2020

Carney Hospital Community Benefits

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Carney Hospital
A STEWARD FAMILY HOSPITAL

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Carney Hospital
A STEWARD FAMILY HOSPITAL


planner
Carney Hospital

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Steward

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.

About Us

Carney Hospital (Carney) is a member of Steward Health Care, the largest private, for-profit physician-led health care network in the United States. Headquartered in Dallas, Texas, Steward operates 36 hospitals in the U.S. and the country of Malta that regularly receive top awards for quality and safety. The company employs approximately 40,000 health care professionals and is recognized as one of the world's leading accountable care organizations. The Steward Health Care Network includes thousands of physicians who help to provide more than 12 million patient encounters per year. Steward Medical Group, the company's employed physician group, provides more than 4 million patient encounters per year. The Steward Hospital Group operates hospitals in Malta and states across the U.S. including Arizona, Arkansas, Florida, Louisiana, Massachusetts, Ohio, Pennsylvania, Texas, and Utah.

Since 1863, Carney Hospital has served the City of Boston and neighboring communities. Carney Hospital has received the Joint Commission's Gold Seal of Approval for health care quality and safety and numerous other quality and safety awards, including being designated a Top Hospital for 2014, 2015 and 2017 by the Leapfrog Group. The 159-bed hospital has more than 400 physicians and delivers high-quality care to our community. Carney Hospital provides Dorchester and surrounding communities with convenient, local access to quality primary care, emergency medicine and a range of specialties and subspecialties including; critical care, family medicine, cardiology, neurology, orthopedics, ambulatory care and adolescent, adult and geriatric psychiatry.

Carney Hospital operates a stand-alone Emergency Room located in the city of Quincy with on-site diagnostic radiology, including CT scans and ultrasound, pharmacy, and laboratory services. Carney Hospital is part of the Steward Health Care Network.

Carney maintains a Community Benefits Department that focuses on integrating care across the spectrum of hospital, primary, and community-based care for members in our community as well as serving as advocates to the poor and underserved in our region. A Community Benefits Advisory Committee comprised of hospital leadership, representatives of local health and human service organizations, city health departments, youth community centers, and senior centers guide the planning and execution of the community health initiatives. This plan details the health conditions and social factors affecting the people living in the communities surrounding Carney Hospital, as well as the key issues the hospital should address to support the health and well-being of the residents of the communities primarily served by Carney Hospital, which include Dorchester (02122), Dorchester (02124), Dorchester (02125), Mattapan, South Boston, Hyde Park, Braintree, Milton, and Quincy.

Community Benefits Mission Statement

Carney Hospital is committed to collaborating with community partners to improve the health status of our community residents by addressing the root causes of health disparities and educating community members around prevention and self-care, as well as providing current and potential patients with a general introduction to health care options that are accessible in their community.

Community Benefits Statement of Purpose

The Carney Hospital community benefits purpose is to improve the overall health status of people in our service area:

- Provide accessible, high quality care and services to all those in our community, regardless of their ability to pay;
- Collaborate with staff, providers and community representatives to deliver meaningful programs that address statewide health priorities and local health issues;
- Identify and prioritize unmet needs and select those that can most effectively be addressed with available resources; and
- Contribute to the well-being of our community through outreach efforts including, but not limited to, reducing barriers to accessing health care, preventive health education, screenings, wellness programs and community-building.

Community Health Needs Assessment

The 2018 Carney Hospital Community Health Needs Assessment (CHNA) was developed in full compliance of the Commonwealth of Massachusetts Office of Attorney General-The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals released in February 2018. In order to accomplish this, a multi-dimensional approach to the collection of health and social demographic information from its primary service area was conducted. In accordance with this process, Carney Hospital engaged various community partners to ensure that varying perspectives on health and social topics were taken into account in order to complete the CHNA. Below is a brief description of the actions taken to gather community data.

