# MASSACHUSETTS GENERAL HOSPITAL

## Background – A History of Commitment

Massachusetts General Hospital (MGH) is world-renowned for its excellence in patient care, teaching and research. What is less well known, but equally compelling, is its historic commitment to underserved communities and patients. This commitment is embedded in the hospital's mission to provide high quality care for all regardless of ability to pay, has deepened over the past thirty years with full support for three health centers in low-income communities, and has been renewed in the past decade with the creation of the Community Benefit Program.

The health care system today is under increasing strain to provide care to growing numbers of uninsured and under-insured patients as the result of dramatic reductions in state funding of health care for the poor. MGH is the largest private provider of free care in the Commonwealth, serving almost 7,500 uninsured and under-insured patients at a cost of $41 million a year. MGH is also the fifth largest Medicaid provider in the state, treating nearly 30,000 patients at a loss of $51 million from undereimbursed care. These numbers are growing rapidly.

In addition, the hospital provides full licensing and support for health centers in the low- to moderate-income communities of Chelsea, Revere, Charlestown, North End, and Back Bay. From humble roots in church basements and above post offices over thirty years ago, the MGH health centers last year provided comprehensive primary and specialty care in state-of-the-art facilities to over 65,000 individuals in nearly 350,000 visits. Many of these patients are low-income and recently arrived immigrants and refugees, and present with multiple socioeconomic problems. MGH subsidized health center operations with almost $34 million per year. In addition, MGH Community Health Associates raises $1.2 million annually to provide a range of public health programs at the health centers ranging from smoking cessation to breast and cervical cancer screening.

Increasingly, however, the hospital has come to recognize that medical care alone cannot solve the complex issues engendered by violence, substance abuse, homelessness, and other socioeconomic problems that affect the health of underserved communities. To address these root determinants of health, the Community Benefit Program (CBP) was founded in 1995 with the mission of collaborating with underserved communities to improve health, and working to improve the hospital's responsiveness to diverse patients from these communities. Today the CBP comprises more than twenty-five programs and is supported by over $3 million from the hospital which leverages an additional $1.3 million from state, federal and private funders.

## Mission Statement

Partnership is at the heart of the mission of the MGH Community Benefit Program. That mission is:

> ***The MGH Community Benefit Program collaborates with community and hospital partners to build and sustain healthier communities, and to enhance the hospital's responsiveness to patients and community members from diverse cultural and socioeconomic backgrounds.***

The following principles guide the community benefit program:

- **Health must be defined broadly.** Poverty, violence, substance abuse, environmental pollutants, poor housing, and lack of economic opportunity all contribute to ill health and can be defined as public health concerns, and measurably improved.

- **Building trust** between the community and the academic medical center is an essential prerequisite to meaningful progress on improving the health of the community.

- **Partnership** with community agencies, schools, police, local government and residents is the most effective strategy for making progress on issues which do not reside clearly in any one domain, but in which all players in the community have a stake and a role.

- **Measurable outcomes** are essential to determine program efficacy and population impact. Tailoring evaluation measures and strategies to community health improvement efforts is a unique challenge.

## Community Needs Assessment and Planning Process

When the Massachusetts Attorney General's community benefit guidelines were issued, MGH decided to build upon its decades long history in Chelsea and Revere. Community Benefit Advisory Committees were formed in both communities comprising local government, schools, police, citizens, health and human services providers. The charge to the committees was to identify a key community health concern to address collaboratively. Substance abuse among youth in Revere, and youth violence in Chelsea, were identified as priorities.

The community health assessments are updated regularly. Last year, a comprehensive assessment of health status indicators for Chelsea was compiled, and interviews conducted with fourteen key stakeholders. Youth violence remained the priority. Revere CARES recently completed a new four-year strategic plan, building on the success of the past four years.

What began as a series of separate and discrete programs to improve health more than six years ago has evolved into a comprehensive set of partnerships to reduce violence, improve access to care, and reduce and prevent substance abuse among youth. Through these processes, communities have learned to work together to improve health, vitally important to the long term sustainability of this work.

MGH has also benefited enormously. As the result of lessons learned in the community, MGH recognized opportunity to improve services for underserved patients and populations. New services, including domestic violence, substance abuse and child protection services, as well as expanded medical interpreters, have been added to community and hospital-based practices.

Recognizing the link between education, economic opportunity and health, the community benefit program is also committed to the academic achievement and career development of Boston Public School students. The hospital has long had a science partnership with the James P. Timilty Middle School in Roxbury. The Community Benefit program recently formed a new relationship with East Boston High School through ProTech, a program to provide high school students paid internships and career exposure.

## Community Benefit Management

The community benefit plan is carried out through the hospital's Community Benefit Program Office. The director of this program reports to the Chief Medical Officer of the hospital, and has a matrixed reporting relationship to the director of community benefits at Partners HealthCare. There is an annual presentation of the community benefit program to the hospital's General Executive Committee, the senior leadership and decision-making body of the hospital, as well as to its Trustees. A working group guides each major priority. Finally, the local work is guided through coalitions (Revere CARES), and regular contact with all partners on the local level.

## Evaluation

Another imperative for the Community Benefit Program is to continuously evaluate the outcomes of programs and to ask the question, "are we making a difference?" To that end, the Community Benefit program works with the MGH/Partners Institute of Health Policy to conduct evaluation and measurement of most of the programs. Much of the data included in this report was produced through this office under the leadership and direction of senior research scientist Georgia Willis, Ph.D. Dr. Willis, Leslie Aldrich, MPH, and the team have made tremendous contributions to this work.

# Recent Developments

## *Disparities in Health and Health Care*

*Joseph Betancourt, MD, MPH, co-chair, MGH Disparities Committee*

*Joan Quinlan, MPA, co-chair, MGH Disparities Committee*

In late 2002, Boston Mayor Thomas Menino convened the Boston teaching hospitals to explore their role in eliminating disparities in health and health care among racial and ethnic minorities in the City of Boston. These disparities are well documented nationally and locally. As part of that effort, Peter Slavin, MD, CEO of MGH, created an MGH disparities committee in the spring of 2003, and charged it with identifying and addressing disparities wherever they might exist at MGH. The committee is co-chaired by Dr. Joseph Betancourt, a senior research scientist in the MGH/Partners Institute of Health Policy, and a member of the Institute of Medicine's (IOM) committee that produced *Unequal Treatment*, a definitive look at health disparities in America.

The Disparities Committee, comprised of senior leaders from throughout the hospital and physician's organization, has divided into subcommittees and decided to focus on three "target areas" from the IOM"s recommended actions for 2004. Examples of their activity follow:

**Quality**

The Quality subcommittee will work to change the culture so that the results of all quality improvement initiatives are stratified by race and ethnicity. The group will start with the MGPO's quality initiatives around asthma and diabetes in 2004. The group will also produce a report that describes the hospital's patients and the services they use.

**Education and Awareness**

This subcommittee will sponsor at least two major educational presentations in 2004, and develop a comprehensive communications strategy to educate all hospital staff about disparities.

**Patient Experience of and Access to Care**

The subcommittee will conduct focus groups and/or structured interviews to learn of minority patients' experience of care at the MGH, and will also look at access to subspecialists for the patients who receive their care on the teaching service.

## *Substance Abuse Working Group*

*Joan Quinlan, Chair*

The Substance Abuse Working Group was formed to improve quality and efficiency of care for patients with substance-related diagnoses. In late 2002, an interdisciplinary group representing medicine, psychiatry, nursing, social work and others formed to address this issue. The group found that inpatients with a substance-related diagnosis had a length of stay 2.5 days longer than other patients, and patients in the Emergency

Department (ED) who were not going to be admitted inpatient, stayed in the ED three hours longer than other patients. The Working Group presented three key recommendations to the Clinical Performance Management Executive Committee in May 2003. They are:

- **Improve medical management of alcohol withdrawal** – The Committee created a new medical management pathway that is in the process of being implemented on house medicine units. The new pathway is now on-line and plans are underway to roll it out throughout the hospital. The pathway should play a significant role in improving quality of care for alcohol withdrawal and thus reducing length of stay.
- **Hire Clinical Nurse Specialist in the ED** – A new clinical nurse specialist for the emergency department with expertise in substance abuse is in the process of being hired. This position will allow for earlier identification and treatment of withdrawal, education of clinical staff, continuity with the inpatient units if a patient is admitted, and connection to community-based resources.
- **Enhance non-acute services –** Lack of community-based resources is a major contributing factor to long lengths of stay. Even if a patient is ready to enter treatment, there are often no beds available. The Committee recommended creating relationships with community-based providers of substance abuse services. This recommendation is particularly important given the reductions in the state budget that have come close to eliminating detox capacity for uninsured patients.

# Community Partnerships

## *Chelsea*

*Thomas C. Sterne, MD, Medical Director, MGH Chelsea*
*Jeannette McWilliams, Administrative Director, MGH Chelsea*
*Sarah Abernethy-Oo, MSW, Director, Community Health Programs*
*Elisha "Skip" Atkins, MD, MS, Community Benefit Liaison*
*Kathleen Healey, CPNP, MSN, Community Benefit Liaison*

### Community and Health Center Background

Chelsea is a city of approximately 35,000 residents located across the Tobin Bridge from Boston. According to the 2000 census, about 50 percent of Chelsea residents are Latino, five percent Asian, and six percent are African-American. In 2001, the Massachusetts Department of Education reported that almost 70 percent of the Chelsea High School students were Latino, 17 percent were white, seven percent were African-American or of African descent, and six percent were Asian. Twenty-five percent of Chelsea's total resident population is under the age of 18 years, creating a tremendous need for youth services. 43 percent of Chelsea residents live at or below 200 percent of poverty or $36,200 per year for a family of four. Nearly 40 percent of children under the age of 18 are living below the poverty line, or $18,100 per year for a family of four.

MGH has a long history of involvement in Chelsea. In 1971, MGH worked with community leaders to open the first MGH Chelsea HealthCare Center in a local church basement. The center eventually moved to the former Chelsea Memorial Hospital building. Twenty-five years later, in August 1996, after an investment of $10 million, the MGH Chelsea HealthCare Center moved to a new modern building. MGH Chelsea provides comprehensive primary and specialty health care, as well as urgent care through a Medical Walk In Unit that is open from 6:00 a.m. to 1:00 a.m. daily. **In fiscal year 2003, more than 25,000 people made more than 152,000 visits to the health center**.

Chelsea identified youth and community violence as its priority public health concern in the original Community Benefit-led health assessment conducted in 1995-96. MGH reassessed these findings in 2001 by interviewing 15 key community stakeholders and by producing a comprehensive report on Chelsea's health status. Since that time, the needs in Chelsea have burgeoned and a comprehensive community health team comprised of over twenty outreach workers and community health specialists has developed. Following is a description of each of those programs.

**Family and Community Violence**

***Police Action Counseling Team - PACT***
*Georgia Green, MSW, MGH Chelsea*
*Beth Muccini, MSW, MGH Chelsea*
*Aimee Chalifoux, MSW, MGH Chelsea*
*Frank Garvin, Chief, Chelsea Police Department*

The Police Action Counseling Team (PACT) is a partnership between the MGH Chelsea and the Chelsea Police Department to provide crisis intervention to children who have witnessed violence. Statistics indicate that domestic violence in Chelsea represents a major source of trauma affecting the City's children. MGH social workers are available by beeper 24 hours per day, seven days per week for on-scene response to 911 calls where children are present. PACT formally began in January 1998, with a four-year grant from the Jessie Ball duPont Fund, and is modeled on the Child Development-Community Policing Program developed at the Yale Child Study Center in collaboration with the New Haven, Connecticut Police Department. MGH Community Benefit presently funds PACT.

PACT social workers and police officers first assess physical safety when they respond at a scene. Social workers then provide clinical time to children with the goal of empowering them and allowing express their feelings about the traumatic experience. The social workers often use materials such as puppets and crayons aimed at the child's developmental level to assist with their clinical interventions. The primary goals are to reduce the short-term effects of trauma through immediate intervention, and ultimately to reduce the effects of trauma on a child's ongoing development. The longer-term goal is that of interrupting the cycle of family violence. PACT social workers also teach parents

about the effects on children of witnessing violence, provide parents with language appropriate materials and offer parents assistance in managing the aftermath of such incidents. PACT connects children and families with medical care and mental health care and intervenes when necessary with child protection and other community agencies.

Since the beginning of the program, MGH social workers and Chelsea police officers have coordinated urgent responses to more than **350 families, including more than 750 children,** identified as being victims of or witnesses to family or community violence. In February 2003, PACT celebrated its five-year anniversary. A celebration was held at MGH Chelsea to honor the PACT team and to thank the program sponsors, including the Jessie Ball duPont Fund, the MGH Community Benefit Program and the National Center for Children Exposed to Violence. Massachusetts Attorney General Thomas Reilly as the keynote speaker.

In 2002, PACT, along with ten other Child Development-Community Policing Programs across the country, received a one-year research grant from the National Center for Children Exposed to Violence in New Haven. The goal of this grant is to coordinate data among these eleven programs in order to create a national database documenting the effects of violence on children. MGH social workers, Chelsea police officers, and research staff from MGH's Institute for Health Policy have participated in several meetings at the NCCEV to collaborate in this national effort.

In July of 2003, PACT hosted a site-visit and training for 18 clinicians and police officers from Minneapolis, Minnesota who were launching a Child Development-Community Policing initiative in that City.

**In 2003, PACT responded to 67 families, involving 135 children.** The following is data on 2003 PACT interventions.

- 29 adults and 15 children were injured; nine of the adults and seven of the children received medical assistance. There was one child fatality due to asthma.
- More than half of the children seen, 54 percent (73 children) witnessed domestic violence or another type of violence.
- 11 children were physically assaulted.
- Eight children were neglected by their caretakers.
- 14 children were perpetrators.
- 39 percent (26 children) of cases had a DSS 51A filed.
- 25 percent (17 adults) of cases involved substance abuse.

***Chelsea Children's Advocacy Team (CHAT)***
*Georgia Green, MSW, MGH Chelsea*

Recognizing that PACT's crisis intervention services and that more traditional mental health counseling services are essential but not sufficient in meeting the clinical needs of children exposed to domestic violence, MGH Chelsea began the Chelsea Children's Advocacy Team (CHAT) to address the special and ongoing clinical needs of these

children. CHAT provides comprehensive mental health assessments, clinical follow-up services, and case management to children who witness, have witnessed or are otherwise affected by domestic violence.

CHAT is funded by the Massachusetts Department of Social Services (DSS) and by MGH Community Benefit. CHAT is a partnership between MGH Chelsea and Harbor COV, Chelsea's local battered women's program. CHAT consists of members from PACT, HAVEN, (the hospital's domestic violence program), Harbor COV, and MGH Chelsea's Mental Health and Social Services Unit. The addition this year of a bilingual/bi-cultural social worker and outreach worker have increased the team's accessibility to Spanish-speaking families. The outreach worker provides assistance to families in need of concrete services. An MGH Chelsea pediatrician also provides consultation to the CHAT team to improve the medical care of children with issues of violence.

**In 2003, CHAT served 67 families, maintaining ongoing involvement with 20 families and receiving 47 new referrals.**

This year the team piloted concurrent treatment groups for children age's eight to 11, and their non-offending parent. In 2003, the team has completed five 12-week treatment groups for children, with concurrent groups for those children's female caretakers. Two of these mothers' groups were conducted in Spanish. Thirty-one children and 20 mothers participated in these groups. Preliminary data collected from these groups in pre- and post- testing is being combined with that of eight other DSS supported programs across the state to evaluate the group curriculum and to inform future treatment interventions for children affected by domestic violence.

The complexity of domestic violence cases requires careful and time intensive collaboration with outside agencies. Safety, custody and timing of treatment interventions often necessitates that the team and individual clinicians collaborate with attorneys, guardians ad litem, MGH's Child Protection Team and other agencies.

In 2003, an internal Coordinated Approach to Family Violence Group was formed at MGH Chelsea with membership from each of the main clinical units. The goal of this new initiative is twofold. The first is to provide critical case management to the most complex families, with the understanding that the cycles of family violence are very challenging to break. The second is to provide in depth case review of specific events in the health center's treatment of family violence in order to create new systems, strengthen communication between different disciplines and update existing policies and procedures to provide more effective interventions.

***HAVEN***
*Bonnie Zimmer, MSW, Director, HAVEN*
*Marisol Coreas, HAVEN Advocate*
*Niza Troncoso, HAVEN Advocate*
*Bridget Spann, HAVEN advocate*

HAVEN is the hospital's program, which provides advocacy for patients and employees facing domestic violence. A full time advocate from the HAVEN program works at MGH-Chelsea. (See Boston section)

Since 1997, HAVEN in Chelsea has provided advocacy services to more than **400 patients,** 72 percent of whom are Latina and 93 percent of whom have children. Additional information on the abusers of those patients shows that 71 percent are active users of alcohol or drugs, 55 percent have a criminal history, 55 percent have threatened to kill the patient, 37 percent have threatened the patient with weapons and 23 percent have actually harmed the patient with weapons.

***Chelsea Visiting Moms Program***
*Adela Marquez, Visiting Mom*
*Fadumo Hirsi, Visiting Mom*
*Samia Benkirane, Visiting Mom*
*Ricarda Romao, Visiting Mom*
*Marybeth Bronson, MSW, MGH Chelsea*

MGH Chelsea received a three-year grant from the Jessie Ball duPont Foundation to begin a long-term home visiting program for the most vulnerable expectant and new mothers in Chelsea in January of 2002. In December of the same year, the Ladies Visiting Committee of MGH contributed a gift to support this program as well. The program was developed following a comprehensive assessment of the needs of low-income women who deliver their babies at MGH, most of whom are immigrants or refugees. These mothers are particularly vulnerable because they have lost much of their cultural framework and many of the parenting techniques traditional to their native cultures are difficult to maintain. The women are referred to the Visiting Moms Program from MGH Chelsea Prenatal, Pediatrics, or Mental Health, as well as from the inpatient MGH Boston Obstetrics Unit.

Over the past year and a half four para-professional, bi-cultural, home visitors have been using a relationship-based model of home visiting and support to help mothers of infants, ages 21 and above, adjust to and care for their child. The home visitors are multi-lingual and bi-cultural, and have capacity to speak Spanish, Somali, Swahili, Arabic, French, and Portuguese. The shared language and culture helps to reduce social distance between the home visitor and the mother. The Visiting Mom also serves as a role model, demonstrating ways to adapt to a new country and culture. The overall goal of the program is to achieve stability in order to enable a healthy long-term outcome for the child, the mother, and the family.

