The case managers also attend workshops throughout the year to stay informed about these and other issues. In FY2005, the case managers attended trainings on the Baby Basics Book Program, the Baby Basics Diaper Program, the Comadres Program of the Latin-American Health Institute, the Department of Social Services, the Healthy Baby/Healthy Child Program, immigration policies, listening skills, and the Room to Grow Program.

During FY2005, the six health centers provided services to 1,543 patients. Fifty-four percent of the patients had more than one visit, and 46 percent were new patients. Most patients had an average of three visits, and the average age of patients served was 29 years old. The majority (76 percent) of patients were Latina, with thirteen percent African American, three percent Haitian, three percent Caucasian, three percent other, one percent Somali, and one percent not recorded. The majority of services were provided in the health centers, and 33 percent of patients had MassHealth as their insurance, while fifteen percent were Free Care recipients. Reflecting the changing demographics of Boston, 23 percent of patients used immigration services at least once. Twenty-three percent of patients needed assistance getting an infant car seat.

Data collected for FY2005 at the six PCMP health centers indicate that the five most frequently provided services are in the areas of:

- Medical support/scheduling: translation for providers, scheduling and accompanying patients to medical appointments
- Material needs: information and referral to resources for furniture, Christmas presents, cribs, clothing, or layettes
- Food/nutrition: education, information and referral to Women, Infants, and Children Program (WIC), food pantries, and food stamps
- Education: prenatal and postpartum education, accessing schools for children, job and computer training, and ESL and GED classes
- Housing issues: information and referrals, assistance with filling out forms and providing letters for courts or landlords, assistance with court proceedings, and assistance with finding shelters or transitional housing

To assist women with gaps in community resources, the PCMP provides the Perinatal Emergency Fund. Case managers apply to the Perinatal Emergency Fund for financial assistance for items such as rent, utility bills, layettes, strollers, or groceries.

The Infant Car Seat Program provides car seats at minimal cost to women who are low-income. This year, the Infant Car Seat Program provided 109 car seats to 102 women. More than half of the women who received a car seat spoke another language besides English. About 63 percent of women received their car seat during prenatal care.

To ensure that women are able to get to their medical appointments, the Perinatal Van Program provides assistance with transportation. In FY2005, 113 women made 419 van trips to health-related appointments for themselves and/or their children.

Outreach and Financial Support for Women with Breast Cancer

The Connecting Hope, Assistance, and Treatment (CHAT) Program assists women with breast cancer who do not have adequate financial resources or insurance to cover the services and treatment related to their breast cancer diagnosis. Women with individual incomes of $25,000 or less or with family incomes of $42,000 or less are eligible to receive up to $1,200 per year. Assistance is provided for items such as medication, wigs, breast prostheses and bras, compression sleeves, transportation to treatment, childcare during treatment, dressing changes in a hospice, and denture replacement (if related to bone loss due to chemotherapy). In the absence

of the CHAT Program, many women would have to choose between paying for items related to their breast cancer treatment and paying for rent, utilities, food, and other basic necessities.

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

Many of the women in the program travel a long distance to get to their treatment in the Boston area. Patients often rely on family and friends for transportation because they are unable to drive after surgery or chemotherapy treatment. The CHAT Program provides transportation assistance to patients through cab vouchers. Many women have limited private health insurance, which may not cover, or may cover only partially, the cost of counseling. Although the CHAT Program targets low-income women, many do not qualify for MassHealth. Medications such as Tamoxifen are expensive and are often not the only medication women are taking for treatment. Many insurance companies do not cover the cost of other similar medications such as Femara or Arimidex. The program works with women to identify other sources of payment.

Through collaboration with vendors such as Brooks Pharmacy, the program is able to refer women to vendors for services. In return, vendors distribute information about the program through newsletters and by displaying applications and a program description at their sites.

In FY2005, the CHAT Program provided assistance to 62 women, and a total of $25,259 was disbursed. The majority of requests were for transportation (26 percent) and medication (26 percent). Requests were also received for breast prostheses and bras (twenty percent), wigs (ten percent), compression sleeves (ten percent), psychological counseling (six percent), and other items related to breast cancer treatment (two percent). Fifty-six percent of participating women submitted more than one request for assistance.

The average age of women who submitted a request was 54. The average annual individual income of applicants was $8,019, and the average annual family income was $18,115.