Health Indicators and Demographics – Data Analysis

Demographic data was collected using publicly available databases maintained by the U.S. Census Bureau, the MA Department of Early and Secondary Education (DESE) with some cross-referencing of Center for Disease Control and Prevention (CDC) databases. Health indicator data such as mortality, incidence, prevalence, and hospitalization rates were provided by the Massachusetts Department of Public Health (MDPH), and by using other state, regional and national information sources (i.e. Uniform Crime Reporting (UCR) Program of the Federal Bureau of Investigation).

Key Informant Survey

A Key Informant Survey was distributed to the Carney Hospital Community Benefits Advisory Committee, Carney Hospital and other key community-based organizations. Local health and human service organizations, government agencies, community centers, local businesses and churches were among the organizations who were sent the survey. The survey gathered key opinions about the Carney Hospital community and perceived issues within the community.

Focus Group

In order to engage community partners in the data collection process a focus group was conducted. The focus groups captured community perspectives on perceived health issues and explored barriers to health resources. In total, 11 individuals participated in the focus group. The goal was to collect information from participants that could be used to inform population health improvement strategies.

Literature Review

A literature review was conducted in order to gather information from recent governmental, public policy, and academic works. The relevant information was summarized and synthesized into a comprehensive literature review addressing the priority areas for community benefits, including: chronic disease, cardiovascular disease, cancer, diabetes, behavioral health, substance abuse disorders and housing stability/homelessness.

Findings

Chronic Disease

According to the Massachusetts Department of Public Health (MDPH), prevention and treatment of chronic disease is a public health priority. Nutrition, physical activity, and tobacco use and exposure are three key risk factors that directly impact cancer, diabetes, chronic lower respiratory disease, and cardiovascular disease rates. These chronic conditions in turn contribute to (56%) of all mortality in Massachusetts and over (53%) of all health care expenditures ($30.9 billion a year) (MDPH, 2014).

Various studies have shown that, although the three leading risk factors are modifiable, the conditions in which people live, learn, work, often traps them in an unhealthy environment. For example, a history of policies rooted in structural racism have resulted in environments in which there are inequities in access to healthy foods, safe spaces for physical activity, walkable communities, quality education, housing, employment, and health care services. The health implications of this are evident in the fact that Black and Hispanic residents of Massachusetts are consistently and disproportionately impacted by the high prevalence of all chronic diseases, as well as the related deaths and high acute care service utilization (MDPH, 2017).

Based on the Key Informant Survey conducted by Carney Hospital, respondents agreed that chronic diseases are a major issue in the community. When asked to identify the chronic diseases prevalent in their respective communities, participants noted that diabetes and cardiovascular disease were most common. Respondents noted a very low level of concern regarding cancer. Carney Hospital also conducted a focus group within their service area to engage community members in the data collection process. Diabetes and heart disease were the primary chronic disease concerns of focus group participants.

Mental Health

Data from 2015 revealed inequities across categories of age, sex, and race/ethnicity in mental health hospitalizations. The rate of mental health hospitalizations was higher for those ages 30-65 years compared with those 65 and older, males compared with females, and White residents compared with Asian, Black, and Latino residents. Mental health intersects with many areas of public health, including addiction, cancer, cardiovascular disease, and HIV/AIDS, therefore requiring common services and resource mobilization effort. Integrated treatment is critical for treating people with co-occurring disorders and can ultimately help achieve better health outcomes and reduce costs (MDPH, 2017).

To reduce the inequities of mental health conditions in Boston, interventions targeting subpopulations at higher risk of mental illness are needed. It is also necessary to educate the public about the availability of mental health services and to decrease the stigma of seeking such services. Work also must be done to stop discrimination, which impacts the mental health of those most likely to face it. Additionally, as the World Health Organization (WHO) suggests, in order to reduce the inequities in the occurrence of mental disorders, the conditions of everyday life, which are the social determinants of health, must improve (BPHC, 2017).

