

# St. Elizabeth's Medical Center

COMMUNITY BENEFITS IMPLEMENTATION STRATEGY 2019

# St. Elizabeth's Medical Center

A STEWARD FAMILY HOSPITAL





# Table of Contents

Mission and Values.....4

About Us.....5

Community Benefits Mission Statement.....5

Community Benefits Statement of Purpose.....5

Community Health Needs Assessment Summary.....6

Population of Focus.....8

Priorities.....10

Community Benefits Advisory Committee.....23

References.....24



# 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

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### 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

St. Elizabeth's Medical Center (SEMC), founded in 1868, is part of the Steward Health Care System. Steward Health Care is the nation's largest private, tax paying physician-led health care network in the United States. Headquartered in Dallas, Texas, Steward operates 36 hospitals in the United States and the country of Malta that regularly receive top awards for quality and safety. The company employs approximately 42,000 health care professionals. The Steward network includes multiple urgent care centers and skilled nursing facilities, substantial behavioral health services, over 7,900 beds under management, and approximately 2.2 million full risk covered lives through the company's managed care and health insurance services. St. Elizabeth's primary service area is comprised of metro-Boston towns including the Allston-Brighton, Back Bay and West Roxbury neighborhoods of Boston, Brookline, Newton, Waltham, Weston, and Watertown.

St. Elizabeth's is a 282-bed academic medical center affiliated with Tufts University School of Medicine and located in the Allston-Brighton neighborhood of Boston. Allston-Brighton is one of 22 neighborhoods in the city of Boston, Massachusetts. Located in the heart of an urban community, St. Elizabeth's serves a culturally diverse population. As an integral member of these ethnically and racially diverse neighborhoods. The hospital primary service area includes the neighborhoods of Allston-Brighton, Back Bay and West Roxbury neighborhoods of Boston, Brookline, Newton, Waltham, Weston, and Watertown. St. Elizabeth's strives to provide culturally and linguistically competent services for all patients.

SEMC maintains a Community Health department that focuses on integrating care across the spectrum of hospital, primary, and community-based care. The hospital hosts a quarterly Community Benefits Advisory Committee comprised of hospital leadership, representatives of local health and human services organizations, community centers, schools, and faith organizations, among others, which guides the planning and execution of the hospital's community health initiatives. The hospital is also an active member of the Allston Brighton Health Collaborative, a collaboration of organizations devoted to working together to promote and improve the health and wellbeing of the communities of Allston and Brighton.

## Community Benefits Mission Statement

Steward Health Care is committed to serving the physical and spiritual needs of our community by delivering 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.

## Community Benefits Statement of Purpose

- SEMC is committed to serving the entire community, including the uninsured, underinsured, poor, and disadvantaged.
- SEMC is dedicated to providing accessible, high-quality health care services to all within its culturally-diverse community; particularly its host community of Allston-Brighton.
- SEMC is dedicated to maintaining the well-being of its community by providing excellence in health care through preventative health, education, and wellness services.
- SEMC is dedicated to collaborating with our community to identify and respond to issues by fulfilling the physical, spiritual, emotional, and social needs of the people it serves.

## Community Health Needs Assessment – Findings

This report is a comprehensive analysis of health indicators for the St. Elizabeth Medical Center (SEMC) service areas which include Brighton and its neighboring communities, those being Newton, Waltham, Watertown, Allston, Brookline, West Roxbury, Weston, Back Bay 02115, Back Bay 02116 and Back Bay 02215. Data was gathered by analyzing publicly available information, by reviewing community feedback gathered through focus groups, by conducting an extensive review of published literature on the health of the population residing in the region and in the Commonwealth of Massachusetts, and by surveying service providers. This data-driven methodology allows SEMC to investigate the resource requirements of the community in order to better streamline resources and inform community-based initiatives. The information from our 2018 Community Health Needs Assessment highlights some of the needs identified within the community and may be used to develop targeted population health improvement strategies.

### *Chronic Disease*

In many of the areas St. Elizabeth's serves, heart disease is the leading causes of death due to chronic disease. In 2015, six communities in the SEMC service area had a higher percentage of heart disease mortality than the service area as a whole at (22%); itself modestly above the state at (21%). Weston had the highest percentage of heart disease mortality at (26.96%) in 2015, followed by Brighton, Brookline at (26.25%) and (25.84%), respectively. Heart disease was the second leading cause of death in most towns within the SEMC service area.

