

St. Elizabeth's Medical Center

COMMUNITY BENEFITS IMPLEMENTATION STRATEGY 2020

St. Elizabeth's Medical Center

A STEWARD FAMILY HOSPITAL



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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

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: Cardiac Disease, Stroke, Stress

Gender: All

Age Group: Youth, elderly, immigrant population

Ethnic Group: All

Language: English, Spanish, Russian

Statewide Priority: Chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations.

Partners: SEMC Cardiology Department YMCA, Boston Police, Veronica Smith Senior Center, Providence House, B'nai B'rith and Golden Meir House/Jewish Community Housing for the Elderly, Presentation Skilled Nursing, and local businesses and schools.

Short Term Goals:

- Collaborate with YMCA in Oak Square on numerous educational programs and events throughout the year focused on prevention of high blood pressure, good nutrition, fitness, and other wellness programs in the community.
- Increase the number of blood pressure screenings annually by 40% to disadvantaged populations.
- Collaborate with the Golden Chinese Home for Seniors, Victoria Smith Senior Center, Farmer's Market, Jewish Community Senior Housing, and B'nai B'rith's Covenant House in Brighton to offer education, recipes, education on stress, diet, and cardiovascular health.
- Continue to work with the American Red Cross three times a year to host blood drives at SEMC, as well as provide educational table on improvements to cardiovascular health.
- EMS Week: Offer 1-2 free community trainings on CPR at SEMC by Boston Police Department and to people that many need to be re-certified every two years.
- Provide materials in community regarding the importance of early blood pressure screenings to prevent heart disease and collaborate with SEMC Cardiology Department and Cardiac Lab covering the topics of nutrition, exercise, stress, heart failure, and cholesterol management.
- Reach teenagers and tweens at area high schools, middle schools and elementary schools at 2 events to learn about the benefits of healthy living and steps to prevent future cardiovascular issues and obesity.

Long Term Goals:

- Continue to offer at least 4 free preventative care blood pressure screenings each year to disadvantaged populations.
- Strategically promote blood pressure screenings to increase the total number of people reached each year by 10%.
- Increase the number of educational programs by 20% to learn about the benefits of good nutrition, weight control/loss and exercise.

Diabetes

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 lifestyle, healthy eating, and disease self-management are important to diabetes prevention and maintenance. St. Elizabeth’s will support programs listed below focused 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/Allston Brighton Health Collaborative, Oak Square YMCA, and TEEEN (Teens, Empowerment, Exercise, Education, and Nutrition) and area businesses.

Short Term Goals:

- As part of American Diabetes month offer 3 blood sugar screenings in the community and education around prevention.
- Work with the Allston Brighton Health Collaborative on ways to improve food distribution and food access in the community by encouraging more programs and future partnerships.
- Provide nutrition education to teenagers at the Jackson Mann Center that are planting and cultivating an herb garden to serve healthy recipes at local restaurants.
- Work with nutritionists at SEMC to provide educational shopping tours at supermarkets with for patients in the community to make healthier purchase decisions, as well as offer guidance on meal preparation.
- Promote the Mobile Fresh Truck every week in the community in a partnership with CharlesRiver Community Health Center in Brighton.
- Collaborate with the YMCA Diabetes Prevention Program with our SEMC Diabetes team in a yearlong program offering coaching and counseling on eating better. This includes smaller portions, reducing fat and sugar in one’s diet, and offering healthier food choices to prevent onset of Type 2 diabetes.
- A concerted effort in the community to create a drop-off needle disposal center at remote locations in Brighton working with area businesses and partners.
- Promote in collaboration with WGBH the screening of the documentary film “Blood Sugar Rising,” focused on diabetes care with the rising costs, host a panel of clinicians, as well as share new innovations in technology changing the course of treatment and prevention.
- Partner with TEEEN (Teens, Empowerment, Exercise, Education, and Nutrition) in an effort to reach 40+ children 10-19 years old. This program provides an effective approach to obesity and changing behaviors to improve health in ethnically diverse teenagers.