Substance Abuse Disorder

In 2015, there were 1,637 opioid-related deaths in Massachusetts. The rates of substance misuse deaths, unintentional drug overdose hospital patient encounters, and unique-person treatment admissions were

higher for men than women. At the neighborhood level, the rate of overall substance misuse deaths (including alcohol misuse, drug misuse, and unintentional opioid overdose/poisoning deaths) during the five-year time period 2011-2015 was higher for Dorchester (zip codes 02122, 02124), and South Boston compared with the rest of Boston (BPHC, 2017).

Individual-level risk factors such as socioeconomic status, family history, incarceration, and stressful life events are associated with drug use. Increasingly, evidence suggests that social determinants of health may contribute to one's decision to initiate drug use and shape other substance use behaviors. Additionally, addiction is a chronic neurological disorder and needs to be treated as other chronic conditions (BPHC, 2017).

Housing stability

Our data point out that race, ethnicity, and socio-economic factors are indicators of health outcomes within the region. To take this into consideration and enhance efficacy of Carney Hospital programs, Carney Hospital will focus its efforts toward individuals and families who are at greatest risk for health inequities due to socio-economic and/or sociodemographic status, lack of access to health and social services, and lack of chronic disease self-management support. Providing care coordination services and facilitating access to social services are essential components of a population health improvement strategy, as indicated by participants in the focus groups conducted in the Carney service area, and in responses gathered through the Key Informant Survey. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Treatment planning should be client-centered, addressing clients' goals and using agreed upon treatment strategies (MDPH, 2017).

Safe and stable housing provides personal security, reduces stress and exposure to disease, and provides a foundation for meeting basic hygienic, nutritional, and healthcare needs. Average income gains over the past decade have failed to keep pace with rising housing costs, pushing thousands of residents into unstable housing situations. Without consistent access to health care, homeless individuals are less likely to participate in preventive care and are much more likely to utilize the emergency department for non-emergencies. Such patterns of use are not only a burden on the healthcare system, but detrimental to personal health as well (BPHC, 2017).

Recommendations

Carney Hospital is well positioned to partner with other community-based organizations and coalitions to address the following key strategic priorities to improve health outcomes and wellness in the region:

1. Chronic Diseases
    a. Cancer
    b. Heart Disease
    c. Diabetes
2. Mental Health
3. Substance Use Disorders
4. Housing Stability
    a. Homelessness

In recognition of the need for further investments in the social determinants of health, Carney Hospital will also consider these six priorities in Community Benefits planning:

- Built Environment
    - The built environment encompasses the physical parts of where we live, work, travel and play, including transportation, buildings, streets, and open spaces.
- Social Environment
    - The social environment consists of a community's social conditions and cultural dynamics.
- Housing
    - Housing includes the development and maintenance of safe, quality, affordable living accommodations for all people.
- Violence
    - Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, with the behavior likely to cause physical or psychological harm.
- Education
    - Education refers to a person's educational attainment – the years or level of overall schooling a person has**.**
- Employment
    - Employment refers to the availability of safe, stable, quality, well-compensated work for all people.

Populations of Focus

Who we are directly impacts how we interact with our community and society. Our race, gender identity, age, disability status, etc. influences the social environment that we experience. Our social environment impacts many mental and physical health outcomes, including: mental health, violence, risk behaviors (tobacco and drug use), physical health and well-being, and disease morbidity and mortality. We are influenced by the social environment on three levels: interpersonal, community, and society (MDPH, 2017).

Across all three levels, systems of oppression such as structural racism and gender bias lead to social isolation, social exclusion, poor mental health, increased risk of violence, increased rates of poverty, higher hospitalizations, longer recovery times, and higher mortality rates for many conditions. Social isolation, social exclusion, racism, discrimination and poverty disproportionately affect low-income communities and communities of color and all negatively impact many aspects of health. Communities of color are more likely to have lower levels of resources and connectedness with other neighborhoods and higher levels of racial segregation. They also face more challenges when engaging in group action in neighborhoods to shift these conditions (Hobson-Prater T, 2012).