When observing diabetes mortality in the SEMC service area we note that some of the cities and towns were above the state percentage of (2.4%) in 2015. The top three towns with the largest percentage of diabetes deaths were Brighton, at (3.48%), Boston (as a city) at (2.87%), and Watertown at (2.77%). The percentage of diabetes mortality for the SEMC service area at (2.27%) was slightly lower than the state. Given what has been reported in the literature, regarding populations most impacted by diabetes, there is an opportunity here to examine what can be done to work with high priority populations in the SEMC service area. Brighton, in particular, appears to have been a community in which diabetes mortality was a significant issue when compared to others within the service area.

The Boston neighborhood of Back-Bay (02116), recorded the highest percentage of cancer mortality within the SEMC service area at (34%). Back Bay (02215) had the second highest cancer mortality as a percentage of all mortality causes at about (31%). The Boston neighborhood of West Roxbury along with the city of Newton had the third highest cancer mortality percentages, both at just above (24%). As a whole, the SEMC service area recorded total cancer mortality of (23.3%) slightly above the state at (22%). The Boston neighborhood of Brighton, where SEMC is located and in which focus groups were conducted, cancer mortality was documented at (20.8%). Within the SEMC service area, Weston recorded the lowest percentage at (15.6%).

In both the Key Informant Survey and focus groups, cancer was recognized as the primary concern of all chronic diseases. Health professionals that responded to the key informant survey noted that their patients are not sufficiently educated on cancer as a chronic disease. In one of the focus groups, it was noted that in communities of color, people often do not discuss cancer openly as it is seen as taboo.

### *Substance Abuse*

Looking at DPH-funded substance and alcohol abuse programs from 2013 to 2017, Waltham had the highest numbers of individuals attending DPH funded programs. In 2017, Waltham had 487 admissions,

followed by Brighton with 249 admissions and Newton with 238 admissions. Moreover, Waltham recorded an upward trend from 2015 to 2017 in the number of those admitted to DPH funded substance and alcohol abuse programs. All other communities, with the exception of Newton, noted a downward trend in admissions. Weston recorded the least number of admissions to DPH funded programs with only 10 admissions in 2017.

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 Charlestown, Dorchester (zip codes 02122, 02124), and South Boston compared with the rest of Boston (BPHC, 2017).

### ***Mental Health***

In 2015, the rate of mental health hospitalizations was higher in Allston/Brighton, Back Bay, Fenway, and the South End compared with the rest of Boston. However, data from 2015 reveal inequities across categories of age, sex, and race/ethnicity. 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. At the neighborhood level, elevated rates of mental health hospitalizations were observed for Allston/Brighton, Back Bay, Fenway, and the South End. (BPHC, 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 needs to be done to stop discrimination, which impacts the mental health of the person facing discrimination. 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).

### ***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 the efficacy of SEMC programs, SEMC 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 SEMC service area, and in responses gathered through the Key Informant Surveys. 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).

## Populations of Focus

Race, gender identity, age, disability status, etc. influence the social environment that individuals experience. The 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. Individuals 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 & Leech, 2012).

Racial and ethnic inequities were found in indicators of health care access, particularly for Latino adults. Higher percentages of Latino adults compared with White adults reported both the inability to see a doctor in the past 12 months because of cost and the lack of a doctor or health care provider. Inequities in these indicators tend to disproportionately affect adults with less than a high school diploma or household income less than \$25,000, as well as adults who are non-homeowners or foreign-born residents who lived in the U.S. for 10 or fewer years. To reduce the inequities associated with being uninsured or barriers to health care access, multi-sector interventions that target subpopulations at higher risk, should address social determinants, (e.g. by improving employment opportunities and wage conditions among vulnerable sub-populations, and sources of structural racism that affect health care provider-patient interactions (BPHC, 2017).

The hospital will target populations in their primary service area in Allston-Brighton and the surrounding communities and will partner with organizations to address health disparities specifically to disadvantaged populations in the SEMC service area. These groups include youth and elderly populations as well as those at an elevated risk of developing or with an existing substance use disorder or chronic disease.

## Implementation Strategy

In this Implementation Strategy Plan, SEMC will identify the target populations it will support, specific programs or activities that attend to the needs identified in the 2018 Community Health Needs Assessment, as well as our short and long-term goals for each program or activity. SEMC 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.