Since the Visiting Moms Program began, 53 cases have been opened, with 49 actually being enrolled in services. The average age of a mother is 28, with women ranging from 20 to 44 years old (75 percent are under 30). About half of the women are married and close to 40 percent were pregnant when they were referred. Most of the fathers (70 percent) are involved with the children. Close to half of the women are new mothers, with the remaining having one or more children. However, none of those remaining children were born in the United States, and many remain in home countries with relatives.

Seventy-two percent of the women are from Latin America and the Caribbean (with 50 percent from Central America alone), 22 percent are from Africa, four percent are from the Middle East, and two percent are from the United States. Collectively the women speak more than nine languages, with the majority speaking Spanish (64 percent) and the remaining divided among Somali, Arabic, Portuguese, Swahili, Ugandan, Dari, Haitian Creole, and French. Approximately 60 percent of the women rely on some form of public assistance. 59 percent have less than an elementary school education, 22 percent have nearly completed or completed high school, and eight percent have attended some college or trade school.

The program participants have experienced numerous stressors while adapting to the United States. The five most prevalent stressors experienced by at least 70 percent of the women include: lack of finances, unemployment, language barriers, mental health problems, and difficulty accessing benefits. Many of the couples exhibit excessive arguing, emotional or physical abuse, struggles with divorce or separation, and a close family member with serious illnesses. Almost all are separated from extended family and are having difficulties balancing work and family needs. According to the Visiting Moms, 68 percent of the program participants are mildly to moderately uncomfortable in caring for their infants and seem to lack confidence in that process. Approximately 71 percent are noted to have some attachment difficulties with their babies. In addition, 57 percent of the mothers have minimal or no knowledge of child development and 23 percent only have some knowledge about caring for their babies.

The Visiting Mom develops a supportive relationship with the participating mother by visiting her regularly at home, seeing her at the clinic, or offering to attend other appointments with her as needed. Visiting Moms offer emotional support, concrete assistance, advocacy, and referral to resources. The focus of the intervention remains twofold. Of primary importance are the physical and emotional needs of the mother and her baby. Secondarily, in order to enhance the functional stability of the family, the Visiting Mom will offer many supportive services. The Visiting Mom is able to maintain these supportive relationships for up to three years. Most of the families so far have used the services for approximately 6 to12 months establishing a medium of stability. At the time of case termination, many of the mothers have returned to work and have fewer needs for the services of the Visiting Mom.

**Access to Care/Special Populations**

***Immigrant and Refugee Health Program***
*Adnan Zubcevic, Refugee Counselor*
*Saida Abdi, Refugee Counselor*
*Tamara Leaf, Ph.D, MGH Chelsea*
*Maria Albadalejo Meyer, Chelsea Public Schools*

Chelsea has long been a gateway community to immigrants and refugees, including Bosnians, Somalis, Afghanis, Northern Africans and Western Africans in recent years. Not only do these groups have great challenges adjusting to a new country, but many are also suffering from war-related trauma. The Chelsea Public Schools and MGH Chelsea have partnered to provide an array of health, counseling and supportive services to these individuals and families to ease their transition and to meet their physical and mental health needs.

The Immigrant and Refugee Health Program was originally created to serve Bosnian and Somali refugee patients. The program has evolved in response to the changing demographics of Chelsea's refugee and immigrant population. The two counselors have expanded their services to include new refugee and immigrant groups such as Afghanis, Sudanese, Russian, Arabic-speaking and French-speaking patients along with Bosnians and Somalis. Over 85 percent of the patients served by the program are low-income patients who receive either Free Care or Mass Health.

The counselors spend half of their time in the Chelsea Public Schools, and half at MGH Chelsea. They have trained teachers to identify children who may be suffering the effects of trauma. The counselors work with school children individually and in groups, and then frequently begin to work with parents and entire families to find jobs, enroll in education, engage in counseling and connect with primary care and other health services. The counselors are supported by a multi-lingual and multi-cultural staff in the Community Health Team who are also advocates for the families. The counselors also work closely with MGH Chelsea primary care practices such as Mental Health, Pre-natal, Pediatrics and Adult Medicine to enhance the health center's delivery of culturally competent primary health care.

The Immigrant and Refugee Health Program provides direct services in Bosnian, Somali, French, Arabic, and Russian; and calls on other Community Health Team staff to help with Swahili, Dari, Farsi, Pashtu, Haitian Creole, and Portuguese. **Between October 2002 and September 2003, the program at MGH Chelsea served over 550 individuals and families. The two Counselors had over 2,500 combined encounters within the past year.**

Patients and families came seeking assistance with a multitude of problems such as physical and mental health, housing, unemployment, and family conflicts. Most of the patients referred to the program had experienced trauma in their native country. Over 21 percent reported a history of direct violence in their home country. Over 18 percent were facing adjustment issues such as family conflicts, depression, alienation, and broken

social networks. Whenever possible, a comprehensive plan of care was put in place. In 2003, the two Counselors saw over 100 students at the Chelsea Schools, providing counseling and support to children and their parents in their native languages.

***Medical Interpreter Services***
*Ana Maria Zea, Coordinator Interpreter Services*

The medical interpreters at MGH Chelsea meet the needs of racially, ethnically, culturally and linguistically diverse patients who seek care at the health center. They contribute to eliminating ethnic and racial disparities in health care by improving access for minorities from Chelsea and the surrounding communities.

With dual job descriptions as interpreters and outreach workers, the staff participate in the delivery of culturally competent care by facilitating accurate communication between patients and health care providers, by providing a cultural framework that facilitates the understanding of verbal communication and by taking actions beyond the boundaries of interpreted interviews to advocate for patients and help them better navigate the system.

Part-time and full-time staff interpreters are available on-site for patients who speak Bosnian, Spanish, Portuguese, Dari and Arabic. MGH Chelsea also relies on a wide list of freelance, on-call interpreters to meet the needs of smaller immigrant and refugee groups who speak several different languages such as Somali, Swahili, Russian, Vietnamese, Japanese, Haitian Creole and others.

MGH Chelsea's Medical Interpreter Services has worked to improve systems and train support staff on the procedures for requesting interpreting assistance in order to ensure consistency and reliability of services. **For the 2003, staff interpreters have attended more than 3,800 medical encounters** averaging 321 encounters per month, the majority of the encounters lasting 16 to 30 minutes. Of those encounters 78 percent were for Spanish, 11 percent for Portuguese and nine percent for Bosnian. 67 percent of these requests were for Adult Medicine patients, nine percent for Pediatrics and the remaining 25 percent for all other departments and programs in the health center.

In addition, interpreters performed more than 1200 **outreach and support activities** such as making telephone calls to or on behalf of patients (46 percent), providing assistance to patients on filling out forms, translating and explaining documents (23 percent), meeting with community agencies, making home visits, interpreting offsite and providing patient navigation (26 percent). Thirty-four percent of these outreach activities were with Brazilian patients, 30 percent were with Bosnian patients, 21 percent were with Latino patients and 15 percent were with patients from other countries (primarily Northern African, Afghanistan, Somalia, Sudan, Haiti and Vietnam).

***Brazilian Occupational Health Program***

*Marcelo Siqueira, Outreach Worker*

MGH Chelsea Health Care Center initiated an outreach program targeting the occupational health issues of the Brazilian community in November 2003. Research has shown that undocumented Brazilians face high morbidity and mortality rates in the work place. This new program, which is funded by a grant from the National Institute of Environmental Health Sciences, is a collaboration between the University of Massachusetts in Lowell, the Lowell Community Health Center, the Brazilian Immigrant Center and MGH Chelsea. The Brazilian Occupational Health Program provides an exciting opportunity for MGH Chelsea to enrich its outreach capacity within Brazilian community, to learn about the needs and obstacles their members face in work environments and to address and prevent occupational health issues within a primary health care setting. The program will focus primarily on the health issues affecting Brazilian workers in the hospitality, food service and landscaping industries.

***Refugee Health Assessment Program***

*Mike Damjanic, Program Coordinator*

MGH Chelsea has a contract with the Massachusetts Department of Public Health to provide health assessment exams to newly arrived refugees and asylees. This contract allows MGH Chelsea to conduct the comprehensive health assessment that the United States State Department requires of all refugees and asylees as a step towards their resettlement. A goal of the program is to engage new arrivals in primary care.

**During 2003, the Refugee Health Assessment Program provided services to 115 refugees:** The countries of origin were: 28 from Afghanistan, 16 from The Congo, 14 from Sierra Leone, nine from Liberia, seven from Bosnia, seven from Colombia, six from Sudan, six from Vietnam, five from Russia, three from Albania, three from Haiti, two from Algeria, two from Cameroon, two from Ghana, two from Pakistan, one from Iran, one from Iraq and one from Kenya.

Through this program MGH Chelsea has developed strong working relationships with the Boston-area refugee resettlement agencies. The health center has organized several round tables for health providers with the refugee resettlement agencies to better understand the needs of various refugee groups. A goal of the program is to provide refugees with both comprehensive and culturally appropriate health care.

To solidify the connection between the refugee families and the health center, the program coordinator often makes home visits prior to the first health assessment visit to educate the families about health care services in the United States. In 2003, the program stared providing a basic dental screening and a mental health screening as a part of the health assessment. The dental screening enables providers to identify urgent conditions that need immediate follow up and to stress the importance of ongoing dental hygiene. All the children of the refugee families are referred to the free dental clinic held by the Boston University School of Dentistry and the Chelsea Williams Middle School.

Because so many refugees have a history of trauma, the program has added a mental health screen. The process of resettlement often exacerbates mental heath illness, so it has proven very valuable to begin to address these concerns as early into a patient's care as possible.

***Refugee Family Donation Program***
*Ebed Jacques, Program Assistant*

Last year, employees from the MGH Chelsea Community Health Team, Pediatrics and Administration organized a Refugee Families Donation Program to serve the concrete needs of patients. Newly arriving families are given new or used items to help them settle into their lives in the United States. These donations are collected from more than 60 staff members who have signed up to participate in the program. When a family in need is identified an email is sent, listing the specific items the family needs. These can include winter coats, dishes, blankets, towels, lamps, bicycles, toys, etc. This program has allowed both staff at MGH Chelsea and staff at the Chelsea Public Schools to participate more broadly in meeting the physical needs of newly arriving families.

***Bridging the Gap - The Refugee Family Service Project***
*Saida Abdi, Refugee Counselor*
*Elizabeth Miller, MD, Harvard Medical School and MGH Revere*
*Suzanne Dieter, Harvard Medical School*

As an outgrowth of the Immigrant and Refugee Health Program, The Refugee Family Service Project was created in collaboration with volunteer students from Harvard Medical School. This year the project received a Pathways to Culturally Competent Health Care Grant from the Massachusetts Blue Cross and Blue Shield Foundation. This funding allowed the project to hire a part-time coordinator and to a clinical advisor. The program also has added more educational components for both Harvard Medical students and refugee families. In 2003, **23 students, with varying linguistic and cultural experiences, have been paired with 23 newly arriving refugee and immigrant** families from Afghanistan, Sudan, Morocco, Western Africa, Central Africa and Latin America who receive their primary care at MGH Chelsea.

The students support the families in addressing simple health-related needs and act as advocates, educators, mentors and friends as the families continue the process of adaptation to life in a new country. The project provides the students with the opportunity to support refugee families with concrete needs, while learning first hand the cultural issues that pose challenges to the provision of primary health care. The project gathers all of the families together several times in larger events as well, including field trips, dinners and cultural celebrations. To date, the program has held two focus groups, one family and student celebration, an educational workshop on refugee and immigrant issues for students and another for providers at MGH Chelsea. All these events are geared towards enhancing provider-patient interaction. In effect, the program is meant to "bridge the gap" between cultures, languages and experiences and to open communication between providers and the communities they serve.

**Disease Management/Improving Health Outcomes**

***CHAMP (Chelsea Asthma Management Program)***
*Wanda Velazquez, Program Coordinator*
*Elisha Atkins, MD, MS, MGH Chelsea*
*Eduardo Budge, MD, MGH Chelsea*

MGH Chelsea and the City of Chelsea Health Department joined together in 1997 improve the care management of patient and to reduce environmental causes of asthma. Today, the program has four components: care management, the NHP program, school support and education, and environmental changes.

**Patient Care Management.** The Chelsea Asthma Management Program identifies patients with asthma, conducts a case assessment and does outreach and follow-up, often in the home. The program has seen more than **336 patients** through home and office visits. Fifty percent of those patients have had at least one follow-up home or office visit or telephone call. Fifty-five percent of patients have been referred by their primary care physicians, 25 percent have self-referred, 16 percent have been referred by school nurses, and the remaining four percent have been referred by other sources.

During the home visits the Program Coordinator assesses potential hazards that may exacerbate asthma, gives recommendations on how to eliminate them, and if necessary, advocates to landlords and local agencies for solutions to those problems. The Program Coordinator also teaches patients how to manage their symptoms and medications. The results of the home visit and the medical treatment of the patient are reviewed by the program physicians, and recommendations are made to the Program Coordinator and the patient's primary care providers.

CHAMP encourages and accepts referrals from doctors and nurse practitioners at the health center, and school nurses from Chelsea Public Schools. CHAMP also seeks patients with unrecognized asthma through community education at health fairs and talks to local groups. CHAMP staff conduct educational sessions for Adult Medicine, Pediatrics, Medical Walk-In and school nurses, and have developed ‘asthma boxes’ with educational and monitoring materials for each medical exam room. CHAMP has developed templates for asthma action plans in English and Spanish for the electronic medical record system (LMR), to be printed and given to patients. CHAMP has updated and extended its resources on asthma educational material in different languages and made it available to patients and providers at the health center.

- **Processes of Care.** CHAMP has been evaluated in several ways. In 2003, CHAMP used data obtained from the patient baseline and follow-up assessments to evaluate processes associated with improved outcomes. Processes of care measures include quality of life (as measured by asthma symptom reduction and days missed from school or work), use of asthma controller medications, and indoor environmental triggers. The median time between the baseline and follow-up assessments was six

months. CHAMP analyzed behavior change in 50 participants that had a follow-up contact at the time of the analysis. Major findings are:

- The mean number of days for each asthma symptom significantly decreased, including wheezing and coughing), nocturnal symptoms, activity limitations, and changes in daytime or evening plans due to asthma.
- The average number of asthma symptoms experienced by participants dropped 50 percent from baseline to follow-up (2.24 vs. 1.12 respectively).
- Use of asthma controller medications increased significantly.
- Little change occurred in asthma triggers between baseline and follow-up.
- No significant changes in school or work absences.

Recent changes to the protocol and full implementation of the community-based asthma management program, including follow-up contacts and letters regarding allergen remediation sent to landlords and building managers by legal staff rather the Program Coordinator, may result in better clinical and quality of life outcomes in future studies of the program.

Another evaluation compared those in the program (the study group) and those who were not (the control group) in regards to urgent care visits, hospitalizations, and physician office visits. The study included198 patients identified as having an asthma-related physician or urgent care visit or hospitalization during the past 12 months. Each of these study patients was paired with an asthma patient in the Chelsea community who had not participated in CHAMP.

There are several significant findings:

- There was a statistically significant difference in hospitalizations between study and control groups. The study group had a much larger decrease in hospitalizations (66 percent) than the control group (11 percent).
- Patients 19 years and older in the study group had a 57 percent decrease in hospitalizations while those in the control group had a seven percent increase in hospitalizations. These differences were statistically significant
- Patients 19 years and older in the study group had a 31 percent increase in physician visits while those in the control group had a nine percent decrease in physician visits. These differences were statistically significant.

**Neighborhood Health Plan and Medical Walk-In Patient Intervention.** For the past two years, the program has been contacting patients who are insured by Neighborhood Health Plan, as well as patients who have been treated for asthma in MGH Chelsea's Medical Walk-In Unit. The goal of this follow up with patients is to identify those who are not receiving regular care or having difficulty controlling their symptoms. The goals of this intervention are to help these patients better manage their asthma, enroll them in primary care and connect them to the CHAMP program. The CHAMP Program Coordinator calls patients and conducts in-depth assessments of compliance with prescribed medications. The information gained through the interview is compared with the patient's medical record note. The patient's management plan is reviewed with the program clinicians and the information is forwarded to the primary care provider with

recommendations for an adjustment of medical regimen, as the CHAMP physicians consider appropriate. If necessary, follow-up calls and appointments are made.

Since 2002, more than **500** NHP and Walk-In patients were identified (386 in the Fiscal Year 2003). Out of those 386 patients (358 Walk in and 28 NHP) 93 percent were contacted by the Program Coordinator, 70 percent had letters sent to their primary care provider, 68 percent had their records reviewed by the program's physicians and 83 percent received recommendations such as making a referral to primary care, scheduling follow up appointments with primary care, sending reports to the patient's provider, giving education on medication usage and scheduling home visits.

**Asthma School Support and Education Groups.** In 2003, CHAMP conducted two series of support and education groups for children with asthma in cooperation with the Chelsea Public School Department. The purpose of these groups was to address the learning needs of children with asthma, to teach about medication compliance, to avoid symptoms including proper use of inhalant medications, to teach breathing and relaxation exercises and to encourage children in a fun environment to cultivate more social interactions with other children with asthma. With their parent's prior approval, nine children enrolled in first grade at the Kelley and Berkowitz Schools participated in the first series of group sessions held in the Spring of 2003 and 11 participated in the second one held in the Fall of 2003. Children's knowledge about asthma was evaluated through a pre and post test A survey was sent to parents about their child's symptoms, medicine use and school absences. Results indicated that on average, children scored 45 percent higher on the post-tests after receiving the curriculum.

**Environmental Changes**. In addition to caring for patients in the doctor's office and home, CHAMP works with city officials to change the conditions that exacerbate asthma. First CHAMP worked with high school students to plot on a map where pockets of asthma most frequently occurred within the community. A public housing development built on a swamp emerged as a key problem, with several CHAMP patients living in apartments seriously contaminated with mold, an allergen that worsens asthma. Through CHAMP, an environmental consultant was hired to evaluate the development and make recommendations. The consultant documented serious problems of water infiltration leading to conditions ideal for mold growth.

CHAMP assisted the Housing Department in obtaining state funding for an ambitious, three-stage project to correct these conditions. The first and second stages, which are completed, include plumbing repairs to reduce water in the basement, ventilation improvements, and barrier installation to prevent flooding into the building. The third stage is currently in process and may include additional measures to reduce moisture, such as a new roof and/or windows, waterproofing the walls, and installing dryer vents. The City has also constructed two playgrounds that will allow children in these developments to get fresh air and exercise outside of the housing development.

CHAMP, the environmental consultant and staff from the Housing Department, continue to work together to detect and correct conditions that affect indoor air quality in this Chelsea public housing development. CHAMP continues to support the Housing Department on additional funding requests. CHAMP is also working on new educational material for tenants on how to manage mold and pest problems while permanent repairs are performed, along with developing a seminar for the Chelsea community on indoor air quality and tenants rights.