Cities/towns within the Carney Hospital service area generally exhibited greater diversity than the state as a whole. Notably, (86.1%) of all residents in Mattapan identified as Black or African American. With the exception of South Boston, Quincy and Braintree, each service area city/town had a greater percentage of Black or African American residents than the state average. Only Braintree and South Boston had a higher percentage of White residents than the state level. Quincy, Dorchester (02125), and Dorchester (02122) each had a higher than average percentage of Asian residents with the highest percentage being seen in Quincy at (28%). The Carney community may have a larger percentage of elevated risk individuals from these groups thus the community benefits programs of Carney Hospital will continue to target these elevated-risk groups and adjust programming based on the unique needs of the service area cities/towns.

Implementation Strategy Plan

The unprecedented coronavirus pandemic led to an urgent public health need in the community. In March of 2020, Carney was designated the first COVID 19 hospital in the nation. In a matter of days, the hospital became the leader in the community addressing COVID 19, shifting our focus from our documented implementation program and refocused on testing approximately 3,747 community members for COVID 19 and treating over 3000 patients admitted to the hospital with COVID 19 .

Although, we were unable to implement our community health initiatives and community outreach because of the coronavirus pandemic, we continued to offer our behavioral health patients the services of the BEST team and were able to screen 100% of the behavioral health patients' needing to be screened. We also continued to offer our transportation program for hardship through LYFT and were able to offer $24, 455.79 worth of rides to our patients. We continued to support the Harvard St. health center to advance health access and health equity goals of the Carney community benefits plan and with the assistance of our Financial Counselors, we were able to help 1932 individuals navigate and enroll in government sponsored health insurance programs achieving health access and equity to quality care goals.

We are currently working on resuming our normal hospital business which includes plans to resume to pre-pandemic outreach as explained in our community benefits plan.

Ever so mindful of changing needs, the hospital will continue its work with community partners, leaders, and its Community Benefits Advisory Committee to ensure that programming addresses some of the most pressing community health issues. In this Community Benefits Strategic Implementation Plan, Carney Hospital will identify the target populations it will support, specific programs or activities that attend to the needs identified in the 2018 CHNA, as well as our short and long-term goals for each program or activity. Carney Hospital will identify opportunities for innovative community-clinical linkages as well as policy/environmental and/or community-wide strategies that will create self-sustaining community supported programs.

Carney Hospital will align its community benefits priorities and goals with guidance provided by the Massachusetts Attorney General's Office and the Department of Public Health such as those identified The Massachusetts Attorney General's Community Benefits Guidelines for Non-Profit Hospitals (released February 2018). We recognize that our success in addressing community health issues present in the Carney Hospital service area will come from coordinated regional strategies with public health and population health management agencies. To prioritize the needs of our community, Carney Hospital will consider the health care problems of medically underserved and disadvantaged populations and will aim to reduce racial and ethnic disparities in health status.

Priority 1 - Chronic Disease Management and Prevention

According to MDPH, the prevention and treatment of chronic disease is a public health priority. Nutrition, physical activity, and tobacco use/exposure are three key risk factors that directly impact cancer, diabetes, chronic lower respiratory disease, and cardiovascular disease rates. These chronic diseases account for (56%) of all mortality, and over (53%) of all health care expenditures in Massachusetts ($30.9 billion a year) (MDPH, 2014).

Although these three leading risk factors are modifiable, the environments in which people live, learn, work, and play do not always offer equal access to the necessary resources or opportunities to modify these risk factors. A history of policies rooted in structural racism have resulted in environments where there are inequities in access to healthy foods, safe spaces for physical activity, walkable communities, quality education, housing, employment, and health care services. The health implications of these inequities are evident in the fact that Black and Hispanic residents of Massachusetts are disproportionately impacted by chronic diseases. These inequities are evident in the fact that the Black and Hispanic populations experience increased prevalence of, and mortality related to chronic diseases. Healthy people cannot exist in unhealthy environments. Because of this, MDPH frames its chronic disease prevention and wellness efforts around the social determinants of health with a focus on policies that ensure that all individuals have the ability to make healthy choices (MDPH, 2017).