SEMC will align its community benefits priorities and goals with guidance provided by the Massachusetts Attorney General's Office and the Department of Public Health. We recognize that our success in addressing community health issues present in the SEMC service area will come from coordinated regional strategies with public health and population health management agencies, community partners and community coalitions.

## Priority 1: Chronic Diseases

Chronic disease is accountable for 56% of all mortality in Massachusetts and over (53%) of all health care expenditures (\$30.9 billion a year (MDPH, 2014). Based on the Key Informant Survey conducted by SEMC, respondents agreed that chronic disease is a major issue in the community. When asked to identify the chronic diseases prevalent in their respective communities, participants noted that diabetes and cancer were most common. Respondents noted a higher level of concern with cancer. SEMC also conducted five focus groups within their service area to engage community members in the data collection process. In one of the focus groups, participants stated that cancer was the main concern among other chronic diseases. In response to the Community Member Survey, when asked to identify the top three health issues [in the community], respondents (n=129) noted (1) mental health issues (n=67) and, (2) substance abuse (n=57).

### Cardiovascular Health

Cardiovascular disease is a broad term that encompasses a number of adverse health outcomes, including congestive heart failure, myocardial infarction, and stroke. In Massachusetts, cardiovascular disease is the second leading cause of death after cancer (MDPH, 2017). Hypertension is a critical risk factor for adverse cardiovascular and cerebrovascular outcomes including stroke, heart attacks, and congestive heart failure. In 2014, hypertension contributed to \$19 million in total hospitalization costs in Massachusetts. Studies have shown that hypertension disproportionately impacts people of color. These disparities are grounded in social and economic inequities such as access to health care and poverty (MDPH, 2017). In 2015, (29.6%) of Massachusetts adults said they had been diagnosed with hypertension, similar to previous years. A larger percentage of Black non-Hispanic adults were diagnosed with hypertension (39.4%) compared to White non-Hispanic adults (30.7%). Racial/ethnic disparities in hypertension are likely an important contributing factor to hospitalizations for congestive heart failure, myocardial infarction, and stroke. (MDPH, 2017)

Heart disease is the leading cause of death for Black, Latino, and White individuals in the U.S., and it is the second leading cause of death for Asian individuals. In Boston, it is the second leading cause of death for these groups. Nearly half of Americans have at least one of the three key risk factors for developing Coronary Artery Disease (CAD): high blood pressure, high LDL cholesterol, or cigarette smoking. Other risk factors include diabetes, overweight/obesity, a diet with few fruits and vegetables, physical inactivity, and excessive alcohol use. Educational attainment and household income are inversely related to CAD (BPHC, 2017).

**Target Population:** Areas with elevated prevalence of chronic heart disease

**Geographic location:** Allston-Brighton

**Health Indicators:** Other: Cardiac Disease, Stroke

**Gender:** All

**Age Group:** Youth, Elderly

**Ethnic Group:** All

**Language:** English, Spanish

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

**Partners:** SEMC Cardiology Department, Thomas Edison School, Oak Square YMCA, Veronica Smith Senior Center, Oak Square Farmer's Market

### Short-Term Goals:

- Engage SEMC Cardiology Department to provide educational materials regarding the importance of early screening to prevent heart disease and information covering the topics of nutrition, exercise, stress, heart failure, and cholesterol. Offer five information tables onsite at the hospital and one Heart Health presentation to the Thomas Edison School during Heart Health Month.
- Attend Oak Square YMCA Healthy Kids Day and engage with 100 families on the topics of nutrition, exercise, and stress.
- Increase the number of screenings offered annually by 50%, to offer 6 free preventative care blood pressure screenings to disadvantaged populations at the Oak Square YMCA, Veronica Smith Senior Center, and Oak Square Farmer's Market.
- Increase the total number of people screened for cardiovascular disease by 20% to 70 individuals for the year.

### Long-Term Goals:

- Continue to offer at least 6 free preventative care blood pressure screenings each year to disadvantaged populations.
- Strategically promote these screenings to increase the turnout at each screening and increase the total number of people screened each year by 10%.