Passageway at Brigham and Women's/Faulkner Hospitals and the Health Center Domestic Violence Initiative

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

The program model is based on an empowerment philosophy and rooted in the grassroots history of the battered women's movement. In developing Passageway, the OWFCP created a program that would both incorporate the perspectives and experiences of women and assist the hospital in integrating screening for abuse and domestic violence interventions into routine health care. In the fall of 2004, the hospital expanded Passageway to its community sites at Faulkner Hospital and Southern Jamaica Plain Health Center.

Passageway has become a leader in integrating domestic violence advocacy services and training for health professionals into the health care system. While women's shelters and domestic violence hotlines continue to provide critical emergency services for victims, placing domestic violence advocacy services within the health care setting offers additional avenues for help and for earlier intervention and prevention.

Victims who may not be ready to access shelters or hotlines may still seek health care. As health care professionals become skilled in routinely screening for and identifying domestic violence, victims may benefit in numerous ways. First, the act of domestic violence screening is itself an intervention and informs patients that health care providers care about their safety and well-being. Second, the screening process and availability of an on-site domestic violence program offer victims access to services in a private setting. If a patient discloses abuse, their health care provider can refer them immediately to Passageway for safety planning and ongoing support. Third, employees can find easy access to assistance within their workplace.

Passageway strengthens the health care system's response to domestic violence and improves the safety, health, and well-being of individuals and families experiencing domestic violence through its four program components:

- **Comprehensive Advocacy Services** for patients and employees who are abused
- **Training/Education** for multidisciplinary health care providers and hospital employees
- **Community Collaboration** to ensure a strong network of services to address domestic violence within and beyond the health care setting
- **Evaluation** to support the continuous improvement of care for domestic violence victims and effective training and education programs for health care professionals

Since its inception, Passageway has responded to more than 4,200 requests for advocacy services and trained nearly 7,000 health care providers and staff. In addition to working with individual clients, Passageway provides three distinct survivor support groups in English and Spanish.

Comprehensive Advocacy Services and Consultation

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

During FY2005, Passageway responded to a total of 716 Brigham and Women's and Faulkner Hospital patients and employees experiencing domestic violence. The Passageway Advocates recorded 14,954 service contacts on behalf of all individuals assisted.

Demographic information on individuals served is as follows:

GENDER	NUMBER	PERCENT
Female	687	96
Male	29	4
Total	716	100
RACE	**NUMBER**	**PERCENT**
Asian	9	1
African American	208	29
Caucasian	250	35
Latino	206	29
Other	28	4
Unknown/ Unrecorded	15	2
AGE RANGE	**NUMBER**	**PERCENT**
Under 18	12	2
18 to 19	23	3
20s	171	24
30s	165	23
40s	178	25
50s	82	11.5
60s	29	4
70s	15	2
80+	3	0.5
Unknown/ Unrecorded	38	5
LANGUAGE	**NUMBER**	**PERCENT**
English	561	78
Spanish	120	17
Other	13	2
Unknown/ Unrecorded	22	3

Passageway has a collaborative intervention model that includes domestic violence advocates, nurses, physicians, social workers, mental health providers, and other health care providers. Domestic violence intervention is provided at the academic medical center campus, community hospital, and health centers. The intervention model is flexible and tailored to individual needs. Services include safety planning, crisis response, counseling, education, outreach, support groups, medical advocacy, legal assistance, and referrals.

Passageway's Advocates come from diverse backgrounds reflecting the populations served. The Advocates offer services in English and Spanish and use hospital interpreters for all other languages. The details of the 14,954 service contacts for all clients in FY2005 are listed below:

TYPE OF SERVICE	NUMBER OF SERVICE CONTACTS	PERCENT OF SERVICE CONTACTS
Direct Contact with Individuals:		
Advocacy/Counseling	1,595	11
Phone Contact	2,234	15
Support Groups	219	1
Indirect Advocacy:		
Outreach and Client Follow-up	3,872	26
Consultation and Collateral Contact:		
with a BWH Provider	5,028	34
with a Community Provider	2,006	13

The **Passageway Health-Law Collaborative** is a unique legal services program within a health care domestic violence program**.** By conducting a full legal assessment for victims, Passageway helps victims to move beyond legal crises and identifies ways that lawyers can be proactive in their assistance with issues such as health care proxies, disabilities, insurance, access to systems and rights, housing and tenant problems, financial issues, guardianship and permanency planning for children, and others. After piloting this project with limited staffing for one year, a full-time lawyer funded by a public interest fellowship began to direct this project in September 2005. Despite only eight to ten hours per week dedicated to the legal services pilot project, Passageway assisted 121 clients and provided ongoing technical assistance with legal issues.