***Legal Initiative For Kids (LINK)***
*Laura Maslow-Armand, Lawyers Committee for Civil Rights Under Law*

The MGH Chelsea Legal Initiative for Kids (LINK) Program was launched in July of 2003. The goal of LINK is to establish a medical-legal collaboration in order to remove obstacles to the effective treatment of pediatric patients. MGH Chelsea contracted for legal services from the Lawyers Committee for Civil Rights Under Law to achieve this goal

Housing and public assistance are the priority areas for legal assistance. In the first five months of the program, 30 families were referred to LINK by MGH Chelsea pediatricians. Of these patients, 60 percent were in need of assistance with housing and 17 percent with questions of eligibility for cash assistance programs.

The following is an example of one of LINK's successful interventions.

> LINK provided assistance to a refugee family from Afghanistan. The family was referred to LINK because one of the children had asthma that was exacerbated by the conditions of the rental apartment where the family was living. The family faced much trauma during the war including the death of the father. The mother herself suffered from various medical conditions and felt overwhelmed by the stress of caring for her children in a new country where she felt isolated and incapacitated by the sheer weight of her responsibilities. Her English was very limited and her attempts at asking the landlord to address the conditions of the apartment were unsuccessful. After the family was referred to the program, the lawyer dealt with the family's multiple needs and was successful in remedying some of the immediate problems very quickly. The lawyer was able to get back a significant sum of money owed to the family by a utility company. The family's landlord was contacted by LINK to exterminate roaches and mice and to restore heat in the unit. The LINK interventions improved the family's well being by both remedying the unhealthy living conditions in their apartment and by helping to resolving a significant financial stress.

***Avon Breast Health Program / Comprehensive Cancer Support Program***

*Atala Esquilin, Cancer Support Coordinator*

*Adilson Horta, Cancer Support Coordinator*
*Diana Maldonado, Interpreter/Outreach Worker*
*Stacy Engel, MD, MPH, MGH Chelsea*
*Sheila Jewett, MSW, MGH Chelsea*

MGH Chelsea is one of three sites for an innovative program aimed at improving access to breast health services for underserved women. The program is funded by The Avon Foundation and is conducted in collaboration with the Avon Comprehensive Breast Evaluation Center at MGH and Partners Community Benefits. The other sites for the program are at the Mattapan Community Health Center and Geiger Gibson Community Health Center /Harbor Family Health Center. In Chelsea, the program conducts outreach to women at risk for breast cancer within the health center and the community and helps women navigate the variety of breast health services available at MGH Revere and MGH in Boston. Since the program started in May 2001, it has served **246 patients**, all with some abnormal finding on a mammogram or clinical exam, including 29 patients diagnosed with breast cancer. One diagnosed patient in the program has died from this illness.

An important component of this program is the creation of a close clinical linkage to the Avon Comprehensive Breast Evaluation Center at MGH. Patients from Chelsea who have an abnormal finding and need further evaluation attend a designated clinic at the MGH Breast Center every Thursday morning. These specialized appointments are designed so that the patient can have 'one stop shopping' including ultrasound, mammography, as well as appointments with pathology, radiology, oncology and surgery, all accompanied by a Spanish interpreter. This system allows patients to schedule their specialty appointments within one week of initial finding.

Another component of this program has been the creation of two breast cancer support groups – one in English and one in Spanish -- conducted by an MGH Chelsea social worker**. The Spanish language support group is the only one of its kind for breast cancer survivors in the Boston area.** On November 24, 2002, 'The Boston Globe' published an article about the Spanish support group and the Chelsea Breast Health Program. On the day the Globe reporter attended the support group (which is usually held at the health center every Wednesday from 5:00 – 6:30), the group was held at the home of a patient who was very sick with advanced stage breast cancer. Sadly, this patient died just three weeks after the article was published in the Globe.

The Chelsea Breast Health Program is targeted at addressing the alarming rate of breast cancer mortality for Latina women in the Boston area that has increased 38 percent from 1991/94 to 1995/97.

In September of 2003, with additional funding from Mr. Eugene Ribakoff, MGH Chelsea hired two additional Cancer Outreach Staff. Adilson Horta and Diana Maldanado were

hired to help support the breast cancer work and to expand the existing program to be able to support patients dealing with other types of cancer including cervical, prostate and colon cancers.

**HealthCare Centers Access Project**
*Eileen Kirk, Project Director*
*Abigail McDonald, Practice Liaison*

The MGH HealthCare Centers Access Project, funded by a grant from Neighborhood Health Plan's Campaign for Excellence, places a liaison in the primary care practice of each of MGH's major community health centers. Working with the project director and a local nurse supervisor, the practice liaison works with patients and primary care providers to assess patient problems and provide outreach, case management, education and assistance with concrete services and treatment plan compliance.

The tri-lingual Chelsea practice liaison works with the diverse population of adult medicine patients to address a variety of social and medical needs with patients and their families. The practice liaison sees patients in a variety of settings, including at the health center, at the patient's home or at medical specialty appointments. The practice liaison may meet with a patient once or many times over a period of several weeks or months. Referrals generally request help connecting a patient to outside services, which commonly include dentists, homeless shelters, transportation, food programs, ophthalmologists, prescription plans or nursing homes.

An important aspect of the practice liaison's role is to assist patients in securing the home-based services necessary to remain in the community. For elderly patients and those with worsening disabilities, this may involve enrolling the patient with a long-term case management agency, beginning a program of delivered meals, securing transportation appropriate to the patient's level of mobility and initiating homemaking and personal care services. The practice liaison works closely with the Adult Medicine inpatient nurse-case manager to facilitate services for patients upon discharge. Many Chelsea patients arrive in the community from other countries with existing disabilities and require assistance enrolling in appropriate programs, such as Social Security, Medicare and adult day health, and many patients lack education around their rights to benefits.

The practice liaison also responds to requests from providers to locate patients who have a condition requiring treatment, but have failed to keep their appointments. Most of these patients are known to have difficult home lives and many also suffer from psychological conditions. Some examples include a schizophrenic man on anticoagulation therapy who stopped coming in for blood tests, a woman with HIV who had an abnormal pap smear and a homeless man with a rare immune disorder who missed his monthly transfusion. To date, the Practice Liaison has located more than a dozen missing patients, usually through a combination of phone calls, letters and home visits.

In 2003, the practice liaison received **470 referrals, initiated 1204 contacts and made 27 home visits.** In a survey of clinicians in Adult Medicine, 94 percent of respondents said they were 'very satisfied' with the Practice Liaison and 100 percent reported receiving the kind of assistance they wanted.

***HIV/AIDS Program***
*Gayle Hearns, Program Coordinator*
*Vikki Segovia, Outreach Worker*

The MGH Chelsea HIV/AIDS Program provides English and Spanish services to men, women, adolescents, and children in Chelsea, Everett, and Revere. Currently, there are 349 individuals in the three communities with an HIV/AIDS diagnosis. The program targets individuals at risk of becoming infected, those who are already infected, and those affected by HIV/AIDS. The program provides culturally competent education, outreach, referral, case management, counseling, and support groups.

The overall HIV/AIDS Program is managed by a team of multi-disciplinary clinical professionals who provide a comprehensive approach to serving the needs of their clients in a community based setting. The Programs' objectives are to increase the numbers of individuals at risk of HIV infection who know their status, to reduce the number of new HIV infections, and to improve the health and quality of life of those already infected, including providing support to their family members. In 2003, well over 80 individuals and families were served, 41 of whom were from Chelsea. There is an ongoing bi-weekly support group for people living with HIV/AIDS. This group consistently has 12 core members.

The MGH Chelsea HIV/AIDS Program patient profile includes 68 percent men, 32 percent women, and seven percent children and adolescents. The leading modes of transmission include 42 percent through heterosexual sex, 28 percent through injecting drug use and 19 percent through men who have sex with men. The remaining 11 percent of patients were infected through blood transfusion, occupational exposure, peri-natal transmission, and "unknown" reasons.

In June of 2003, the Massachusetts Department of Public Health released data indicating that Chelsea has the highest rate in the Commonwealth of new HIV infections for individuals aged 16-24 years. AIDS surveillance data from 2002 from the Massachusetts Department of Public Health has identified 152 persons living with HIV/AIDS in Chelsea. The city of Chelsea has nearly three times the state rate of newly diagnosed AIDS cases, 40.7 vs. 13.9 respectively.

Chelsea's City Manager called together a task force over the summer, hosted by MGH Chelsea, to look at this troubling trend, to develop a plan to reduce the number of new HIV/AIDS infections, examine funding issues, and to improve access to services within the community for those affected by HIV/AIDS.

***Children with Special Health Care Needs***
*Ana Sanchez, DPH*
*Bobbie Goldman, DPH*

In the fall of 2001, MGH Chelsea was awarded a grant from the Massachusetts Department of Public Health to institutionalize the delivery of services for children with special health care needs. This program enhances the MGH Chelsea's ability to provide extended services to disabled children of newly arrived immigrants, low income and under-served patients. The Children with Special Health Care Needs Program provides a connection to a comprehensive array of outside programs aimed at enhancing the health care and welfare of children with complex medical needs and their families. **The program is currently serving more than 100 clients.** Cases have been referred to the program for help with school-related issues, insurance issues, mental health issues, and the need for linkages to community resources. All of the families have tremendous psychosocial problems caring for their medically complicated children.

***Reach Out and Read***
*Janice Lowe, MD, MGH Chelsea*
*Margaret Johnson, Practice Manager*

The Reach Out and Read Program was initiated at MGH Chelsea in 1997 to promote family literacy by providing quality children's books in the Adolescent & Pediatric Unit waiting areas and exam rooms. Initially the program was funded through an MGH Customer Service Grant. Since 1998, this well-received program has received annual support from the National Reach Out and Read Foundation. Expansion of the program has been achieved with donations from the Exergen Corporation, MGH Community Benefit, The Berry Fund, Pillsbury Foundation, The Kempczinski Foundation, Mellon Trust and the MGH Chelsea Stebbins Fund. A study done by a Harvard medical student intern at the end of 1998 demonstrated that parents have become more aware of the importance of reading to their children as a result of this program. **MGH Chelsea has received $50,044 in contributions for Reach Out and Read and has distributed over 30,000 new and used books since the beginning of the program in 1997.**

**Community-Based Health Care Services**

***Chelsea High School Student Health Center***
*Jordan Hampton, CPNP, MSN, MGH Chelsea*

The MGH Chelsea High School Student Health Center (SHC) has now completed its 13th year of operation. The SHC is clinically overseen by M. Sheila Desmond, MD, Chief of Adolescent and Pediatric Medicine MGH Chelsea and physician for Chelsea Public Schools in collaboration with the Chelsea Public School system, which continues to be managed in partnership with the Boston University School of Education, with Irene Cornish as Superintendent.

**Patient Care Activities.** The SHC provides confidential, comprehensive care, including physical exams, reproductive health care, mental health counseling, nutrition, preventive

health education, and treatment for acute, episodic and chronic illnesses. All Chelsea High School students are eligible to enroll in the SHC. The SHC staff collaborates with primary care providers and specialists to ensure continuity of care and appropriate follow up. Students may be seen at the SHC between 8:00 AM and 4:00 PM during school days from the last week in August to the last week in June. Students under the age of 18 years old must have signed consent from their parent or guardian to be seen at the SHC. Some of the special services provided by the SHC include classroom presentations on reproductive health for ninth grade health education classes, teaching at GAPPS (Graduation and Attendance for Pregnant and Parenting Students), the program that provides supportive services to this particularly high risk group of students, and sponsorship of the Stay in Shape group which is a project designed to address the health, nutrition, physical activity and self confidence among female students.

The number of students visiting the Student Health Center increased from 254 in 2002 to 340 in 2003. An additional 272 parental consents are on file, meaning that almost half of the student body is enrolled in the health center. The 2003 enrollment numbers represent a 33.8 percent increase in active patients from last year. There was a 57 percent increase in the total number of visits from last year. This was broken down by a 30 percent increase in nurse practitioner visits, a 196 percent increase in mental health visits and a 54 percent increase in nutrition visits.

***MGH ROCA Youth Health Center***

*Lisa Carr, MD, MGH-Chelsea*

*Lisa Watt-Doherty, CPNP, MSN, MGH Chelsea*

*Teresa Grignon, MS, RNCS, MGH Chelsea*
*Jennifer Parra, Family Planning Counselor*

ROCA, Inc. (reaching out to Chelsea Adolescents)began as a teen pregnancy prevention program in 1988 and has since grown to become a locally and nationally recognized multicultural youth, family, and community development organization. With the support of MGH Community Benefit, MGH Chelsea and ROCA, Inc. collaborated to open an on-site clinic in ROCA's 25,000 square foot state of the art facility in 1998. Recognizing that many high-risk youth do not seek medical care at facilities such as MGH Chelsea, the partnership sought to integrate health care into the arts, education and leadership programming that serves several hundred teens daily at ROCA. Whether seeking pregnancy testing or evaluating a sports injury, all young people seen at the clinic receive a comprehensive adolescent risk assessment. The MGH ROCA Youth Health Center seeks to promote health awareness in the daily lives of at-risk young people and to develop relationships between youth and health care providers. In particular, the center seeks to:

- Introduce young people to the health care system in a directed, age-appropriate fashion
- Encourage young people to take a proactive role in making healthy life choices by providing access to culturally sensitive health information
- Contribute to an improved understanding of the health needs of young people.

In 2003, the clinic experienced growth in both the number of patients cared for and in the services offered. On average the clinic providers see 5 to 10 adolescents during a session. A part-time Family Planning Counselor has been added to the team who has enhanced educational efforts and developed a client database to facilitate follow up. The Family Planning Counselor also provides group education to adolescent mothers involved with ROCA's Healthy Families Program and young people involved with La Via, ROCA's school for high-risk youth.

The increased presence at ROCA has increased referrals for medical services. In addition to providing STD testing and contraceptive services, anonymous HIV counseling and testing services are now offered. The Family Planning Counselor has assisted patients directly with their application process for medical insurance. Also, a Nurse Practitioner has been hired to work an additional clinic session. She is currently a nurse practitioner at the Charlestown High School and is enrolled in an adolescent fellowship at Children's Hospital. This position has improved access to care, and decreased wait times during clinic sessions.

Recognizing the high prevalence of mental health issues in the patients, clinic providers have worked with MGH Chelsea's Mental Health Unit to strengthen mental health services for adolescents in Chelsea. There is now a mental health nurse practitioner with dedicated time to provide on-site counseling and medication treatment for ROCA young persons suffering from depression, anxiety or PTSD. This has greatly improved access to mental health services with patients being able to access care within one week.

The clinic has also partnered with ROCA's Americorp-funded Youth Star Program to provide peer education on such topics as substance abuse, healthy lifestyles and tobacco cessation. In addition to holding problem-oriented discussions, MGH and ROCA work together on an annual health fair that mobilizes a broad array of health services for young people in Chelsea and Revere. Finally, the MGH ROCA Youth Health Center staff have recruited both Harvard Medical students and residents from the Harvard Combined Internal Medicine, Internal Medicine, and Pediatrics Program to explore both adolescent medicine and the role of community-based health care as they train for their careers.

## *Revere*

*Roger Pasinski, MD, Medical Director, MGH Revere HealthCare Center*
*Deborah Jacobson, Administrative Director, MGH Revere HealthCare Center*
*Kitty Bowman, Director, Revere CARES*
*Eric Weil, MD, Community Benefit Liaison*
*Lily Awad, MD, Community Benefit Liaison*

### Community & Health Center Background

Revere is a residential, coastal community of approximately 47,300 people. While still a predominantly white community, Revere is home to many newly arriving immigrants, including natives of Cambodia, Vietnam, the Caribbean Islands and Latin American

countries, as well as Bosnia, and Somalia. The Massachusetts Department of Education reports that the student population was 65 percent White, nearly ten percent Asian, more than 19 percent Hispanic, and over five percent Black. Almost 24 percent of Revere students come from homes where the primary language is not English, compared to the state average of 12 percent. Of Revere's 19,463 households, 14.6 percent are living in poverty. More than 12 percent receive public assistance (compared to 7.6 percent statewide).

In 1981, MGH first provided financial support for the Revere Health Center. In July 1995, the center moved to a 35,000 square foot, state of the art health care facility at 300 Ocean Avenue, directly on Revere Beach. MGH provided nearly $12 million in capital for the new center. The new facility has greatly enhanced the center's ability to serve the community and to provide a more comprehensive range of services, including lab, x-ray, and mammography, as well as specialty care. Within the last few years several units expanded including Obstetrics/Gynecology, Mental Health and most recently Physical Therapy, increasing occupancy to 50,000 square feet. In 2003, the center recorded more than 85,000 visits by nearly 17,000 patients.

**Revere CARES**
*Kitty Bowman, Director*

Revere CARES (Community Awareness, Resources, and Education to Prevent Substance Abuse) is a community coalition committed to the reduction of substance use among Revere's youth and grew out of the original community benefit-led health assessment.

The Revere CARES philosophy grew out of the basic tenets and lessons of the Healthy Communities movement.

- The challenge of substance use can best be solved at the community level by changing the environment and community norms within which Revere youth make choices about tobacco, drinking and drugs.
- The whole community must be engaged and feel ownership of the substance use problem. Only by working together toward a shared vision with a specific action plan can long-term change be achieved.
- Efforts must build on the many strengths of the community to reduce the risk factors and increase the protective factors related to substance use.

Revere CARES is based on the belief that a community that works together to send clear and consistent messages about substance abuse to teens, offers positive alternative activities, and makes appropriate services available can reduce alcohol and drug use among youth. The Coalition measures its success not only by indicators of substance use, but also in terms of community change that is sustainable for the long term.

The Coalition uses research-based strategies including education, counseling and community action to build resiliency among youth. In this context, resiliency refers to the set of characteristics in young people that enable them to make healthy choices and avoid substance use and other health risk behaviors. Research has shown that youth can

become more resilient as a result of such factors as success in school, a significant relationship with a parent or caregiver, a significant relationship with another adult member of their school or community, and/or involvement in community service. The Revere CARES program works to support and strengthen all these factors.

The Coalition numbers 160 and includes a growing and diverse group of community members, including:

Concerned parents and other adults

- Teens
- Health Care and human service providers
- Churches and other from the faith community
- Revere Police Department
- Revere Public Schools
- Revere Chamber of Commerce
- City government
- State government
- Other community group

Financial support for Revere CARES is provided by the MGH and Partners HealthCare Community Benefit programs, the MGH Revere HealthCare Center, and White House Office of National Drug Control Policy' Drug Free Communities Support Program. A director, a coalition coordinator and a youth coordinator staff the Coalition. However, the numerous Revere CARES activities are actually accomplished by the participating organizations and community at large, reflecting their commitment to a comprehensive and sustained effort to reduce substance use among the youth of their community.

