St. Elizabeth's Medical Center

A STEWARD FAMILY HOSPITAL

St. Elizabeth's Medical Center
Community Benefits Plan
FY 2016

2016

Table of Contents

Our Mission Statement

Mission Statement

Steward Health Care is committed to providing the highest quality care with compassion and respect.

We dedicate ourselves to:

- *Delivering affordable health care to all in the communities we serve*
- *Being responsible partners in the communities we serve*
- *Serving as advocates for the poor and underserved in the communities we serve*

Values

Compassion:

Providing care with empathy in such a way that the person experiences acceptance, concern, hopefulness and sensitivity

Accountability:

Accepting responsibility for continuous performance improvement, embracing change and seeking new opportunities to serve

Respect:

Honoring the dignity of each person

Excellence:

Exceeding expectations through teamwork and innovation

Stewardship:

Managing our financial and human resources responsibly in caring for those entrusted to us.

Introduction

St. Elizabeth's Medical Center (SEMC) is a community hospital in Boston, Massachusetts, and is a member of the Steward Health Care System. Steward is a community-based accountable care organization and community hospital network with more than 17,000 employees serving over one million patients annually in Massachusetts, New Hampshire, and Rhode Island.

St. Elizabeth's Medical Center (SEMC) is a community-based tertiary care hospital located in the Brighton neighborhood of Boston. With 272 acute beds, St. Elizabeth's is an inpatient and outpatient facility that is also a teaching affiliate of Tufts University School of Medicine. The major clinical strengths of SEMC include family medicine, cardiovascular care, women and infants' health, cancer care, neurology care, and orthopedics. The hospital's primary service area, as defined by the Massachusetts Department of Public Health, includes the cities and towns of Allston-Brighton, Back Bay, Brookline, Newton, Waltham, Watertown, and West Roxbury, with populations totaling approximately 360,000.

St. Elizabeth's Medical Center maintains a Community Health Department that focuses on integrating care across the spectrum of hospital, primary, and community-based care. Community Health planning is led by the Director of Community Health with guidance from the medical center's Community Benefits Advisory Committee (CBAC) and representatives from the hospital's leadership team. The CBAC is comprised of hospital leadership, representatives of local health and human service organizations, city health and community centers, and schools, and guides the planning and execution of the community health initiatives. This group comes together quarterly throughout the year to provide direction on community health programming.

The results and recommendations found in our most recent Population Health Impact Report (PHIR), which are outlined in this document, are designed to be the basis for strategic community health planning actions for SEMC and its community partners.

2015-2016 Community Health Needs Assessment

In 2015-2016, SEMC completed a Population Health Improvement Report (PHIR). The purpose of this process was to use a thorough data analysis to identify the health priorities in our service area. We looked at the assets and deficits in the community so that we are better positioned to inform and improve existing programs currently in place through our collaborative community network. In addition, we were able to identify emerging health issues that may require programmatic intervention or the development of new strategies going forward.

Armed with the results of the PHIR, including feedback from a diverse focus group, our aim is to enhance the patient experience, improve population health, and reduce per capita medical costs.

The Massachusetts Department of Public Health-defined service area for SEMC was used as the geographical area for the report. This includes the cities and towns of Allston-Brighton, Back Bay, Brookline, Newton, Waltham, Watertown, and West Roxbury, with populations totaling approximately 360,000.

The extensive data for the report were pulled from online data sources (including the U.S. Census, MassCHIP, the Federal Reserve Bank, and others), from Community Provider and Community Resident Surveys that were distributed to the SEMC Community Benefits Advisory Committee and other key community based organizations, and from two focus groups comprised of community members from diverse backgrounds who shared their perspectives on important community health issues.

After compiling information from all of these sources, the PHIR was developed as a framework to guide the discussion for what St. Elizabeth's Medical Center, in close coordination with community partners, can do to improve the health of local populations.