## Diabetes

Socioeconomic disparities exist in diabetes prevalence. In Massachusetts, adults with an annual household income of less than \$25,000 (15.6%) have three times the prevalence of diabetes as compared to those with an annual household income more than \$75,000 (5%). The prevalence of diabetes also decreases as educational attainment increases. A total of (14.5%) of adults without a high school degree were diagnosed with diabetes compared to (5%) of adults with four or more years of post-high school education. Diabetes prevalence and mortality in Massachusetts also differs by race/ethnicity. In 2015, a greater proportion of Black non-Hispanic (12.3%) and Hispanic (11.7%) adults reported being diagnosed with diabetes compared to White non-Hispanic adults (8.7%) (MDPH, 2017).

According to the report *Health of Boston 2016-2017* prepared by the Boston Public Health Commission, in 2015, 8% of Boston adult residents reported having diabetes. There was a significant increase in the percentage of adults with diabetes between 2006 and 2015. The percentage of adults with diabetes was higher for the following groups:

- Black (15%) and Latino (11%) adults compared with White adults (5%)
- Adults ages 45-64 (16%) or 65 and older (24%) compared with adults ages 25-44 (2%)
- Adults with less than a high school diploma (18%) and adults with a high school diploma (11%) compared with adults with at least some college education (6%)
- Adults who were out of work (10%) or whose employment status was “other” (16%) compared with adults who were employed (5%)
- Adults who were Boston Housing Authority residents (18%) and renters who received rental assistance (16%) compared with adults who owned a home (8%)
- Foreign-born adults who lived in the United States for over 10 years (15%) compared with those who were born in the United States (8%)

Promoting healthy behaviors such as an active life, healthy eating, and disease self-management are important to diabetes maintenance. St. Elizabeth’s will support programs listed below focused on promoting healthy lifestyles and on increasing awareness of diabetes.

**Target Population:** Areas with elevated prevalence of chronic diabetes

**Geographic location:** Allston-Brighton

**Health Indicators:** Other: Diabetes

**Gender:** All

**Age Group:** Youth, Adults

**Ethnic Group:** All

**Language:** English, Spanish

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

**Partners:** SEMC Diabetes Center, Oak Square Farmers Market, Oak Square YMCA, TEEEN, Carney Hospital, Mass Farmers Market, St. Mary’s Women and Children, Gardner Pilot Academy

## Short-Term Goals

- Work with the SEMC Diabetes Center to promote their Diabetes Support Group held at SEMC.
- Promote education in the community around diabetes and healthy lifestyle choices by hosting a healthy cooking demo at the Oak Square Farmers Market. Have at least one member of the SEMC Diabetes Center attend as well as distribute copies of SEMC heart-healthy cookbook.
- Partner with the Oak Square YMCA to promote their Diabetes Support group program to eligible patients being treated for diabetes at SEMC.

- Provide financial resources for the TEEEN Program, provide space and parking for their monthly meetings. Increase collaboration on exercise and healthy lifestyle among kids by promoting their events as well as having a SEMC presence at these events.
- Provide financial resources for the Food For Free Program offered at the Gardner Pilot Academy ESOL language classes. Increase collaboration by promoting their ESOL language classes and by having SEMC staff help with disseminating meals to ESOL students.
- Provide financial resources for the Veggie Voucher Program, run by Mass Farmers Market. Support Veggie Voucher distribution through the SEMC Diabetes Center, Carney Hospital, and St. Mary's Women and Children.
- Partner with SEMC Diabetes Center on promotion and marketing of the SEMC program to increase the utilization of the Veggie Vouchers distributed and have materials available at the Oak Square Farmers Market to promote new participants and usage of vouchers.

### Long-Term Goals:

- Host at least one cooking demo at the Oak Square Farmers Market and work to increase to hosting two cooking demos per year.
- Partner with SEMC Diabetes Center to track and analyze health data outcomes year over year of participants in the SEMC Diabetes Program.
- Work with Carney Hospital and St. Mary's Women and Children on the promotion and marketing of their programs and help to increase the utilization of the Veggie Vouchers distributed.

## **Cancer Care**

Since 2006, cancer surpassed heart disease as the leading cause of death in Massachusetts. Although cancer incidence and mortality rates decreased in Massachusetts from 2010 to 2014, there were still more than 36,000 new cancer cases diagnosed annually during this period. The age-adjusted cancer incidence rate in Massachusetts was (471.1 per 100,000) with men having a higher cancer incidence rate than women (505.7 versus 450.4 per 100,000). From 2010 to 2014, cancer incidence decreased (3.2%) annually among men (MDPH, 2017).