***Revere CARES Measurable Results***

The long-term goal of the coalition is to reduce alcohol, tobacco, and other drug use among Revere youth by ten per cent. Data from the 1999 and 2003 Revere Teen Health Survey, a survey of teen behavior conducted by Revere Public Schools, indicate that the efforts of Revere CARES are having a positive impact in many areas.

Among high school students:

- **Tobacco use is down**. The percent of youth ever having smoked declined from 69 percent to 60 percent, representing a three per cent decrease in lifetime use of tobacco. The percent currently smoking declined from 37 per cent to 30 per cent, representing a 19 per cent decrease in current tobacco use.
- **Alcohol use is down**. Although lifetime use of alcohol is fairly stable, the percent of youth who drank alcohol during the past month declined from 59 percent to 53 percent. This is a ten per cent decrease in current drinking. The percent ever having been drunk declined (66 percent to 60 percent), representing a nine per cent decrease in ever been drunk. The percent having engaged in binge drinking dropped (41 per cent to 35 per cent), representing a 15 per cent decrease in binge drinking. Reducing underage drinking is the Coalition's major priority.

- **Marijuana use is down**. The percent of youth ever having used marijuana declined from 54 percent to 48 percent, representing an 11 percent decrease in lifetime use of marijuana. The percent currently using marijuana declined from 35 percent to 30 percent, representing a 14 percent decrease in current use of marijuana.

Of concern, fewer Revere teens reported negative consequences from adults for drug and alcohol use. This figure had been on the upswing. This may be explained by the fact that state budget cuts resulted in dramatic reductions in police and teachers in Revere. On a positive note, there was a 29 per cent increase in youth talking with adults about their alcohol or other drug use during the same period of time. Increasing communication between youth and adults about alcohol or other drug use is an important component of Revere CARES efforts to reduce substance use.

Data from the Massachusetts Youth Risk Behavior Survey, conducted by The Massachusetts Department of Education in collaboration with the Centers for Disease Control and Prevention (CDC) and the Massachusetts Department of Public Health, will not be available until spring 2004. Until the release of the state data, comparisons between Revere substance use rates and rates statewide cannot be made.

***Revere CARES Accomplishments***

The efforts of the Revere CARES Coalition have focused on three major areas:

- Public policy changes/enforcement
- Interventions
- Education, prevention and alternative activities

**Public Policy Changes**. Revere CARES has been instrumental in promoting public policies and their enforcement to ensure that a clear and consistent message about the dangers of substance use is delivered to the youth of Revere.

- ***Restrictions on additional alcohol licenses.*** In August 2003 Revere CARES successfully organized opposition to a new beer and wine license for a popular convenience store. The store is in close proximity to two other liquor stores, a block from a fully licensed pizza restaurant, next to a YMCA, and approximately 100 yards from a K-Grade Eight school. Faced with strong show of opposition, the Revere License Commission unanimously denied the application. The Coalition is also pursuing a commitment by the License Commission to develop criteria for issuing one-day liquor licenses for events where children will be present.
- ***Establishment of a Zero Tolerance Policy and Diversion Program***. In 2001 Revere adopted a Zero Tolerance Policy for losing any child to drugs or alcohol. The policy was developed by Revere CARES, in collaboration with the Revere Public Schools, city government, North Suffolk Mental Health Association, the Suffolk County District Attorney's Office, the Boston Juvenile Court, Chelsea District Court and the Revere Police Department. The Diversion Program, which demonstrates the connection between behavior and consequences, is a major

component of this policy. Youth attend six group sessions at North Suffolk Mental Health Association on decision-making, anger management, peer pressure, and drugs and alcohol, attend two AA meetings, and perform twenty hours of community service overseen by the Revere Police Department, and provide restitution where appropriate. Successful completion of the Program results in dismissal of the case without creating a permanent record.

- ***Improved enforcement of alcohol and tobacco signage ordinances***. Revere CARES, with assistance from concerned residents, continued a citywide campaign designed to convince retailers to voluntarily follow city ordinances that restrict the posting of signage, specifically banners and signs advertising alcohol and tobacco. The messages included in these advertisements contribute significantly to the mixed message youth receive about the costs and benefits associated with smoking and drinking. Teens and adults were trained in the specifics of local ordinances, mapped all alcohol and tobacco retailers and restaurants/bars, and established a schedule for conducting an audit of these establishments in early 2004. The information collected will be presented to the Policy Group with recommendations for action.
- ***Youth tobacco possession ordinance***. Revere CARES was very involved with the Five Cities Tobacco Control Collaborative, the Massachusetts Department of Public Health, Revere's Health Department and MGH Community Health Associate Tobacco Program in the development of a youth tobacco possession ordinance. The ordinance, enacted by the Revere City Council in 2002, allows the Revere Police Department to confiscate cigarettes from youth within 1,000 feet of school property and to mandate tobacco education and/or fines
- ***Smoking restrictions in restaurants***. Revere CARES played a leadership role in recent efforts to eliminate smoking in the dining areas of Revere restaurants. Again working with the partners described above, Revere CARES gathered community input, assisted with strategy development and visibly advocated for the new health regulations. The new regulations went into effect July 1, 2003, with no visible problems. Revere CARES will support additional regulations in 2004 to ban smoking in all workplaces.
- ***Home delivery of alcohol and hosting laws.*** The Policy Group has begun research on home delivery of alcohol and adult hosting of underage parties where alcohol is present. The Group is expected to complete its research and to make recommendations to the full Coalition in 2004 regarding proposed ordinances that address these important issues. The Coalition will then adopt an action plan for presentation to the Revere City Council.

**Interventions.** Revere CARES has developed a number of strategies to intervene with youth who are beginning to experiment with alcohol and other drugs and to ensure that adequate treatment services are available.

- ***Strengthening Families Program.*** In 1999 and again in 2003, the Massachusetts Department of Public Health awarded the North Suffolk Mental Health Association, in collaboration with Revere CARES, grants to develop a Strengthening Families Program. The Strengthening Families program is a science-based skill building program for families with children that focuses on

building protective factors among children and young adolescents and their parents or caregivers and reducing family related risk factors. The goals of the program are to delay the initiation of adolescent substance abuse and reduce substance abuse and other risk behaviors in teens. With the first three-year award, the Strengthening Families Program served 128 English-speaking families and 18 Khmer speaking families with children between the ages of 10 to14. With the second award of five years, the Strengthening Families Program will serve English, Khmer, and Spanish speaking families with children between the ages of 6 to12. Revere CARES staff supervise the outreach efforts and the Revere CARES Mental Health Services Group serves as the Community Advisory Board for the program.

- ***High school education and counseling.*** A substance abuse prevention and counseling program has been in place at Revere High School for the past seven years. The program includes a two semester elective course and a variety of counseling programs. The counseling program serves approximately 130 youth annually, approximately ten percent of the high school student population. It is designed to help Revere teens develop the skills necessary to avoid substance abuse and other high-risk behaviors.
- ***Building Bridges Project.*** North Suffolk Mental Health Association, Revere Public Schools, Massachusetts General Hospital Community Health Associates, and Revere CARES were awarded a three year grant by Blue Cross/Blue Shield to increase mental health services for children ages 9 to 13 and their families. Revere CARES Mental Health Services Group serves as the advisory board and assisted with the community assessment, resource mapping, and project design. The project includes better coordination of existing services, expansion of available services, increase in collaboration and community involvement, publicizing resources, and implementation of the Second Step Curriculum at the intermediate grades (fifth and sixth). The Coalition is currently working with the Revere Public Schools to determine the feasibility of implementing an age-appropriate version at the early childhood grades. The Second Steps Curriculum is a science-based program that teaches students social skills to reduce impulsive and aggressive behavior and increase their level of social competence.

**Education, Prevention and Alternative Activities for Revere Youth and Adults.**
Education, prevention and positive alternative activities for youth have been documented to prevent high-risk behavior by teens. The accomplishments achieved by Revere CARES in working with others to create these opportunities include the following:

- ***An active youth group.*** Building youth leadership skills is a key strategy of Revere CARES. A youth group known as Revere Teens CARE was established to provide educational and community service activities. The group includes approximately 12 Revere teens. Members have participated in educational programs about alcohol, drugs, tobacco, peer leadership, adult/youth partnerships and advocacy. A member of Revere Teens CARE served as a panelist for the Underage Drinking Town Meeting, spoke at the Night Out Celebration, and presented at the U.S. Department of Justice site visit. They are trained to survey

advertising practices of local merchants, and have participated in mapping of community resources. Revere Teens CARE was recognized by their peers for their efforts in the adoption of a public health regulation in Revere to eliminate smoking in dining areas.

- ***Growth of a teen center.*** The Youth Zone, a teen center operated by the MGH Revere HealthCare Center's Broadway location has expanded to three afternoons a week, has increased the number of youth served, and has a tentative agreement to expand to a second site. Presently the Youth Zone and Revere CARES are transitioning three programs to the Youth Zone, the Job Fair, the Sea Kayaking Program, and Revere Teens CARE.
- ***Summer jobs.*** Revere CARES, working in partnership with Revere Public Schools, the City of Revere and the Revere Chamber of Commerce has conducted four annual Summer Job Fairs. Each of these job fairs has attracted between 200 and 300 youth and up to 23 businesses and scores of volunteers. In prior years between 65 and 75 teens found summer jobs as a result of the job fairs. In 2003 a minimum of 25 youth found jobs, a reflection the poor economic climate. In an effort to better serve the students and the businesses, a web based job bank will replace the Job Fair in 2004.
- ***Kayaking at Revere Beach.*** Many community leaders have supported the Revere CARES Coalition in its efforts to provide positive alternatives activities for youth. Massachusetts Senator Robert Travaglini and Revere Mayor Thomas Ambrosino were both instrumental in the development of a Community Boating initiative for youth. During the past three summers, over 170 youth and 120 individuals, children and adults, participated in eighteen sea kayaking clinics and three Demonstration Days on Revere Beach. Several beach clean-up days were also sponsored as part of the program. The sea-kayaking program began in 2001 and is viewed by the community as a tremendous success. A culture of alcohol and drug abuse has developed on the beach, and bringing youth and their families to the beach for activities is seen as an important part of changing that negative culture. The Community Boating Initiative provides Revere's young people with healthy alternatives to using drugs and alcohol or other high-risk behaviors and opportunities to take appropriate emotional and physical risks to develop new skills, new relationships, and increased self-confidence and self-esteem. Additionally, the program is an opportunity to strengthen the connection between adults and youth.
- ***Community Awareness.*** The community awareness activity of the Coalition seeks to raise awareness of: the Coalition's work and activities; the Zero Tolerance Policy and Diversion Program, and; an Underage Drinking Campaign.
  - *Coalition work and activities/Zero Tolerance Policy and Diversion Program.* The Revere CARES community awareness campaign includes newspaper advertisements and op-ed pieces, cable television appearances and the placing of Revere CARES banners throughout the business areas of the city. The Mayor and Superintendent of Schools play major roles in the awareness campaign and the Revere Chamber of Commerce and local businesses have paid for many of the efforts. Finally, Revere CARES also maintains visibility

and awareness of its work by participating in all major community events and activities.

- *Underage Drinking Community Awareness Campaign.* The MGH/Partners Institute of Health Policy recently conducted a survey of 1,500 adults to measure their attitudes about adolescent tobacco, alcohol and other drug use. The purpose of the survey was to determine the need for and direction of a campaign to raise awareness about the harms of underage drinking. The survey was conducted on behalf of Revere CARES in collaboration with the City of Revere. Preliminary findings from this survey indicate that most residents consider teen alcohol and drug use to be a serious problem and that tobacco, alcohol and drugs are easy for youth to obtain.
    - 88 percent thought teens were either very or somewhat likely to have tried tobacco before age 13
    - 75 percent thought teens were either very or somewhat likely to have tried alcohol before age 13
    - 70 percent thought teens were either very or somewhat likely to have tried marijuana before age 13
    - 91 percent believe it's very easy or easy for teens to get cigarettes
    - 87 percent believe it's very easy or easy for teens to get alcohol
    - 86 percent believe it's very easy or easy for teens to get marijuana
    - 88 percent of parents of 11 to14 year old teens did not think their child had used alcohol without their permission.

In the 2001 Youth Risk Behavior Survey over 50 percent middle school teens reported they had drank and 25 percent reported that they had been drunk.

Based on the findings of the Community Survey and the 2001 Youth Risk Behavior survey Revere CARES contracted with Education Development Corporation (EDC), of Newton to develop a campaign to change community norms about underage drinking. As part of that campaign has developed a message, which will be promoted through various media in an effort to reach parents, particularly of 9 to 14 year olds. The message is:

> ***The Power of Know***
> ***What your kids are doing; Who they are with; Where they are; and When they will be home. Because you CARE. Because Revere CARES***

In addition Revere CARES conducted a special Town Meeting on Underage Drinking. Participants in the forum included the Mayor, the Police Department, School Superintendent, mental health and general health care physician experts, a youth and parents. Information was provided to the community about the physical and psychological aspects of alcohol use, its impact on learning, signs in youth that might indicate alcohol use and how to educate teens about and protect them from alcohol use. Over 30 community residents attended the forum and it was televised on the local cable television station.

**Youth Zone**
*Bill DeMars*
*Elizabeth Miller, MD*
*Debra Jacobson*

The MGH Revere Youth Zone is located in the center of Revere and provides services to youth between the ages of 10 to18. The mission of the Youth Zone is "to provide a safe place for youth to develop positive life skills, within the context of a caring environment that will better prepare them to deal with the challenges of adolescence." The Youth Zone provides a wide variety of preventive, educational, recreational and vocational planning, programs and resources that facilitate the development of the innate strengths found in all youth. The Youth Zone is based on building family and community networks through a strong, supportive environment, where youth can explore and lay the foundation for positive changes in all areas of their lives."

Services at the Youth Zone include confidential medical care, health education, homework support, arts and crafts, babysitting certification and a variety of social skills enhancement activities. Monthly parent chat group provides information and support regarding adolescent issues. The Youth Zone is open three afternoons per week. Staff include a program coordinator, two youth/outreach workers and two student interns.

Programs that have been very popular at the center include: babysitting certification, sports activities, arts and crafts, and field trips to the Science Museum, Aquarium and Canobie Lake. A variety of fund-raising activities have been held including the annual road race, a silent auction and several bake sales. The proceeds are used to support the cost of snacks and materials for the youth zone.

A nurse practitioner is available three afternoons per week to provide confidential medical care, including testing for pregnancy, sexually transmitted diseases (STD's), and HIV, and dispensing of contraceptives. Treatment for STDs is given on site, with observed therapy for increased compliance. Consistent with the American Academy of Pediatrics and the Center for Disease Control (CDC), retesting is linked to the dispensing of contraception, thus increasing treatment compliance. This is. Intake includes the collection of cell phone numbers for confidential contact, screening for partner violence, drug use, eating disorders, mental health issues, as well as access to primary care providers and health insurance. Teens are counseled on ways to discuss these sensitive subjects with their parents and health care providers. The director of adolescent medicine provides medical oversight, and the administrative director of the health center provides general oversight of the YouthZone.

Most youth live in Revere and walk to the center after school. The majority come from low-income single parent families where parents often work late to meet the needs of their homes and many deal with the complicated issues of poverty, substance abuse and domestic violence - to name a few - in their homes. Membership has grown considerably over the year with a daily census averaging between thirty-five and forty and an active membership list of one hundred and sixteen. On a daily basis approximately three to

seven youth are seen for confidential medical services. When the NP is not seeing teens for confidential services, she is working in the Youth Zone with the younger teens in health prevention, case finding, and consultation with staff.

In the coming year, the YouthZone will survey members and families on a quarterly basis. This information will be used to develop future goals and objectives for the center. The Youth Zone recognizes the importance of building community collaborations. Current relationships are with Revere Cares, Revere Public Schools and the Revere Police Dept. The YouthZone seeks seek to broaden our visibility and presence in the community by actively seeking new and supportive collaborations within Revere and the surrounding communities.

**MGH Revere School-Based Health Center**
*Rita Olans, R.N.C*
*Elizabeth Miller, MD*

MGH Revere opened the first School-Based Health Center (SBHC) at Revere High School (RHS) and the Seacoast Alternative School in fall of 2002. The SNHC provides comprehensive health care, immunizations, and mental health.

The first patient seen at the SBHC was sent for surgery. Since then, the health center has dealt with everything from eating disorders to ear infections, STD and HIV testing, sports physicals, burns and sprains. One hundred patients were seen for 251visits at the SBHC during the school year 2002-03. Services for students and their families were integrated with the MGH-Revere Health Center and included insurance outreach for uninsured patients, follow-up and referrals to Health Center physicians and nurses, mental health providers, referrals to OB/GYN for pregnancy, and radiological studies. There is also coordination with services at the YouthZone clinic.

The SBHC is conducting an 8-week course on sexuality for the Seacoast, and medical supervision for football and hockey games for Revere High School home games. MGH Revere pediatrics also provides school health services to all Revere Public Schools including same day immunizations, referral for physical exams and insurance for school entry, as well as consultative services to all city's school nurse, health and physical education teachers, and resource services for the Director of Comprehensive Health.

**Healthy Steps for Young Children**
*Harwood Egan, MD*
*Susan Curley*
*Jennifer Bronsdon*

The first three years of life is the focus of a national initiative, the Healthy Steps for Young Children Program. This approach emphasizes a close relationship between health care professionals and mothers and fathers in addressing the physical, emotional, and intellectual growth and development of very young children from birth to age three.

The program adds new members to pediatric teams--Healthy Steps Specialists, who have special training in child development--to enhance the information and services available to parents. The Specialists address major behavioral and developmental issues, and give the practice the opportunity to focus on a whole baby, whole family brand of pediatrics. In FY 2003, Healthy Steps had a total of 500 patients enrolled, including 175 new referrals. The staff had 1,800 encounters with patients, and made 224 home visits.

The Healthy Steps approach is being implemented and tested in numerous pediatric practices. MGH- Revere is one of fifteen sites nationwide selected by the Commonwealth Fund, in a local partnership with the Boston Foundation and Partners HealthCare. The nation's first, large clinical trial designed to improve delivery of developmental and behavioral services to young children has improved quality of care, enhanced communications between pediatricians and parents, and helped children receive appropriate preventive services, according to a national evaluation of the program that appears in the December 16, 2003 issue of the *Journal of the American Medical Association*.