The following is recommended as the St. Elizabeth's Medical Center FY 2016 Community Benefits Plan. The plan is a working document that may be amended at any time.

Targeted Underserved Populations

We will focus our community benefits efforts towards individuals and families who are most vulnerable due to unemployment, poverty, substance abuse, mental health illness, chronic disease, and issues related to accessing primary health care or health insurance for manageable conditions. Our data indicate that race and ethnicity play a role in disease susceptibility. We will apply resources to understanding and compensating for this phenomenon.

Community Benefits Plan

Priority 1: Farmers' Market Voucher Program

The hospital will continue its farmers' market voucher program to provide diabetic community members with vouchers that can be used at local farmers' markets to buy fresh fruits and vegetables. Since 2013, participants have been enrolled through the SEMC Diabetes Education Program, where they had one-on-one sessions with the diabetes center nurse and dietician as well as group sessions that provided instruction in healthy eating and portion control. In 2016, SEMC will continue to collaborate with St. Mary's Center for Women and Children in Dorchester, MA. This organization serves women and children who have experienced trauma and are living in poverty. St. Mary's supports 600 women and children annually with shelter, clinical and educational services, job training, employment placement, and search for affordable permanent housing. This funding assisted St. Mary's in creating a food access and education program aimed at educating women and children in residence about healthy eating through an introduction to local farmers' markets.

Target Population: Adults with Diabetes or Adults who are overweight or obese.

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Demonstrate improvement in health indicators for program participants (measurements include but are not limited to: blood pressure, waist circumference, and weight).

- Coordinate the program annually in partnership with the St. Elizabeth's Diabetes Center and the Mass Federation of Farmers' Markets.
- Increase education around food access and incorporating healthy fruits and vegetables into daily meals.

Date/Time/Location: Ongoing; participants can purchase vegetables and fruit at farmers' markets throughout the spring, summer, and fall.

Responsible Parties: St. Elizabeth's Director of Community Health; Case Manager at St. Mary's Center

Potential Community Partners: Mass Federation of Farmers Markets; Allston Village Farmers Market; St. Mary's Center for Women and Children

Estimated cost: $54,868

Priority 2: Medical Legal Partnership

Saint Elizabeth's has experienced a dramatic increase in substance abuse and Neonatal Abstinence Syndrome (NAS). A Medical Legal Partnership (MLP) will provide attorneys and paralegals to socially high-risk pregnant and parenting women (OB-GYN, Comprehensive Addiction Program). The MPL will work alongside our physicians to determine what is needed to live a healthier lifestyle e.g. food stamps, insurance, housing.

Target Population: socially high-risk pregnant and parenting women

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Integrate attorneys into OB-GYN Practice providing assistance during pregnancy to educate on the best plan of action for the fetus. Ultimately reducing the number of infants with NAS
- Assist infants with NAS and their families to get the help needed in the hospital as well as when they arrive home

- Reduce health care cost and increase reimbursement from Medicare and Medicaid

Date/Time/Location: Ongoing throughout the year in OB-GYN

Responsible Parties: St. Elizabeth's Director of Community Health; Medical Legal Partnership

Potential Community Partners: ABSATF, Charles River Community Center, Tuffs University School of Medicine Residency Program

Estimated cost: $55,190

Priority 3: Cancer Care

In most of the towns within St. Elizabeth's service area, heart disease, followed by cancer are the leading causes of death from chronic disease. The rates of cancer were either at or above the state average in all towns with available data, and Waltham and Watertown have higher percentages of deaths due to cancer. Programs providing cancer screenings are essential in early identification cancer. Identified early, the consequences of these diseases can be mitigated, reducing the number of deaths that they cause each year.

Target Population: Adults in all towns within the PSA

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Determine which types of cancer are the most prevalent across the hospital PSA.
- Determine which types of cancer have the highest fatality rates in Waltham and Watertown.
- Continue participation in regular screening programming to address the most prevalent types of cancer in the hospital's PSA.

