MASSACHUSETTS GENERAL HOSPITAL

CENTER FOR COMMUNITY HEALTH IMPROVEMENT

2019

COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

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EXECUTIVE SUMMARY

Introduction

Since opening its doors in 1811, Mass General has understood that the role—and the responsibility—of the hospital is to attend to the needs of all, especially those who find access to health care difficult. The founders wrote, "...when in distress, every man is our neighbor."

Today we recognize that access to health care is necessary but not sufficient to achieving good health. Social and economic factors—like equitable access to employment, healthy food, quality education, and affordable housing—play a critical role in overall health. These are often referred to as the Social Determinants of Health (SDoH). They are compounded by significant racial and ethnic inequities in health status.

Health care cannot tackle these issues alone and must partner with other sectors as a strategy for improving health, reducing cost, and achieving racial and ethnic health equity. Since 1995, Mass General's Center for Community Health Improvement (CCHI) has done just that. We have partnered with neighboring communities to advance our shared vision of safe, thriving, and healthy neighborhoods. We have identified priorities and developed strategies based on highly participatory Community Health Needs Assessments (CHNAs). This is the 2019 Mass General CHNA, our first that is collaborative with other health care providers and extends into additional communities.

New, Collaborative Community Health Needs Assessments

The report reflects four new and innovative developments:

1. Mass General participated for the first time ever in three collaborative Community Health Needs Assessment (CHNA) processes in Boston, North Suffolk (Chelsea, Revere, and Winthrop), and Everett-Malden. Previously, Mass General—and most providers—conducted assessments independently. The goal of collaboration is to develop coordinated strategies as well as solutions that can achieve results.
2. The communities identified housing quality and affordability and economic stability and mobility, important social determinants of health, among their top four priorities for the first time ever. Substance use disorder remains a top priority, with the new addition of mental health.
3. Mass General has a historical commitment to the communities of Chelsea, Revere, and Charlestown where we have health centers. But, because we are part of the Boston CHNA Collaborative, we will also include the neighborhoods in Boston with the greatest disparities—Roxbury, Dorchester, Mattapan and East Boston, among others—as neighborhoods of focus.
4. For the first time, Mass General is including additional information on communities where we have licensed health care facilities, including Waltham, Newton, Danvers, and Concord.

Regulatory Requirements

The Affordable Care Act requires health care institutions to conduct CHNAs every three years in communities where they have licensed facilities, submit the report to the Internal Revenue Service, and post the report publicly on the hospital website by the last day of the fiscal year in which the CHNA is conducted (September 30 for Mass General). The Massachusetts Attorney General has a similar requirement. A Community Health Improvement Plan (CHIP) detailing how the hospital will engage with the community to address the prioritized issues must be completed and posted by February 15. (For updates on past implementation plans, see Appendix A.)

While each collaborative will have a CHNA and CHIP, Mass General is required by law to also have its own. This report is the Mass General Community Health Needs Assessment, based on the work of the collaboratives. For more information and full access to the Boston and North Suffolk reports please go to bostonchna.org and www.northsuffolkassessment.org.

While we are required to conduct CHNAs and CHIPs, we are also allowed to prioritize which communities and issues to focus on as long as there is a clear rationale. Therefore, we have determined that Mass General will focus on the communities with the greatest health disparities in Boston and the North Suffolk communities.

The Community Collaborations

In Boston, a first-ever citywide collaborative formed that includes every Boston teaching hospital, the Boston Public Health Commission, community health centers, and community-based organizations (see steering committee members, Appendix B). The process was facilitated and guided by Health Resources in Action (HRiA), a non-profit public health consulting group in Boston. The Conference of Boston Teaching Hospitals acted as the "backbone" organization, providing infrastructure support. As a member of the Boston Collaborative steering committee, Mass General helped guide the entire process, including data gathering, analysis, prioritization, and strategy development.

In North Suffolk (Chelsea, Revere, and Winthrop), city and town leaders formed the North Suffolk Public Health Collaborative (NSPHC) to increase their collective impact on improving health. Like Boston, the Collaborative was made up of area hospital systems, health centers, local health departments, and community-based organizations (Appendix C). Mass General co-led the North Suffolk CHNA process, overseeing data collection, analysis, and reporting. Mass General also provided technical support for the design of focus groups, key informant interviews, and survey questions.

In Everett-Malden we joined with two healthcare providers to conduct a rapid CHNA. Mass General acted as co-coordinator with Cambridge Health Alliance and Melrose-Wakefield HealthCare, developing a survey instrument and focus group guide, assisting with data collection and analysis, and piloting a new CHNA framework called THRIVE, a tool for engaging communities in understanding impacts on health and how to respond. In four towns west of Boston (Concord, Danvers, Newton, and Waltham) where MGH has outpatient facilities, we reviewed data and confirmed the health needs reported in each hospital's CHNA.

The Methods

In each collaborative, participants engaged community organizations, local officials, schools, health care providers, the business and faith communities, residents, and others in an approximately year-long process, tailored to unique local conditions, to better understand the health issues that most affect communities and the assets available to address them. The key methods of the CHNA included:

- Primary data collection via broadly distributed multilingual (up to seven languages) community surveys with 4,298 total respondents; 39 focus groups with 350 community residents in English, Spanish, Chinese, and Haitian Creole; and, 73 key informant interviews with organizational, government, and community leaders.
- Review of secondary data from multiple city, state, and national sources including the U.S. Census, the Massachusetts Department of Public Health, the Boston Public Health Commission, and the Behavioral Risk Factor Surveillance System (BRFSS).

- Rigorous data analysis, including reviewing differences among certain populations, specifically youth and elderly, as well as by race and ethnicity.
- A highly participatory process. In Boston that meant the public was invited to three separate meetings attended by 75-150 people each to guide the process design, review data, select priorities, and develop strategies.

The Priorities

The guiding principle for the Boston, North Suffolk, and Everett-Malden collaboratives is to reduce racial and ethnic health disparities. In all communities, social determinants of health emerged as top priorities, as up to 80% of health status is determined by the social and economic conditions where we live and work. These determinants include access to stable, secure, and quality housing; a job that pays a living wage; healthy food; quality educational opportunities; and, connected and safe communities. Notably, this is the first CHNA ever in which housing and economic issues rose to the top of the list.

The health priorities that emerged across communities and have been adopted as Mass General priorities were strongly aligned and include:

- Safe, affordable, and stable housing.
- Economic and financial stability and mobility, including living wage jobs and educational pathways.
- Behavioral health, including substance use disorders (SUDs) with an emphasis on youth and families.
- Access to health, social, and child care services.

Based on past assessments and historical commitments, Mass General has also selected the following priorities:

- Community/intimate partner violence and safety.
- Obesity and food insecurity.
- Elder/aging health issues.
- Chronic disease with cancer, diabetes focus.

Both collaboratives, as well as Mass General, are now preparing a Community Health Improvement Plan (CHIP) to be completed by February 15, 2020, that outlines goals and objectives in support of the priorities and provides detailed strategies, plans, and timetables for achieving them.

Conclusion

Building upon 24 years of partnering with local communities, Mass General now has new opportunities to work with communities across the region to improve health.

The data from all the communities were notable in showing that, despite varying demographics and resources, communities struggle to prevent and treat mental health challenges and improve access to health and social services. In all of Suffolk County these issues are exacerbated by a lack of affordable and available housing and concentrations of poverty. We believe that our new collaboration and impending CHIPs will enable us to use our collective voice, resources, and strategies to make lasting and positive health impacts.


MASSACHUSETTS GENERAL HOSPITAL
CHARLESTOWN HEALTHCARE CENTER

MASS GENERAL 2019 COMMUNITY HEALTH NEEDS ASSESSMENT

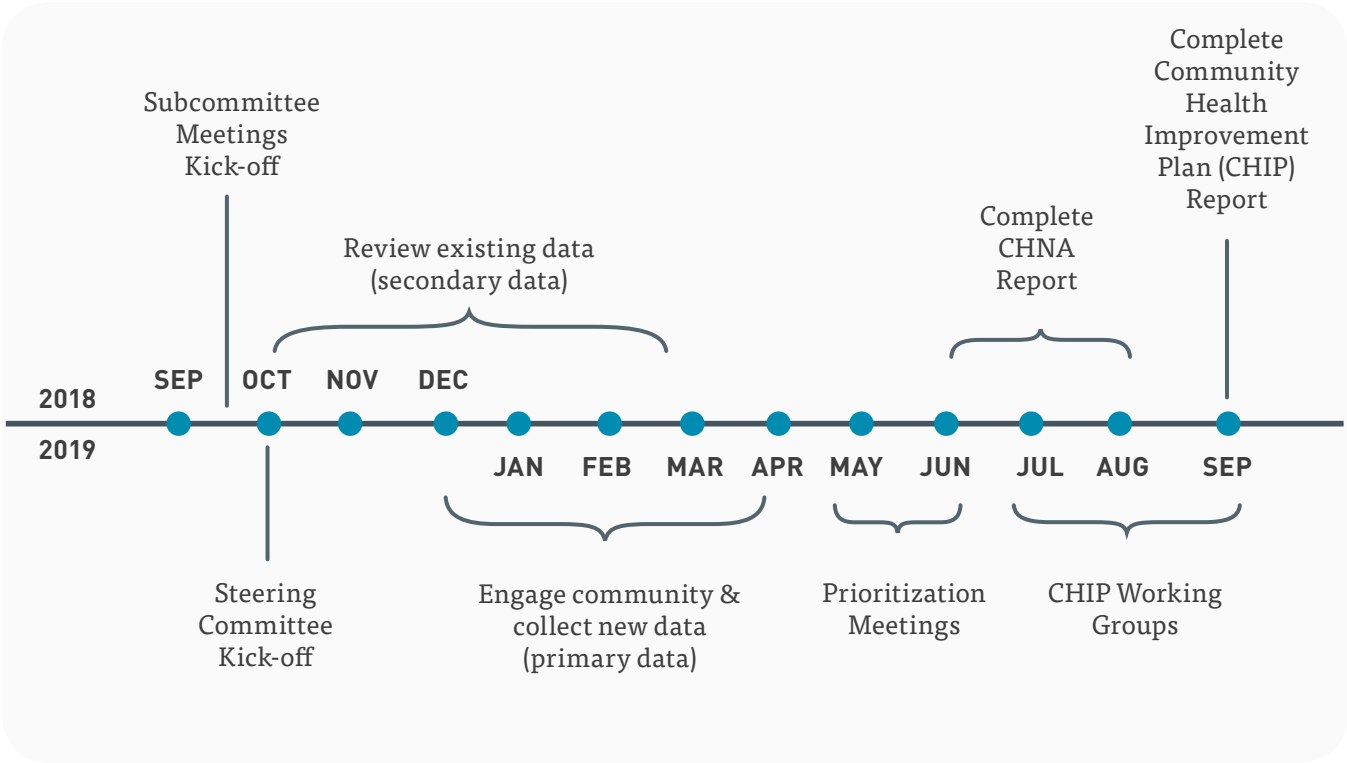
Community Collaboratives, CHNAs, and CHIPs

Mass General joined in 2018 with other member hospitals of the Conference of Boston Teaching Hospitals (COBTH) www.cobth.org to create Boston's first city-wide health collaborative to conduct a Community Health Needs Assessment. We also co-led a regional community health needs assessment in the North Suffolk region (Chelsea, Revere, and Winthrop). And, in 2019 we joined the first health care CHNA collaborative established in Everett-Malden. This report brings together the findings of these collaborative processes and is Mass General's CHNA to be approved by hospital governance by the end of the fiscal year (September 30, 2019).

The Affordable Care Act requires healthcare institutions to conduct CHNAs in any community where they have a licensed facility. Thus, in 2019, in four towns north and west of Boston, MGH connected with other health systems, reviewed the data and health priorities identified in their 2018 CHNAs and determined if MGH's existing programming, relationships and/or resources addressing multiple health priorities could be leveraged and shared. The priorities identified in the towns' CHNAs ranged from access to health care, to behavioral health and substance use disorders, aging, cancer, domestic violence, and the well-being of adolescents.

Community Health Improvement Plans (CHIPs) are being developed in all these communities. Each CHIP will contain detailed strategies to address the prioritized needs that have been identified and the resources needed to implement them. These include possibilities for policy and system changes and new programs. Mass General's CHIP must be completed by the 15th day of the fifth month after the end of the taxable year (February 15).