## MGH Charlestown

*Lorenzo Lewis, MD, Medical Director*
*Margaret Carolan, Administrative Director*

MGH has a long history of involvement in the Charlestown community. In 1968, MGH worked with the City of Boston, Health and Hospital Harvard Medical School and other community partners to develop one of the first hospital licensed ambulatory care, multidisciplinary community health centers. MGH opened the "Bunker Hill Health Center" in l968 with a primary focus on children and youth. Today, MGH-Charlestown offers comprehensive services in a four-story brick building owned by the City of Boston. Last year the health center served 9,900 people in almost 52,000 visits. Charlestown, with a population of about 15,000 residents bears a disproportionate burden of disease compared to other Boston neighborhoods, particularly in the areas of heart disease and substance abuse. Following is a description of YouthCare, among MGH-Charlestown's major community commitments.

### *YouthCare*

*Scott McLeod, Ph.D., Executive Director*
*Sylvia Lewinstein, MPA, Administrative Director*
*Lori Hodgins, MSEd, Director of Training and Educational Services*

YouthCare is a family of therapeutic programs that serve school-aged children with social, emotional, cognitive and behavioral disabilities. More than 20 years ago a respected clinician from Massachusetts General Hospital began taking disadvantaged urban children with behavioral and learning disabilities to the country for weekend wilderness excursions. Through these brief adventures youngsters discovered that they were capable of overcoming obstacles, taking risks, and developing group trust and cohesiveness. These excursions grew into Camp Bunker Hill, which then grew to become

YouthCare, a range of services for children with learning and behavioral disabilities. YouthCare has also become increasingly known for its successful work with children on the autism spectrum. Today YouthCare works to improve the lives of **114 children per year** ages five through 14 through its therapeutic after school program, summer day camp program, teen options program, social skill groups and parenting support program.

YouthCare's uniqueness is found not only in the population it serves but also in its multidisciplinary approach. This approach, which complements the recreational, academic and social/cultural activities, includes: extensive structured activities; cognitive and behavioral interventions; milieu therapy; behavior management and enhancement strategies; academic enrichment; group therapy; drama therapy; and, parent skills training. A cadre of dedicated and experienced professionals strengthens this comprehensive multidisciplinary approach.

YouthCare serves children who have difficulty functioning and succeeding in non-therapeutic environments. Some of the children have either been suspended from traditional community based programs, day schools, or have been temporarily hospitalized for emotional difficulties. Children enrolled in YouthCare's programs typically present with mental health and developmental disabilities such as non-verbal learning disabilities, Asperger's disorder, attention deficit disorder, language delays, post-traumatic stress, depression and anxiety disorders.

In addition to mental health disabilities, many children face difficult social and family issues. The majority of the children come from low-income families, with many parents facing their own mental health disabilities. Nearly 50 percent of the children have or have had a parent with a significant substance abuse problem. Over 30 percent have been physically abused, sexually abused or neglected. At least 25 percent have been in foster homes or hospitalized in a psychiatric facility at some point in their lives. Close to 75 percent either receive or have received special education services. All of the youth have serious emotional and/or behavioral problems

The need for programs like YouthCare is acute. According to the Disability Law Center "there is a concerning lack of therapeutic after school programs and services for children with social, emotional and behavioral disabilities in Boston" (Mass School-Age Coalition Conference, 1999). This is supported by YouthCare's own experience. Currently **twice** the number of families applies for YouthCare's programs as it is able to accept. To the best of YouthCare's knowledge there is only one other comparable therapeutic program in the City of Boston.

**Notable Challenges and Accomplishments**

During the past year, YouthCare's success is highlighted by the following key achievements

- In September 2003, YouthCare moved to a newly renovated facility at the Charlestown Boys and Girls Club. This beautiful new facility houses YouthCare's

summer, after school and teen options programs as well as essential administrative office space.

- YouthCare has successfully raised funds to subsidize 48 socially and economically at-risk boys and girls to attend its summer program in each of the past five years.
- Six of eight elementary school aged boys and girls achieved individual and group developmental goals while participating in structured recreational, educational and social activities in YouthCare's therapeutic *After-School Program.*
- YouthCare and MGH staff have supervised ten college interns in the areas of psychology, counseling, speech communications and special education over the past two years who also successfully completed their master level programs.

**Outcomes**

YouthCare's approach has proven effective. According to a recent Parent Satisfaction survey, the summer program received a 4.29 average (on a scale from one-poor to five-excellent), on its effectiveness at meeting the children's behavioral goals. In an evaluation conducted of the children comparing their behavior at the beginning and end of the summer, over 80 percent display improvements in the areas of self-esteem, depression, and impulsiveness.

Individual and group goals are established at the beginning of the program. These are also used as indicators of success. Intended to improve social skills and group problem-solving abilities, these goals are reviewed periodically and at the end of the summer session. Goals are formulated with the input of the camper, parent and staff. Examples of such goals include: improving eye contact; keeping hands and feet to oneself; practicing routine *Stop, Think and Act* in a variety of situations; and increasing positive self-statements. Progress on these goals is monitored throughout the summer. Parents are trained and strongly encouraged to coach their child in these areas at home as well. This past summer, over three-quarters of the children exhibited signs of noticeable improvement.

**Goals for Next Year**

The move to the Boys and Girls Club will allow YouthCare to double its enrollment at its after school and teen options programs over the next year. In addition, YouthCare and the Club have begun an exciting collaboration where YouthCare will train high school mentors from the Club to work one-on-one with YouthCare's children and then help integrate them into the normalized setting of the Club. Over the next two years, YouthCare will also be serving an increasing number of children on the autism spectrum.

In addition to its school-age care therapeutic programs, YouthCare is increasingly sought for its expertise and multidisciplinary approach to helping schools, providers and parents to improve their effectiveness in working with children with complex behavioral issues. YouthCare is therefore continuing to expand its training and consultation services throughout the Boston metropolitan area. The focus of these services is on children with

Asperger's and related disorders, ADHD, social skill development, and effective classroom strategies for optimal academic, and social growth.

# Other Health Center Programs

## *MGH Community Health Associates*

*Anne Richmond, Director*

MGH Community Health Associates' mission is the delivery of comprehensive, high quality, primary and preventive health services to low income, uninsured and underserved populations who live and work in the Back Bay, Charlestown, Chelsea, Revere and Everett. To realize its mission, MGH Community Health Associates provides programmatic support, clinical supervision, fiscal grant management oversight, and technical assistance for five MGH community health centers serving more than 50,000 individuals and families annually. MGH HealthCare Centers in Back Bay, Charlestown, Chelsea, and Revere, and a family practice satellite site in Everett provide an on-site community based service delivery model. In addition, the health centers are committed to working in partnership with communities to improve the health status of the city at large.

What follows is a summary of reports for the many programs that fall under the umbrella of MGH Community Health Associates.

### ARCH: Access to Resources for Community Health

*Ming Sun, MPH*

ARCH improves access, especially electronic access, to health information and resources in the communities of Back Bay, Charlestown, Chelsea, Everett, and Revere. Resources provided by ARCH include a library, web site, information pick-up and drop-off service, computer training, Internet search courses, coordination if patient health information for the health centers, and practice support – providing health information to physicians for their patients. Since opening on December 5, 2000, over 4,500 web site hits, presentations about ARCH to over 500 individuals, 25 training sessions with hands on practice to 60 individuals, publicity, marketing and continuing education program development.

The NER National Library of Medicine and Massachusetts Board of Library Commissioners provided funding for this project

### Dana-Farber/Partners Breast and Cervical Cancer Screening Collaborative (BCSC)

*Mary Neagle*
*Eileen Manning, RN*

MGH Community Health Associates is the program and fiscal administrator for BCSC, providing programmatic support, clinical supervision, fiscal grant management oversight, and technical assistance. The goal of BCSC is to reduce breast and cervical cancer

mortality through early detection for uninsured and underinsured women age 40 and over through services in 14 health centers located in Greater Boston. Member health centers provide breast and cervical cancer screening, diagnostic, and case management services to eligible women in their community.

In FY03, the BCSC provided services to more than 1,450 women. Program enrollment data indicate that BCSC is reaching a significant number of medically underserved women: 88 percent between the ages of 40-64; 34 percent Latinas, 30 percent Black, 32 percent White, 3 percent Asian; 43 percent did not have a high school diploma; and 62 percent reported a primary language other than English.

The Mass. Department of Public Health, Avon Breast Cancer Foundation, Dana Farber Cancer Care, MGH Community Benefits, MGH Community Health Associates, National Breast Cancer Foundation, New England Region Wine Makers Association, and Partners Health Care System provided funding for this program

**Building Bridges in Children's Mental Health Care**

In September 2002, the Blue Cross/Blue Shield Foundation awarded MGH Community Health Associates, in collaboration with the MGH Revere Health Center, Revere CARES, the North Suffolk Mental Health Association, and the Revere Public Schools, a three-year grant for *Building Bridges in Children's Mental Health.*

With the goal of increasing capacity for the delivery of appropriate mental health services to middle school students and improving integration of these services, the Building Bridges program is designed to: 1) Improve communication between front line staff and mental health service providers; 2) Increase overall knowledge in the community about systems of care; 3) Facilitate and track the completion of referrals made to mental health providers from the Middle Schools; 4) Implement the *Second Step* Program (a violence prevention program) in the Middle Schools.

Blue Cross Blue Shield of Massachusetts Foundation provided funding for this project.

**CPR Training**

MGH Community Health Associates provides CPR training and re-certification to a wide array of professionals and residents of Chelsea, Revere, and Everett. Participants include MGH HealthCare Center staff, community nurses, teachers, students, parents, grandparents, day care providers, Department of Social Services workers, Cub Scouts, and other youth groups. The community program is provided four times a year at no cost to participants.

Since 1989, the program has issued more than 100 certification cards per year. Since 1999, the program has been offered in Spanish.

**Car Seat Program**

The MGH Car Seat Program was created to provide car seats (infant, toddler and booster models) and car seat training to children and their families who would otherwise be unable to afford this safety restraint. Each health center participating in the program designates an on-site contact person, who is trained in appropriate use of restraints and trains recipients of the car seats in proper installation. With a referral from primary care providers, those patients who need car seats for their children can get them from MGH Community Health Associates with or without a fee depending on their ability to pay.

Since April of 2000, the program has distributed 129 infant and toddler car seats.

**Celebrating Women, Living A Vibrant Healthy Life!**

The MGH Community Health Associates, in collaboration with the MGH Community HealthCare Centers of Back Bay, Charlestown, Chelsea, Everett, North End and Revere, the MGH Quit Smoking Service, Revere Public Schools and Revere Board of Health hosted an intergenerational event for women from the Harbor communities. The overarching goal of the event, *Celebrating Women, Living a Vibrant Healthy Life, is* to educate women about the community-based resources available to assist them to maintain good health.

Five hundred women attended the event on May 29, 2003. Dr. Mallika Marshall, WBZ Medical Reporter and Assistant Director of Urgent Care at the MGH Chelsea HealthCare Center, was the host. The event generated an increase in referrals to the MGH Pack It In and Quit Smoking Services as well as to the MGH Breast and Cervical Cancer Initiative.

The following organizations provided funding for this program: AstraZeneca Pharmaceuticals LP, Harvard Pilgrim Health Care Foundation, Harvard Center for Excellence in Woman's Health, Ladies Visiting Committee - Massachusetts General Hospital, MGH Community Benefit Program, MGH Marketing Department, Neighborhood Health Plan Partners Community Benefit Program, and Wild Oats Markets, Inc..

**Community Health Center Enhancement Grants**

Resources from the Bureau of Family and Community Health (MDPH) provide infrastructure support for community health programming to each of the MGH HealthCare Centers, including medical interpreters, outreach staff and health education.

The Mass Department of Public Health provided two grants to fund these initiatives.

**Combined Primary Care Program**

Resources from the Bureau of Family and Community Health (MDPH) provide support for primary care services in children from birth to 18 years old in each of the MGH HealthCare Centers. This includes nutrition services, mental health services, outreach to pregnant women, and obstetric services.

The Mass Department of Public Health provided funding for this initiative.

**Family Planning**

With resources from Action for Boston Community Development, the Family Planning program provides free and confidential services for adolescents in Chelsea and Revere. The services include counseling, education, diagnosis, treatment, and lab tests.

The Mass Department of Public Health/ABC provided funding for this initiative.

**HIV/AIDS Program**

The MGH Chelsea and Revere Health Centers HIV/AIDS Program provides bilingual English/Spanish services for people at risk of becoming infected, those who are already infected, and those affected by HIV/AIDS. The program provides education, outreach, referral, case management, counseling, and support groups. The overall HIV/AIDS program is managed by a team of multi-disciplinary clinical professionals who provide a comprehensive approach to serving the needs of their clients in a community based setting. The programs objectives are to increase the numbers of individuals at risk of HIV infection who know their status, reduce the number of new HIV infections, and to improve the health and quality of life of those already infected and at high risk for infection. There is an ongoing bi-monthly support group for people living with HIV and AIDS. In FY 2003, 80 individuals and families were served.

The Mass. Department of Public Health/ Ryan White Title IV Program provided funding for this program

**NHP/MGH HealthCare Center Access Project (NHP Access Project)**
*Eileen Kirk, RN*

The NHP Access Project promotes access to primary care for residents of Back Bay, Charlestown, Chelsea, and Revere. Outreach workers, called Practice Liaisons (PL), are located in primary care practices at the health centers to facilitate and coordinate linkages among patients, providers, and health resources. NHP Access is tailored to the needs of the health center. Typical activities of the Practice Liaison include: compiling and maintaining a list of community resources; establishing relationships with community agencies; accompanying patients to specialty medical visits or community agencies; and following-up on patient "no shows."

At MGH-Revere HealthCare Center, 100 percent of patients complied with the preparation for colonoscopy after working with the NHP Access practice Liaison. At

MGH-Chelsea HealthCare Center, the Practice Liaison contacted 388 newly enrolled NHP patients and arranged for an appointment with a primary care provider. At MGH Back Bay HealthCare Center, the Practice Liaison identified and contacted for follow-up 300 patients who had missed Pap smear and mammography appointments. At MGH-Charlestown HealthCare Center, the Practice Liaison spearheaded efforts and is the designated site team leader for the health center's participation in the Chlamydia Education Project, designed to ensure routine screening of adolescents.

Neighborhood Health Plan provided funding for this program.

**Pack It In: Tobacco Treatment, Outreach, and Referral Programs**
*Ann-Marie Duffy*

Pack It In provides tobacco treatment, outreach, and referral services to residents of the Back Bay, Charlestown, Chelsea, Everett, and Revere. As the only tobacco treatment service in many of these communities, Pack It In fills an important need. Building on existing services provided in MGH's health centers since 1993, Pack It In enhances the ability of providers and staff to identify, encourage, and help smokers to quit. Available to all community residents, Pack It In targets new immigrant, minority, low-income and working class populations. The program currently has outreach staff offering services in English, Khmer, and Spanish. Since 1993, more than 2,500 clients have received services from tobacco cessation programs implemented by MGH Community Health Associates.

In FY 2003, Pack It In reached more than 1,025 individuals through case finding, individual and group counseling, lectures, nicotine replacement therapy, and referral services; conducted 20 daytime and evening tobacco treatment support groups serving a total of 142 individuals; conducted 14 hypnotherapy sessions for 325 participants; and offered presentations and workshops to throughout the community.

In October of 2002, the Department of Public Health terminated all funding for smoking programs across the state. Since that time the program has been supported by the MGH, MGH Community Benefit, and the Neighborhood Health Plan.

**School-Based Health Centers**

This program successfully obtained funding to develop the first school based health center in Revere that opened in October 2002. The program also supports the SBHC at Chelsea High School currently operating in its thirteen year. Services provided include primary care, mental health counseling, prevention education, violence prevention, and assistance with health insurance enrollment. The program seeks funds and uses them to establish and support health centers and health promotion programs in local schools.

The Mass Department of Public Health has provided funding through December 31, 2003 only. Additional support is pending.

**Smart Choices For Charlestown**

The Smart Choices for Charlestown was developed as a program for the Massachusetts Biomedical Research Corporation (MBRC) to give back to the community when it moved into the Charlestown waterfront. MBRC is a subsidiary research corporation of MGH. Smart Choices is designed to help Charlestown agencies meet the health and human service needs of the community. Each year the program awards one-year grants of up to $25,000. MGH Community Health Associates coordinates the application process.

In 2001, twenty-one community agencies were awarded a total of $200,000, up from $180,000 the previous year. In general, funds are used to augment or support existing programs.

The Massachusetts Biomedical Research Corporation funds these community grants.

**Stay in Shape**
*Ming Sun, MPH*

*Stay In Shape* is a voluntary ten-week/20-session fitness program for female adolescents at Chelsea High School. The goals of the intervention are to enhance positive body image, increase knowledge of health and nutrition, and promote healthy eating and regular exercise.

Participants include African, African American, Cape Verdi, Latina, and white adolescent females. Attendance ranged from three to eighteen participants in a given session; seven adolescents attended the entire program. To encourage more and consistent participation, the Fall 2001 program offered extra academic points toward gym and health classes to those participants who attend regularly. As of December 2003, 48 students had earned these extra academic credits who signed up in September, six participants had earned these extra academic points.

Blue Cross Blue Shield of Massachusetts Jump Up and Go Program and Chelsea Public Schools provide funding for this program.

## *North End Community Health Center (NECHC)*

*John Foster, MD - Medical Director*
*James Luisi - Executive Director*

The North End Community Health Center (NECHC) delivered care to individuals and families living and working in the North End and surrounding areas for over 30 years. In July 2000, the health center formally affiliated with Massachusetts General Hospital (MGH). The NECHC provides primary care, behavioral health care, dental services,

obstetrics and gynecology, vision services. Special programs include an adult day service center, health education programs, a children's center, personal care/homemaking, transportation services, a teen clinic, and a youth outreach program. The Health Center also provides radiology and laboratory services on-site. In the last year, the Health Center has provided care to nearly 11,000 patients through almost 50,000 visits.

During the past year, the NECHC participated in the U.S. Bureau of Primary Health Care's National Disease Collaborative Program to enhance the care provided to diabetic patients in all age groups.

NECHC is in the process of expanding an outreach program to enhance their ability to serve all residents of the neighborhood including newcomers, newly arrived immigrants, those not currently engaged in a health care delivery system, the uninsured, and those who are low-income and underserved. Because the program will build on a comprehensive array of services that will complement the primary care provided by the health center, residents will be offered a system of care that extends beyond traditional medical services and incorporates a public health approach.

NECHC is a licensed independent, non-profit corporation. It is a Federally Qualified Health Center, and receives partial funding under the Public Health Service Act Section 330. As an affiliate of MGH, it is one of six community health centers serving communities in and around Boston. The Health Center has recently completed its third JCAHO survey, and has been successfully accredited once again.