- Continue to offer the *Chocolate and Roses* mammogram event in October.
- Continue to offer free skin cancer screenings in May.
- Educate community members about the importance of early screening as a means to cancer prevention in partnership with the American Cancer Society.
- Take part in awareness events, such as the Making Strides Against Breast Cancer walk.

Date/Time/Location: Ongoing throughout the year; locations can include the hospital, health fairs, churches, community centers, and other community venues

Responsible Parties: St. Elizabeth's Director of Community Health and the St. Elizabeth's Medical Center Cancer Care Committee

Potential Community Partners: American Cancer Society

Estimated cost: Approximately $4,000; costs associated with event planning (flyers, marketing support, giveaway items, and incentives for attending).

Priority 4: Cardiovascular Health

In most of the towns within St. Elizabeth's service area, heart disease, followed by cancer are the leading causes of death from chronic disease. Brookline and Newton have higher percentages of deaths due to heart disease than the state or national rates. Programs providing cardiovascular health and cancer screenings are essential in early identification of heart disease and cancer. Identified early, the consequences of these diseases can be mitigated, reducing the number of deaths that they cause each year.

Target Population: All

Statewide Priorities: Supporting Health Care reform; chronic disease management in disadvantaged populations; reducing Health Disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Identify partners in the surrounding communities to help create regular cardiovascular screening and education programming.

- Coordinate annual heart health screening and education events with community partners.
- Educate community members about the importance of early screening as a means to prevent heart disease.
- Coordinate with staff members to host free blood pressure screening events in the community at least monthly.

Date/Time/Location: Ongoing throughout the year; locations can include the hospital, health fairs, churches, community centers, and other community venues

Responsible Parties: St. Elizabeth's Director of Community Health

Potential Community Partners: Watertown Mall; Watertown Housing Authority; Allston Village Farmers Market; Brighton High School

Estimated cost: Approximately $4,000; costs associated with event planning (flyers, marketing support, giveaway items and incentives for attending) and compensation for event staffing.

Priority 5: Allston Brighton Health Collaborative

St. Elizabeth's will provide funding to support the Allston Brighton Health Collaborative, a collaboration of community organizations devoted to working together to promote and improve the health and wellbeing of the communities of Allston and Brighton.

Target Population: Residents of Allston and Brighton

Statewide Priorities: Supporting Health Care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Leverage greater funding resources to support community health programming that benefits the Allston and Brighton neighborhoods
- Improve access to and utilization of health resources through greater awareness of resources available

- Increase awareness and understanding of steps that can be taken to live a healthier lifestyle

Date/Time/Location: Ongoing throughout the year; locations can include the hospital, health fairs, churches, community centers, and other community venues

Responsible Parties: St. Elizabeth's Director of Community Health; Allston Brighton Community Development Corporation; Joseph M. Smith Community Health Center; Oak Square YMCA; Allston Brighton Substance Abuse Task Force.

Potential Community Partners: Allston Brighton Community Development Corporation; Joseph M. Smith Community Health Center; Allston Brighton Substance Abuse Task Force; all interested community organizations and residents

Estimated cost: $59,775

Priority 6: Farmers Market

Together with the Allston Brighton Community Development Corporation and Allston Village Main Streets, St. Elizabeth's partners each spring, summer and fall to implement the Allston Village Farmers Market, which provides fresh, healthy foods to local residents.

St. Elizabeth's utilizes the weekly market as an opportunity to promote and address healthy nutrition within its local community. A key partner in this effort is Boston University's Sargent College of Health & Rehabilitation Sciences. Their Masters level nutrition students, who are also completing their Dietetic Internships at St. Elizabeth's, participate in the program by counseling community members on healthy eating habits and recipes and doing occasional cooking demonstrations. Members of the Medical Center's nursing staff are also frequently on hand to check blood pressures and talk with local residents about the correlation between a healthy diet and overall heart health.