Timeline of the Boston and North Suffolk CHNA Collaborative Process

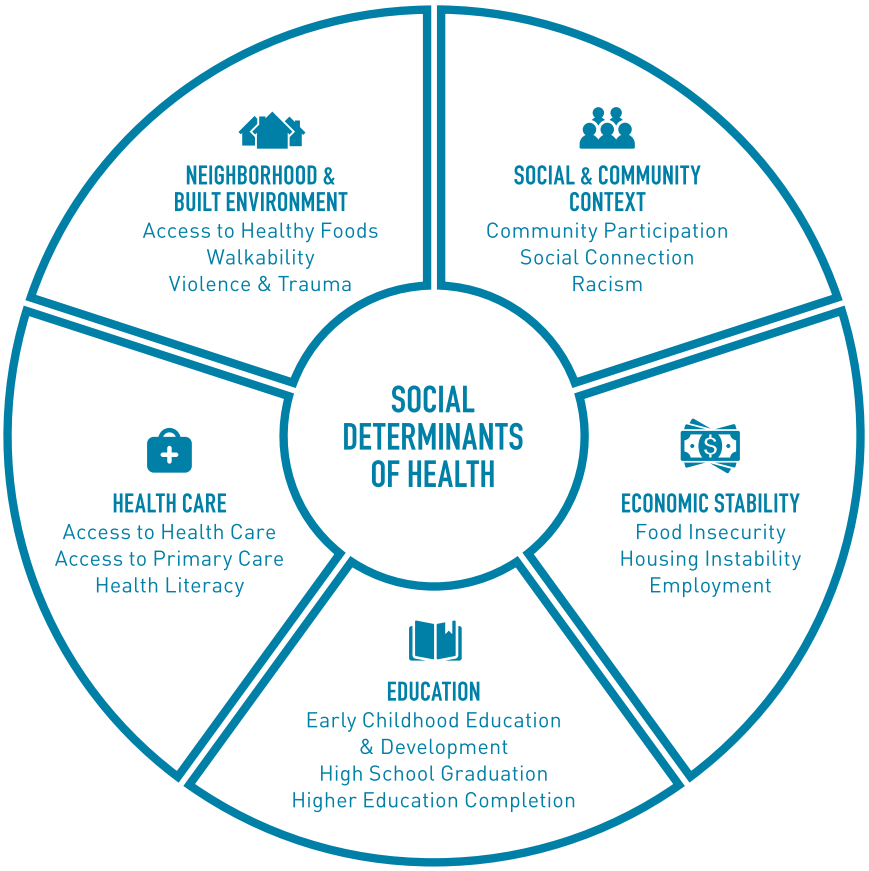


The Social Determinants of Health

Data show that cancer, heart disease, diabetes, and other chronic diseases are drivers of mortality in Boston and North Suffolk communities. There are significant racial and ethnic disparities in these conditions that result in higher mortality rates. For example, the age-adjusted mortality rate per 100,000 is higher in Chelsea (963.8), Revere (734), and Winthrop (928.7) than the Massachusetts rate (668.9). Likewise, Charlestown (758.2), Dorchester (737), East Boston (759), Hyde Park (840.4), and Roxbury (769.9) are higher than Boston's age-adjusted mortality rate per 100,000 (702.5).

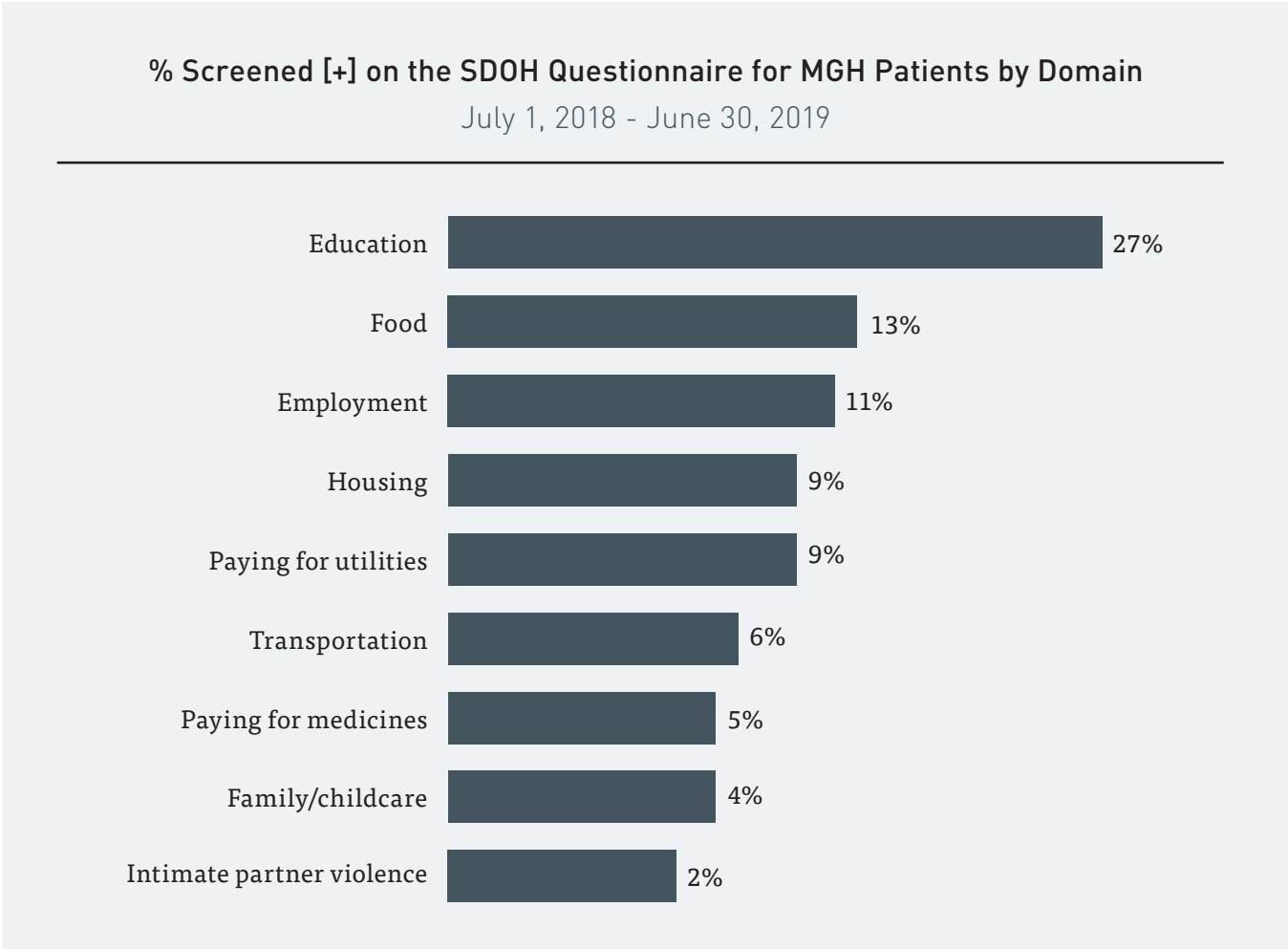
Access to high quality health care—such as that offered at Mass General Hospital—is critical to preventing and treating these conditions. However, medical treatment alone is not enough to eliminate these inequities. Social and economic factors contribute up to 80% toward health status. Issues such as access to safe and affordable housing, healthy food, quality education, and employment opportunities impact health.

That is why this report focuses on the social and economic factors that are such powerful influencers of health status. Health care alone cannot be responsible for solving these societal problems. But health care can play a leadership role in convening and collaborating with business, government, and other sectors to create innovative solutions to complex and longstanding problems.



Mass General Patients and Social Determinants of Health

Mass General patients report experiencing significant challenges with social and economic determinants. As part of the Medicaid Accountable Care Organization (ACO) contract, all primary care practices must screen MassHealth patients for the social determinants of health. The screening questionnaire covers 9 different domains. If patients screen positive, they are referred to the appropriate resources. In the figure below, education, food, employment, and housing are the domains that patients screen positive for the most.

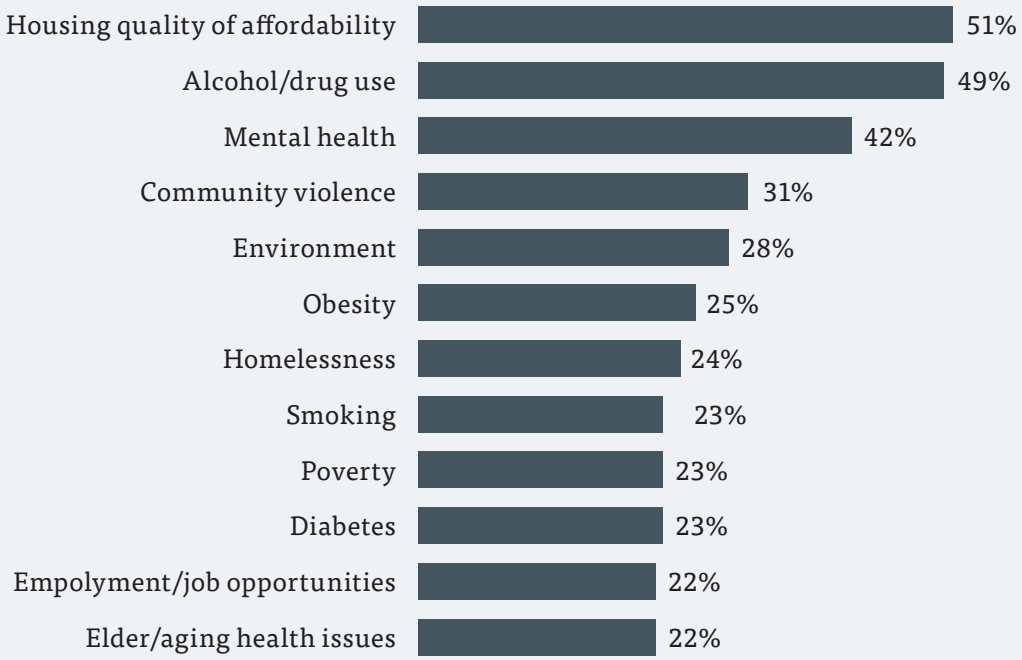


DATA SOURCE: Data Source: Partners HealthCare Enterprise Database Warehouse, accessed 8/22/19

Introduction to the Priorities: Quality of Life Survey Results

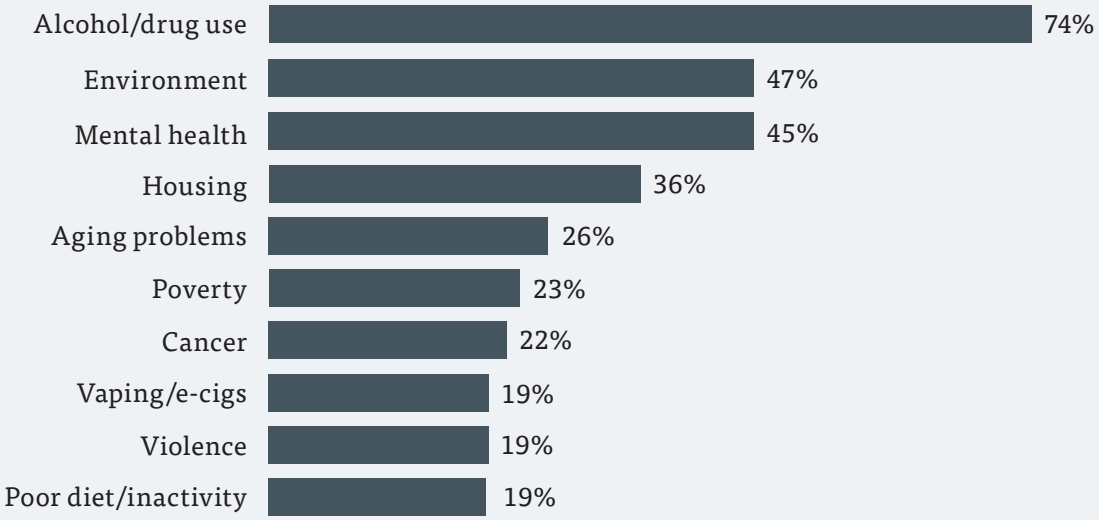
Below are charts representing survey results on the most important concerns in Boston and North Suffolk. Of note are significant differences in the concerns, particularly housing (50.5% Boston v. 36% North Suffolk) and alcohol/drugs (49% Boston v. 74% North Suffolk). This data was considered, along with primary data and community processes, in determining the final priorities.

% Boston CHNA Survey Respondents Reporting Top Most Important Concerns in Their Community/Neighborhood That Affect Their Community's Health (N=2,053), 2019



DATA SOURCE: Boston CHNA Community Survey, 2019

% North Suffolk CHNA Survey Respondents Reporting Top Most Important Concerns in Their Community/Neighborhood That Affect Their Community's Health (N=1,827), 2019



DATA SOURCE: North Suffolk CHNA Community Survey, 2019

Mass General Priorities from the CHNA Collaboratives

The following pages outline the data, both primary and secondary, that led to the chosen priorities of the Boston and North Suffolk CHNA Collaboratives. Mass General is a proud participant of these collaboratives, and a guiding principle of the community health work is to listen to, collaborate, and learn from the communities we work with. Thus, the health priorities of Mass General Community Health are:

- Safe, affordable, and stable housing.
- Economic and financial stability and mobility, including living wage jobs and educational pathways.
- Behavioral health, including substance use disorders (SUD), with an emphasis on youth and families.
- Access to health, social, and child care services.
- Community/intimate partner violence and safety.
- Obesity and food insecurity.
- Elder/aging health issues.
- Chronic disease with cancer, diabetes focus.

A NOTE ABOUT DATA:
Secondary data sources will differ in the upcoming sections between Boston and North Suffolk as different sources are available for different periods of time. For example, the Boston Public Health Commission conducts a Behavioral Risk Factor Survey every other year which provides rich data on healthcare access and behavioral that is not available for North Suffolk communities.


RECOVERY ROAD
MOAR

BOSTON

Overview

Boston's health care sector plays a prominent role in the health and economic status of the entire city and region. Its 9 hospitals and 22 neighborhood-based community health centers, located in all of Boston's 23 neighborhoods, facilitate access to care and add more than 150,000 jobs to the economy. Community health centers care for populations that are diverse in income, race, ethnicity, age, and gender, and address the social determinants of health.

Boston's Collaborative was formed in 2018 as the first city-wide effort to comprehensively understand the health needs of its residents. The Collaborative encompassed all of the city's neighborhoods, was managed by a 19-member CHNA-CHIP Collaborative Steering Committee (the Boston Collaborative), and involved over 100 members that formed the broadest possible array of stakeholders from health centers to hospitals, the Boston Public Health Commission, education, community development, social service organizations, the faith-based community, and, perhaps most importantly, the true experts about challenges to good health—residents who contributed their first-hand knowledge, experience, and ideas for improving the health of the city and the people who live there.

Health Resources in Action (HRiA), a non-profit public health consulting organization, facilitated and supported the Collaborative. The Conference of Boston Teaching Hospitals provided "backbone" or infrastructure support.