Target Population: Those at an elevated risk of or diagnosed with chronic diseases such as cancer, heart disease, obesity, and diabetes; adult men and women; seniors; low-income families
Geographic Location: Dorchester (02122), Dorchester (02124), Dorchester (02125), Mattapan, South Boston, Hyde Park, Braintree, Milton, and Quincy
Health Indicators: Cancer, Heart Disease, Obesity, Diabetes
Gender: All
Age Group: All
Ethnic Group: All
Language: English, Haitian Creole, Vietnamese
Statewide Priority: Chronic Disease Management in Disadvantaged Populations, Reducing Health Disparity; Access to Health Care; Promoting Wellness in Vulnerable Populations
Partners: Steward Health Care Network (SHCN), Steward ACO, YMCA, Boston Senior Home, Standish Village

Short-Term Goals:

- Increase collaborative efforts with community organizations to better disseminate information related to treatment, educational programs, and available resources for those affected by cancer, heart disease, and diabetes in the community by 10% annually.
- Continue to offer a minimum of 5 community suppers that bring physicians in to discuss health living and communicate opportunities for guests to access our additional services for 360 care within Carney Hospital.
- Promote the consumption of healthy diets including fruits and vegetables with participation at local Farmers Markets and by continuing the Steward Farmers Market Voucher Program to diabetes and cardiac rehabilitation participants with the goal of supporting 50 community members and their family. Implement a participation tracking system.
- Seek a partnership with Dorchester and Quincy YMCA to promote healthy diets and physical activities for children, adults, and families with the goal of reaching 200 community members with disease prevention and/or management educational information.

- Host monthly prostate cancer event on campus.

Long-Term Goals:

- Seek partnership with 3 local faith-based organizations for regular participation in healthy living and physical activity events.

Priority 2 - Mental Health

Mental health intersects with many areas of public health, including addiction, cancer, cardiovascular disease, and HIV/AIDS. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders (MDPH, 2017).

Mental health impacts the overall health of individuals of all ages. Interventions addressing social and emotional risk factors can greatly improve outcomes for children and adolescents. The impact of depression and other mental disorders on overall health in older adults can be severe. Current research has found that depression is associated with worse health outcomes in people with conditions like heart disease, diabetes, and stroke. Undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing negative outcomes, such as homelessness, incarceration, medical illnesses, suicide, or even early death (SAMHSA, 2016).

Mental health was a top three health concern among survey participants and was the number one health concern of focus group participants.

Target Population: Individuals with or at an increased risk for behavioral health issues; residents in underserved areas; individuals at-risk for substance abuse; adults and adolescents
Geographic Location: Dorchester (02122), Dorchester (02124), Dorchester (02125), Mattapan, South Boston, Hyde Park, Braintree, Milton, and Quincy
Health Indicators: Mental Health
Gender: All
Age Group: All
Ethnic Group: All
Language: English, Haitian Creole, Vietnamese
Statewide Priority: Mental Health; Access to Health Care; Promoting Wellness in Vulnerable Populations; Reducing Health Disparity
Partners: Domestic Violence Ended (DOVE), National Alliance of Mental Illness (NAMI), Dimock Health Center and Harvard Street Health Center, Steward Health Care Network (SHCN)

Short-Term Goals:

- Expand partnership with Harbor Health Center and Harvard Street Health Center to develop a campaign aimed at reducing the stigma surrounding mental illness with the goal of reaching 400 community members.

- Support victims of violence and their families though increasing partnership and outreach with CHEERS/domestic violence support group with the goal of supporting a minimum of 50 community members.