Referrals and service contacts have steadily increased since Passageway started. In 1997, the program assisted nearly 200 women. In FY2004, services were provided to 571 individuals, which represented a seven percent increase from FY2003. As compared to FY2004, this year's data represents a 25 percent increase in individuals served and an almost thirteen percent increase in service contacts without any increase in the number of staff delivering services.

Passageway's health education and outreach project with the Adolescent Reproductive Health Service reaches young women who are at risk. This project won a hospital Dennis Thomson Compassionate Care Scholar Award acknowledging the collaborative work of a team comprised of nurse practitioners, a social worker, and the Passageway Advocates. The team conducted an initial focus group with adolescent girls to solicit their input about ways to reach their peers and break the cycle of violence. Because BWH is Massachusetts' largest birthing center with more than 9,900 babies born here annually, Passageway plans to replicate the health education project to reach pregnant women of all age groups.

Training/Education for Health Professionals

Mandatory abuse competencies are required as part of credentialing for nurses and physicians to learn about domestic violence, appropriate screening, and the critical role providers play in reaching out to victims. With over 1,600 nurses and 2,400 physicians employed at the hospital,

this competency along with ongoing clinical rounds and educational forums provide a strong basis for domestic violence screening, intervention, and prevention at BWH and beyond. The abuse competency training modules, on-line through training software and formatted as PowerPoint presentations, could be replicated for other health care settings across the U.S.

Passageway was a member of the Adolescent Dating Violence Prevention Advisory Group at Harvard Medical School's Center for Excellence in Women's Health. The Advisory Group developed a new program to prepare medical students to educate teens about healthy and unhealthy relationships and safety options. A Passageway Advocate served as a trainer and mentor to the medical students. As more medical students become aware of domestic violence as a health issue, more practitioners will be able to screen for abuse and make referrals within a health care setting.

BWH's screening rates for domestic violence range between 80 and 100 percent depending on the hospital service. While this does not mean that Passageway is identifying all domestic violence victims, we know that we are increasing the integration of domestic violence assessment into routine health care. Referrals come from all areas of the hospital, including cardiology, neurology, renal, thoracics, oncology, obstetrics and gynecology, emergency medicine, and primary care. Domestic violence does not always present as an obvious issue. Rather, it is often identified as a factor undermining a person's health and well-being or as the root cause of a medical condition or an exacerbation of symptoms.

Community Collaboration

Passageway collaborates with a Boston-based, citywide health program that provides home care to people living with HIV and AIDS to reach those who are most vulnerable and in need. We offer case consultation at a community program to provide staff with a place to discuss complex domestic violence situations that raise concerns about immediate safety for victims and for outreach workers. We implemented a comprehensive domestic violence protocol for this program and conducted eight hours of intensive staff training.

Passageway was invited to participate in the Women's Health Legislators' Day, sponsored by the Connors Center in Women's Health and Gender Biology, where over 40 Massachusetts Senators, Representatives, and Aides were present to learn about four different women's health issues in small group discussions. Passageway's staff led the group discussion "Domestic Violence as a Health Care Issue for Women."

Passageway's staff participated in numerous community groups and coalitions to strengthen the response to domestic violence victims and survivors. Current community linkages include:

- Domestic Violence Council of the Conference of Boston Teaching Hospitals
- Jamaica Plain/Roslindale Domestic Violence Provider Network
- NASW Committee on Domestic Violence and Sexual Assault
- SAGE Boston
- Domestic Violence Committee of the Children's Advocacy Center of Suffolk County
- Family Justice Center

Evaluation

Passageway developed and maintains a comprehensive database for tracking and analyzing services and for continuous quality improvement. The database enables Passageway to document the growth of the program and to identify clinical areas and departments that make referrals to the program. This information guides program development and training priorities.

Each October, Passageway administers a survey to hospital staff with the goal of identifying areas for program improvement. From last year's survey, which generated almost 300 responses, Passageway learned about key clinical practice questions and about how to focus training efforts (e.g., more content on mandatory reporting and how to intervene with abusers who may accompany victims in the health care setting). This year, the survey will assess providers' attitudes toward victims and systemic barriers to effective interventions. About 500 surveys were completed and returned in October 2005.

Health Center Domestic Violence Initiative

Established in 1999, the Health Center Domestic Violence Initiative is a collaborative among Passageway and Brookside, Whittier Street, and Martha Eliot Health Centers. Each health center has a domestic violence advocate supported by community benefits funding and administered through Passageway. Currently, advocates from the health centers and Passageway meet quarterly to improve communication and continuity of care for patients and to participate in resource sharing and trainings.