The five leading types of cancer deaths among Boston residents were generally consistent with what is observed for the U.S. overall, with lung cancer as the top cause. Some patterns emerge for lung cancer mortality rates across sex and race/ethnicity. Lung cancer mortality rates are generally higher in men than women. Across race/ethnicity, rates were generally lowest among Latinos (BPHC, 2017). From 2011-2015 the cancer mortality rate decreased in Boston. Among all Boston residents, this figure decreased by (12%) and among black residents by (18%). In 2015 the cancer mortality rate for women was (29%) lower than that of men. In 2015, 85% of women reported having had received a mammogram in the past two years (BPHC, 2017).

**Target Population:** Areas with elevated prevalence of cancer

**Geographic location:** Allston-Brighton, Back Bay 02116

**Health Indicators:** Cancer, Obesity, Physical Activity

**Gender:** All

**Age Group:** All

**Ethnic Group:** All

**Language:** English

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

**Partners:** SEMC Center for Breast Care, SEMC Nutrition, SEMC Radiology, SEMC Respiratory, SEMC Cancer Registrar, American Cancer Society, Facing Cancer Together, Dana Farber Cancer Institute

## **Short Term Goals:**

- Promote colorectal cancer awareness during the month of March. Have at least one information table at the hospital and engage with 100 community members and distribute 35 of pamphlets. Work with scheduling to determine how many Colonoscopies were done in March in comparison to other months.
- Promote Breast cancer awareness during the month of October. Have one information table on wear pink day at the hospital and one table at the Oak Square YMCA event fall event. Have at least one staff member from the Center for Breast Care attend these events and sign up people for mammogram screenings.
- Partner with the SEMC Center for Breast Care to promote extended hours for mammograms and increase the number of mammograms done for the month of October by 10% to a total of 733 mammograms.
- Have one information table at Oak Square Farmer's Market to promote skin cancer awareness. Engage with 100 people and distribute 40 pamphlets.
- Offer a free skin cancer screening for staff and the community at the hospital and work with the Cancer Registrar to promote the event. Increase the number of people who get screened by 30% to 40 total people screened.

- Partner with the Cancer Registrar and American Cancer Society to promote the Great American Smoke Out at the hospital and have one information table in the hospital.
- Partner with the SEMC Respiratory department to offer a free “Fresh Start Smoking Cessation Program” twice a year and to expand the reach and to increase the total number of participants by 50% to 10 total. If appropriate refer patients to the low- dose lung CT Screening Program and work with the Nutrition Department to have them as a guest speaker.
- Attend the Professional Fire Fighters of MA conference and provide information and engage with 200 firefighters on early lung cancer detection and other relevant screenings.
- Partner with SEMC Radiology to expand the First Responder Cancer Screening program to more firefighters and other first responders including police officers.
- Partner with the Cancer Registrar and American Cancer Society to promote Movember the hospital and have one information table in the hospital.
- Partner with the SEMC Cancer Registrar and Facing Cancer Together and determine how we can better promote their services. Host one resource fair at the hospital and have representation from Facing Cancer Together.
- Work with Dana-Farber Cancer Institute’s to increase access to cancer prevention education, early detection and screening across the hospital PSA with a particular focus in Back Bay (02116) which had the highest mortality rate.

#### Long-Term Goals:

- Increase the number of colonoscopies given in March in comparison to other months and increase this number year over year.
- Maintain extended hours for mammograms during the month of October and promote these hours to increase the number of mammograms done in October each year 5%.
- Partner with SEMC Radiology to expand the First Responder Cancer Screening Program to specifically women and breast cancer.
- Offer two free skin screenings, one in the community and one at the hospital. Work with the Cancer Registrar to promote the events and increase the number of people who get screened in total with screenings totaling 100 people.
- Continue to offer “Fresh Start” Smoking Cessation program twice a year and promote this to increase the total number of participants by 1 patient each year. Expand the departments at SEMC that are involved in the program as guest speakers and the locations where this is offered.

## Priority 2: Substance Abuse

In 2015, there were 1,637 opioid-related deaths in Massachusetts. Both Watertown and Waltham had the highest number of mortalities related to opioids with 10 mortality counts each. Newton had the second highest count with 7 opioid-related mortalities, followed by West Roxbury with 5. 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 Charlestown, 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 the social determinants of health may contribute to one's decision to initiate drug use and shape other substance use behaviors. For example, the lack of a supportive social network or circumstances related to neighborhood poverty may influence substance use behaviors. Additionally, addiction is a chronic neurological disorder and needs to be treated as other chronic conditions (BPHC, 2017).