- Distribute a community resource directory for mental health and substance abuse services within the hospital and at 5 community events.

Long-Term Goals:

- Partner with a minimum of 3 youth serving organizations to offer programing such as the Youth Mental Health First Aid program to a minimum of 200 youth in the community.

Priority 3 - Substance Use Disorders

Substance use was the number one concern among survey respondents, opioids in particular were of great concern to focus group participants. Both indicated a lack of availability of addiction center/ rehab services in the Carney Hospital service area. Carney Hospital should promote the use of substance use disorder treatment best practices. The hospital should also continue to partner with community organizations to promote increased access to screening for SUD. In addition to collaborating with community-based service providers working in various local settings. Carney Hospital should also offer free use of hospital space for a wide variety of support groups including Alcoholics Anonymous and Narcotics Anonymous.

Target Population: Individuals with or at increased risk for substance abuse; residents in underserved and high-risk communities; adults and teenagers
Geographic Location: Dorchester (02122), Dorchester (02124), Dorchester (02125), Mattapan, South Boston, Hyde Park, Braintree, Milton, and Quincy
Health Indicators: Substance Use Disorder
Gender: All
Age Group: All
Ethnic Group: All
Language: English, Haitian Creole, Vietnamese
Statewide Priority: Substance Use Disorder**;** Mental Health; Access to Health Care; Promoting Wellness in Vulnerable Populations; Reducing Health Disparity; Homelessness/Housing
Partners: Domestic Violence Ended (DOVE), National Alliance of Mental Illness (NAMI), Local homeless shelters and health centers, AA, NA, Boston Public Health Commission (BPHC), Steward Health Care Network (SHCN)

Short-Term Goals:

- In partnership with BPHC, promote substance use awareness, prevention, and access to treatment especially in a minimum of 3 local schools.
- Through partnerships with local adult serving organizations, such as adult learning centers, engage with 200 community members belonging to at-risk or underserved populations regarding substance use prevention and treatment.
- Offering a minimum of 2 training programs to staff in the Emergency Department and throughout the hospital, providing education on caring for substance use patients.
- Engage community-based providers in developing and/or implementing a care coordination model to support hospital discharges to detox and/or substance abuse treatment program for a minimum of 100 patients.
- Support prescription drug take-back programs within the service area.
- Have information tables at the hospital for Overdose Awareness Day and National Recovery day.

Long-Term Goals:

- In partnership with SHCN and/or other ACOs develop, pilot and implement a care plan and care coordination system for patients seen in the emergency department for SUD with the goal of assisting 200 patients get appropriate care upon discharge.

Priority 4 – Housing Stability / Homelessness

Homeless individuals are at a heightened risk of developing chronic and acute health conditions. The homeless are also at a heightened risk of developing a mental illness, substance use disorder, and in some cases co-occurring substance and mental health disorders.

Housing stability was not a major concern of focus group participants or survey respondents. That said, housing related issues are prevalent in the Carney Hospital service area and should be addressed by the hospital. Carney Hospital should consider working closely with organizations with a goal of improving housing stability. A partnership with organizations like Boston Housing Authority could provide opportunities for individuals and families who are facing challenges with housing.

Target Population: Individuals at increased risk of homelessness/housing instability; residents in underserved and high-risk communities; adults, families
Geographic Location: Dorchester (02122), Dorchester (02124), Dorchester (02125), Mattapan, South Boston, Hyde Park, Braintree, Milton, and Quincy
Health Indicators: Housing Stability/Homelessness
Gender: All
Age Group: All
Ethnic Group: All
Language: English, Haitian Creole, Vietnamese
Statewide Priority: Substance Use Disorder**;** Mental Health; Access to Health Care; Promoting Wellness in Vulnerable Populations; Reducing Health Disparity; Homelessness/Housing
Partners: National Alliance of Mental Illness (NAMI), Dorchester YMCA, Harvard Street Health Clinic, Neponset Health Clinic, Heading Home, Medical Legal Partnership (MLP)

Short-Term Goals:

- Engage with local shelter such as Heading Home to explore ways the hospital can support housing stability programs with the goal of helping 20 individuals/families avoid becoming homeless.
- Provide resource support to local shelters with the goal of lifting 10 individuals/families out of homelessness and find long-term housing.
- Offer support to emergency services and stabilization programs working with those who are homeless as a result of fleeing from violence and/or domestic abuse, with the goal of helping a minimum of 20 individuals/families.