The Boston CHNA sought to understand health inequities from a wide perspective across race and ethnicity, gender identity, income, and neighborhood. The work of the Boston Collaborative is guided by the following principles and shared values:

- **Equity:** Focus on inequities that affect health with an emphasis on race and ethnicity.
- **Inclusion:** Engage diverse communities and respect diverse viewpoints.
- **Data driven:** Be systematic in our process and employ evidence-informed strategies to maximize impact.
- **Innovative:** Implement approaches that embrace continuous improvement, creativity, and change.
- **Integrity:** Carry out our work with transparency, responsibility, and accountability.
- **Partnership:** Build trusting and collaborative relationships between communities and organizations to foster sustainable, community-centered change.

The Boston Collaborative prioritized an inclusive process for engaging the community to provide input about the communities' needs, strengths, and opportunities. In particular, the CHNA used a variety of approaches to seek input from individuals and groups that typically are unlikely to participate in such a process due to language, lack of transportation, responsibility for children, age, behavioral health issues, substance use disorders (SUDs), physical limitations, or other barriers. The CHNA process was designed to be inclusive with almost 300 people attending three separate participatory community meetings including a kick-off, prioritization, and strategy development.

Data were gathered from primary and secondary sources. Primary sources included:

- A community survey, completed by 2,404 individuals reached through 91 organizations, administered online and in-person in seven languages.
- 13 focus groups with a total of 104 community residents.
- 45 interviews with organizational, government, and community leaders.

Secondary data were gathered from city, state, and national sources including the U.S. Census, the Massachusetts Department of Public Health, the Boston Public Health Commission, and the Behavioral Risk Factor Surveillance System (BRFSS).

In order to gain the fullest possible understanding about impacts on health, particularly the social determinants of health, an exhaustive list of considerations, from education, to race, ethnicity, culture, and language diversity, to income, food insecurity, green space, community cohesion, and more were addressed. After an inclusive review and assessment of the data, the Collaborative used a careful rating system to identify the priorities that would then form the city's Community Health Improvement Plan (CHIP).

In April 2019 the CHIP working group, co-chaired by a Mass General representative, created prioritization criteria:

- **Burden:** How much does this issue affect health in Boston?
- **Equity:** Will addressing this issue substantially benefit those most in need?
- **Impact:** Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Is it possible to address this issue given infrastructure, capacity, and political will?
- **Collaboration:** Are there existing groups across sectors willing to work together on this issue?

The prioritization process had several stages. First, a 16-page draft executive summary of the CHNA report was sent to over 150 organizations and individuals along with an online survey which asked participants to rate 9 key issues on the above criteria. Next, over 100 community residents and organizational staff across a multitude of sectors attended a three-hour meeting to consider all of the input and choose the priorities. The Boston CHNA-CHIP Collaborative Steering Committee refined those priorities.

The priorities identified in the Boston CHNA from public sources, surveys, focus groups, community meetings, and key informant interviews are:

- Safe and stable housing (affordability, quality, ownership, gentrification, displacement).
- Financial security and mobility (jobs, income, education, training).
- Behavioral health including SUDs.
- Access to health, social services, and child care.

The CHNA and the subsequent development of a Community Health Improvement Plan (CHIP) have provided a structure for including more voices at the table, from hospitals to community residents to community development corporations, leading to more accurate identification of the health and social needs in the city, and sharing of the ideas, solutions, and resources that comes with increasing trust among diverse constituents.

For Mass General, the process was a welcome opportunity to work as a true partner among many. It's a learning process that is both important and fruitful, and a journey that allows us to more fully do our part to improve the health and well-being of the diverse communities we serve.

The Boston Context

The Boston CHNA focuses on those with the greatest health disparities. With a population of nearly 670,000, Boston is experiencing rapid population growth—about 8% in just the past ten years. The city expects this trend to continue to include a total anticipated population of 723,500 residents by 2030. Boston is a young city; about one-third of residents are under age 24. It's also diverse and becoming more so, including residents who are Black (23%), Latino (20%), and Asian (10%). It has a large immigrant community; most immigrant residents were born in the Caribbean or Asia, and one-third speak a language other than English at home, primarily Spanish. Some groups are concentrated in certain neighborhoods with a greater number of Black residents in Mattapan, Dorchester, Roxbury, and Hyde Park; more Latinos (the group with the greatest growth in recent years) living in East Boston; and, more Asians living in the South End, Fenway, and Allston/Brighton.

Total Population, by Boston and Neighborhood, 2008-2012 and 2013-2017			
	2008-2012	2013-2017	% population change 2012 to 2017
Boston	619,662	669,158	8.0%
Allston/Brighton	61,159	63,270	3.5%
Back Bay	51,735	55,635	7.5%
Charlestown	17,052	18,901	10.8%
Dorchester (02121, 02125)	58,797	63,733	8.4%
Dorchester (02122, 02124)	75,304	79,717	5.9%
East Boston	41,680	46,655	11.9%
Fenway	52,897	54,267	2.6%
Hyde Park	29,219	33,084	13.2%
Jamaica Plain	36,866	39,435	7.0%
Mattapan	27,335	29,141	6.6%
Roslindale	30,370	32,819	8.1%
Roxbury	37,454	43,871	17.1%
South Boston	34,452	39,866	15.7%
South End	34,395	34,777	1.1%
West Roxbury	27,163	28,505	4.9%

DATA SOURCE:
U.S. Census, American Community Survey 5-Year Estimates, 2008-2012 and 2013-2017

NOTE:
Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Boston population count includes some areas that are not covered by neighborhood definitions per ZCTAs

Racial and Ethnic Distribution, by Boston and Neighborhood, 2013-2017					
	Asian	Black	Latino	White	Other
Boston	9.4%	22.7%	19.4%	44.9%	3.6%
Allston/Brighton	17.7%	4.9%	11.7%	61.7%	8.6%
Back Bay	10.6%	4.1%	6.8%	76.1%	2.4%
Charlestown	7.2%	5.8%	11.8%	73.2%	2.0%
Dorchester (02121, 02125)	6.7%	44.8%	24.6%	17.5%	6.5%
Dorchester (02122, 02124)	9.9%	49.0%	14.8%	21.6%	4.7%
East Boston	3.8%	2.6%	57.4%	32.6%	3.7%
Fenway	18.3%	5.6%	12.9%	60.0%	3.2%
Hyde Park	2.1%	42.2%	27.1%	25.1%	3.4%
Jamaica Plain	6.7%	10.6%	21.8%	56.8%	4.0%
Mattapan	NA	77.2%	15.0%	4.2%	2.8%
Roslindale	2.2%	21.4%	24.5%	48.9%	3.0%
Roxbury	8.3%	40.8%	27.3%	20.0%	3.7%
South Boston	4.8%	5.9%	10.2%	77.5%	1.6%
South End	23.0%	11.7%	16.6%	45.8%	2.8%
West Roxbury	6.7%	5.6%	7.9%	77.8%	2.0%

DATA SOURCE:
U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

NOTE:
Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Latino includes residents who identify as Latino regardless of race and racial categories include residents who do not identify as Latino; Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Some other race, and Two or more races; NA denotes where data not presented due to insufficient sample size

There are also disparities in education. Forty-eight percent (48%) of all Boston residents have a college degree or higher; however, rates vary substantially across race and ethnicity: Whites (70%), Asians (57%), Latinos (21%), and Blacks (20%). In the Boston Public Schools (BPS), nearly 42% of students identify as Latino and 32% as Black, and many school-age children have special needs that affect their educational achievement. BPS data show that 76% of students have "high needs," meaning they are low-income, English Language Learners, and/or have a disability.

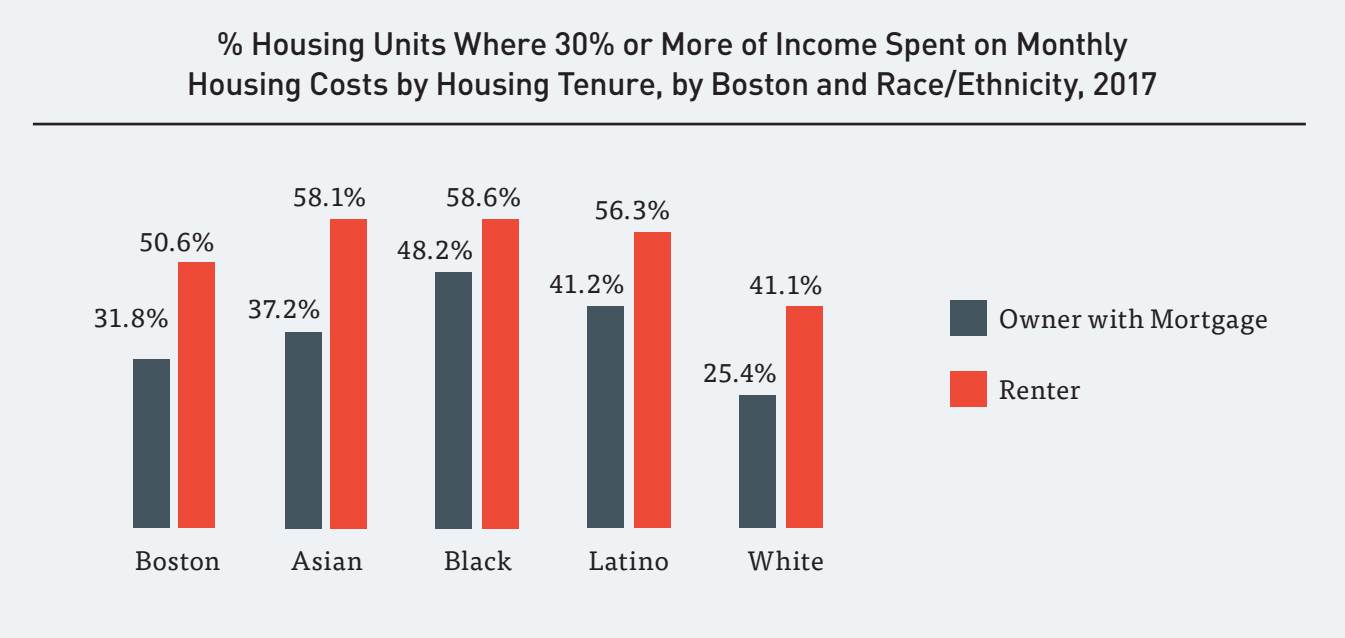
CHNA survey respondents described many strengths in their communities and neighborhoods. The top five strengths cited across ethnicities are:

- My community has people of many races and cultures.
- My community is close to medical services.
- People speak my language.
- My community has good access to resources.
- People are proud of their community.

Improving health: The Boston CHNA Priorities

Housing

Boston is known for its high cost of housing. CHNA participants across neighborhoods consistently stated that the rising cost of housing in Boston is a major day-to-day concern and leaves few resources for other needs. The cost of a single-family home rose by 48% between 2011-2016. Among renters, Blacks, Latinos, and Asians are significantly more likely to spend 30% or more of their income on housing compared to all Boston renters. The availability of affordable housing has dropped considerably between 1996-2016. More than 39% of all new housing permits in 1996 were affordable, compared to only 18% in 2016. Almost 20% of CHNA survey respondents (19.5%) reported trouble paying their rent or mortgage. For some groups the rate was much higher, including respondents who were Black (29.4%), Latino (27.1%), Non-binary/transgender (42.3%), those with some college or a certificate program (34.2%), LGBTQ individuals (24%), and the parent of a child under age 18 (23.7%).



DATA SOURCE: U.S. Census, American Community Survey 1-Year Estimates, 2017

The pressures of housing stability and affordability are intense and are associated with poor physical and mental health outcomes, as well as disruptions in work, school, and day care arrangements. Poor housing quality can have direct negative health impacts including respiratory conditions such as asthma due primarily to poor indoor air quality, cognitive delays in children from exposure to neurotoxins (e.g., lead), and accidents and injuries as a result of structural deficiencies.

There are other impacts. CHNA participants noted that high housing costs are especially difficult for people with low or fixed incomes, such as seniors and residents who work low-wage jobs. Those who are undocumented and non-English-speaking are especially vulnerable. One focus group participant shared, "The people who live here do not have access to the new apartments coming up in East Boston. How are we supposed to access rents that are $2,000-3,000 and maintain a life?"

"The people who live here do not have access to the new apartments coming up in East Boston. How are we supposed to access rents that are $2,000-3,000 and maintain a life?"

In Boston in 2018, an estimated 6,188 residents were homeless, and nearly one-third of homeless households included at least one child. Those with behavioral health issues and/or SUDs, LGBTQ youth, seniors, immigrants, those with a criminal record, single mothers, and survivors of trauma are most vulnerable to homelessness. The number of homeless persons has remained relatively consistent between 2015-2018, with modest variation in racial composition.

Gentrification, long waiting lists for housing assistance (up to ten years for public housing), discrimination, and overcrowding are part of daily life for the poor and near-poor. Families struggle to meet basic needs, make credit card payments, or pay medical bills. Access to quality education and training programs is essential for economic mobility but limited by poor preparation in substandard educational systems in poor areas. For those at housing risk, the absence of a safe and secure home can affect every other dimension of their lives.

CHNA respondents called for increasing opportunities for home ownership and the assets it brings in non-White communities, and for mitigating the impact of gentrification and displacement.

Financial Security and Mobility

The average income in Boston is $62,021, but the range is large and there are disparities—from $27,952 in Dorchester to $170,152 in South Boston. In four neighborhoods—Dorchester, Fenway, Roxbury, and the South End—25-37% of residents live below the federal poverty level. Median income is highest for Whites ($98,317) and lowest for Latinos ($36,998). One interviewee summarized, "Real wages have been going down for low income people [for decades]. This is at the heart of all of it: people have no time because they are working four jobs to get the same salary they used to get from one [job]. If you can't rest, how can you be healthy? The sleep and the downtime are fundamental, and people have less of it. Some people have to work 70 hours to make ends meet."