**Target Population:** Areas with elevated prevalence of substance abuse

**Geographic location:** Allston-Brighton, Waltham

**Health Indicators:** Alcohol and Substance Abuse, Smoking/Tobacco

**Gender:** All

**Age Group:** Youth, All

**Ethnic Group:** All

**Language:** English

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

**Partners:** SECAP, Allston Brighton Substance Abuse Task Force, PAATHS, Medical Legal Partnership, Road to the Right Track, Alcoholics Anonymous and Narcotics Anonymous, Charles River Community Health Center

### Short Term Goals:

- Have information tables at the hospital for Overdose Awareness Day and National Recovery day and staff with members of SECAP.
- Partner with the Allston Brighton Substance Abuse Task Force on the Walk for Recovery. Participate in the planning committee to help plan and promote the walk. Additionally, provide financial resources as well as volunteers for the walk.
- Partner with PAATHS to ensure a smooth transition of patients being referred from their facility and provide financial resources.
- Partner with Medical Legal Partnership and collaborate on developing new programs and training for social workers to meet the needs of high-risk pregnant women. Support MLP with financial resources. Meet regularly to discuss training and ensure training is effective and targeted social workers.
- Provide space and support for Alcoholics Anonymous and Narcotics Anonymous and collaborate with them to promote their services.
- Partner with Road to the Right Track and help to increase participation of youth by 25% of weekly workouts and monthly meetups by providing financial support for the Summer Sports Camp Scholarship program in order to incentivize youth. Have SECAP members present at

least 2 monthly meetings on the importance of staying out of trouble and living a healthy lifestyle.

### Long Term Goals:

- Expand partnership with Road to the Right Track to include additional quarterly events and involve SECAP department.
- Partner with the Substance Abuse Task Force on events in the community, such as documentary screenings that promote education. Additionally, host at least one Narcan training in the community in partnership with the task force.
- Work the Substance Abuse Task Force to have members of the Respiratory department present at Life Skills courses being taught in schools on the health effects of smoking, tobacco and vaping.
- Partner with Charles River Health Community Center to address substance abuse in the Waltham population through at least two educational events.

## Priority 3: Mental Health

In 2015, the rate of mental health hospitalizations was higher in Allston/Brighton, Back Bay, Fenway, and the South End compared with the rest of Boston. 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. At the neighborhood level, elevated rates of mental health hospitalizations were observed for Allston/Brighton, Back Bay, Fenway, and the South End. (BPHC, 2017).

**Target Population:** Areas with elevated prevalence of mental health issues

**Geographic location:** Allston-Brighton, Weston, Watertown

**Health Indicators:** Mental Health, Substance Abuse

**Gender:** All

**Age Group:** Youth, Elderly, All

**Ethnic Group:** Nonnative English-speakers

**Language:** All

**Statewide Priority:** Reducing Health Disparities; promoting wellness of vulnerable populations

**Partners:** SEMC Behavioral health department, Allston Brighton Health Collaborative, SEMC Emergency Department, Providence House, Winship Elementary School, City Connects, Saint Joseph's Preparatory High School

### Short Term Goals:

- Provide educational materials to the community focusing on high-risk populations in both Weston and Watertown and by hosting tables at least 2 resource fairs.
- Collaborate with the Allston Brighton Health Collaborative Mental Wellness Committee to promote and establish a training curriculum and create a "Safe Space Ambassadors/Allies Program" where individuals can attend multi-series training on how to be a front-lines "safe" person. Ensure that at least half of our social work team attends these multi-series training.
- Provide financial resources to the Winship Elementary School to fund a City Connects staff member on-site at the school who provides behavioral health service to the students.

### Long Term Goals:

- Collaborate with Providence House to offer SEMC behavioral health department training specifically related to the elderly.
- Work with the SEMC Emergency department and engage community partners around implementing mental health screening for services program.
- Partner with Saint Joseph Preparatory High School to increase mental health resources for students and advocate for early screening of mental illness within schools.

## Priority 4: Address Social Determinants of Health

Social determinants of health, including social, behavioral and environmental influences have become increasingly prevalent factors in addressing population health. The literature recommends linking health care and social service agencies in addressing social determinants of health to increase the efficacy of health promotion and chronic disease prevention programs. Multicultural communities face particularly complex issues when accessing and receiving treatment in their daily lives. Seniors are also a particularly vulnerable population and it is essential to enriching their social environment.