Target Population: Allston-Brighton community

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Enhance offering of nutrition information and resources available to market attendees.
- Include periodic cooking demonstrations as part of monthly attendance.
- Enhance community knowledge of the market and attendance at the market.

Date/Time/Location: Saturdays from May-October

Responsible Parties: St. Elizabeth's Director of Community Health

Potential Community Partners: Allston Village Main Streets and the Allston Brighton Community Development Corporation

Estimated cost: $3,000

Priority 7: Providing Access to Addictions, Treatment, Hope and Support Program (PAATHS)

In collaboration with the Boston Public Health Commission, Carney Hospital, and local community health centers, SEMC should continue to support the PAATHS Program, an enhanced resource and referral center for individuals with substance abuse disorders (SUD) -- particularly those identified as most at risk for fatal and non-fatal overdose. The PAATHS program will operate with a Navigator who will identify needed services and supports as well as provide care and linkages to care that address all of the clinical and non-clinical care needs of the individuals. The Navigator, who is stationed at the BPHC and at Carney Hospital on a regularly-scheduled rotation and who is available to SEMC as well via phone, will effectively link active drug users with clinical services that incorporate primary care, social, and mental health services and will improve engagement, retention, and adherence. The presence of a staff resource dedicated to substance abuse issues will support primary care teams at the partnering health facilities.

Target Population: Adults in the community with substance abuse disorders

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Continue to support Substance Abuse Navigator to serve as a resource for community members in need of support for their substance abuse disorder.
- Develop a network of partnerships within the substance abuse treatment community as a means of enhancing referral capabilities for patients.
- Assist BPHC in developing a real-time electronic tracking system for available beds at substance abuse treatment facilities in and around the Boston area.
- Reduce the amount of fatal and non-fatal overdoses within the St. Elizabeth's service area.

Date/Time/Location: Ongoing

Responsible Parties: St. Elizabeth's Director of Community Health; Manager, Access to Care, Bureau of Addictions Prevention, Treatment and Recovery Support Services, Boston Public Health Commission

Potential Community Partners: Boston Public Health Commission and SECAP

Estimated cost: $59,775/year

Priority 8: Partnership with the Allston-Brighton Substance Abuse Task Force

The Allston-Brighton Substance Abuse Task Force is a coalition of community agencies and residents that mobilizes youth, families, community members and leaders to prevent and reduce substance abuse among youth and adults in our community. Formed in 2003 in partnership with St. Elizabeth's Medical Center, the task force has become a recognized leader in fighting underage drinking and prescription drug abuse in the Allston-Brighton community.

Target Population: Adults and youth in the community with substance abuse disorders

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Provide ongoing support and partnership to the Allston-Brighton Substance Abuse Task Force

Date/Time/Location: Ongoing

Responsible Parties: St. Elizabeth's Director of Community Health

Potential Community Partners: To be determined

Estimated cost: $77,500

Priority 9: Behavioral Health Navigators

In 2014, as part of a Steward system-wide initiative, St. E's started a Behavioral Health Navigator program. Our navigator works with teams comprised of corporate and hospital staff to create structures and processes to support the successful integration of newly-insured behavioral health patients with primary care and outpatient services to alleviate gaps in care and provide a continuum of quality services to improve overall patient health. The Behavioral Health Navigator serves as the primary liaison for coordinating community wrap-around services for frequent users of emergency services. Through screening, the Behavioral Health Navigator provides early detection, a brief intervention, and referrals for patients with behavioral health problems (e.g., mental health and alcohol and drug-related health problems). They also provide direct services to psychiatric patients of all ages in the hospital's Emergency Department, including evaluations and level of care assessments along with other duties as assigned. The Behavioral Health Navigator is responsible for conducting appropriate assessments of the patient and providing any psychosocial intervention as needed. The Behavioral Health Navigator also accepts referrals from the outpatient areas, refers to community agencies as necessary, and provides

education and consultation to clinical staff to ensure achievement of quality outcomes.