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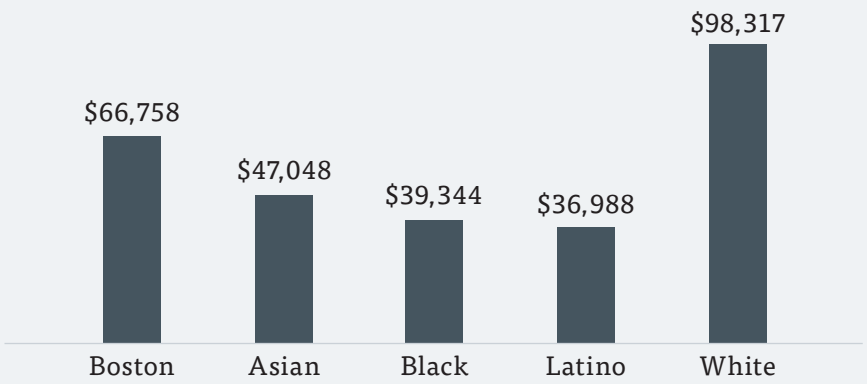
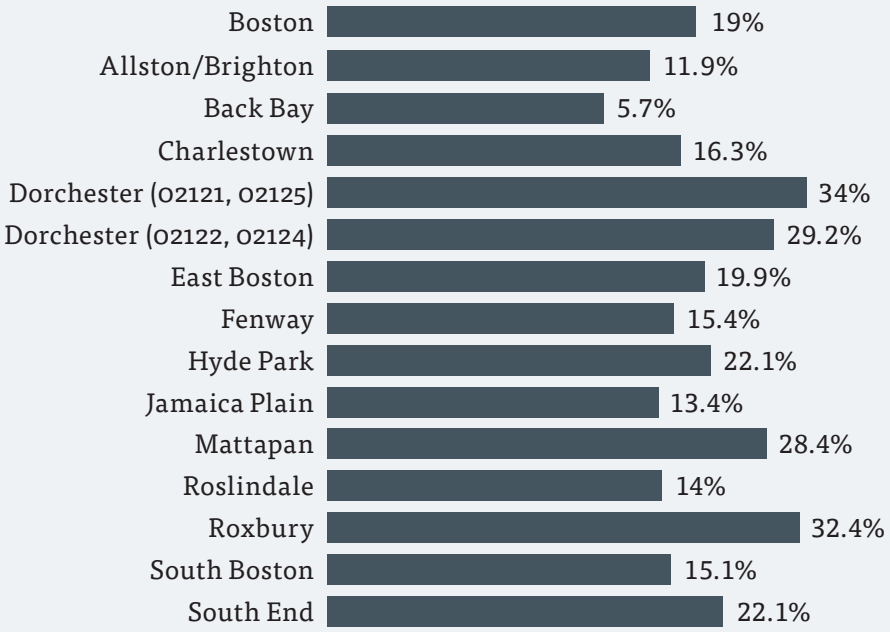
Median Household Income, by Boston and Race/Ethnicity, 2017



DATA SOURCE:
U.S. Census, American Community Survey 1-Year Estimates, 2017

Roxbury (44%), Fenway (40%), parts of Dorchester (02121 and 02125 zip codes—36%), and the South End (31%) had the highest proportion of households with incomes below $25,000. The percentages of households receiving food stamps (known as SNAP—Supplemental Nutrition Assistance Program) across Boston neighborhoods ranges from a low of 5.7% in Back Bay to a high of 34% in parts of Dorchester and 32% in Roxbury.

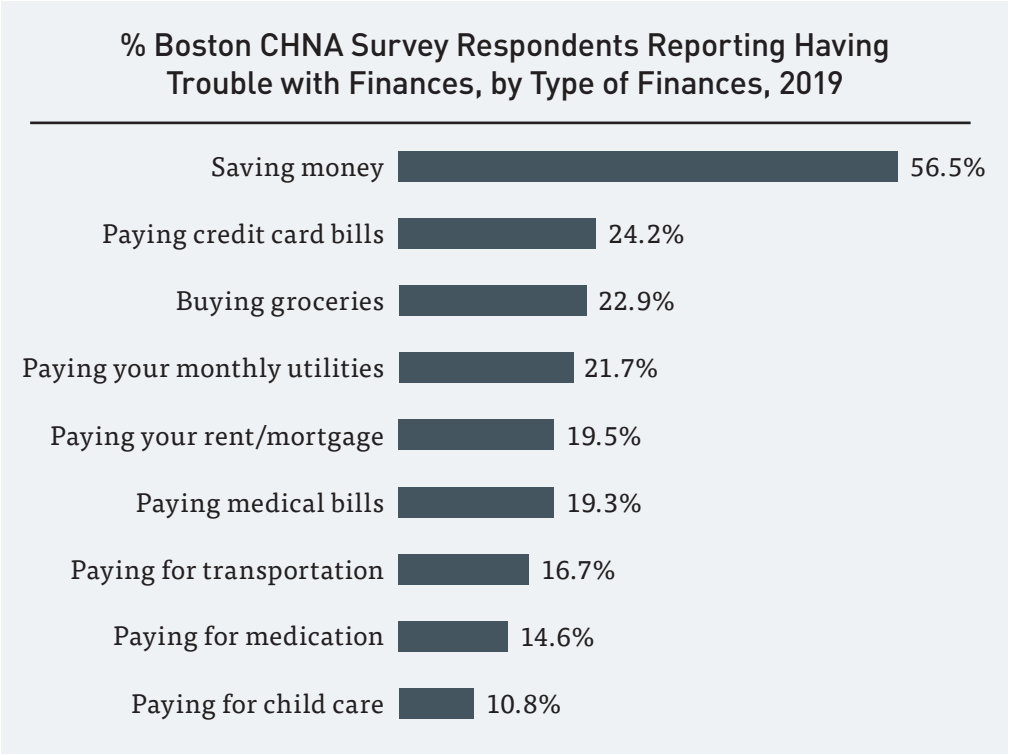
% Households Receiving Food Stamps/SNAP Benefits by Boston and Neighborhood, 2013-2017



DATA SOURCE:
U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

NOTE:
Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown

Many residents struggle to meet basic needs, while non-White more than White CHNA respondents described struggles with credit card debt, housing costs, medical bills, child care, and more.



DATA SOURCE:
Data Source: Boston CHNA Community Survey, 2019

NOTE:
Percentage calculations do not include respondents who selected "don't know/prefer not to answer"

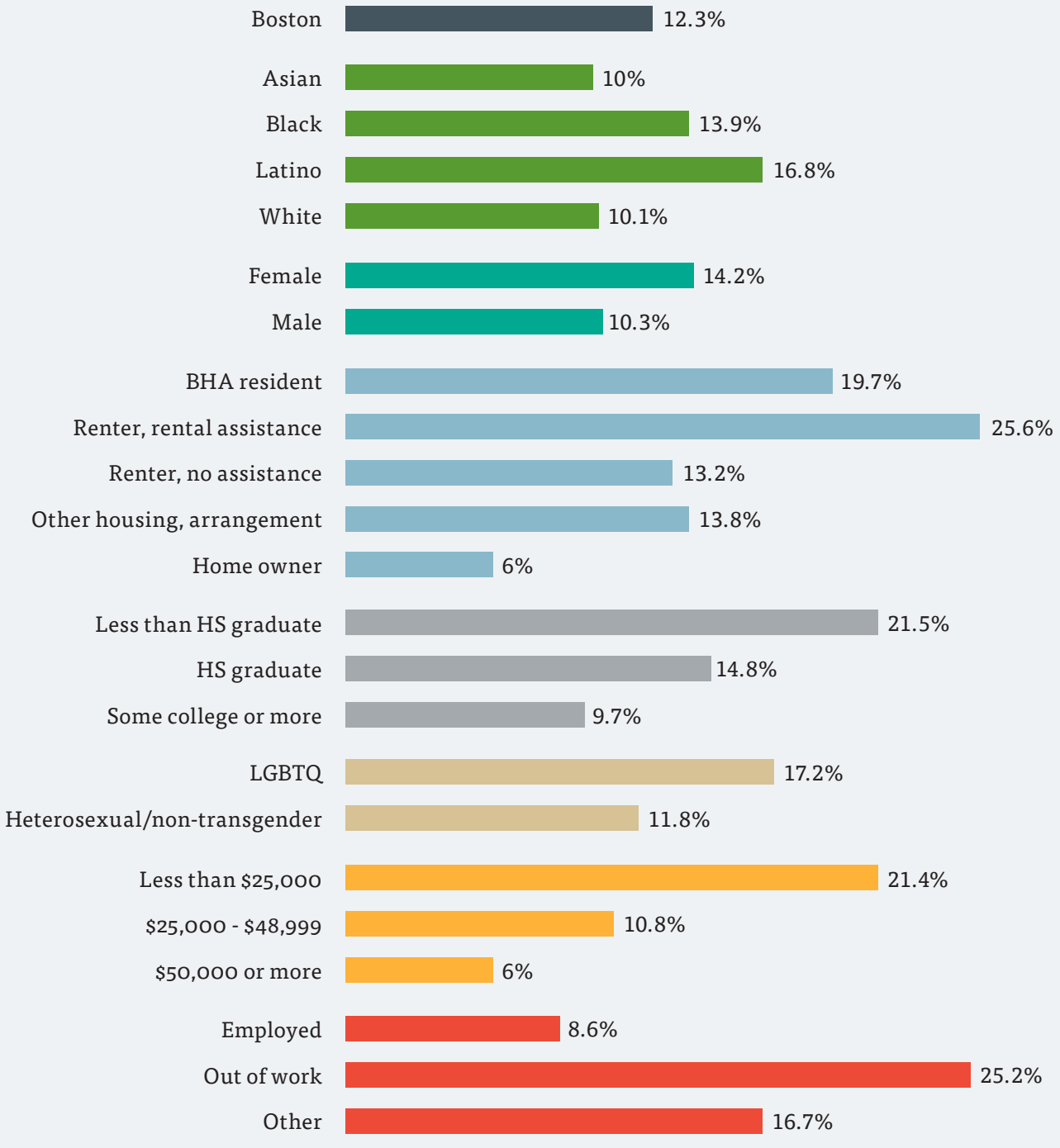
Boston's unemployment rate is deceptive. In 2018, overall unemployment was 3.0%; however, it was significantly higher in Roxbury (12%), Dorchester (11%), Fenway (10%), and Mattapan (11%). The health care and education sectors are Boston's largest employers with substantial growth, but CHNA participants noted challenges in securing employment in these and other industries due to required education credentials, online applications that are challenging for those with limited technical knowledge, and a criminal record. According to the American Community Survey, nearly one-third of Boston residents 16 years or older are employed in education, health care, or social assistance industries; followed by professional, scientific, and management jobs; and administrative and waste management services positions (industry categories are pre-defined by the U.S. Census).

CHNA participants recommended reducing employment barriers by addressing minimum education requirements, valuing the lived experience of applicants, and increasing youth employment opportunities.

Behavioral Health Including Substance Use Disorders

The CHNA showed widespread concern about behavioral health challenges among families, friends, and neighbors. Stress, anxiety, and depression were the most frequently-cited behavioral health issues among Boston residents, especially those who identify as LGBTQ, low-income, women, renters, seniors, children, immigrants, communities of color, and the unemployed. Data show persistent sadness (12%) among Boston adults. Rates are higher among Blacks (14%), Latinos (17%), Boston Housing Authority (BHA) residents (20%), renters and those receiving rental assistance (26%), those with less than a high school education (22%), LGBTQ individuals (17%), those earning less than $25,000 (21%), and those who are unemployed (25%).

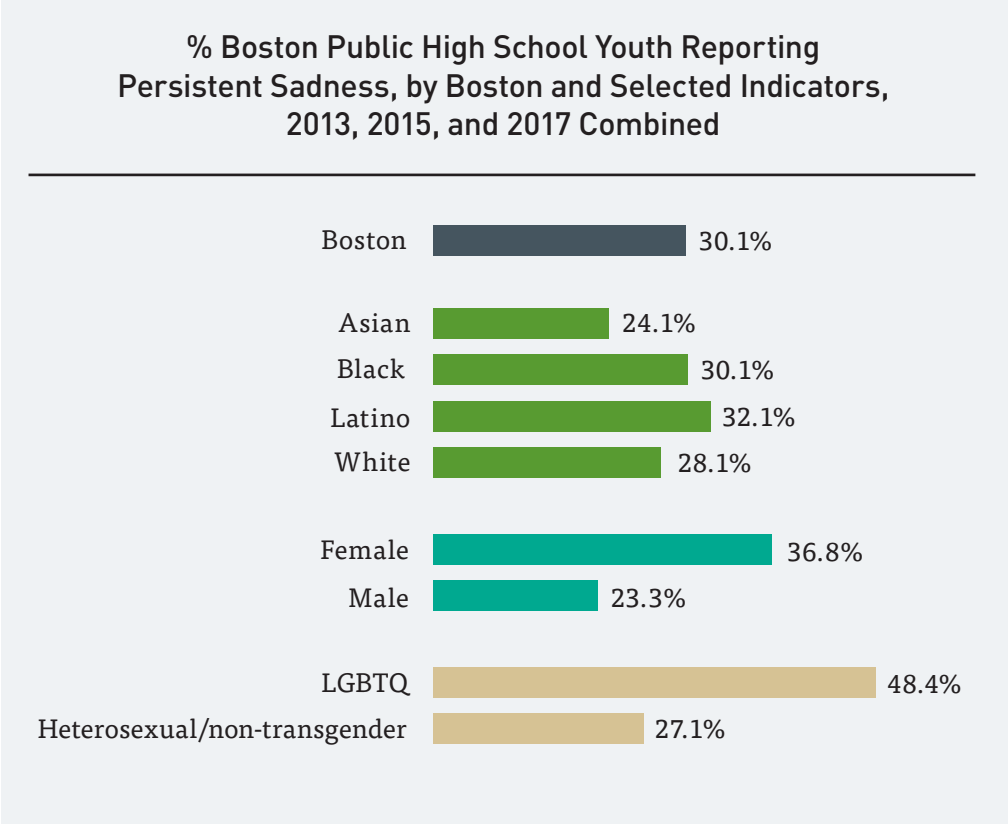
% Adults Reporting Persistent Sadness, by Boston and Selected Indicators, 2013, 2015, and 2017 Combined



DATA SOURCE:
Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2013, 2015, and 2017 combined

NOTES:
Persistent sadness is defined as feeling sad, blue, or depressed for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

The data for those with persistent anxiety are also concerning, with high rates for Boston adults (21%), women (24%), people with low income (28%), young people ages 18-24 (24%), and the unemployed (33%). Boston's Youth Risk Behavior Survey (YRBS) data show concerning trends in children and youth: nearly one-third of BPS high school students report persistent sadness, with higher rates among female and LGBTQ students.