**Target Population:** Areas with elevated prevalence of isolation of elderly or specific ethnic groups

**Geographic location:** Allston-Brighton

**Health Indicators:** All

**Gender:** All

**Age Group:** Youth, Elderly, All

**Ethnic Group:** Nonnative English-speakers

**Language:** All

**Statewide Priority:** Reducing Health Disparities; promoting wellness of vulnerable populations

**Partners:** Veronica Smith Senior Center, Providence House, Oak Square YMCA, Friendshipworks, Presentation Rehabilitation Skilled Nursing Facility, MASE Clinic, Brazilian Women's Group, SEMC Interpreter Services Department, Covenant House, B'nai B'rith Housing, Charles River Community Health Center, Allston Brighton Health Collaborative

### Short Term Goals:

- Participate as a member of the Senior Supper Planning Committee with other elderly organizations including Providence House, Friendshipworks, and Presentation Rehabilitation Skilled Nursing. Host at least one Senior Supper at the hospital and support with financial resources the remaining 3 Senior Supper hosted in the community.
- Host at least one Community Resource Fair at the hospital and attend at least one resource fair in the community bi-monthly.
- Work with MASE Clinic Brazilian Community outreach staff and the Brazilian Women's Group to engage the Brazilian community by attending the Brazilian Independence Day Fair and Brazilian Health fair and providing financial resources to support both of these events.
- Provide translated materials and/or interpreters, as appropriate, at community education events targeting immigrants communities.
- Host multiple flu clinics in the community. Host flu clinics at the Veronica Smith Center, Brazilian Health Fair, and the Charles River Community Health Centers in both Brighton and Waltham.
- Provide financial and resource support to the Allston Brighton Health Collaborative to collaborate with community members to address neighborhood social health determinants including transportation equity and resource connection.

### Long Term Goals:

- Expand membership of the Senior Supper Planning Committee and broaden the committee to a general Senior Events Planning Committee to combat elderly isolation and by offering at least one new program quarterly.
- Partner with the Veronica Smith Senior Center, Oak Square YMCA, and Providence House to offer Yoga to seniors. Provide financial resources for yoga classes.
- Partner with the Covenant House and B'nai B'rith Housing who have particularly high Russian elders on events to engage the Russian community.

## Priority 5: Housing Stability

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).

Average rental prices in Boston are among the highest in the U.S., just behind New York, San Francisco, and Silicon Valley, with almost (40%) of residents paying more than \$1,500 a month. Subsidized housing is available on a limited basis to those with incomes ranging from less than (30-80%) of the city-wide median income level depending on the program. Programs have a wait ranging from 10 weeks to more than 5 years depending on the application and housing availability. Meanwhile, over half of Boston renters pay more than (30%) of their income toward rent, meaning finances can't go to other necessities such as childcare and food. The benefits of home ownership, including tax deductions, cost savings over time compared to renting, and the ability to build equity, are reserved for higher-income individuals. Lower-income individuals who cannot afford home ownership often struggle with the negative impact that residential instability has on crime, mental health, and social capital. Compared with Boston overall, a higher percentage of renter-occupied households in Allston/Brighton, Fenway, and Roxbury paid at least (30%) of their income toward rent (BPHC, 2017).

**Target Population:** Areas of prevalent homelessness

**Geographic location:** Allston-Brighton

**Health Indicators:** All

**Gender:** All

**Age Group:** Youth, Elderly, All

**Ethnic Group:** Nonnative English-speakers

**Language:** All

**Statewide Priority:** Reducing Health Disparities; promoting wellness of vulnerable populations

**Partners:** Allston Brighton Community Development Corporation, Charlesview Community Center, SEMC Case Management Team

### Short Term Goals:

- Partner with the Allston Brighton Community Development Corporation and Charlesview Community Center and attend at least 2 resource fairs at the ABCDC. Have a SEMC presence including providing a blood pressure screening.
- Work with SEMC Case management team to determine those patients who may present at the hospital with a need for stable housing.

### Long Term Goals:

- Expand programs and partnerships with Allston Brighton Community Development Corporation and Charlesview Community Center to address the housing crisis. Particularly provide financial resources for these organizations and programs.