### *MGH Back Bay HealthCare Center (formerly Boston Evening Medical Center)*

The MGH Back Bay HealthCare Center, formerly Boston Evening Medical Center, founded in 1927 by a young Romanian immigrant, has a long history of reaching out to the underserved. Over the past year (FY 2003) the health center served more than 4,000 individuals and families in more than 12,000 visits. The MGH Back Bay HCC provides primary care, mental health, cardiology, community health education and outreach, developmental/behavioral pediatrics, health education, HIV counseling and testing, laboratory, nutrition, pediatric and adolescent medicine, physiatry, social services, substance abuse education and prevention, and tobacco cessation and education.

The MGH-Back Bay HealthCare Center reaches out to the community in order to serve all residents, including newly arrived immigrants, linguistic minorities, those not currently engaged with the health care delivery system, the uninsured and those who are low income and underserved. Health center staff are fluent in English, Spanish, and Vietnamese. Because the outreach program is built on a comprehensive array of services that complement the primary care provided at the health center, care extends beyond traditional medical services and incorporates a public health approach.

Program highlights from the past year include:

- **Reach Out and Read** – Reach Out and Read is a national program that seeks to make early literacy an integral part of pediatric primary care. Pediatricians encourage parents to read aloud to their young children and give books to their patients to take home at all pediatric check-ups from six months to five years of age. Parents learn that reading aloud is the most important thing they can do to help their children love books and to start school ready to learn. The program supports the purchase of children's books in large quantity and in multiple languages.
- **Healthy Kids Talks for Parents and Families** – Bimonthly programs focus on the cognitive, developmental, and emotional development of children from birth to three yeas. The program includes a series of presentation/discussion groups for parents. Onsite childcare is provided for the events, which have been well attended and enthusiastically received. Topics offered to parents included: *Constructive ways of Expressing Anger; Things Kids Do That Drive Us Nuts!; Temperament; Self Esteem; Toilet Training; and Effective Communication Skills*. These programs are offered to staff from local preschool and daycare centers and the parents of children attending these programs.
- **New Pediatric Patients & Families** – Practice provides a copy of the *Care of Your Child from age 0 – 5 years* to each new patient.
- **Diabetes Education** - A diabetes nurse educator continues to provide diabetes education to clients of the HealthCare Center.
- **Patient Practice Liaison** – Through the Neighborhood Health Plan Quality Access grant, MGH Back Bay has an outreach worker who works as a member of the team with the primary care and mental health practices. Referrals are made for high-risk patients and she is able work with patients to create a care coordination plan in addition to working with patients who may be in immediate crisis.
- **Dana-Farber/Partners Cancer Care Breast and Cervical Cancer Screening Program** - The program is funded by the Massachusetts Department of Public Health and provides free breast and cervical screening at the healthcare center to low income, underinsured, or uninsured women ages 18-64. The clinical coordinator works very closely with clinicians at the health center to identify and follow up with women who are eligible for the program.

# Boston and Beyond

## *MGH/Boston Public School Partnerships*

*Candace Burns, Director, MGH/BPS Partnership Program*

MGH has worked with the Boston Public Schools to expose underserved and underrepresented youth to opportunities in science and healthcare careers for more than 15 years. MGH sustains this commitment not only because it is the right thing to do, but also as a strategy to develop a diverse future workforce. Labor shortages in highly skilled professions such as nurses and radiology technicians are projected to be a major challenge for health care for some time to come. In addition, MGH is committed to increasing the ethnic and racial diversity of its staff to become more

culturally competent. One strategy for achieving these goals is collaboration with Boston Public Schools (BPS) to create a pipeline of candidates to meet the ever-changing workforce demands.

MGH/Boston Public School Partnership programs work to enhance science and health curricula while fostering students' career exploration and skill development. Through partnerships with the James P. Timilty Middle School in Roxbury and East Boston High School -- both designated effective-practice schools by the Boston's School Superintendent as centers for innovation in public education -- the community benefit program is bringing a new perspective to the hospital's teaching mission.

**MGH/James P. Timilty Middle School Partnership**
*Valeria Lowe-Barehmi, Principal*
*Jamila Tolbert, Science Connection Administrative Coordinator*
*Susan Berglund, Science Connection Program Manager*
*Wanda Velazquez, Summer Works, Project Coordinator*

Since 1989, MGH has been a partner of the James P. Timely Middle School located on historic Fort Hill in Roxbury. The goal of the partnership is to enhance the academic performance and expand the career horizons of the more than 600 students by working with students, teachers, administrators and families. The collaboration also greatly enhances the professional lives of the MGH scientists, physicians, and employees who volunteer their time to the program.

The core of the partnership is the **Science Connection Program**, funded by the Howard Hughes Medical Institute (HHMI). The overarching goals of this academic achievement program are to stimulate an interest in science and to create positive relationships between the students and caring adults. In the 2002-2003 academic year, the Science Fair Mentoring Program, a component of the Science Connection, paired 31 students with 39 MGH science fair mentors with whom they spent every other Friday morning on the MGH campus for four months. The partnership also recruited 82 judges, 49 of whom were from MGH or Partners, for the four-day school-wide science fair. As in the past decade, the mentoring students produced award-winning science projects through this mentoring, including one first place, two second place, and one third place award, along with one honorable mention award, in the Citywide Science Fair. The first place winner was also awarded the Ann Hamadeh Engineering Award. Winners were invited to participate in the Massachusetts State Fair for Middle Schools.

The Timilty Science Connection program provides professional development and curriculum support for science teachers at the school through weekly grade level curriculum sessions and science department meetings. The program manager, an experienced science teacher and teacher trainer, works with the teachers on cooperative learning strategies, curriculum development, differentiated instruction, materials management, assessment strategies and science fair preparation. The partnership also works in conjunction with the BPS Science Department to support implementation of new inquiry-based science modules.

During the summer of 2003 the program manager created lessons to support the state technology/engineering standards. These lessons were implemented by a Timilty science teacher in a class of sixth, seventh and eighth grade students. The program manager also worked with the teacher to pilot a new science module, Models and Designs.

**Science in the Classroom (SiC)** was piloted last year in one sixth grade classroom. SiC brings MGH scientists and clinicians into classrooms to present hands on, inquiry-based activities, which enhance the unit of study being taught by the classroom science teacher. SiC offers content enrichment and a modeling of inquiry methods. During 2002-2003 a post-doctoral researcher from the Molecular Biology department presented two Science in the Classroom lessons. She modeled appropriate lab techniques and facilitated group activities with a total of 80 students for each lesson. Over the next four years the SiC model will be a part of all science classes at the Timilty.

The **SummerWorks** program provides employment opportunities for Timilty eighth graders. SummerWorks is a career exploration/summer employment program that combines an interactive educational curriculum with exposure to worksites at the Massachusetts General Hospital. SummerWorks introduces graduating eight graders from the James P. Timilty Middle School in Roxbury to career opportunities and promotes positive work habits. In 2003, half of the students participating in the Summerworks program were once students of the Science fair mentoring program.

In the summer of 2003, twelve interns selected through a rigorous application and screening process completed the comprehensive program, which consisted of weekly workshops, and job placements within various departments throughout the hospital. Students must be at least 14 years of age, not attending summer school, and able to participate in the program through its completion. Teacher recommendations and interviews with human resource staff are completed prior to the selection of the interns.

All selected interns participate in job-readiness workshops that are based on the nine school-to-career competencies: communication and literacy, organizing and analyzing information, problem solving, using technology, completing entire activities, acting professionally, interacting with others, understanding all aspects of the industry, and taking responsibility for career and life choices.

Student interns met regularly with the program manager who monitored their progress and assisted them with their transition from the classroom to the workplace. Students were placed in departments such as: the Center for Clinical and Professional Development, Police and Security, Information and Ambassador Services, the Bulfinch Medical Group, and the Photography Lab.

**MGH/East Boston High School Partnership**
*Michael Rubin, Headmaster*
*Galia K. Wise, Manager, MGH/East Boston High School Partnership*

***ProTech Program***

For more than a decade, the MGH has been an industry partner for ProTech, a multi-year School-to-Career program through the Boston Private Industry Council that combines classroom instruction and work-based learning to prepare high school juniors and seniors for the workplace. Every year, 24 ProTech interns are employed in clinical departments such as Patient Care Services, radiology, and histology. For twenty months starting in January of their junior year, students work alongside MGH staff and employees where they contribute as team members in supportive work environments that foster mutual professional growth among students and their department colleagues.

EBHS has a Health and Human Services Pathway for juniors and seniors considering a career in health care. The pathway reflects system-wide efforts underway throughout the BPS to establish small learning communities within schools. East Boston's Health and Human Services Pathway includes courses like anatomy and physiology and health professions technology, supplemented by an integrated English language arts and science curricula designed to complement and strengthen the school's health curriculum.

A competitive process is used to select students from EBHS for ProTech, including a program application, attendance and academic records, teacher recommendations and interviews with MGH Human Resources staff and department managers. Students also participate in a series of mandatory pre-ProTech, School-to-Career activities prior to applying to ProTech to ensure this is the right program for them. In 2003 the first EBHS ProTech interns graduated. All ten graduates were accepted into post secondary institutions, and six of the ten graduates are/will be pursuing programs in health. In addition, six of the ten graduates were hired as permanent part-time employees in the department in which they interned, while attending college full-time.

***Classroom at the Workplace Program***

In Summer 2003, MGH participated in the Private Industry Council's Classroom at the Workplace, along with **19** other Boston companies. Initiated in 1999, Classroom at the Workplace provides academic instruction to students who failed the Math and/or English portions of the MCAS, the state's high stakes test required to graduate high school. The class of 2003 was the first to face this graduation requirement. During Summer 2003, as part of their workday, 19 East Boston High School juniors and seniors received paid academic instruction for 90 minutes each day. Nine out of the above 19 students passed the MCAS.

Thousands of Massachusetts's students were not able to attain their high school diplomas in June 2003 as a result of not passing the 10th grade-grade English and/or math portions of the exam. Without a high school diploma, many of these students were not able to apply to colleges or find sustainable employment. In an effort to assist with this crisis, MGH has extended the program into the school year to provide seven East Boston High School graduates (class of 2003) with additional MCAS support until the re-test in March 2004.

***Youth Summer Jobs Program***

For more than a decade, the MGH has provided Massachusetts youth part-time (25 hours per week) summer employment throughout the hospital. The Youth Summer Jobs Program links Massachusetts youth, including Timilty alumni, students from East Boston High School and other Boston Public schools with job opportunities at the MGH.

As the city's largest private employer, the MGH recognizes a responsibility to provide meaningful employment opportunities to Massachusetts Youth. Each year, through employment programs, SummerWorks, ProTech, and Jobs for Youth (J4Y), the MGH provides young people with employment in supportive work environments with supervisors and colleagues who help students develop positive work habits. In the summer of 2003, MGH hired **139 Massachusetts youth, 109 of whom were from Boston.** Seventy-five of the 109 were students from East Boston High School, MGH's partner high school. MGH health centers in Chelsea, Revere and Charlestown also participate.

In preparation for summer jobs and prior to being hired at MGH, students participated in professional development workshops, a mandatory program orientation and interviews with MGH Human Resources. Supervisors also received a program orientation and training on how to work with youth. Following the 2003 summer jobs program, eleven students were hired into permanent full and part-time positions at MGH.

## *HAVEN*

*Evelyn Bonander, MSW, Director, Social Services*
*Bonnie Zimmer, LICSW, Director, HAVEN*

**Mission and Purpose**

The mission of HAVEN at MGH is to:

***"Work as part of a broader community response to end intimate partner abuse by improving and enhancing our institutional response and care to patients and employees whose lives have been impacted by domestic violence."***

HAVEN trains doctors, nurses, social workers and other health care providers to ask patients

about partner abuse sensitively and effectively. If a patient discloses abuse, the clinician offers the services of a HAVEN advocate. The role of the advocate is to support and empower survivors to better understand the dynamics and impact of abuse, increase their safety, review available choices, and heal from the abuse in their own lives and the lives of their children. HAVEN was created in 1997 through a community benefit-led initiative and was inspired by feedback from the community that violence was a key concern. The hospital further came to understand that domestic violence has a significant impact on patient health status and medical utilization.

**Client Services**

Since 1997, HAVEN has provided advocacy services to over 2,460 clients, and provided over 2,725 consultations to clinicians. In addition to ongoing individual and group advocacy services, this year HAVEN added a new group for Latina women called ***De Mujer a Mujer***. ***De Mujer a Mujer*** explores the cultural lives of Latina women and focuses on common women's health concerns including abuse in intimate relationships. HAVEN participates on the assessment team of the CHAT program at MGH Chelsea, providing evaluation and case consultation on behalf of children who have witnessed violence. HAVEN has continued to build connections with the MGH Child Protection Consultation Team in efforts to continue to address the overlap between woman abuse and child abuse. HAVEN's newly funded project in ***Participatory Photography*** (funded by a Making a Difference Grant from MGH) allows clients to use photography and accompanying prose to communicate about abuse experiences and healing processes. HAVEN plans to create permanent displays and teaching tools for the MGH community from this project.

**Employees**

An important component of the HAVEN program is assistance to employees affected by intimate partner violence. The Partners Employee Assistance Program employs a full time domestic violence specialist who, in conjunction with other EAP counselors serves employees or family members who have been affected by violence. Services included advocacy, safety planning, counseling, referral to shelters and other related services, support in the workplace, assistance with restraining orders and other legal matters, and linkages with other hospital department such as Police and Security, Human Resources, and Occupational Health. The domestic violence specialist facilitates support groups for employee survivors, with five to eight women participating in each group. Finally, the specialist provides training and education to supervisors and others on the effects of domestic violence in the workplace and strategies for dealing with it.

**Training**

HAVEN continues to train providers throughout the hospital and health centers. This year HAVEN rolled out a new screening protocol in the Gillette Center for Women's Cancers with the goals of enhancing screening and identification rates, and studying the impact of intimate partner abuse on the course of cancer care. HAVEN trains all incoming residents in the Acute Psychiatry Service of the MGH Emergency Department,

all new employee orientees to Patient Care Services at MGH, chaplains, social workers and other disciplines upon request. HAVEN serves as a placement site for a Simmons College School of Social Work intern and two Harvard Medical School volunteer interns. HAVEN interns assist with client work, co-facilitate support groups and complete individual projects to benefit the program. This year, students are working on a support group manual and an annotated bibliography on DV and pregnancy. During Domestic Violence Awareness Month in October 2003, HAVEN and the DV Working Group at MGH sponsored a weekly forum covering the following topics: Stalking, DV in the Lesbian/Gay/Bisexual/Transgendered Communities, Fathering After Violence, and Healing Through the Arts. This spring, HAVEN will co-sponsor (with the obstetrics and gynecology department) a daylong conference entitled "A Safer Start: Empowering Pregnant Women Living with Domestic Violence."

**Research**

Program evaluation research, coordinated through the MGH Institute for Heath Policy, continues to inform all aspects of program development. In addition, this year HAVEN joined other members of the Conference of Boston Teaching Hospitals' (COBTH) Domestic Violence Advisory Council in a joint research project funded by AHRQ (Agency for Health Research and Quality) testing the validity and reliability of a new client progress form to be used across COBTH affiliated domestic violence programs.

**Community Connections**

HAVEN remains an active member of the Conference of Boston Teaching Hospital's Domestic Violence Advisory Council, the Chelsea Domestic Violence Task Force, the Chelsea Department of Social Services monthly Domestic Violence Case Review meeting, the Revere Domestic Violence Task Force and SAGE Boston, a collaborative addressing the needs of abused women over the age of 60. In addition HAVEN staff sit on the Immigrant and Refugee Subcommittee of the Governors' Commission on Sexual Assault and Domestic Violence and the Jamaica Plain Tree of Life Providers Meeting, as well as the Association of Haitian Women in Boston.

**The Future**

HAVEN's re-application for funding for an advocate at MGH-Revere was accepted by the Massachusetts Office of Victim Assistance (MOVA). This new grant allows for the creation of a new initiative with the Revere High School Based Health Clinic focusing on survivors of teen dating violence. As part of the MOVA grant, *Harvard Helping HAVEN* (a program of the Office of Community Programs at Harvard Medical School) continues to provide two medical student interns per academic year who assist with program development and facilitating support groups at the Revere Health Center. In turn, the students receive monthly training and hands on experience in the domestic violence field.

HAVEN plans to continue its commitment to providing culturally and linguistically appropriate services to patients and employees of MGH. Four of our six staff are bi- or

multi-lingual and that can provide services in French, Spanish, Haitian Creole and English. This year HAVEN has embarked on work with the MGH Development Office to create a focused plan for future program growth. Our first goal is to create and fund a new position for a training and outreach coordinator for the program. Through two generous gifts received this past year from the State Street Foundation and TJX, advocacy coverage of MGH Chelsea will increase in order to better meet the needs of this thriving, active health center.

## *Child Protection Consultation Team*

*Susan Lipton LICSW*
*Alice Newton MD*
*Andrea Vandeven, MD*

The Child Protection Consultation Team was launched in 2000, with the support and collaboration of the MassGeneral Hospital for Children, the Social Services Department, the Department of Nursing and the Community Benefits Program. The need to enhance child protection services resulted from a number of factors:

- Through community health assessments conducted by the Community Benefit Program, family and community violence were repeatedly identified as top priorities.
- One response to that identified community need was to create HAVEN, a hospital-based domestic violence program. Because there is child abuse in a significant number of families where there is domestic violence, it became incumbent upon the hospital to address this issue more comprehensively.
- MGH's largest pediatric practice is in Chelsea, which has the second highest rate of reported child abuse and neglect in the state.
- Finally the growth in pediatric services at the hospital and the launching of the MassGeneral Hospital for children created an affirmative mandate to provide the highest standard of care.

The mission of the Child Protection Consultation Team is:

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

The Child Protection Consultation Team presently consists of a clinical social work coordinator and two part time pediatric specialists. Consultation from the team is available to all MGH staff regarding the assessment and management of cases, twenty-four hours a day, seven days a week. The Team interacts with and is supported by many disciplines within MGH, including clinical social workers, physicians, nurses, advocates from the HAVEN program, psychiatrists, Police and Security, and attorneys.

In addition, the Child Protection Consultation Team interfaces with multiple community agencies including the Massachusetts Department of Social Services, local police departments, district attorneys offices, and the courts. The Team also participates in a multidisciplinary, interagency committee sponsored by the Suffolk County Children's Advocacy Center. This committee has undertaken several efforts to develop suggested guidelines for consistency in practice and response by Suffolk County providers to issues of child abuse and neglect.