The Initiative's aim is to ensure consistent and safe domestic violence interventions across the health care system and increase access to support for women experiencing domestic violence. This year, there was an emphasis on advocacy practice standards and resource sharing among the advocates.

In FY2005, advocates at Brookside and Whittier Street Health Centers assisted 177 women who were coping with domestic violence, and they reported 477 service contacts. The demographics of race/ethnicity and age are listed below:

RACE/ETHNICITY	**NUMBER**	**PERCENT**
African American	24	14
Caucasian	15	8
Haitian	3	2
Hispanic/Latina	133	75
Trinidadian/Tobagonian	1	0.5
Unrecorded	1	0.5
Total	177	100
AGE RANGE	**NUMBER**	**PERCENT**
Under 18	2	1
18 to 19	5	3
20s	35	20
30s	52	29
40s	47	27
50s	25	14
60s	9	5
70 and above	2	1

In addition to direct advocacy services with individuals, the advocates conducted 24 support group sessions in English and Spanish.

Access to Care

BWH is one of the largest providers of free care to people without means to pay for health care in the Commonwealth. In FY2005, nearly $31.2 million worth of care was provided to more than 8,500 patients. More than one-third of these free care patients came from the communities of Dorchester, Mattapan, Jamaica Plain, and Roxbury.

BWH is also a major provider of health care for patients on Medicaid, providing more than $98 million worth of care to nearly 27,000 patients in FY2005. Almost one-half of those patients were from Jamaica Plain, Dorchester, and Roxbury.

Measuring the Commitment

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

Components of FY2005 Community Commitment
(in $ Millions)
Compiled According to the Attorney General Guidelines

Community Benefit Programs		
Direct Expenses		
	Program Expenses	3.2
	Health Center Subsidies (Net of Uncompensated Care)	7.8
	Grants for Community Health Centers	1.2
Associated Expenses		N/A
DoN Expenses		N/A
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	1.7
	Doctors Free Care	6.6
Net Charity Care (Shortfall plus Assessment)		24.0
Corporate Sponsorships		N/A
Total per AG Guidelines		44.5

Components of FY2005 Community Commitment
(in $ Millions)
Compiled According to a Broader Definition

Community Benefit Programs		
Direct Expenses		
	Program Expenses	3.2
	Health Center Subsidies(net of UC and Medicaid Loss)	3.9
	Grants for Community Health Centers	1.2
Associated Expenses		N/A
DoN Expenses		N/A
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	1.7
	Doctors Free Care	6.6
Net Uncompensated Care – Hospitals		27.8
(Shortfall plus assessment net of Insurer Contributions)		
Bad Debt (at Cost)		
	Hospitals	6.0
	Doctors	6.4
Medicaid Loss (at Cost)		
	Hospitals	23.3
	Doctors	9.4
Unreimbursed Expenses for Graduate Medical Education		17.0
Linkage/In Lieu/Tax Payments		1.0
Total Broader Definition		107.5

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

Depending upon the definition used, BWH contributed between four and nine percent of patient care-related expenses to the community in FY2005.

Health Centers

Southern Jamaica Plain Health Center

Background

One of the health centers operating through the license of BWH, Southern Jamaica Plain Health Center (SJPHC) has been serving the community for over 30 years. Starting as a well-child clinic in Jamaica Plain's Curtis Hall and then moving to a Centre Street storefront, SJPHC moved to a beautiful modern facility at its current Centre Street location in 1998. The health center now

serves almost 10,000 patients with its comprehensive services of adult medicine, pediatrics, women's health, mental health/substance abuse services, cardiology, dermatology, nutrition and podiatry. SJPHC's mission is to provide personal, high quality health care with compassion and respect to a diverse community. Health center providers include seven internists, four pediatricians, an obstetrician/gynecologist, midwives and nurse practitioners in women's health, a podiatrist and cardiologist, dermatologists who are part of the BWH Dermatology staff, and social workers, psychologists and psychiatrists in the mental health/substance abuse department. A bi-lingual staff of five nurses provide and coordinate services to patients. Patients made more than 45,000 sick and health maintenance visits last year, taking advantage of the health center's accessible schedule and 24-hour on-call service.

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

The patient population of the health center is quite diverse, both ethnically and economically, reflecting the community in which it is situated. Approximately 52 percent of the patient population is Latino, fifteen percent African American and 33 percent White. The health center attracts many patients who have recently emigrated from the African continent, Asia and the Caribbean Islands. Seventy-five percent of the health center staff is bilingual in Spanish to serve the patient population.