Long Term Goals:

- Offer live cooking demos focused on diabetes prevention and maintenance inviting seniors and youth at different locations throughout the community.
- Partner with SEMC Diabetes Center to track and analyze health data outcomes year over year of participants in the SEMC Diabetes Program.
- Consider future ways to enhance the availability of nutritious foods and providing access to services and counseling.

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

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

Partnerships: Dana Farber, Facing Cancer Together, Breast Care Center at SEMC, SEMC Radiology, SmartlifestylesMD.com, MA Quitworks, American Cancer Society and the Smoking Cessation Program SEMC Cancer Registry, Boston College, YMCA, Camp Kesem, corporations and other area partners.

Short Term Goals:

- Work with the American Cancer Society to provide education on screenings for lung, prostate, colorectal cancer, and breast cancer throughout the year.
- During National Colorectal Cancer Awareness Month, SEMC will promote awareness with educational events in the community and expert clinicians.
- Continue to collaborate with the SEMC Cancer Registrar, Facing Cancer Together, and other area support groups.
- Partner with SEMC Radiology to expand the First Responder Cancer Screening program to firefighters and police officers by increasing the reach to over 300 participants.
- Promote Breast Cancer Awareness month:
 - Information table at the hospital and distribute materials to other community centers

- Wear pink day at SEMC and encourage people to attend and promote the annual walk
 - Extended hours for mammograms and other incentive gifts for people to schedule their screenings
- Offer skin cancer screenings at hospital and promote it at community centers, churches, and other community partners.
 - Melanoma / Skin Cancer Detection and Prevention Month in June
- SEMC Pulmonary department to attend 2 local schools educating children on the dangers of smoking/vaping/chewing tobacco, as well as offer “Fresh Start” Smoking Cessation classes available to local participants.
- National Smoke Out – Work with MA Quitworks and American Cancer Society by providing education on lung disease, the SEMC lung screening program and the benefits of quitting smoking at information table located at hospital.
- SEMC will continue to collaborate on the promotion of the YMCA LIVESTRONG program referring patients to the program. Offer cancer survivors an opportunity to receive a membership at the fitness facility and learn more about the benefits of exercise and healthy eating to prevent reoccurrence of the disease.
- Promote SmartLifestylesMD.com to create plans for overweight patients living with cancer to lose weight and stay in shape during chemo treatments and while in remission.
- Dana Farber at SEMC to collaborate with an annual bone marrow registry in the fall with hopes to increase the number of participants to 15+ participants.
- Offer and provide assistance to children of parents affected by cancer by promoting Camp Kesem to clinicians, as an opportunity for children to spend a week away at camp with others for a fun-filled escape in the summer.

Long Term Goals:

- Increase the number of colonoscopies screenings by 5% each year and expand the First Responder Lung Cancer Screening Program to reach 350 people.
- Maintain extended hours for mammograms during the month of October and promote these hours to increase the number of mammograms done each year by 6%.
- Increase the number of skin care screenings to 120 people within the next year.
- Increase the total number of participants in the “Fresh Start” Smoking Cessation program and continue to grow group class size by 3% each year.

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, Fenway, Back Bay, and Watertown

Health Indicators: Alcohol and Substance Abuse, Smoking/Tobacco

Gender: All

Age Group: All

Ethnic Group: All

Language: English, Spanish

Statewide Priority: Chronic disease management in disadvantaged populations; reducing health disparities; promoting wellness of vulnerable populations

Partnerships: Allston Brighton Substance Abuse Task Force, SEMC Behavioral health department, Allston Brighton Health Collaborative, SECAP, CharlesRiver Community Health, Road to the Right Track, Veronica Smith Senior Center, Alcoholics Anonymous, local schools businesses and other area partners.