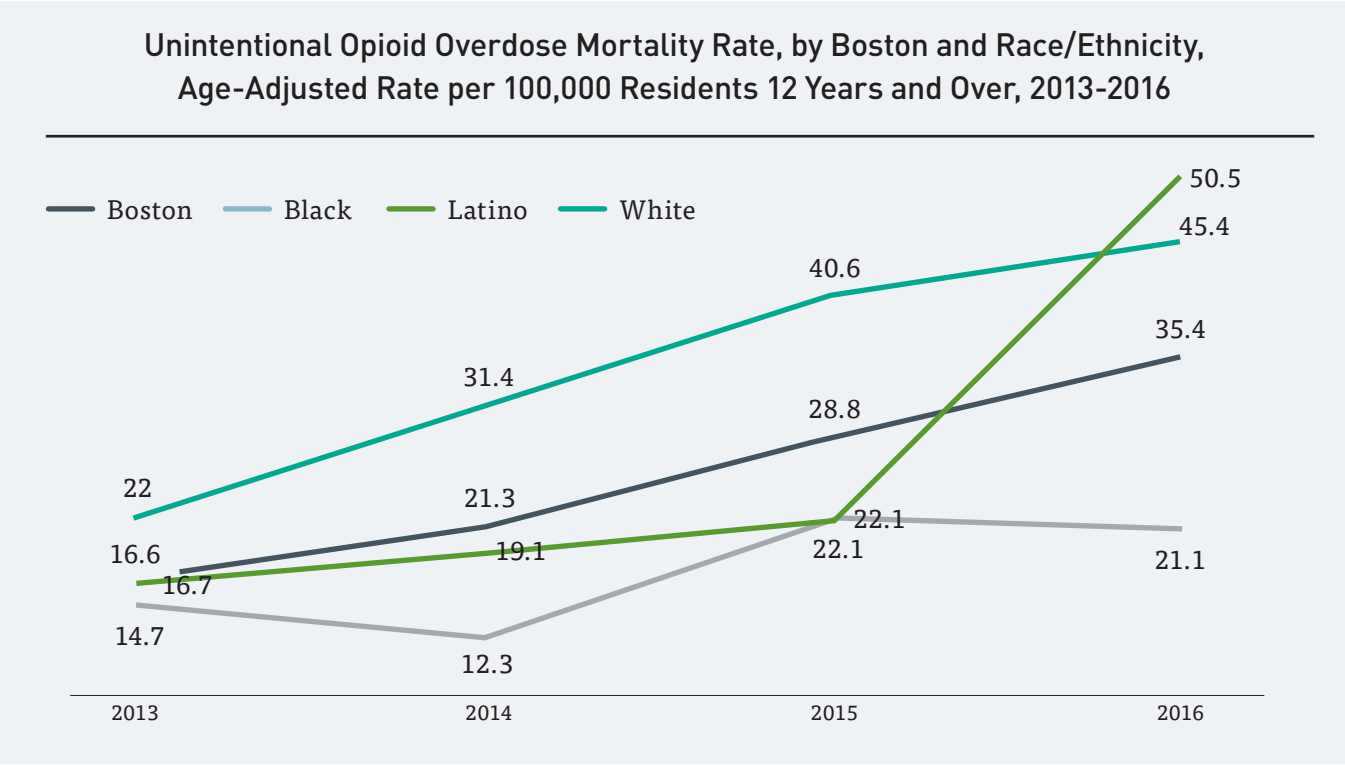


DATA SOURCE:
Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2013, 2015, and 2017 combined

NOTE:
Students were asked in the past 12 months if they felt sad or hopeless every day for 2 weeks or more; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

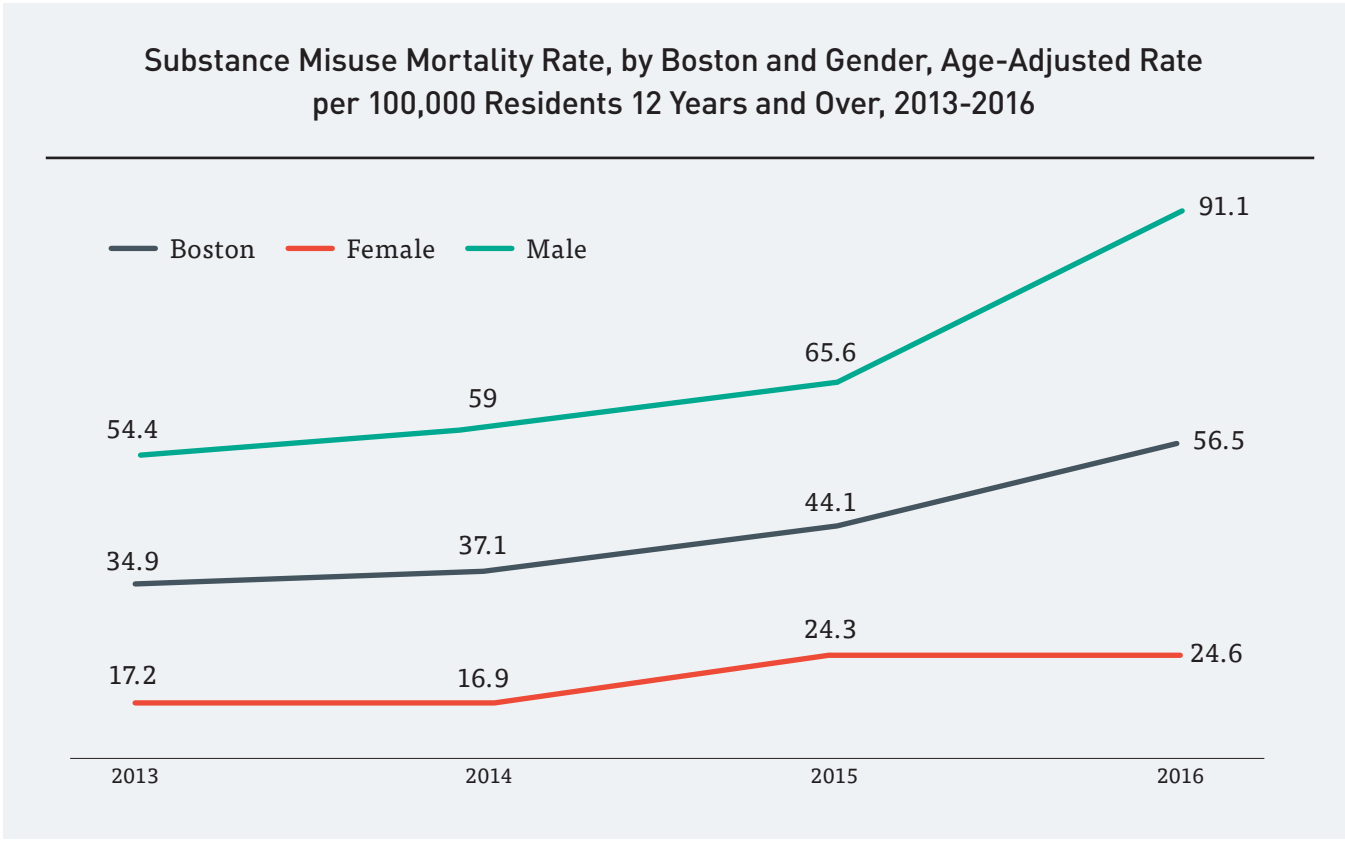
Other influences on behavioral health cited by CHNA participants included unstable housing; parental incarceration, especially of Black and Latino men who are thereby not present in the home; and, domestic violence. Immigrants and communities of color were described as especially vulnerable to behavioral health concerns due to limited English language skills, cultural norms, and stigma related to seeking mental health services.

Participants discussed the co-occurrence of behavioral health issues with SUDs, including opioid use disorder (OUD) and trauma. Together these challenges are among the leading causes of disability in the U.S. In 2016, unintentional opioid overdose accounted for 69% of all accidental deaths, with rates highest among Latinos, followed by Whites. Increases in opioid overdose mortality leveled off between 2013-2016, with an alarming exception among Latinos. Data released from the Massachusetts Department of Public Health during the writing of this report does suggest some good news, though. Between 2017 and 2018, Boston saw an 8.5% decrease in the number of opioid-related overdose deaths, from 198 to 181, respectively.



DATA SOURCE: Data Source: Massachusetts Department of Public Health, Boston resident deaths, 2013-2016

There is also substantial and concerning gender difference in the substance misuse mortality rate.



DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2013-2016

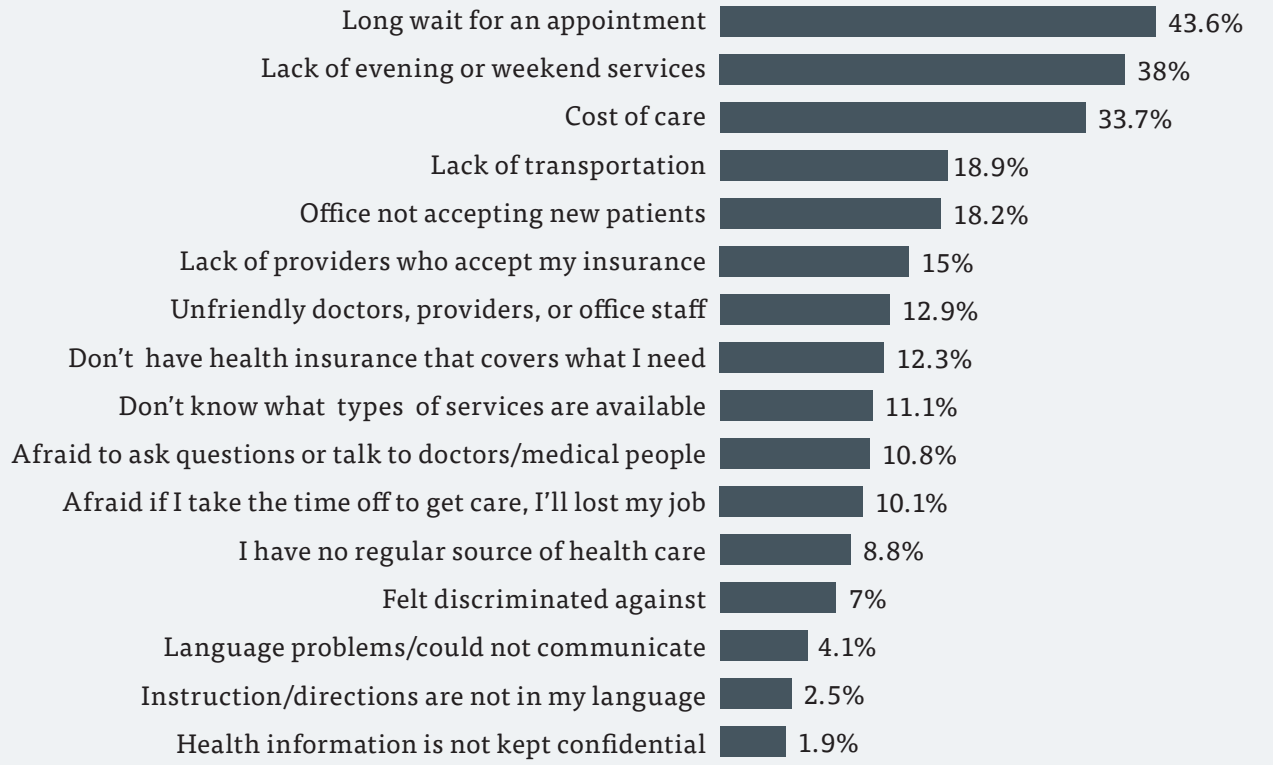
CHNA respondents report that access to help is limited by stigma, culture, language, cost, and provider competency in treating immigrant communities. They recommended investing in more behavioral health support in public schools, reducing cultural stigma linked to behavioral health services, and recruiting behavioral health clinicians who reflect the diversity of Boston. One key informant illustrated these barriers by sharing, "There is far too little access to treatment programs, and those that do exist are not linguistically and culturally competent."

"There is far too little access to treatment programs, and those that do exist are not linguistically and culturally competent."

Access to Health Care, Social Services, and Child Care

Across focus groups, interviews, and surveys CHNA respondents expressed satisfaction with their health care; the Boston Behavioral Health Risk Factor Surveillance System (BRFSS) survey results show that 80% of respondents identify at least one personal doctor. Nevertheless, they described barriers to care including language, navigating the health care system, understanding health care benefits, transportation, a lack of culturally sensitive approaches to care, and immigration status. In particular, CHNA participants spoke about the fear in undocumented or mixed status families that prevent family members from seeking care. CHNA respondents also cited long wait times for appointments (44%) and a lack of evening and weekend services (38%) that limit access to health care.