Following is a report on activity of the team:

| | FY03 | FY02 | FY01 |
|---|---|---|---|
| Cases of possible child abuse or neglect team became aware of | 446 | 374 | |
| Consultations to MGH providers | 384 | 301 | 136 |
| Reports of suspected child abuse and Neglect filed by Team with DSS (51 A's) | 162 | 141 | |
| 51 A's filed by other hospital staff | 52 | 67 | 55 |

The requests for consultations came from the following services: Pediatrics, Emergency Services, Obstetrics, HAVEN, Adult Medicine, Mental Health, and other services. The number of consultations has risen steadily as greater awareness of the Team and its availability has occurred. There has also been a significant increase in consultations provided to MGH's community health centers and to other community providers.

The team presents seminars to both multidisciplinary and discipline specific groups of providers throughout MGH Boston and the MGH community health centers, as well as to community agencies and organizations on the psychosocial and medical aspects of child maltreatment. This past year, the Team updated the MGH policy on the assessment and management of child abuse and neglect and provided review sessions to providers throughout the hospital community. The Team is also working with other area teaching hospitals and agencies to develop and implement a Shaken Baby Syndrome prevention educational initiative. Providing outreach and training will continue to be a major priority for the Child Protection Team in the coming year.

## *MGH Senior HealthWISE*

*Barbara E. Moscowitz, MSW, LICSW, Program Director*

*Frank D. Bellistri,* MS, RN-CS, GNP, Nurse Practitioner
*Lindy A.Wilks*, BA, Resource Specialist
*Shelley H. Amira*, MPH, Administrator

The mission of **MGH Senior HealthWISE** (**W**ellness, **I**nvolvement, **S**upport, **E**ducation) is to enhance the health and well being of older adults in Boston's West End and Beacon Hill neighborhoods. The program's design and operation reflects collaboration with the Massachusetts General Hospital's Geriatric Medicine Unit and the

Departments of Social Services, Nursing, and the Institute of Health Professions, as well as many community agencies. The chief components of HealthWISE are weekly health and wellness clinics for residents of three neighborhood housing developments, and educational and wellness programs for all older adults in the community at the hospital campus.

**Wellness Clinics**

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

The Wellness Clinics have been open for a year and a half, and meet weekly for three-hour sessions at each of the three local buildings; The Amy Lowell, Blackstone, and Beacon House. HealthWISE provides each building with appropriate medical equipment and supplies, and the service is free of charge to residents and building staff. Individuals are registered and are required to provide consent for communication between Senior HealthWISE staff and other designated healthcare providers. A number of residents are followed at the Veterans Hospital, New England Medical Center, and Boston Medical Center, in addition to MGH.

An MGH registered nurse and social service resource specialist staffs the clinics. To date, the program has enrolled **175 residents** into the program, and there have been a total of **732 nursing and social service visits**. Upon the request of building managers, the team conducts home visits to frail elders unable to attend the Wellness Center. Some of these visits have resulted in hospitalizations of individuals in crisis. Others have averted unnecessary visits to the emergency department (ED), instead triaging people appropriately to their primary care providers.

The types of nursing visits and support include, but are not limited to:

- **Screenings:** Memory loss, hypertension, cholesterol,
- **Routine:** Blood pressure check, glucose checks (diabetes)
- **Follow-Up**: Hypertension, diabetes, caregiver stress, congestive heart failure, depression, explanation of lab results, medication issues, sleep disorders, and supportive education for chronic illness management.
- **Episodic:** Anxiety, stroke, cellulitis, gait instability, leg edema, memory deficits, dysphasia, hearing loss, medication issues, chest pressure, pain, dental issues, glaucoma and urinary incontinence.

- **Home Visits:** Recent hospital discharge, medication checks, dehydration screens, home bound resident "check-in", confusion, disabling depression.
- The center staff also provides support and education to the building management and other agencies that provide services to residents in the buildings (i.e. Boston Senior Home Care).

The goal of the resource specialist is to identify individuals who are eligible for community services, and guide them through the referral process. HealthWISE has worked closely with Little Brothers- Friends of the Elderly, Match-UP Interfaith Volunteers, and Boston Senior Homecare to facilitate referrals for medical escort and homecare services. The resource specialist also assists residents with obtaining medications, adaptive equipment, and in accessing health care insurance. When Secure Horizons was terminated from MGH, the social work team met individually with residents to clarify options and collaborated with MGH to host informational sessions dealing specifically with this issue.

The social work team has responded to crisis situations in the buildings, which have included staff and resident deaths. The social work team conducted bereavement sessions for residents as necessary.

In addition to individualized attention, HealthWISE has provided health promotion programs and screenings for all residents in each of the buildings. Topics to date have included:

- Skin and foot care
- Meditation workshop
- Fall Prevention and Screenings
- Cholesterol Screenings
- Flu clinics
- Hyperthermia education
- Nutrition workshops
- Volunteer Opportunities

**Community: Programming for all Neighborhood Seniors**

***HealthWISE Lecture Series***

The program sponsors a community lecture series free to all older adults in the community. For the first lecture series in 2002, attendance ranged from 6 to 25. This year attendance has increased, and ranges from 25 to 50**!** Past program topics have included: Healthy Cooking for One, Age Appropriate Exercise, Vitamins & Supplements, Arthritis, Advanced Directives, and Grief and Loss and many others. The lectures continue to be free of charge and open to all seniors. Programs are advertised through out the community in the Beacon Hill Times, The Regional Review and the MGH Hotline.

### *Senior Supper Club*

The Senior Supper Club is a community program for individuals aged sixty and older. This program offers a 10 percent discount on food at MGH cafeterias and products from the MGH Retail Shops, which include Images Hair Salon, Flower Shop and General Store. The Supper Club hours have been extended this past year and now include breakfast.

### *Flu Clinics*

Flu clinics were offered in each of the three buildings this year. In addition, two free community flu clinics were also held in the West End and on Beacon Hill. The HealthWISE nurse and volunteer nurses from the MGH Department of Nursing staffed the flu clinics. In total, 200 elderly Boston residents were immunized this year.

### *HealthWISE and The Clubs at Charles River Park*

As a part of a new initiative for all community elders, HealthWISE has partnered with The Clubs at Charles River Park to provide special elder programming. The health club, in conjunction with HealthWISE, offers free exercise workshops for all community seniors. Programs to date include:

- "Sit to Be Fit"
- "Stretch and Relax"
- "Strengthen and Lengthen"

### *ACCENT*

Action for Boston Community Development (ABCD) was awarded a grant to provide nutrition education to low income elders who are at risk for poor nutrition. HealthWISE is a collaborating partner in the grant along with The City of Boston and Boston Medical Center. HealthWISE staff assisted in developing the curriculum for the project, which has since been effectively implemented at two other community locations. The intensive twelve-session curriculum includes education on various nutrition topics such as:

- How to read food labels
- "Good fats vs. bad fats"
- Low Sodium Cooking
- Healthy Cooking Techniques
- Food Safety
- Barriers to Healthy Nutrition

HealthWISE will be facilitating an ACCENT group beginning in January 2004.

### *Future Planning*

Future goals are to build on existing programming, which will be applied to both the needs of those attending the Wellness Clinics, and individuals who participate in the HealthWISE lecture series and community programs. HealthWISE staff is in the process of implementing a research based, evidence based, and patient driven wellness

curriculum that assists participant in identifying goals through in depth assessments. Participants will receive support to achieve their self-selected goals from the HealthWISE nurse and social work team. Programming will offer strategies to approach such issues as smoking cessation, nutrition, exercise, socialization and depression.

## *MGH Residency Community Medicine Experience*

*Valerie Stone, MD, Associate Chief, General Internal Medicine Unit, Director, Primary Care Program*
*Celina Garza Mankey, MD, Program Coordinator*

The community medicine experience was implemented in July, 2002 with support from the Department of Medicine and Community Benefits. The goals of the program are to increase medical residents' (doctors in training) awareness of and familiarity with community health programs and resources, and to provide residents with experiences in community settings, which will improve their comfort with and knowledge of diverse patients and communities. Through the experience, residents are exposed to programs serving underserved communities, and residents have the opportunity to design, carry out and complete a community health project to meet needs of a special population being served by a community program.

The experience takes place during Ambulatory Care Rotation (ACR). Primary care residents and categorical residents stating an interest spend time at community sites once or twice a week. So far, 90 primary care and categorical residents have rotated through the experience during their ACR block. Many have been to different community sites as they have rotated through ACR more than once. Five to eight residents are involved in a community medicine rotation every month.

In addition, several residents have been involved in community health projects that they have designed and implemented. Community sites and projects have included:

- Boston Health Care for the Homeless, including the Barbara McInnis, St. Francis House and Methadone clinic
- Rosie's Place
- Shattuck Hospital HIV/Hepatitis C clinic and HIV/TB clinic
- MGH Chelsea Health Center ROCA clinic (Reaching out to Chelsea Adolescents)
- MGH Charlestown Health Center including Encuentro Latino, McLaughlin and House Kennedy Center
- MGH Revere Health Center Hepatitis B project
- Codman Square Health Center Urgent Care Clinic
- South Cove Health Center
- Family Van (various sites across the city)
- Geiger-Gibson Health Center
- Boston Living Center

## *The Translation Initiative*

*Pat Rowell, Director, MGH Volunteer and Interpreter Services*
*Karin Hobrecker, MGH Interpreter Services*
*Lydia Schapira, MD, MGH-Cancer Center*

The MGH Translation Initiative was launched in October, 2003 as a pilot program to develop high quality, culturally appropriate materials in Spanish and test their impact on a number of variables, including patient satisfaction. The pilot project was carried out with the collaboration a multi-disciplinary team from the Breast Center of the Gillette Center for Women's Cancers and is currently in the final evaluation stages.

The translation specialist is now applying the model developed in the pilot to other medical specialties and to hospital translation initiatives. A translation management software package has been purchased and qualified translators for other languages are being identified to support this initiative.

Key components of this work are to give ongoing support the creation of patient forms, medical information and education materials at adequate literacy levels using plain language techniques and to help identify the information needs along each patient pathway to develop sets of materials for translation into Spanish and other languages of our diverse patient population.

## *Addictions Services, West End Clinic*

*Martha Kane, Ph.D., Director*

West End Clinic provides comprehensive outpatient services to any patient seen within the MGH system, including the health centers. These services are available in all inpatient sites including all medical floors, emergency and walk-in medical service sites. Services are available on-site to all outpatient treatment sites as well. Patients may be evaluated at the site where they are receiving medical care, or may schedule an appointment to come to the West End Clinic. West End Clinic is a part of the MGH Department of Psychiatry, and receives additional support through Partners Psychiatry and Community Benefits.

In 2003, 912 patient assessments were conducted. The average age of a patient was 40, although patients ranged in age from 15 to 87. Seventy-two percent of the patients were male, 86 percent white, 8 percent Black and 6 percent Hispanic. Services for patients include:

- Comprehensive, standardized assessment of substance use disorders for each patient referred, including patients with multiple psychiatric disorders (dual diagnosed patients)
- Treatment planning based on level of care as determined by standard criterion developed by the American Society of Addiction Medicine
- When necessary, placement into appropriate treatment sites either within or outside of the Partners system, as determined by patient need, as well as linkage to other appropriate community based services

- Coordination with primary care and psychiatric services
- Comprehensive, traditional outpatient care, including individual, group, couples and family therapy, specialized services for the dually diagnosed
- Psychopharmacologic management by psychiatrists with specialized training in managing the dually diagnosed
- Services for family members of individuals with substance use disorders, including consultation, intervention, and therapy
- Follow-up services such as additional evaluation, treatment planning and placement when requested by patients or professional staff

West End Clinic also provides services for professional staff across the MGH system. Services include:

- Consultation to staff regarding any issue of patient care related to substance use disorders
- Training on a variety of substance related topics
- Facilitation and coordination of treatment team, as necessary
- Coordination of care across the MGH system as needed

This year the efforts to integrate effective substance abuse care in both inpatient and outpatient settings have intensified at MGH. Increased numbers of patients receive routine substance abuse screenings in primary care and inpatient settings due to ongoing trainings. With the support of the Community Benefits Office, a task force was formed to evaluate the standard of care for patients needing substance abuse services throughout the hospital. As a result, new guidelines were developed for the treatment of alcohol withdrawal and implemented, resulting in heightened awareness among all medical staff of the need for screening and early intervention. Quality assurance measures will continue the process of refining the guidelines and evaluating the implementation. As a result of task force recommendations, substance abuse care in the emergency department was also enhanced by the addition of a advanced nurse practitioner position with psychiatric and substance abuse skills. Finally, additional bedside services will also be provided as a part of this increased staffing.

Efforts begun last year to initiate screening and brief intervention in primary care were extended this year to include nutrition services. A collaboration was initiated between the West End Clinic and the Nutrition Services Department via submission of a grant proposal to fund an investigation of the utility of brief screening and intervention by dieticians as a part of routine care.

The cutbacks in state services over the last two years created a shortage of acute care services for detoxification from substances of abuse. In response to this crisis, West End Clinic staff and key physicians in both community and hospital based primary care practices are working to develop effective, safe protocols for ambulatory detoxification. This effort requires close coordination between medical and psychiatric services, including collaboration on protocol and effective communication in practice.

## *The Boston Health Care for the Homeless Program*

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### Introduction to the Boston Health Care for the Homeless Program (BHCHP)

From a small grassroots project working within the hospital and shelter communities, BHCHP has created a service delivery model that offers access to quality health care for Boston's homeless individuals and families. Multidisciplinary teams of physicians, nurse practitioners/physician assistants, mental health clinicians, and case workers conduct primary care clinics each day at three major hospitals (Boston Medical Center, Massachusetts General Hospital, and Lemuel Shattuck Hospital) and to provide direct care at over 70 shelter and outreach sites. These include adult and family shelters, soup kitchens and day centers, shelters for victims of domestic violence, jails and detoxification centers, and recovery and transitional programs.

A street team cares for the "rough sleepers" who shun shelters and live under bridges, along alleyways, and on the streets. Another team serves the homeless and migrant workers who live in the backstretch barns of a local thoroughbred racetrack. Comprehensive oral health is available at three sites, and mental health services are fully integrated at each primary care site. More than 8000 homeless men, women, and children received direct health care services in over 50,000 encounters in 2002. BHCHP clinicians use a portable electronic medical record to access and input data from any site in the program.

Medical respite care was another mandate of the original coalition. BHCHP's Barbara McInnis House is a 90-bed freestanding facility dedicated to the acute, sub-acute, peri-operative, recuperative, rehabilitative, and palliative care of homeless persons who might otherwise require costly acute care hospitalization. BHCHP's medical respite program has been an innovative national model and an indispensable component of Boston's continuum of care. The Bureau of Primary Health Care of the U.S. Public Health Service has funded a 10-city pilot project to replicate respite care services in other cities. BHCHP has been responsible for convening and coordinating National Respite Care Annual Gatherings for the past four years, and over 35 respite programs have been developed in cities throughout the USA and Canada.

### BHCHP at MGH

#### *History of the MGH Homeless Clinic in the MWIU*

Among the 19 original health care for the homeless projects funded by the Robert Wood Johnson Foundation in 1985, MGH was the only academic medical center to support and conduct an on-site clinic dedicated to the special needs of homeless persons. The early goal of the MGH Homeless Clinic was to focus and coordinate the care of homeless persons already utilizing the hospital services, especially the Emergency Department. In

1988, the early success of the MGH Homeless Clinic helped BHCHP secure funds from the McKinney Act and the USPHS Bureau of Primary Health Care to significantly expand BHCHP at MGH.

***The Homeless Team: BHCHP at MGH***

The Homeless Team has been fully integrated within MGH for the past 18 years. The team maintains an active ambulatory clinic with the medical Walk In Unite five days each week. The team also assists the emergency department and the inpatient medical and surgical services with the care and safe disposition of homeless persons. In addition, the team's clinicians are members of the General Internal Medicine Unit and participants in the education and training of medical students and housestaff.

The MGH Homeless clinicians conducted direct care services at several BHCHP community-based sites including Pine Street Inn, Pilgrim Shelter, and two Beacon Hill churches that serve homeless and poor persons (St. John of God Church on Bowdoin St, and the Church of the Advent on Brimmer Street). In addition, MGH clinicians are part of BHCHP's Street Team, and regularly conduct clinics at the Boston Night Center, the Pine Street Inn Overnight Van, and directly on the streets, in alleyways, and under the bridges of Boston.

***Activity During 2003***

The team welcomed Dr. Laura Kehoe in August of 2003. Dr. Kehoe trained in internal medicine at MGH and then worked for the past two years at Cook County Hospital in Chicago. While in Chicago, Dr. Kehoe developed a homeless curriculum for medical students and residents, and conducted clinics for homeless persons in inner city Chicago. She has returned to MGH, and spends half her time with BHCHP at MGH and half as an internist at MGH Chelsea. Dr. Kehoe will add significantly to the daily presence of the team at MGH, has actively worked to bolster the team's presence on the inpatient medical wards, and will serve as an inpatient attending physician on the Bigelow Medical Service for one month each year, joining Dr. O'Connell. In addition to Drs. Kehoe and O'Connell, the remainder of the BHCHP at MGH team includes Dr. Carol Waldmann, Joseph Rampulla NP, and Jill Roncarati, PA. Dr. Monica Bharel, the Director of McInnis House, will also be attending on the Medical Service for one month each year, and will serve as a preceptor in the IMA. The two Street Team nurses, Cheryl Kane and Sharon Morrison, join the team for the Thursday Street Clinic in the MWIU to assist with the triage and disposition of homeless persons during this very busy clinic.

With the full use of the two currently available examination rooms in the MWIU, the number of primary care visits to BHCHP at MGH was 2363, a 4 percent decrease from 2461 the previous year. The team's activity accounts for approximately 10% of all activity in the MWIU. The team accounted for 72 referrals to specialty clinics. Twenty-six homeless persons were sent directly from the MWIU to detoxification units. An additional 33 patients were sent from the Homeless Clinic directly to the EW, while 9 were sent for evaluation in the Acute Psychiatric Service (APS). Three patients were

admitted directly to the inpatient medical service from the Homeless Clinic. Interestingly, 60 patients were admitted to McInnis House from the MWIU by the team during the year.

During calendar year 2003, MGH referred 96 individuals for a total of 130 admissions to BHCHP's respite care facility, the Barbara McInnis House. Fourteen (14) respite admissions came directly from the EW, while 50 came from the inpatient medical or surgical services. In addition to the 60 persons admitted to McInnis House from the MWIU, another 6 respite admissions were made from the IMA. This utilization of BHCHP's innovative respite care program continues to be an important component of the service delivery model for homeless persons, and has resulted in vastly improved coordination of care of homeless persons at MGH while offering a cost-effective and high quality alternative to prolonged acute care hospitalization.