- Partner with housing authorities and shelters and support housing initiatives aimed at keeping low-income marginalized community members housed.

## Priority 6: Workforce Development

While being employed is important for economic stability, employment affects health through more than economic drivers alone. Physical workspace, employer policies, and employee benefits all directly impact an individual's health. The physical workplace can influence health through workplace hazards and unsafe working conditions, which lead to injuries, illness, stress, and death. Long work hours and jobs with poor stability can negatively impact health by increasing stress, contributing to poor eating habits, leading to repetitive injuries, and limiting sleep and leisure time. Job benefits such as health insurance, sick and personal leave, child and elder services and wellness programs can impact the ability of both the worker and their family to achieve good health (MDPH, 2017). Unemployment is also associated with poor health, including increased stress, hypertension, heart disease, stroke, arthritis, substance use, and depression; and the unemployed population experiences higher mortality rates than the employed (Robert Wood Johnson Foundation, 2013) (Henkel, 2011).

SEMC is committed to developing the skills of the workforce in our community, local schools, as well as our employees. SEMC staff work with students in preceptorship and mentoring projects, which may offer continuing nursing education (CNE) and continuing education units (CEUs) contact hours. SEMC will maintain clinical affiliation agreements with nursing and paramedic schools. Additionally, through our accredited continuing medical education (CME) program, SEMC will provide CME courses that offer contact hour credit in subject matter related to health priorities identified in the 2018 CHNA. Courses will be open to community providers as appropriate. Moreover, SEMC will collaborate with industry partners to provide education on managing population health. It is imperative that we ensure an adequate and capable workforce that can provide the services needed to meet the needs of the underserved populations in the region.

**Target Population:** General Population

**Regions Served:** Boston, Greater Boston

**Health Indicator:** All

**Gender:** All

**Age Group:** All

**Ethnic Group:** All

**Language:** English

**Statewide Priority:** Promoting Wellness of Vulnerable Populations, Reducing Health Disparity

**Partners:** Local Community Colleges, Universities and, Colleges, Allston Brighton Health Collaborative, Brighton Main Streets

Short Term Goals:

- Explore opportunities to partner with a minimum of 3 high schools in order to promote health careers.
- Maintain internship programs with a minimum of 2 local colleges and/or universities.
- Maintain clinical affiliations with a minimum of 10 schools of nursing and paramedic schools.

- Provide a clinical environment for student clinical placements and preceptorship for a minimum of 80 students.
- Offer a CEU nursing education program.
- Offer a CME program at the hospital, providing CMEs to those that qualify including community participants.
- Offer CME programs in all of the various medical/surgical specialties at the medical center. The CME credits are processed via the Office of Continuing Accreditation at Tufts University School of Medicine and provided to all of the SEMC physicians.

Long Term Goals:

- Partner with all high schools in the primary service area to promote health careers.
- Ensure CME course offerings include priority areas identified in the 2018 CHNA.
- Work with the Allston Brighton Health Collaborative and Brighton Main Streets to determine what specific organizations we can partner with to increase our workforce development in the community.

## COMMUNITY BENEFITS ADVISORY COMMITTEE

Harrison Bane, *President, St. Elizabeth's Medical Center*

Bridget Stewart, *VP of Operations, St. Elizabeth's Medical Center*

Nina DiNunzio, *Manager of Community Relations, St. Elizabeth's Medical Center*

Peter Lacamera, *MD, St. Elizabeth's Medical Center*

Cheryl Cirillo, *NICU Nurse Manager, St. Elizabeth's Medical Center*

Sr. Patricia Andrews, *Director, Sister of St. Joseph, Boston*

Elizabeth Browne, *Director, Joseph M. Smith Community Health Center*

Mark Ciommo, *City Councilor, Boston City Council*

Nicole Sanders-O'Toole, *Account Representative, American Cancer Society*

Helen Connolly, *Project Coordinator, Allston Brighton Substance Abuse Task Force*

Samantha Cowan, *Allston/Brighton Program Director, FriendshipWorks*

Maria DiChiappari, *Director, Boston College Neighborhood Center*

Anna Leslie, *Coordinator, Allston Brighton Health Collaborative*

Tom Myers, *Director, Oak Square YMCA*

Rosie Hanlon, *Administrative Coordinator, Jackson Mann Community Center*

Cynthia Woolcock, *Interim Executive Director, Veronica Smith Senior Center*

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