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

FY2005 Accomplishments

- The health center’s patient population continues to grow rapidly, and SJPHC remains a major resource for access to care for the populations most at need in Jamaica Plain and surrounding communities: immigrant, Spanish-speaking, and low-income residents. The patient population has grown from 4,600 patients to nearly 10,000 patients since the move to the new facility in December 1998, a growth of 117 percent in seven years.
- Collaborating with JP Tree of Life and residents of South Street public housing development, the eighth year of a community-building project was successfully completed, and funding obtained for the next year of the project, with BWH/Partners HealthCare community benefit support as the lead funder. SJPHC is providing supervision to the Teen Peer Leadership Program. During the past year the teen program continued to develop. The teens worked collaboratively to address violence within the community, to promote sexuality education

- The Pediatric Department continued its participation in the Reach Out and Read program and was very successful in securing over 1,000 books for SJP's pediatric patients. Young patients receive a book each time they come for their well-child visits.
- SJPHC participated in major community activities such as the Jamaica Plain World's Fair and the Wake Up the Earth Festival, where SJPHC also provided the First Aid Station.
- SJPHC received staff grants for health education from the Massachusetts Department of Public Health and for case management from the Boston Public Health Commission.
- Collaborating with Pfizer Pharmaceuticals and Partners HealthCare, SJPHC provided two heart parties to the local community. These "parties" include screening for cholesterol and glucose levels and checking blood pressures. Over l00 women participated.
- Access to the health center's women's services continued to improve. The health center provided prenatal care to 220 women, and continues to be a major source of care in the community, particularly for Latinas.
- The SJPHC Community Advisory Board, made up of ten members, continued to provide input from patients and community members about SJPHC's services and programs.
- SJPHC awarded a $500 Martin Leber Scholarship to two health center patients going on to college. The award was established in honor of SJPHC's longtime pediatrician.
- The health center participated in citywide Emergency Preparedness activities through the Boston Public Health Commission, establishing and clarifying roles of health center and staff in the event of an area-wide emergency.

Brookside Community Health Center

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

This group of local residents established itself as the center's Consumer Policy Board functioning under a set of by-laws drafted to govern the Board and its actions. The Board outlined the health center plan and hired the first staff members. The sixteen-seat Board continues to function as an engaged set of consumers and advisors who work directly with the health center's Executive Director and staff. By-laws require an annual election by health center clients and that twelve of the seats be filled by consumers.

In 1974, the Brookside Community Policy Board signed an affiliation agreement with the Peter Bent Brigham Hospital and became part of the Ambulatory and Community Services Department, operating under the Hospital's License. The hospital, now Brigham and Women's Hospital (BWH), and a founding member of Partners HealthCare, has continued to work closely with the health center staff and Board to provide high quality services that meet the needs of the community.

Throughout its 35-year history, the health center has evolved and grown in order to meet the

needs of its patients and improve the health status of the community. In 1970, after initially opening for business in a school classroom, the health center moved to four house trailers and then into a renovated parish hall basement. Within five years the health center had settled into its current location, a manufacturing building leased by BWH in 1974 for twenty years from the city of Boston. The building, a one story, 27,700 sq. ft. space, was renovated in 1975 with funding from a federal government program to meet the health center needs. The building is fully handicapped accessible and on public transportation routes. The health center occupied 20,000 square feet of the building sharing the location with N.I.C.E, a community-run day care program, until the summer of 1999. At that time, the Day Care relocated to a new building of its own, allowing it to increase its capacity and offer services in an updated and fully refurbished space.

In December of 2000, BWH purchased the building from the City of Boston. Long-planned, and much needed, renovations, which included a complete overhaul of the building's infrastructure systems, were initiated in June 2001. This project was completed in the spring of 2003 and allowed the health center to occupy the full building. The increase in space supports improved working conditions for staff and the delivery of high-quality care to clients. This increased and improved space has also had a dramatic impact on the health center's ability to reach more individuals, provide increased services and support staff in these efforts. The health center continuously reviews capacity, its ability to meet a continuing growth of demand and works steadily with Brigham and Women's Hospital and Partners HealthCare to plan for the future.