Short Term Goals

- Offer Narcan trainings to people in the community helping to treat and coach others in partnership with Allston Brighton Substance Use TaskForce.
- Provide resources for patients/ caregivers for whom illness can cause significant stress and anxiety:
 - SEMC to host weekly Alcoholics Anonymous Groups, Boston Grief Group meetings for those grieving a loved one, as well as explore opportunity to offer meeting near the community with Families Anonymous. Work with Allston Brighton Substance Abuse Task Force to create more support groups for families dealing with a loved one challenged with a substance use disorder.
 - Host information table at the hospital for Overdose Awareness Day and National Recovery day with members of SECAP and the Allston Brighton Substance Use Task Force.
 - Participate in CharlesRiver Community Health's Health Fair in Waltham on substance use prevention and education.
 - Work with Allston Brighton Substance Use Youth Task Force to further educate youth and teens by offering peer-to-peer workshops at area youth organizations to promote healthy lifestyles to prevent substance use at least 4 events, as well as share best practices for language use around substance disorders.
 - Partner with Allston Brighton Substance Use Youth Task Force and others to collaborate with schools to address substance use and mental health in a series of panel discussions to be shared. Offer recommendations, support groups, and suggestions for prevention and treatment. Suggested topics include: vaping prevention, opioid crisis, Narcan trainings, and the importance of the Rx Drug Take Back/Safe Med Disposal program.
- Create a 30-hour training program on substance use disorders for community members by offering a Recovery Coach Academy accredited program hosted at SEMC.
- Partner with PAATHS to ensure a smooth transition of patients being referred and provide financial resources.
- Collaborate and promote the Road to the Right Track in Brighton to increase youth participation in athletic activities as a safe deterrent to using drugs or alcohol.

Long Term Goals:

- Continue to partner with the Allston Brighton Substance Use Youth Task Force on 5 events in the community that promote education and prevention.
- Offer more awareness on substance use disorders which is translated into multiple languages to facilitate better communication with international audiences.
- Reduce and address the gap in services with insurance plans for treating high-risk patients with behavioral health and/or substance use disorders.
- Expand access to care and information for underserved population by partnering with CharlesRiver Community Health, Brighton Marine, and other neighboring health care facilities.
- Assess Need for recovery services in the Allston Brighton community in partnership with Allston Brighton Substance Abuse Task Force.

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, Fenway, Back Bay, Waltham, and Watertown

Health Indicators: Mental Health, Substance Abuse Disorders

Gender: All

Age Group: Youth and elderly

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, SECAP, Allston Brighton Substance Abuse Task Force, Providence House, Jackson Mann, B'nai Brith Housing, CharlesRiver Community Health, Veronica Smith Senior Center, local high schools (i.e Brighton High, St. Joseph's, etc.), Alzheimer Association, and other area businesses.

Short Term Goals:

- Decrease the stigma in the community by providing educational materials for patients, employees, and caregivers outlining the signs of depression and anxiety in schools, hospitals, senior centers and assisted living facilities.
- Advocate screenings for mental illness to foster early intervention with access to treatment (suicide hotline, support groups, high schools, etc.)
 - Provide resources for Suicide Prevention Month in September
 - Work with the Massachusetts NAMI (National Alliance of Mental Illness and NAMI Mass Alliance for Student Illness) support groups in the area to provide awareness and education (i.e. educators, clinicians, student, parents, individuals).
- Create more behavioral health training opportunities for counselors at schools, senior centers, hospital, and other community centers in a partnership with the Allston Brighton Health Collaborative.
- SEMC psychiatry department to develop speaking engagements and further outreach for National Mental Health Month and work with the National Alliance on Mental Illness.

- Work with the Alzheimer’s Association to discuss ways for recognizing the signs of dementia, host more support groups in the community for caregivers, encourage participants in community and hospital to join their annual walk.
- Create 3 community events throughout the year at hospital, high school in partnership with other community partners to provide information (isolation, LGBTQ, suicide, violence, depression, bullying, mental illness, etc.).