Target Population: Adults and youth in the community with behavioral health and substance abuse disorders

Statewide Priorities: Supporting health care reform; chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Increase the utilization rate of behavioral health services among individuals within the hospital service area
- Educate community members about behavioral health and substance use programs
- Support the successful integration of newly-insured behavioral health patients with primary care and outpatient services

Date/Time/Location: Ongoing throughout the year

Responsible Parties: Behavioral Health Navigator Program Coordinator

Potential Community Partners: To be determined

Estimated Cost: $117,030

Priority 10: Community Donations

Using hospital giving guidelines, SEMC will provide financial support to our community organizations whose programs and events aid or support targeted, underserved populations. The funds are directed by the receiving organizations to best assist patients who are marginalized because of immigration status, income, lack of insurance, etc.

Target Population: Underserved, vulnerable populations

Statewide Priorities: Chronic disease management in disadvantaged populations; reducing Health Disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Continue to financially support organizations that provide continuum of care services to vulnerable populations after hospital discharge.

- Process, evaluate, and respond to all requests for support received by community organizations adhering to hospital guidelines.

Date/Time/Location: Ongoing

Responsible Parties: St. Elizabeth's Director of Community Health

Potential Community Partners: St. Elizabeth's will continue to support our community partners with annual sponsorships and will evaluate new sponsorship requests to support those that align with our Community Benefits Plan.

Estimated cost: $30,000

Priority 11: Support Groups, Classes, and Donated Space

SEMC will offer hospital space, free of charge, to community groups and organizations whose aim is to improve health and wellbeing of community members.

Target Population: Underserved, vulnerable populations

Statewide Priorities: Chronic disease management in disadvantaged populations; reducing Health Disparities; promoting wellness of vulnerable populations

Three-Year Goals:

- Respond to community needs by providing in-kind resources that are not otherwise available at no cost.
- Serve as a community resource for groups seeking space to hold meetings on health related topics.

Date/Time/Location: Ongoing

Responsible Parties: St. Elizabeth's Director of Community Health

Potential Community Partners: Various

Estimated cost: N/A

Community Benefits Advisory Council (CBAC)

Sr. Patricia Andrews, *Director, Sister of St. Joseph, Boston*
Elizabeth Browne, *Director, Joseph M. Smith Community Health Center*
William Brownsberger, *State Senator, Massachusetts*
Theresa Chiasson*, Director, Allston Brighton/Roslindale Women, Infants, Children Program*
Mark Ciommo, *City Councilor, Boston City Council*
Helen Connolly, *Project Coordinator, Allston Brighton Substance Abuse Task Force*
Sasha Corken, *Director of Community Health and Volunteer Services, Director of Human Resources (interim), St. Elizabeth's Medical Center*
Samantha Cowan, Allston/Brighton Program Director, *FriendshipWorks*
Maria DiChiappari, *Director, Boston College Neighborhood Center*
Valerie Frias, *Director, Allston Brighton Community Development Corp.*
Rosie Hanlon, *Administrative Coordinator, Jackson Mann Community Center*
Kevin Honan, *State Representative, Massachusetts*
Beth Hughes, *President, St. Elizabeth's Medical Center*
Anna Leslie, *Coordinator, Allston Brighton Health Collaborative*
Amy Mahler, *Neighborhood Coordinator, Boston City Mayor's Office*
Millie McLaughlin, *Executive Director, Veronica Smith Senior Center*
Nikkie Mulkern, *Community Health Liaison, St. Elizabeth's Medical Center*
Tom Myers, *Director, Oak Square YMCA*
Anabela C. Quelha, MSC, *Director, Disease Prevention & Education Programs, Massachusetts Alliance of Portuguese Speakers*
Nicole Sanders-O'Toole, *Account Representative, American Cancer Society*
Ruth Stone, *President, Faneuil Housing Complex*

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