While numbers are critically important, many intangibles contribute to excellence in the quality, consistency, and continuity of care for homeless persons. The following case captures a measure of this complexity:

*A 33-year-old woman, living on the streets since running away from her NYC home at age 12, became pregnant in July 2003. A childhood victim of physical and sexual abuse, this woman was ambivalent about motherhood because she had given up a child conceived in rape at the age of 14. She requested prenatal care at MGH, and the Street Team RN arranged the referral to Dr. Blackman. In August, she entered McInnis House and successfully detoxed from alcohol and has been sober since that time. She continued to live on the streets, where the BHCHP Street Team would follow her virtually daily, and she was faithful to each prenatal appointment. An attempt to stay at a family shelter failed in October, primarily because of her poor impulse control and he self-acknowledged angry disposition, which she used to protect herself from others. On December 8, during the annual homeless census, she was approached by the Mayor and she was placed in a family motel. She continues to do very well there, and is visited weekly by the Street Team RN. She is due to deliver in early March, and is currently working with a case manager to obtain Section 8 housing.*

### *Teaching and Education*

BHCHP at MGH remains a vital component of both the inpatient and the ambulatory care training of medical housestaff at MGH. Dr. O'Connell has been regular visiting physician on the Bigelow Medical Service since 1987, and Dr. Kehoe will now be assuming a similar role. All primary care medicine residents attend clinical sessions with Dr. O'Connell and Dr. Kehoe at the Pine Street Inn Clinic during their ambulatory rotations. Dr. Monica Bharel, recruited by BHCHP from the University of California at San Francisco, is now the Medical Director of McInnis House and holds an MGH appointment. She will be attending on the medical service for one month each year in addition to serving as a preceptor in the IMA. Many other housestaff have chosen to spend time in BHCHP clinical sites, including St. Francis House Day Shelter, Suffolk

Downs Racetrack Clinic, the Boston Night Center and the Pine Street Inn Outreach Van, and Barbara McInnis House and Betty Snead House.

BHCHP continues to be a core site for community-based training. Several first and second year medicine residents have rotated through the Barbara McInnis House, and others have worked with BHCHP physicians at Bay Cove's Methadone Maintenance Program on Canal Street. With the hiring of Dr. Kehoe, BHCHP has now employed 10 graduates of the MGH medical residency-training program, by far the most prolific recruiting source for the program.

## The BHCHP Street Team

### *Introduction*

The Street Team of the Boston Health Care for the Homeless Program (BHCHP) provided acute, episodic, primary, and inpatient care to 678 individuals "sleeping rough" in Boston during calendar year 2003. A total of 3198 medical encounters (an increase of 23 percent from 2597 in 2002) occurred in a plethora of unconventional settings: under bridges, in back alleys, on street corners, in soup kitchens and overnight drop-in centers, as well as in emergency rooms and hospitals, detoxification units, nursing homes, rehabilitation centers, and BHCHP's Medical Respite Program at the Barbara McInnis House. The information summarized below, drawn from CY01 data gathered by the Street Team, offers a glimpse into the lives of Boston's "rough sleepers" and underscores the burden of illness and complex health care utilization patterns of this unsheltered street population. These data undoubtedly underestimate the frequency and severity of illness borne by this highly vulnerable population.

### *The Street Team's Service Delivery Model*

The obstacles to health care services faced by the sub-population of homeless persons who live on the streets ("rough sleepers") are daunting. This itinerant group of men and women has difficulty tolerating the crowds and rules of the city's shelters, as well as the bureaucracy surrounding traditional hospital and health center clinics. Yet rough sleepers have extraordinarily high rates of morbidity and mortality, and face the most severe health risks from exposure to the extremes of heat and cold, trauma, violence, complex and chronic medical illnesses, persistent mental illness, and substance abuse.

BHCHP has recognized the special needs of this vulnerable population since 1986, when mortality studies from BHCHP clinicians demonstrated the need for year-round outreach services. Subsequent funding from the Department of Public Health initiated the Pine Street Inn Overnight Rescue Van, and a BHCHP physician has worked two nights a week on this van since that time. In 1996, BHCHP's Street Team was expanded to include a nurse practitioner to accompany the daytime outreach teams of Pine Street Inn, the Friends of Shattuck Shelter, and Tri-City Mental Health Center. Three years later, additional funding from the Bureau of Primary Health Care and the MGH/Partners Community Benefit Program resulted in the addition of two RNs to the MD/PA team.

This Street Team has become an innovative national leader in providing continuity of quality care to this urban population.

The philosophy of the BHCHP Street Team has been to maintain a quiet and consistent presence on the streets, seizing every opportunity for coffee, conversation, and support in order to earn trust and foster a 1:1 relationship between doctor/nurse and patient. The Street Team strives to blanket this group with intensive care management, working on daytime outreach teams, the city's nighttime drop-in center, and the overnight rescue van. This model of care respects the vicissitudes of life on the streets and seeks to make health care accessible and available in places familiar and comfortable for each individual: on park benches, in alleyways, and under bridges. Unique in the country, this Street Team is fully integrated into a citywide service delivery model, allowing a continuum of care and consistency of caregivers from street corner to ICU to respite care.

The goals and objectives of BHCHP's service delivery model have been fourfold:

- Engage the trust of this difficult and hard-to-reach sub-group and provide accessible and continuous health care services to those who assiduously avoid traditional clinics;
- Work with the shelter and human service community to reduce health risks on the streets through immediate and direct access to shelters, detoxification units, recovery programs, hospitals, and clinics
- Improve health indicators and outcomes, especially measures of primary and preventive care
- Decrease morbidity and mortality

***The High-Risk Street Cohort***

In addition to caring for 678 individuals on Boston's streets during 2003, the BHCHP Street Team provided intensive care management for a high-risk cohort of 131 individuals. Individuals who have been sleeping regularly on the streets for six months or more are eligible for inclusion in the high-risk cohort. In addition, each enrollee must have one or more high-risk conditions. These high-risk criteria have been drawn from several studies: an analysis of deaths on Boston's streets between July 1998 and January 1999; and three articles on mortality among Boston's homeless published by BHCHP in recent years.

- "tri-morbidity" of substance abuse, severe persistent mental illness (SPMI), and multiple chronic medical illnesses;
- major medical problem(s) resulting in hospital admission, multiple ED visits, or admission to McInnis House anytime during the previous year;
- three or more visits to the ED in the previous three months;
- age greater than 60 years;
- known HIV/AIDS;
- known cirrhosis, end stage liver disease, or renal failure;
- previous history of frostbite, hypothermia, or immersion foot.

### *Demographics*

The gender, race, ethnicity and age of the high-risk cohort do not differ remarkably from the street population in total or the sheltered homeless population. Seventy-nine percent are male, and 21 percent female, with 77 percent white, 13 percent black, and 8 percent Native American. The majority are between the ages of 35 and 55.

### *Burden of Illness*

While studies suggest an increased burden of illness among homeless versus domiciled populations, no studies have documented the burden of illness faced by the street population. Over the past two years, the Street Team has worked assiduously to describe and document the staggering complexity of medical and mental illness in this sub-group of homeless persons.

Ninety-eight percent of the high-risk cohort suffers from one or more chronic medical illnesses. Ninety-five percent of the high-risk cohort suffer from one or more severe and persistent mental illnesses. Ninety-six percent of the high-risk cohort abuse one or more substances. Most strikingly, 88 percent of the high-risk cohort suffer from the tri-morbidity of chronic medical illness, major mental illness, and active substance abuse.

During calendar year 2003, the street team had 1891 encounters with this high-risk cohort. Consistency of contact with the high-risk cohort requires a reliable presence on the streets complemented by aggressive follow up care when these individuals are admitted to hospitals, respite care facilities, drop-in shelters, detoxification units, and other health care, housing, and recovery settings.

In addition to face-to-face encounters with the high-risk cohort, a weekly Street Team meeting provides a critical opportunity to review the condition, treatment plan, and whereabouts of each patient in the high-risk group. This meeting allows the team members to concentrate on those patients who are ill, seeking assistance, or temporarily missing or lost to follow-up. The whereabouts and condition of 60 to 80 percent of the individuals on the high-risk list were known at each meeting.

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

As a testament to this collaborative model, the Street Team and BHCHP's research department have prospectively followed 127 persons originally identified on the high-risk street list in January 2000. On a somber note, 25 of these 127 individuals (20 percent) have died over this four-year period. This is an extraordinarily high mortality rate for a cohort with an average age in the late 30s, and underscores the risk attendant to life on

the streets. Ten individuals are now in nursing homes. Another 7 are currently incarcerated, a testament to the close intersection of homelessness with the corrections system. On the more positive side, over a quarter of this chronically homeless street population had transitioned to housing during these four years of intensive care management.

***Pattern of Health Care Services Utilization***

Within the BHCHP electronic medical record, a flag is placed in the chart of each high-risk street dweller. This flag alerts other BHCHP providers that the Street Team follows the patient and is available to assist the provider in the care, follow-up, and treatment plan. In calendar year 2003, 64 high-risk patients accounted for 219 admissions to the BHCHP Medical Respite Program at McInnis House. This compares to 200 admissions by 73 patients in 2002. A planned study will examine the utilization of the publicly funded detoxification system by this group. With the Department of Medical Assistance, the aggregate number and charges for acute care hospitalizations and emergency room visits by this population will be examined. Dr. Stefan Kertesz, a BHCHP internist who is now at the University of Alabama at Birmingham, will submit an abstract to this year's annual meeting of SGIM (Society of General Internal Medicine).

***Primary Care Indicators and Health Outcome Measures***

One major objective of the Street Team has been the establishment of a primary care service delivery model that accommodates the unique needs of this itinerant and hard-to-reach population. All previous efforts in Boston and other large cities have concentrated on the delivery of acute and episodic care, while access to continuous and coordinated care has been elusive. The Street Team has conceived and implemented a service delivery model to "rough sleepers" that offers continuity of care and is fully integrated into Boston's mainstream health care system. The program is able to track indicators such as PPD administration (50 percent), and Pneumovax (79 percent). 52 percent of the cohort received a flu vaccine during 2003. The program plans to adopt a more stringent standard of yearly PAP screenings for the female street dwellers in recognition of their increased risk of cervical cancer. An aggressive program during 2003 led to a remarkable number of women receiving timely PAP smears. Using that standard, 36 percent of the women in the cohort had mammograms and 80 percent PAP smears. Our goal is to continue to improve these primary care outcomes, despite the marked difficulties in reaching out to this very elusive population.

The BHCHP Street Team attempts to follow all women who are pregnant and living on the streets. This challenge is consuming of time and emotion, as illustrated in the two cases outlined above. During 2003, the team followed 10 pregnant women. Five healthy babies were born, while three women are still pregnant at the time of this writing. One died of placenta previa at 17 weeks. One woman has left the state and the outcome of her pregnancy is unknown.

***Deaths Among Homeless Persons, 2003***

BHCHP continue to monitor the deaths among homeless persons. An analysis of deaths during 2003 found that sixteen homeless persons died on Boston's streets, the same number as in the previous year. Prior to 1999, Boston witnessed from 20 to30 deaths among rough sleepers each year, including several due to hypothermia, often thought to be a marker for neglect. Two deaths were likely due to hypothermia during this year; no deaths were due to hypothermia in the previous two years.

Of the 16 individuals who died on the streets of Boston during 2003, all were well known to the BHCHP Street Team. Eight (50 percent) of these 16 persons had active medical records at MGH. Three had been inpatients within two weeks of their deaths, and one person had 3 ED visits in the week before he died.

***Future Plans***

Several goals have been established for the coming year in addition to the continued improvement in the primary care outcomes and the constant goal of reducing morbidity and mortality among the very vulnerable street population.

- The BHCHP at MGH team will work closely with the nursing and social service staff in the emergency department (ED) to provide intensive care for the highest utilizers. A regular meeting was initiated after it was determined that 6 of the 10 most frequent utilizers of EW services at MGH were followed by BHCHP. Indeed, all six were folks from the streets and all were well known to the MGH staff. At the end of 2003, four of the six had been in McInnis House for more than four weeks as a result of intensive efforts on the part of both of our staffs. One other man has remained sober for several months and has not been seen in the ED since October 2003. Unfortunately, the final patient was found dead on Staniford Street in early September.

- Dr. Laura Kehoe is now dividing her time between MGH Chelsea and the BHCHP at MGH team. Her role is to re-vitalize the inpatient presence and to serve as the leader in the education and teaching program at MGH. She will supervise residents at Pine Street Inn, and will join Dr. O'Connell in attending on the Bigelow Medical Service.

- Several meetings have been held with the Partners Telemedicine Department, to explore a possible linkage at the Barbara McInnis House. At the current time, Dr. Ernesto Gonzalez of Dermatology comes to McInnis House once a month to hold a didactic and a clinical session. This service has proven invaluable to the patients and to the clinicians at our respite unit, and has given impetus to pursue further access to specialty care through telemedicine. Telemedicine would allow for increased teaching at McInnis, decrease reliance on transportation, and most importantly, provide timely access to specialty care for patients whose current stays are prolonged while awaiting appointments.

# MGH Affiliated Community Health Centers

In addition to its licensed health centers, MGH works closely with other community health centers throughout the city). Collaborative initiatives are described below.

## *South Boston Community Health Center*

MGH, Partners, and South Boston Community Health Center continue to collaborate on a series of public health activities aimed at improving health status in the community. These activities, known as the South Boston Public Health Institute, consist of the health center and community residents working together to develop a community coalition to:

a) Assess the problem of substance abuse among adolescents in South Boston, and
b) Develop a comprehensive plan to address the problem.

Efforts planned for the current year include:

- Conducting focus groups with youth and parents to understand issues leading to substance abuse;
- Identifying effective outreach and intervention strategies;
- Developing a public information campaign to promote education and awareness of the adverse effects of substance abuse; and
- Selecting a science-based model of prevention that is culturally appropriate and can be adapted to best meet the needs of the population of South Boston.

## *East Boston Community Health Center*

Partners, MGH and East Boston continue to make progress in serving the needs of the residents in East Boston. As a result of the affiliation, East Boston and MGH are working on a number of improvement projects. They are as follows:

- Enhancing safety programs, such as the Toddler Home and Child Passenger Safety Programs to benefit the community.
- Developing a 340(B) designated pharmacy program to serve health center patients.
- Improving the urgent care department to better serve as the gateway for primary and specialty care for residents of the immediate and surrounding communities.
- Developing condition-specific groups for Latino children and adolescents to increase access to mental health and social services.

## *Institute of Community Health*

Massachusetts General Hospital/Partners collaborates with and provides support to the Institute for Community Health (the Institute). The Institute was founded in 2000 as a unique collaboration of Cambridge Health Alliance, the Mount Auburn Hospital of CareGroup, and Partners HealthCare. The Institute's goal is to improve the health of

Cambridge, Somerville, and surrounding cities and towns. The Institute works to improve health status through facilitation and collaborative sponsorship of community-based research, assessment, dissemination, and educational activities.

**The Institute's main areas of focus are summarized below.**

- **Overweight Prevention**. In collaboration with the Cambridge Public Schools, the Institute provides fitness and overweight screening for students in grades K–8; family education; and longitudinal data analysis and program evaluation.
- **Physical Activity Promotion**. The Institute has partnered with the cities of Cambridge and Somerville to build programs, policies, and local infrastructure that promote physical activity. Recent activities include the "Cambridge Walks" campaign, "TV Turnoff Week," and a guidebook of physical activities in Cambridge.
- **Health Information**. The Institute conducts community health assessments to address information gaps, develop programs, inform health policy decisions, and monitor trends.
- **Child Mental Health**. The Harvard Children's Initiative and the Institute recently completed a broad-based community needs assessment to identify strengths and opportunities for promoting the emotional well-being of Cambridge children.
- **Service Learning Initiative**. To advance community health education and training, the Institute actively engages graduate students from Harvard Medical School, Harvard School of Public Health, and other local universities to learn about the practice of community health.

## Access to Care

MGH is the largest private provider of free care to people without means to pay for health care in the Commonwealth. In FY2003, nearly $42 million worth of care was provided to more than 12,000 patients. Almost half of those patients came from MGH priority communities.

MGH is also a major provider of health care for patients on Medicaid, providing nearly $105 million worth of care to nearly 30,000 patients in FY2003, at a loss to the hospital of $51 million. More than half of MGH Medicaid patients were from priority communities.

# Measuring The Commitment

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

**Components of FY2003 Community Commitment**
**(in $ Millions)**
***Compiled According to the Attorney General Guidelines***

| | | |
|---|---|---|
| Community Benefit Programs | | |
| Direct Expenses | | |
| | Program Expenses | 4.0 |
| | Health Center Subsidies (Net of Uncompensated Care) | 32.0 |
| | Grants for Community Health Centers | 0.3 |
| Associated Expenses | | N/A |
| DoN Expenses | | N/A |
| Employee Volunteerism | | N/A |
| Other Leveraged Resources | | |
| | Grants Obtained | 2.6 |
| | Doctors Free Care | 7.3 |
| Net Charity Care (Shortfall plus Assessment) | | 41.0 |
| Corporate Sponsorships | | N/A |
| Total per AG Guidelines | | 87.2 |

**Components of FY2003 Community Commitment**

**(in $ Millions)**

***Compiled According to a Broader Definition***

| | | |
|---|---|---|
| Community Benefit Programs | | |
| Direct Expenses | | |
| | Program Expenses | 4.0 |
| | Health Center Subsidies(net of UC and Medicaid Loss) | 25.0 |
| | Grants for Community Health Centers | 0.3 |
| Associated Expenses | | N/A |
| DoN Expenses | | N/A |
| Employee Volunteerism | | N/A |
| Other Leveraged Resources | | |
| | Grants Obtained | 2.6 |
| | Doctors Free Care | 7.3 |
| Net Uncompensated Care – Hospitals (Shortfall plus assessment net of Insurer Contributions) | | 41.0 |
| Bad Debt (at Cost) | | |
| | Hospitals | 5.0 |
| | Doctors | 10.1 |
| Medicaid Loss (at Cost) | | |
| | Hospitals | 51.1 |
| | Doctors | 10.2 |
| Unreimbursed Expenses for Graduate Medical Education | | 43.9 |
| Linkage/In Lieu/Tax Payments | | 2.4 |
| Total Broader Definition | | 202.9 |

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

Depending upon the definition used, MGH contributed between eight percent and 18 percent of patient-care related expenses to the community in FY2003.

# Contact Information

For questions about this report, or for more information about MGH's community benefit activities, please contact:

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