Long Term Goals:

- Seek to provide more education, as well as sharing real-life stories to eliminate the stigma in the community while provide more access to care for mental health.
- A focus on the mind/body connection and offering more workshops on reducing anxiety, stress, and homeopathic and alternative treatments, as well as collaborate with other health related community partners.
- Work with the SEMC and community partners to implement mental health screenings at senior centers, schools, temples and churches.

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 adults

Ethnic Group: Immigrants, elders, low-income, culturally diverse populations – Chinese, African American, Latin, and Russian, and others

Language: All

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

Partners: International Health Solutions, Golden Age Chinese Center, B’nai B’rith Housing, Brighton Main Streets, Veronica Smith Senior Center, Providence House, Oak Square YMCA, Friendshipworks, Presentation Rehabilitation Skilled Nursing, SEMC Interpreter Services Department, Charles River Community Health Center, TMA: A Better City, and Allston Brighton Health Collaborative.

Short Term Goals:

- Expand the Medical Legal Partnership at SEMC offering more training to various SEMC departments to assist with financial and legal resources for high-risk patient populations.
- Partner with the Allston Brighton Health Collaborative on the promotion of their “Inclusive Community Convening: Family Preparedness Training” to SEMC staff in order to help immigrants dealing with unexpected stress due to potential deportation and other health concerns.
- Senior Supper: Collaborate with Providence House, Friendshipworks, and Presentation Rehabilitation Skilled Nursing to host throughout the year for a diverse group of seniors in the community to encourage good physical and mental health and screenings for prevention.
- Work with Brighton Main Streets and other area partners to fundraise, collect donations of socks, shoes, coats and other clothes for community members.

- Work with the Allston Brighton Health Collaborative and TMA: A Better City to help provide more access to cost effective transportation options for patients, as well as address concerns with childcare, or absenteeism from job to go to doctor’s appointments and/or treatment.

Long Term Goals:

- Expand opportunity to reach senior population with education, outreach and events to combat elderly isolation by offering at least one new program quarterly.
- Create more resources for elderly and immigrant populations translated into different languages in collaboration with B’nai B’rith Housing, the Golden Age Chinese Center, Veronica Smith Senior Center, as well as invite clinicians to speak at numerous engagements hosted in different languages.

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). It’s important to focus on making improvements across advocacy, rental assistance, and network strengthening for the betterment of the community and people living within SEMC’s neighboring towns.

Target Population: Areas of prevalent homelessness

Geographic Location: Allston-Brighton

Health Indicators: All

Gender: All

Age Group: Youth, Elderly, all adults

Ethnic Group: Nonnative English-speakers

Language: All

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

Partners: Allston Brighton Community Development Corporation, Charleview Community Center, SEMC Case Management Team, Allston Brighton CDC, Medical Legal Partnership.

Short Term Goals:

- Collaborate with ABCD, Charlesview Inc., and Allston Brighton Health Collaborative on advocacy, trainings on rental assistance, and network strengthening to make improvements to the housing situation.
- Work with SEMC case management team and SECAP department to determine those patients who may need assistance with securing stable housing.
 - Increase training on matters of housing, laws on MA real estate, prevention of evictions, and offer additional resources to provide safe housing.

Long Term Goals:

- Expand programs and partnerships with Allston Brighton Community Development Corporation and Charlesview Community Center to address the housing crisis.
- 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, Boston Universities and Colleges, MassHire, Allston Brighton Health Collaborative, Charlesview Community Center, and Brighton Main Streets

Short Term Goals:

- SEMC to offer scholarships for students pursuing a career in health and create new ways to generate jobs with community partners.
- Maintain internship programs across the hospital with 63 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.
- Host SEMC career fairs throughout the year to attract people on the community to new job opportunities.

Long Term Goals:

- Work with the Allston Brighton Health Collaborative, Allston Brighton Substance Use Task Force, and Brighton Main Streets to determine what specific organizations we can partner to promote our workforce development in the community.

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