% Boston CHNA Survey Respondents Reporting Factors That Made It Harder for Them to Get Health Care Services They Needed in Past Two Years (N=1,014), 2019



DATA SOURCE: Boston CHNA Community, Survey, 2019

Homeless individuals, undocumented immigrants, and students indicated challenges accessing health care due to a lack of insurance. Homeless residents in focus groups specifically discussed the challenge of not having a permanent mailing address or the ability to access birth certificates as a barrier to insurance coverage. Under-insurance was also cited as a challenge to maintaining or regaining health.

CHNA participants recommended increasing help for navigation of the complex health care system and delivering culturally sensitive and linguistically appropriate services to diverse groups. They suggested improving collaboration and information sharing between medical providers and service agencies, especially with the spread of accountable care organizations; pursuing multi-year funding to allow for adequate response to crises and opportunities while building capacity in the health care system; and, long-term renewable leases for nonprofits and social service agencies strained by rising operating costs.

Access to child care

Data about access to child care for Boston residents is limited, prompting the City of Boston to include a survey on child care availability for children ages five and under in its 2019 census. For low-income working families, the cost of child care is a substantial barrier to financial security and employment opportunities, especially for single parents. CHNA participants reported having to work multiple jobs to afford child care and the impact on parenting, by limiting time with their children. Nearly one-quarter (23%) of parents with children under 18 reported difficulty paying for child care, with high rates as well among those age 25-44 (19%), those who have completed some college or a certificate program (20%), and those who are non-binary/transgender (19%).

Other challenges were cited, including long waiting lists for child care, especially for children under age three, and difficulties finding child care during the summer, school vacations, and on days when schools are closed for holidays or other reasons. Grandparents may be available to fill in, but at a cost if they need to miss work to do so. CHNA participants recommended subsidies for child care so that low-income parents can pursue education and training as steps toward economic mobility.

Transportation

Boston residents (34%) rely on public transportation to get to work, health appointments, their children's schools, or for help from social service or other organizations. It's essential to their health and livelihoods. However, transportation options in Boston have limitations: CHNA participants expressed concern about cost, timeliness, and access, especially for the elderly, those with limited English proficiency, or those who live in neighborhoods with limited transportation options. Bostonians spend an average of 11% of their household income on transportation expenses.

NORTH SUFFOLK

Overview

Three communities north of Boston—Chelsea, Revere, and Winthrop—joined together to assess their changing demographics and shared health needs and develop strategies to address them. In 2016, the Mayor, City Manager and Town Manager of Revere, Chelsea, and Winthrop, respectively, formed the North Suffolk Public Health Collaborative (NSPHC) with the assistance of the Metropolitan Area Planning Council. The NSPHC represents the three cities outside of Boston that comprise the remainder of Suffolk County. With funding from the three municipalities, the NSPHC hired a director to work with stakeholders across the three communities to implement shared activities.

The city leaders were committed to building on the community health needs assessments each community had conducted separately with Mass General since 1995. They believed the joint assessments would leverage their shared knowledge, experience, and resources immeasurably. Mass General's Center for Community Health Improvement (CCHI) joined to co-lead and manage the process.

A Steering Committee was formed comprised of municipal leaders and representatives of the three communities' health departments, human services providers, community residents, and other health providers in the area including Cambridge Health Alliance, Beth Israel Deaconess, East Boston Neighborhood Health Center, and Melrose-Wakefield HealthCare. The steering committee created a memorandum of understanding for participation and shared agreement of the roles, responsibilities, and deliverables for each member. The steering committee also established subcommittees to manage the primary components of the work including instrument review, community engagement, and data analysis. Work groups formed to design the CHIP initiatives that will address the assessment priorities.

The North Suffolk Collaborative created a shared vision to drive the community health assessment:

Every individual in the region should have every opportunity to live a healthy life, and all public and private entities and community residents will work in continuous partnership to improve health outcomes for all.

Throughout, the North Suffolk Collaborative prioritized hearing from residents for whom the process may have been unfamiliar and/or may have seemed risky; for example, undocumented residents. Specific approaches were used to reach as many participants from as many groups as possible. The instrument review subcommittee prepared a list of such population groups and developed outreach plans to engage them in key informant interviews and focus groups. An interview with the three city leaders was aired on public access television, in English and Spanish, to inform community members about the assessment and to stress the importance of their participation.

Data were gathered from primary and secondary sources. The primary sources included:

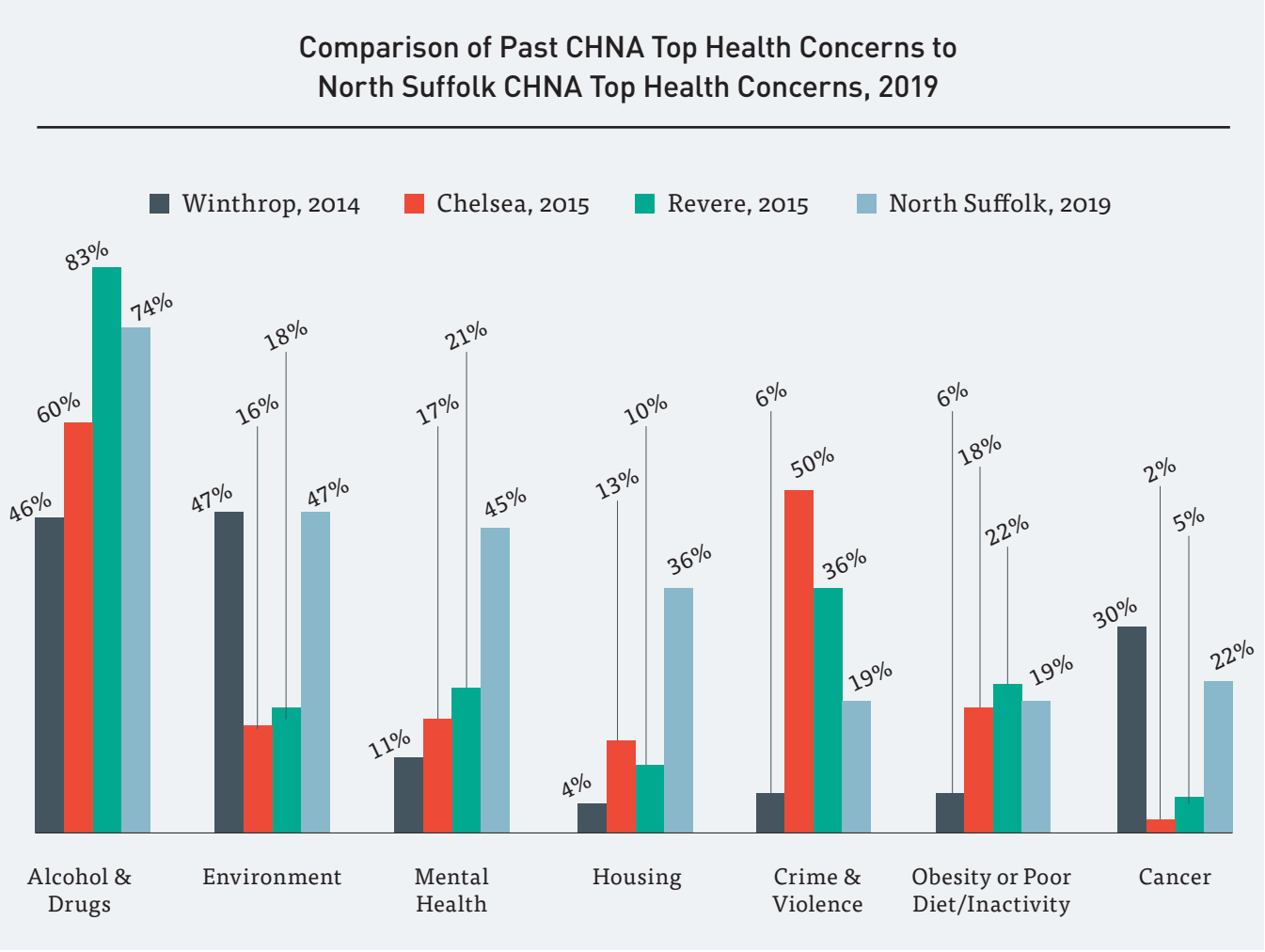
- A community survey, completed by 1,827 individuals reached through 30 organizations, administered online and in-person in four languages (English, Spanish, Portuguese, and Arabic).
- 22 focus groups with a total of 212 community residents or those who work in the communities.
- 28 interviews with organizational, government, and community leaders.

Secondary data were gathered from city, state, and national sources including the US Census, the MA Department of Public Health, the MA Department of Education, the local Youth Risk Behavior Survey (YRBS), the Prevention Needs Assessment (PNA), local police departments, and community-based organizations.

As in the Boston assessment, in order to gain the fullest understanding about impacts on health, particularly the social determinants of health, the CHNA addressed the widest possible range of contributors to health status—from education to racial, ethnic, cultural, and language diversity, to income, food insecurity, green space, community cohesion, and more. After an inclusive review and assessment of the data gathered, the North Suffolk Collaborative used a careful rating system to identify the priorities that would then inform the CHIP. The priorities are:

- Housing – including affordability, quality, stability, gentrification and displacement.
- Behavioral Health – including youth mental health and substance use disorders, especially for youth and families.
- Economic Stability and Mobility – including employment, job training and education.

Most notable in the review of data was the increase in concern by residents around housing and mental health. In the graph below, respondents to past CHNA community surveys did not rank mental health or housing very high on their list of concerns. However, in the 2019 community survey, these are in the top 4 concerns for the region. Also notable is the decrease in concern around crime and violence for Revere and Chelsea.



DATA SOURCE: Winthrop CHNA Community Survey, 2014; Chelsea and Revere CHNA Community Surveys, 2015; North Suffolk CHNA Community Survey, 2019

The North Suffolk Context

Chelsea, Revere, and Winthrop are small, changing cities, each contiguous to East Boston. Their populations range in size, race, ethnicity, rates of poverty and education, and English proficiency. Notably, there are higher rates of child poverty, percentage of the population living in poverty, percentage unemployed, and lower per capita income in Chelsea and Revere.

There are likewise disparities in rates of children living below 100% of poverty (29% in Chelsea, 23% in Revere, and 10% in Winthrop), and students graduating from high school or higher (65% in Chelsea, 82% in Revere, and 95% in Winthrop). There is increasing diversity in each community. Rates of foreign born residents are 44% (Chelsea), 34.9% (Revere), and 15.60% (Winthrop), and those with limited English proficiency among those age five and older are 42% (Chelsea), 24% (Revere), and 7% (Winthrop). Chelsea has by far the greatest percentage of Hispanic residents (64%) though Revere's (26%) and Winthrop's rates (8%) are rising.

Community Characteristics of Winthrop, Chelsea, Revere, and MA				
	Winthrop	**Chelsea**	**Revere**	**MA**
Population	17,962	37,581	53,095	6,705,586
Children living below 100% poverty	9.80%	28.50%	23.00%	14.8%
% High School graduate or higher	94.80%	65.40%	82.20%	89.8%
Percent Population Age 5+ with Limited English Proficiency	6.60%	42.40%	24.10%	8.9%
Foreign born	15.60%	44.00%	34.90%	15.50%
White	93.80%	48%	76%	74.30%
African American or Black	1.70%	5%	4%	7.10%
American Indian and Alaskan Native	0%	0%	0%	0.20%
Asian	1%	3%	6%	6%
Hispanic	8.30%	64.20%	26.40%	10.60%
Other Race	0.80%	7%	9%	4.20%
Two or More Races	2.70%	35%	5%	2.90%

Economic Hardship Index				
	Winthrop	**Chelsea**	**Revere**	**MA**
Economic Hardship Index	28.58	45.73	38.44	36.01
Components of the index:				
Per Capita Income	$36,329	$21,722	$26,746	$39,463
Percent not HS grad (over 25)	5.44	29.29	17.66	10.60
Percent unemployed (over 16)	4.92	5.58	6.95	6.31
Percent dependent (under 18 or over 65)	36.5	34.84	33.62	35.68
Percent in poverty (below FPL)	7.72	18.65	14.25	12.19
Percent Crowding (units with >1 person/room)	1.32	9.175	5.27	2.03
NOTES: The MA Hardship Index is a standardized index across all census tracts in Massachusetts. Higher scores indicate greater economic hardship.				

Despite the challenges residents face in these communities, there are many strengths the residents noted in the community survey as well as in focus groups.