Long-Term Goals:

- Develop a plan to be implemented to screen patients for housing stability prior to hospital discharge and seek ways to identify social support programs able to assist patients with housing instability such as the Medical Legal Partnership.

Priority 5 - Community and Educational Engagement

To reduce the inequities in health care delivery or faced with barriers to health care access, multi-sector interventions that target subpopulations at higher risk should address social determinants, such as by improving employment opportunities and wage conditions among vulnerable sub-populations, (BPHC, 2017). Underemployment is linked to chronic disease, lower positive self-concept, and depression. Workers with incomes below the poverty line are part of the working poor, who are more likely to have low paying, unstable jobs, have health constraints, and lack health insurance. Discriminatory hiring practices have limited the ability of people of color to secure employment. Those who have been arrested, have a conviction, felony or have been incarcerated are severely limited in their ability to find employment due to policies placing limitations on individuals who have interacted with the criminal justice system (MDPH, 2017).

Carney Hospital is committed to engaging with other community organization such as schools and colleges to promote health careers and engage with youth interested in learning more about work opportunities in the medical field. In this way, Carney Hospital will seek to strengthen the community by providing educational opportunities within the hospital and engaging with local schools.

Target Population: unemployed or underemployed, minorities, youth, veterans
Geographic location: Dorchester (02122), Dorchester (02124), Dorchester (02125), Mattapan, South Boston, Hyde Park, Braintree, Milton, and Quincy
Health Indicators: Other; Educational Support
Gender: All
Age Group: Adolescents, Adults
Ethnic Group: All
Language: English
Statewide Priority: Promoting wellness of vulnerable populations
Partners: Curry College, Laboure College, UMass Boston, Westfield State University, local high schools

Short Term Goals:

- Maintain partnerships with a minimum of 4 local colleges and/or universities to provide preceptorship opportunities to community students working towards clinical and/or health care certification.
- Offer a minimum of 2 career fairs to promote jobs in the region, in particular in the healthcare industry.
- Develop an internship program with a minimum of 2 local colleges/universities to offer internships to those seeking work-based experience for secondary education admission and employment opportunities.
- Maintain a CME and CNE program at Carney Hospital providing clinical education to health professionals in the hospital and to community-based providers when appropriate, offering a minimum of 5 such programs on topics such as diabetes management, cancer testing and treatment, stroke prevention and cardiovascular health.
- Engage with a minimum of 2 local high schools to provide information and/or presentations to youth on health care industry jobs and future prospects for a career in the health care field.

Long Term Goals:

- Establish partnerships with all high school systems within the service area interested in implementing a health care career exploration program.

COMMUNITY BENEFITS ADVISORY COMMITTEE

We use our expertise and resources, and leverage the expertise of our community partners, to target the particular needs of underserved and at-risk populations.

- Tom Sands, President, Carney Hospital
- Edward Logan, Community Manager, Harvard Street Health Clinic
- Ami Bowen, Community Manager, Neponset Health Center
- Jessica Prou, Partnerships manager, Senior Whole Health
- Tam Ngyuen, Professor and Community Advocate, Boston College
- Aidee Pomales, Center Director, Senior Day Program
- Antonie Junior Melay, Community Member
- Barbara Couzens, Community Manager and Patient Advocate, Carney Hospital
- Krisha Cowen, Marketing Manager, Carney Hospital

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