In the face of these demands, Brookside's board and staff remain committed to its mission:

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

Brookside's mission is to provide comprehensive, family-oriented, multi-discipline services, regardless of ability to pay. Services are provided through four direct care departments, Medical, Dental, Family Services and WIC/Nutrition. Each of these departments is made up of a multidisciplinary team of staff. The Medical Department provides primary care in pediatrics and adult medicine, OB/GYN care and family planning services and on-site Pulmonary services for both adults and pediatric patients. The Dental Department provides comprehensive preventive and restorative services as well as Endodontics, Periodontics and orthodontic services to adult and pediatric patients. The Family Services Department provides mental health, social services, HIV health education/ prevention, Substance Abuse services, Parenting Education, and Domestic Violence Advocacy Support services. The WIC/Nutrition Department provides nutritional assessment and counseling to adults and pediatric patients, as well as a supplemental food support program. An on-site laboratory, managed by Brigham and Women's Hospital's Laboratory Administration, provides services to all departments. All services provided have been implemented and expanded in direct response to the presenting needs of the health center's populations.

Each clinical department conducts an active teaching program, approved annually by the Community Policy Board. The intent of these programs is to provide an opportunity for future clinicians to experience a learning environment that is culturally appropriate and responsive to the needs of the community it serves. Each department organizes its program in a manner meant to

support the primary focus of its practice while protecting against any interference with patients' access to their primary care providers.

The center is open Monday, Tuesday and Thursday 8:00 - 7:00, Wednesday 9:30 - 7:00, Friday 8:00 - 5:00, and Saturday 8:30 - 12:00. In addition, because of a commitment to patient access and a primary care approach to service, the health center is open on several of the statewide holidays, offering routine appointments and urgent care access in all clinical areas. As an extension of this commitment to access, a physician backed on-call system for pediatric and adult medicine is in place 24 hours a day, 365 days a year. Dentists, midwives and mental health staff are also available for phone consultation whenever the health center is closed.

Brookside services are available to all residents and workers of Jamaica Plain as well as residents of surrounding Boston neighborhoods. The center is easily accessible by public transportation and the building is fully accessible to the handicapped.

Because of the broad diversity of the health center staff, all services are offered bilingually in English and Spanish. In addition, staff members are available as translators in Haitian, Creole, Russian and Polish.

FY 2005 Accomplishments

FY2005 was Brookside's 35th year of service to the community, a remarkable achievement in this time of declining resources and a lack of willingness to care for the most needy in our society. Despite these external pressures, the health center continued its tradition of providing high quality care to patients and families with a commitment to ensuring outstanding services to those in need. Throughout the year, the health center responded to the needs of those who sought assistance and adapted services and programs to ensure that needs were met and successful outcomes were achieved. This dedication is a reflection of the outstanding staff, a rare group of highly skilled, and deeply committed people. Because of them, and their hard work, this was a busy, demanding, productive and, most especially, a rewarding year for all involved in the health center. There were a great number of achievements, all of which are important and many which will have long lasting impact. These achievements are the direct result of staff efforts and our equally dedicated supporters. These include the health center's Community Policy Board, the Leadership and Friends of Brigham and Women's Hospital, Partners HealthCare staff and our community partners.

Some of the highlights were:

- Completed a very productive year of service, providing 67,847 patient visits, recruiting 1,079 new clients and reaching a total of 10,650 individual patients, ensuring high quality patient care with a continued focus on coordination and collaboration to achieve successful patient outcomes.
- Participated in a thorough assessment and strategic planning process for the future of the health center, particularly in the face of the state-mandated "Critical Access' Policy, restricting patients enrolled in the Uncompensated Care Plan from accessing primary care services at hospitals. Took active role in advocacy and support for patient access.
- Increased on-site prenatal services to include non-stress testing utilizing state-of-the-art Fetal

Monitoring equipment, for increased patient compliance, utilization and enhanced level of care.

- Developed successful partnership with Children's Hospital's Neighborhood Partnership Program to increase efforts to recruit and hire a Child Psychiatrist to begin work at the health center in January 2006.
- Initiated Suboxone Treatment service on-site within the Internal Medicine Practice.
- Celebrated the tenth anniversary of the very successful Teen Health Center at English High School.
- Successfully completed extensive re-licensing process to renew DPH issued Substance Abuse license for two-year period.
- Brookside's Jamaica Plain WIC Program was identified as the highest ranked WIC program in the state of Massachusetts by the Department of Public Health, in areas of quality of care and compliance.
- Participated in a Brigham and Womens/Faulkner Hospital Task Force to assist in identifying opportunities for improved patient experience as location of care and services continues to expand.
- Maintained highly successful teaching programs in a broad array of clinical disciplines in Medicine, Nursing, Dental and Behavioral Health departments. Also participated in several administrative internship programs including the Americorps-sponsored Health Corps Internship and the Health Career Connection Programs.
- Successfully sought multiple new grant funds to provide nutritional counseling for children and their families; promoting healthy behaviors within primary care; increasing breastfeeding support for prenatal patients and new mothers; and enhancing the health center's emergency preparedness planning. Continued to maintain all on-going grant-funded programs in place despite cuts to most and substantial reductions in others. Programs that continued despite funding cuts included the Jamaica Plain WIC Program, the CHC Support and Enhancement Project, Infant Mortality and the Primary Care Program.
- Provided increased access to mammography care twice hosting the Cancer Society's Mammogram Van at the health center and reaching over 80 women for screening.
- Continued to provide on-site financial counseling services to the community and increase number of patients receiving financial and administrative assistance with applications for Medicaid and Free Care.
- Held highly successful, day long "Read a Thon", with guest readers that included local officials, community leaders and clinical providers. Participants included patient families, local daycare children and Head Start students.
- Continued to take leadership role in health planning projects such as:
    - City-wide Alliance for Health
    - Boston Conference for Community Health Centers
    - J.P. Asthma Initiative
    - Governmental Affairs Committee of Mass League
    - J.P. Tree of Life
    - JP Health Planning Committee
    - Neighborhood Health Plan (NHP) Advisory Board
- Maintained extended service hours in all clinical departments, increasing utilization and diversifying patient base by offering increased access to the working families of the