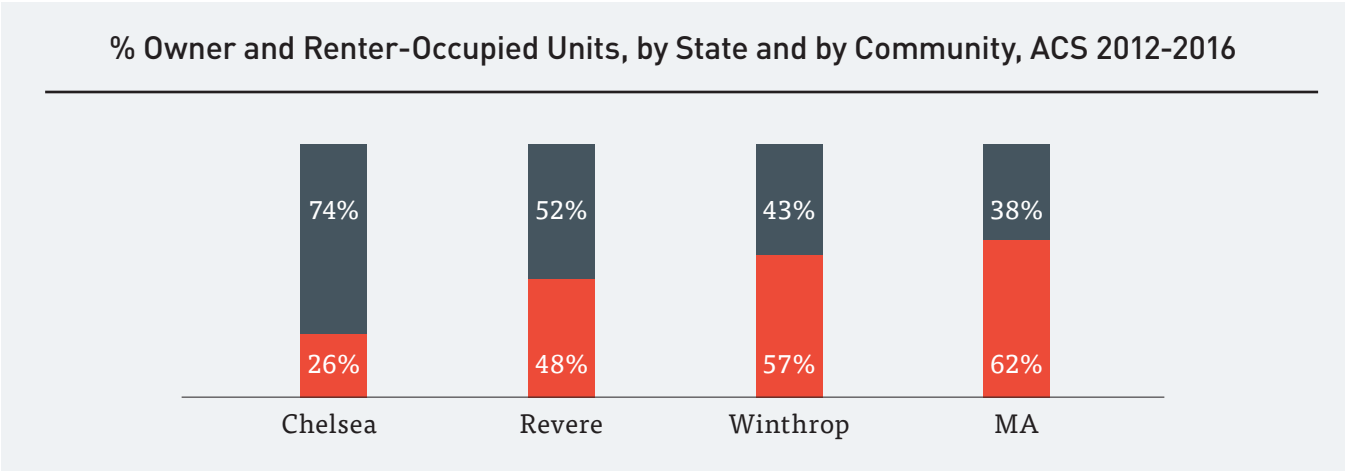
DATA SOURCE: North Suffolk CHNA Community Survey, 2019

Improving Health: The North Suffolk CHNA Priorities

Housing

Like Boston, data across the three communities demonstrate strong concern about housing and its impact on health. The table above shows high rates of housing crowding (greater than one person per room), particularly in Chelsea but also in Revere. Chelsea and Revere survey respondents rated housing as a top concern, with substantial increases in 2019 over prior assessments. For both communities, housing was among the top five health concerns. While housing was not one of the top five health concerns among Winthrop residents, it did rise in the ranking of top ten concerns.

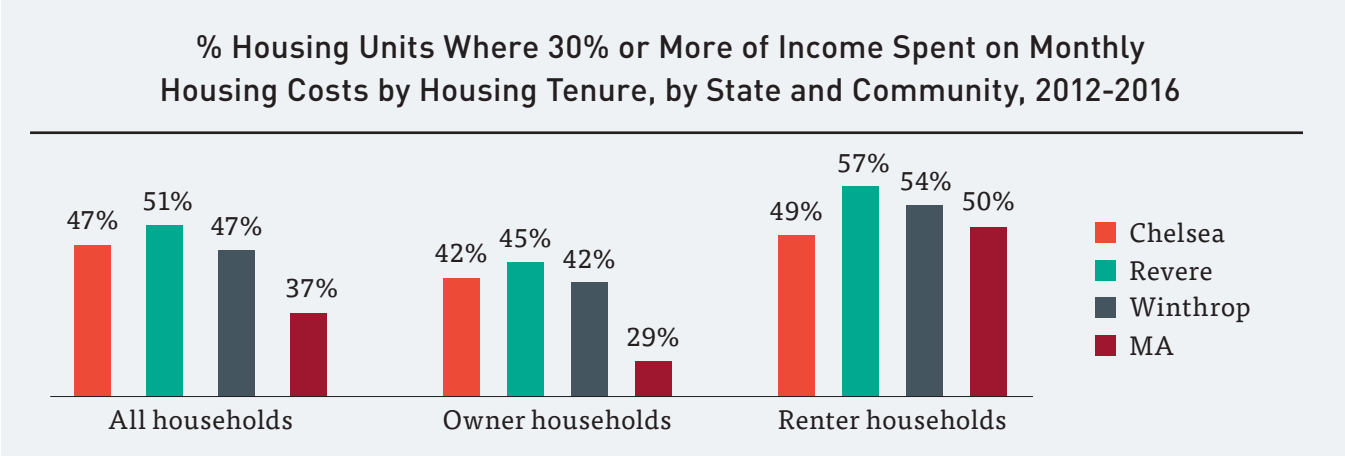
According to the American Community Survey (ACS) data from 2012 to 2016, approximately 38% of all housing units in Massachusetts were renter-occupied. By contrast, rates of renter-occupied housing units were higher than the state rate in all three communities: 74% in Chelsea, 52% in Revere, and 43% in Winthrop.



DATA SOURCE: American Community Survey (ACS), 2012-2016

Renting can be stressful. Focus group participants described necessary repairs, such as broken doors left undone and negligence by landlords in making any improvements at all. According to ACS data from 2012-2016, the majority of renters in Chelsea, Revere, and Winthrop are people of color (Hispanic/Latino, Black/African American, Asian, Multi-race and/or other race, American Indian, and Pacific Islander). Chelsea-based community health workers (CHWs) described "slumlords" who do not maintain adequate housing conditions for their tenants. Their patients who are immigrants are reluctant to complain due to their immigration status, thus remaining trapped in substandard conditions.

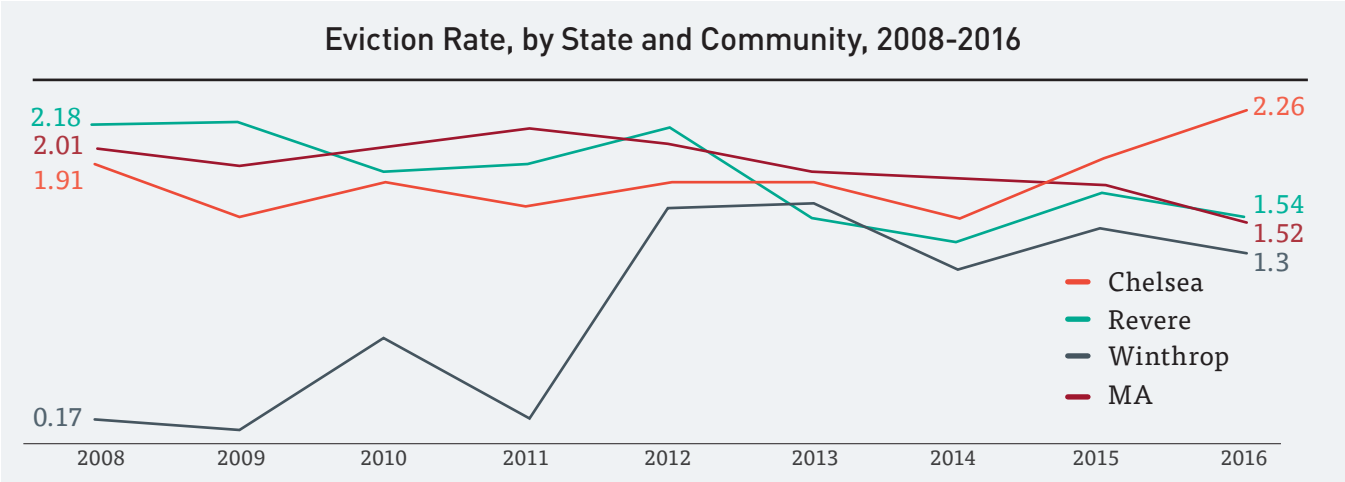
Unaffordable housing increases risk of eviction and gentrification. According to the ACS 2012-2016 data, 37% of all households in Massachusetts—renter and owner—were cost burdened (meaning they pay 30-50% of their monthly income on housing). In North Suffolk, residents in Chelsea (41%), Revere (51%) and Winthrop (47%) indicated they are cost burdened.



DATA SOURCE: American Community Survey (ACS), 2012-2016

Rising costs increase fears of foreclosure, eviction, and homelessness. The figure below shows the eviction rates, calculated by Eviction Lab, which tracks and calculates eviction rates across the country from 2008 to 2016 in Massachusetts, Chelsea, Revere, and Winthrop.

Within the three communities of North Suffolk, there are peaks in eviction rates in 2012 and 2015. In 2016 the rates in Revere and Winthrop decrease, while in Chelsea, eviction rates increase significantly.



DATA SOURCE: Eviction Lab, https://evictionlab.org/

"If people could spend more time at home rather than working to afford their housing, they would be able to spend more time meal prepping, eating healthier foods, and connecting with the community."

There are disparities in fears of eviction. Compared to 11% of non-Hispanic/Latino survey respondents, 23% of Hispanic-Latino survey respondents fear they will be evicted or foreclosed due to lack of rent or mortgage payment. Survey respondents in Revere (44%), Chelsea (30%), and Winthrop (23%) expressed fear of homelessness in the next year. The MA Department of Elementary and Secondary Education estimates that in the 2017-2018 school year, there were 463 homeless youth in Chelsea (including those doubled up with others), 191 in Revere, and 14 homeless youth in Winthrop.

The lack of quality and affordable housing makes healthy behaviors and lifestyles difficult to sustain. A young focus group participant said, "If people could spend more time at home rather than working to afford their housing, they would be able to spend more time meal prepping, eating healthier foods, and connecting with the community."

Fifty-six percent of survey respondents across Chelsea, Revere, and Winthrop defined a healthy community as one with affordable housing.

Economic Stability and Mobility

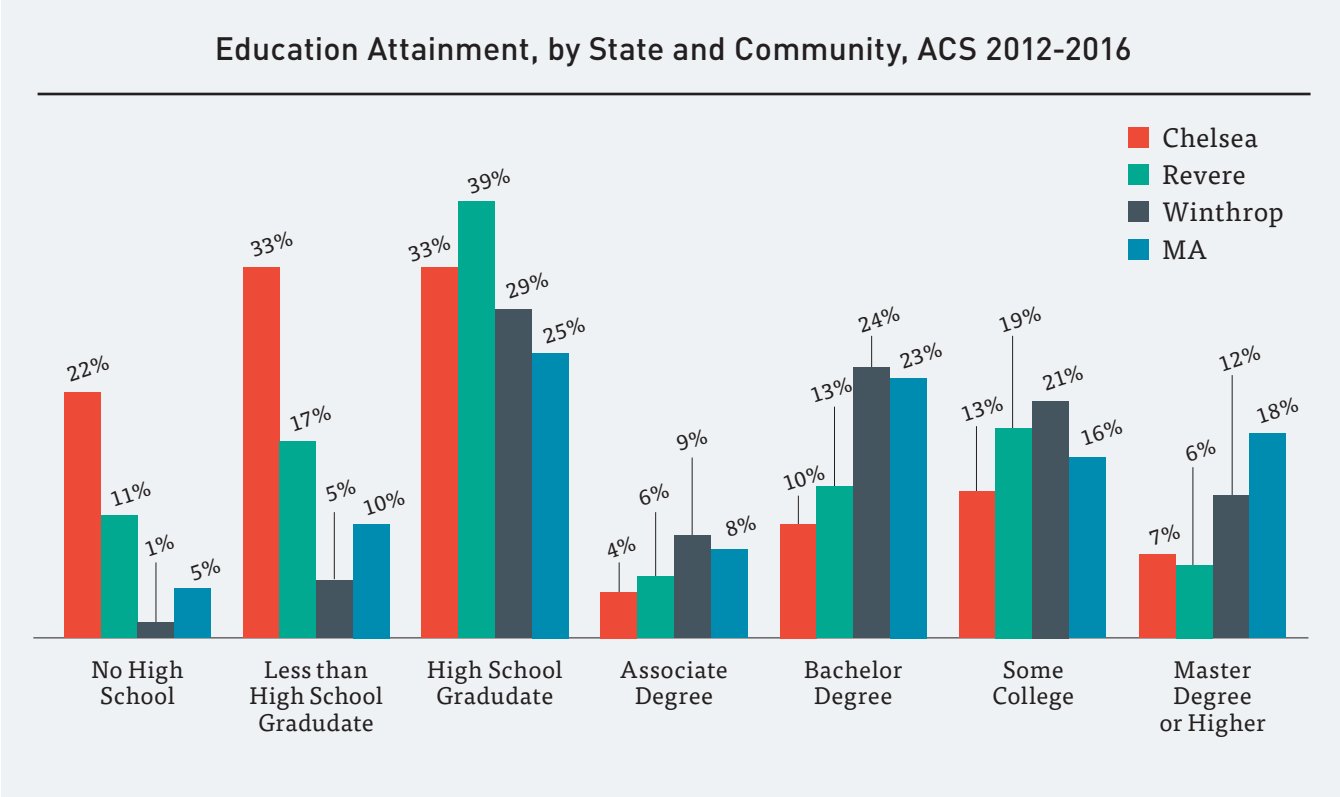
In the 2019 North Suffolk Community Survey, 23% of all respondents selected poverty as a top health concern, a marked change from the 2014 and 2015 surveys when poverty was not a top five health concern. In 2019, 38% of Chelsea survey respondents and 28% of Revere survey respondents identified poverty among their most important health issues. People living in poverty are more likely to have worse health outcomes. Participants suggested more and better employment and educational opportunities to support higher incomes and cultivate a more financially stable community.

Employment: The working-age population is defined as individuals between the ages of 15 and 64. Based on ACS 2012-2016 data, 91% of Chelsea, 86% of Revere, and 82% of Winthrop residents are considered working age. Despite this, unemployment rates for Winthrop (4.9%), Chelsea (5.6%), and Revere (7%) are better or near state average (6.3%). Many focus group members and key informants commented that many people have multiple jobs, many part-time and without benefits. The majority of households have children, but 44% of Chelsea, 38% of Revere, and 29% of Winthrop survey respondents with children ages 5-12 reported difficulty finding after-school programs. Without appropriate child care access, families risk access to just one income since one parent becomes the caretaker.

Education: According to MA DESE, North Suffolk has higher rates of high school dropout. In 2017-2018, the statewide high school dropout rate was 2%, compared to Chelsea's (7%) and Winthrop's (4%). Revere's high school dropout rate was the same as the statewide rate. In 2018 Revere and Winthrop had high school graduation rates similar to the state's (88%), whereas Chelsea had a much lower high school graduation rate of 67%.

For rising seniors of the 2017-2018 school year, the most common plan after graduation for both Chelsea and Revere youth was attending a two-year public college, and their second most common plan was attending a four-year public college. For Winthrop youth, the most common plan after graduation was to attend a four-year private college and their second most common plan was to attend a four-year public college. These differences indicate a substantial disparity in aspirations for higher education between Chelsea and Revere youth on the one hand, and Winthrop youth on the other.