community.

- Continued participation in Blue Cross sponsored initiative to bring together all Jamaica Plain CHC's with local schools to assess the mental health needs of children in the community.
- Took active role in the CHEERS program, as a member of the Board as well as participation in several task forces and exploring initiatives.
- Held on-site voter registration in collaboration with the Board's Advocacy Committee and Boricua.
- Continued important projects to support the work and mission of the health center. These include:
  - Urban Youth Connection Project, offering the increased resource of a on-site coordinator working with providers to increase information on physical fitness programs and develop programs to address issues of obesity in youth
  - The Partners In Asthma Care Program, offering the services of an on-site RN Case Manager to support the needs of asthmatic and diabetic patients
  - Reach Out and Read Program, providing free, age-appropriate books for all children seen for well-child visits
  - REACH 2010 Project, a research project focusing on increasing access to cancer screen programs for women of African descent

BWH-Affiliated Community Health Centers

DotWell
Codman Square Health Center
Dorchester House Multi-Service Center

In 1998, the leadership of Dorchester House Multi-Service Center (DHMSC) and Codman Square Health Center (CSHC), two well-respected community health centers with a combined 150 years of service, made the significant decision to form a management services organization. This partnership, founded as Health Services Partnership of Dorchester and now known as DotWell, operates with a mission to:

> ***provide integrated clinical and community services that address health disparities, build social capital, and meet the complex needs of our community.***

With a combined annual operating budget of $35 million and over 500 mission-driven employees, DotWell benefits 45,000 community members who use the services of CSHC and DHMSC resulting in close to 200,000 patient visits a year and over 50,000 social services visits.

With Partners' support, Codman Square and Dorchester House are working to continuously improve a number of public health initiatives, including:

- Pap smear and mammography rates
- Follow-up for women with abnormal mammograms
- Treatment of hypertension in patients with diabetes

- Screening for tobacco use and implementation of efforts to reduce tobacco use

Harbor Health Services, Inc.
Geiger-Gibson Community Health Center
Harbor Family Health Center
Neponset Health Center

Women's Heart Health Day

On Valentine's Day 2005, with Partners' support, Neponset Health Center hosted its First Annual Women's Heart Health Day. In conjunction with The Heart Truth campaign, a nation wide initiative raising awareness about women and heart disease, the health center hosted a day of activities raising awareness about women and heart disease in the community.

During the event, Neponset offered free cholesterol, glucose, blood pressure and Body Mass Index screenings. Health center providers hosted informational tables regarding nutrition and proper diet in keeping a healthy heart. Staff also hosted two health education classes regarding stroke and heart attack in women, warning signs, and treatment.

Forty-two women attended the event and one attendee registered for primary care at Neponset during the event. Neponset Health Center staff including primary care providers, nutritionists, nurse practitioners and nurses interacted with the participants raising awareness regarding Women's Heart Health, discussing risk factors, and promoting healthy diet.

Participants received a set of questions they may want to ask their own providers about heart health, an all inclusive action plan and tips on working with their physician to prevent stroke and manage heart disease. Feedback from the participants about the event was very positive. Many indicated that they plan to follow up with their own provider on issues that were raised during the day.

Partners will support the 2nd Annual Women's Heart Day on Valentine's Day, 2006.
The event will be expanded to include both Neponset and Geiger-Gibson Community Health Centers.

MGH Avon Breast Care Program

Geiger Gibson Community Health Center and its sister facility Harbor Family Health Center are part of the MGH Avon Breast Care Program. The Avon program funds a breast health nurse as part of the clinical staff at those two health centers. Her role is to connect patients who have abnormal findings on a clinical breast exam or mammogram with follow-up care at a hospital. The nurse ensures that patients get to their appointments and helps arrange for transportation as needed. She also helps patients to understand what will happen to them when they get to the hospital and explains the results of any tests a patient may have at the hospital. The breast health nurse provides similar support to patients who have been diagnosed with breast cancer. Since the program's inception in December 2002, 134 patients have received program services. Four

patients have been diagnosed with breast cancer and received follow up services with the support of the breast health nurse.

Martha Eliot Health Center

Brigham & Women's Hospital has had a relationship with Martha Eliot Health Center for more than 25 years. The relationship is based on the desire to meet the obstetrical, medical, and surgical needs of Martha Eliot patients and to partner with them to improve the health of Jamaica Plain's most vulnerable residents. Partners provides full or partial funding to support a number of key positions at Martha Eliot that improve access to care for underserved patients. These positions include the community program coordinator, a number of financial counselors, and an adult social caseworker. Partners funding also supports a Women's Health nurse who focuses on prenatal care, family planning and case management services.

Mattapan Community Health Center

Breast and Cervical Care

Mattapan and Dana-Farber/Partners CancerCare have been collaborating to increase the number of women in the Mattapan area who are screened for breast and cervical cancer. Through this effort, women are provided with better access to mammography services, including a mobile mammography van that visits Mattapan one day each month.

In addition, Mattapan is part of the MGH Avon Breast Care Program. This program provides funding for a breast health nurse and a patient navigator to help patients who are diagnosed with breast cancer or who require additional follow up after a screening mammogram access care at hospitals. The Avon staff also help connect patients with the services they may need to access care, such as transportation or childcare. These efforts are particularly important in Mattapan, a community with a breast cancer mortality rate that has historically been very high.

Health Care Report Card

For the past four years, Partners has funded the Community Health Report Card for the Mattapan and Hyde Park areas of Boston. The report was created by Mattapan Community Health Center, Boston Public Health Commission and Simmons College and presented to the community at the annual Health Care Revival meeting on September 10, 2005. The Report Card brings together key community health data and shows some of the important work that is being done by the health center in collaboration with community partners. The data assists the community in better understanding the health trends for Mattapan and Hyde Park in relation to the other fourteen Boston neighborhoods.

Partners Vice President of Community Benefit Programs, Matt Fishman, was honored by Mattapan Community Health Center at its annual *Rock the Boat* fundraising event on April 30, 2005.

Upham's Corner Health Center

Funding from Partners supports several key public health initiatives at Upham's Corner Health Center (UCHC), including:

Asthma Management

A full-time Asthma Nurse Educator/Case Manager is responsible for the asthma clinic. She collaborates with the pharmacist and primary care providers to provide a multidisciplinary approach to the care of patients with asthma. In addition to preventing crisis visits, the team works with families to minimize exposure to triggers and to put Asthma Action Plans into place.

Access Management

UCHC's Benefits Office provides outreach, assessment, enrollment and post-enrollment services for appropriate health insurance options, including Medicaid, Medicare, Children's Medical Security Plan, Centercare, and Free Care. The Benefits Office staff are all bilingual and bicultural and thus able to assist patients in a culturally competent manner.

Adolescent Health

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

Other key public health positions that Partners helps to support include a lead specialist, a quality assurance coordinator, and a community health advocate.

Whittier Street Health Center

Partners' support has helped the Whittier Street Health Center to develop and implement critical programs geared at eliminating racial and ethnic disparities in healthcare and to provide reliable, accessible, high quality primary health care and support services to a diverse community.

Recent activities include:

- The development and opening of a comprehensive Geriatric Clinic to serve uninsured and underinsured citizens over the age of 60 years old.
- The expansion of the Center's Behavioral health services and the addition of substance abuse counseling services to address to wide range of behavioral health needs of their patients including dually diagnosed patients. The addition of these services as a result of additional funding from the Bureau of Primary Healthcare.
- The implementation of a highly successful multidisciplinary diabetes clinic and diabetes group visit model that serves patients from diverse backgrounds. The diabetes program has received national recognition by the Bureau of Primary HealthCare for its impact the health needs of diabetes and the focus on prevention for pre-diabetic patients.

- An increase of nearly 300 percent in number of men of color coming to Whittier for cardiovascular screening, diabetes screening, prostate cancer screening and physical exams.

Contact Information

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