From 2012 to 2016 ACS data, 88% of Chelsea residents did not have a college degree compared to 67% of Revere residents and 35% of Winthrop residents.



DATA SOURCE: American Community Survey (ACS), 2012-20166

Income: According to ACS 2012-2016 data, the median household income for MA was $70,954. In North Suffolk, Winthrop's median household income was $62,997, Revere's was $51,482, and Chelsea's was $49,614. Racial and ethnic income inequality statewide and in North Suffolk is significant. In MA Black or African American residents have a median household income of $44,117. North Suffolk Black or African American residents have somewhat higher household incomes in Chelsea ($46,000) and Revere ($62,537).

The table on the next page displays the median household income by race/ethnicity in North Suffolk compared to statewide. Overall, income is much lower in North Suffolk than in Massachusetts. However, Black, and Multi-racial residents have higher incomes than their statewide counterparts.

Median Household Income by Race/Ethnicity, 2012- 2016				
	Chelsea	Revere	Winthrop	MA
Overall	$49,164	$51,482	$62,997	$70,954
Black	$46,000	$62,637	Not enough data	$44,117
Asian	$42,478	$70,455	Not enough data	$82,020
Latino	$50,298	$56,497	$66,726	$37,100
Multi-race	$56,149	$67,722	$40,880	$52,864
White Non-Hispanic	$50,855	$47,469	$63,892	$77,261
Some Other Race alone	$35,938	$68,073	Not enough data	$35,169

Behavioral Health, Including Substances Use Disorders

In Chelsea, Revere, and Winthrop residents face rising rates of behavioral health challenges and substance use disorders (SUDs). These are often connected, and many residents struggle with both. Overall in the three communities, 74% of all survey respondents selected alcohol/drug use/addiction/overdose as their top health concerns, and 45% identified mental health as one of the top three health concerns. Mental health increased significantly as a concern from 2015 to 2019, rising from the 5th most important issue to the 3rd.

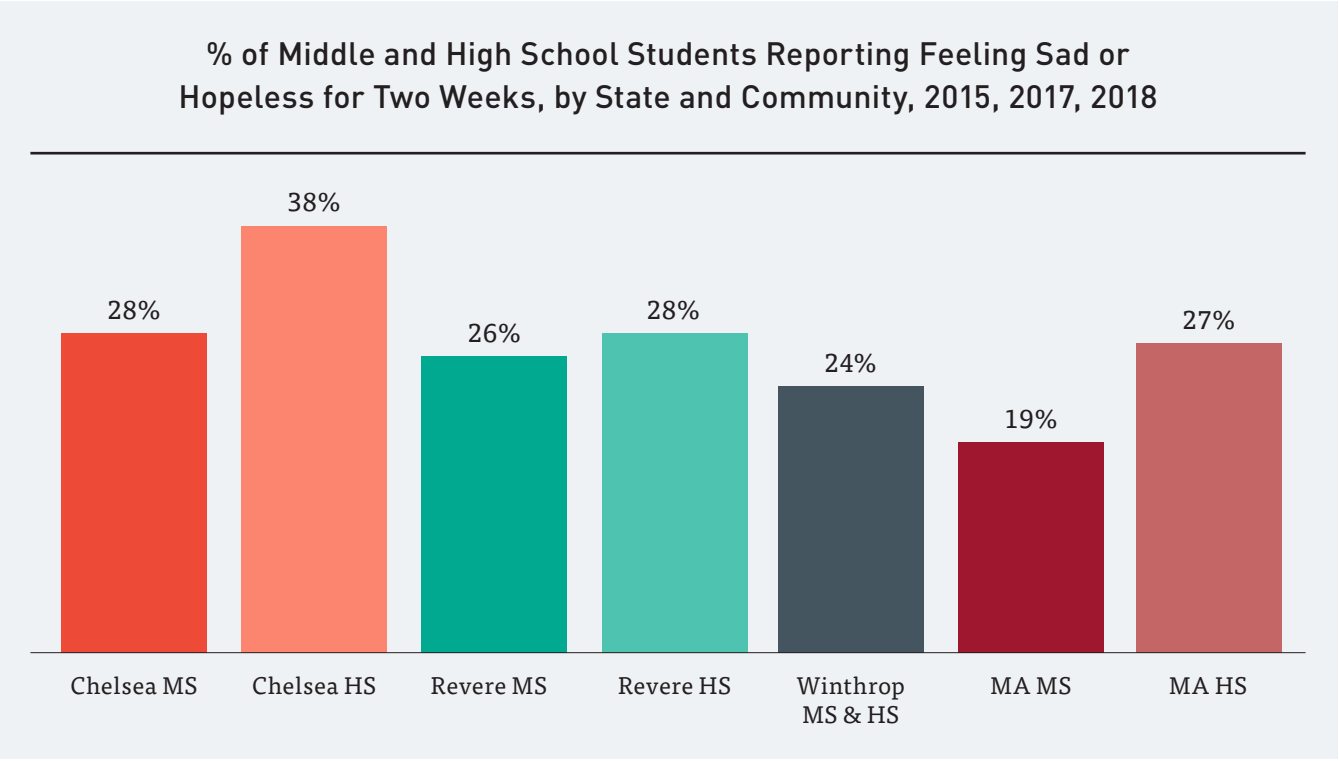
Participants in all focus groups were concerned about mental health. Depression and anxiety were discussed as concerns for those in recovery, current substance users, youth, elders, and veterans. Trauma was cited as an issue, especially among recent immigrants and refugees. Focus group participants said that though North Suffolk residents are dealing with intense stress and pressure, mental health concerns are generally not taken seriously.

Participants talked about the feeling of social isolation and its impact on the mental health with concern about isolation among the elderly and Muslim communities. One person said that Muslims stay in their own group and are isolated from the larger community. Elders also tend to live alone. ACS data from 2012 to 2016 indicate that Chelsea, Revere, and Winthrop all have higher percentages of individuals age 65 and older who live alone compared to statewide (45% in Chelsea, 34% in Revere, and 38% in Winthrop versus 30% in MA).

While 46-50% of North Suffolk survey respondents rated their satisfaction with social activities and relationships as "very good" or "excellent," focus groups from all communities discussed the desire for more activities that bring the community together. One participant from Revere mentioned that Revere needs more activities that bring all of Revere together across age, race, and ethnicity to reduce the social isolation and promote social and emotional well-being.

Youth struggle with social and emotional issues as well. The 2015 and 2017 Youth Risk Behavior Survey (YRBS) data in Chelsea and Revere, the 2018 Winthrop Prevention Needs Assessment (PNA), and the 2017 MA Youth Health Survey all indicate that North Suffolk middle and high school youth reported feeling sad or hopeless for two weeks at higher percentages than middle and high school youth across Massachusetts, with a particularly notable rate among Chelsea High School students.

The need for culturally competent mental health care is great and growing. There is a lack of culturally and linguistically competent mental health providers and resources. Compared to 15% of non-Hispanic/Latino survey respondents, 20.8% Hispanic/Latino survey respondents rated their mental health as "poor" or "fair." Focus group participants expressed a belief that some races and cultures do not think that mental health concerns affect them. If people are feeling sad, it's something that they should just get over. They further commented that for some residents of color or those from different cultures, "Depression is for white people." (See facing page for survey results.)



DATA SOURCE: 2015 Chelsea YRBS, 2017 Revere YRBS, 2018 Winthrop PNA, and 2017 MA Youth Health Survey

NOTES: Winthrop reported a combined Middle and High school percentage.

Overall, there is a disheartening scarcity of mental health services. A focus group participant said that long wait times for mental health care appointments have caused some to threaten suicide in order to expedite care. But, as one focus group participant mentioned, "No one should have to say, 'I'm going to kill myself' in order to get services."

> "No one should have to say, 'I'm going to kill myself' in order to get services."

Statewide, 9% of middle school youth and 12% of high school youth have seriously considered suicide. In North Suffolk the data are deeply concerning, especially for middle school youth. Among middle school youth, 20% in Chelsea and 18% in Revere have seriously considered suicide. Among high school youth, 13% in Chelsea and 8% in Revere report seriously considering suicide. Winthrop's combined data for middle school and high school youth show 14% reported seriously considering suicide.

Percent of Middle and High School Students Reporting Suicide Ideation
Blank boxes=did not ask on survey

	Chelsea		Revere		Winthrop	MA	
	MS	HS	MS	HS	Combined MS & HS	MS	HS
Seriously considered suicide	20%	13%	18%	8%	14%	9%	12%
Made suicide plan	11%		10%	7%	9%		10.9%
Attempted suicide		7%		5%	2%	4%	5%

Substance Use Disorders

The number of opioid-related overdose deaths continues to be a concern. According to the MA Registry of Vital Records and Statistics, in 2013 the number of opioid-related overdose deaths were: Chelsea (7), Revere (15), and Winthrop (2). The numbers of opioid-related deaths have been variable, with highs of 18 (Chelsea), 27 (Revere), and 10 (Winthrop) between 2014-2017. However, data released from the Massachusetts Department of Public Health during the writing of this report does suggest some good news. Between 2017 and 2018, all three communities saw a decrease in the number of opioid related overdose deaths (Chelsea 14 to 10; Revere 24 to 15; Winthrop 11 to 7), while the state saw a slight increase (1,981 to 1,995). While these numbers are promising, the crisis of addiction persists.

In 2014, Massachusetts' heroin overdose hospitalization age-adjusted rate increased to 105 per 100,000. That year in Chelsea the rate was 116.7 per 100,000, 171.7 In Revere, and 87.2 in Winthrop. The rates have been variable over time.

Focus group and key informant interview respondents cited obstacles to receiving care for SUDs. Stigma is a major impediment to getting help. In discussions in Revere and Winthrop, respondents said that shame and a desire for privacy limit openness about challenges with substances, even when evidence is obvious such as visible needles. Youth in Revere described individuals who do not get help, masking the issue until the crisis grows and creating additional problems.

For those who have accepted the need for help, there is a shortage of accessible and affordable providers. Among Hispanic/Latino survey respondents, 24% stated a need for more accessible SUDs services, compared to 0.7% of non-Hispanic/Latino survey respondents. Demand is high for help for SUDs that is culturally and linguistically relevant.

Access to care becomes even more complicated by intersections across social determinants; SUDs and behavioral health challenges often co-exist. For example, in 2017 MA Bureau of Substance Abuse Services (BSAS) enrollment data show that among those seeking SUDs treatment, 33% in Chelsea, 22% in Revere, and 18% in Winthrop were homeless at enrollment. Further, BSAS data indicate that 39% each of residents in Chelsea and Revere, and 47% of residents in Winthrop received prior mental health treatment before currently seeking care. These same data also show prior-year needle use among those enrolled in treatment among Chelsea (41%), Revere (51%), and Winthrop (39%) residents.

Substance Use Disorders Among Youth

There are some reassuring data about youth substance use in North Suffolk, although there are a few areas of concern, and the perception of use among youth is in some cases higher than the actual use.

> "Since marijuana has been legalized, kids have been using it more... like it's fun."

Marijuana - Youth focus group participants expressed that the legalization of marijuana has created a perception of lower risk from marijuana use compared to other drugs. One young participant stated, "Since marijuana has been legalized, kids have been using it more... like it's fun."

- Chelsea and Revere YRBS data show that 5% of middle schoolers used marijuana in the past 30 days, compared to 2% statewide. The Winthrop data show that 10% of Winthrop combined middle school and high school youth reported using marijuana within the past 30 days.
- On the other hand, North Suffolk high school students are using marijuana less often than MA high school youth: 19% of Chelsea high school students and 18% of Revere high school students reported using marijuana in the past 30 days, compared to 24% of high school youth statewide.

Vaping - Another growing concern for youth is the increased use of electronic vapor products, known as vaping. Health and school officials have stated that underage vaping is an epidemic, with addiction among younger teens to nicotine potentially causing harm to developing brains. Youth focus group participants mentioned that the increase in vaping is a huge concern for them. Students openly vape on school property and in front of teachers. A Revere student reported that she saw a student take a hit from a JUUL during class while the teacher was looking at him because he was able to hide the JUUL in his sweatshirt. Youth indicated that they don't think JUUL is harmful or addictive since "Everyone is doing it."

Alcohol - Youth alcohol use in North Suffolk is somewhat higher than state average for middle school, and lower for high school. Four percent of middle school youth statewide reported drinking alcohol in the past 30 days compared to 8% of youth in Chelsea and Revere middle school youth, and 20% of combined Winthrop middle and high school youth. Among high school students, 31% statewide reported drinking alcohol in the past 30 days compared to 26% of Chelsea high school students and 21% of Revere high school youth.


SMILE
YOU'RE ON CAMERA

OTHER HEALTH CONCERNS IN BOSTON AND NORTH SUFFOLK

Although not selected as priorities by their respective collaboratives, there are additional health issues of concern for the residents of Boston and North Suffolk, particularly community violence and safety, obesity and food insecurity, and elder/aging health issues.

Community Violence and Safety

In Boston, community violence was the most frequently discussed type of violence in focus groups, namely in the neighborhoods of Dorchester, Mattapan, Roxbury, Chinatown, and East Boston. When Boston CHNA survey respondents were asked how safe they considered their neighborhoods to be, 25% described their neighborhood as unsafe or extremely unsafe. Twice as many respondents from Roxbury (50%), Mattapan (49%), and Dorchester (45%) described their neighborhood as unsafe or extremely unsafe. One in five Boston CHNA survey respondents described gunshots in the neighborhood (22%) and feeling unsafe when alone on the street at night (19%) as serious problems.

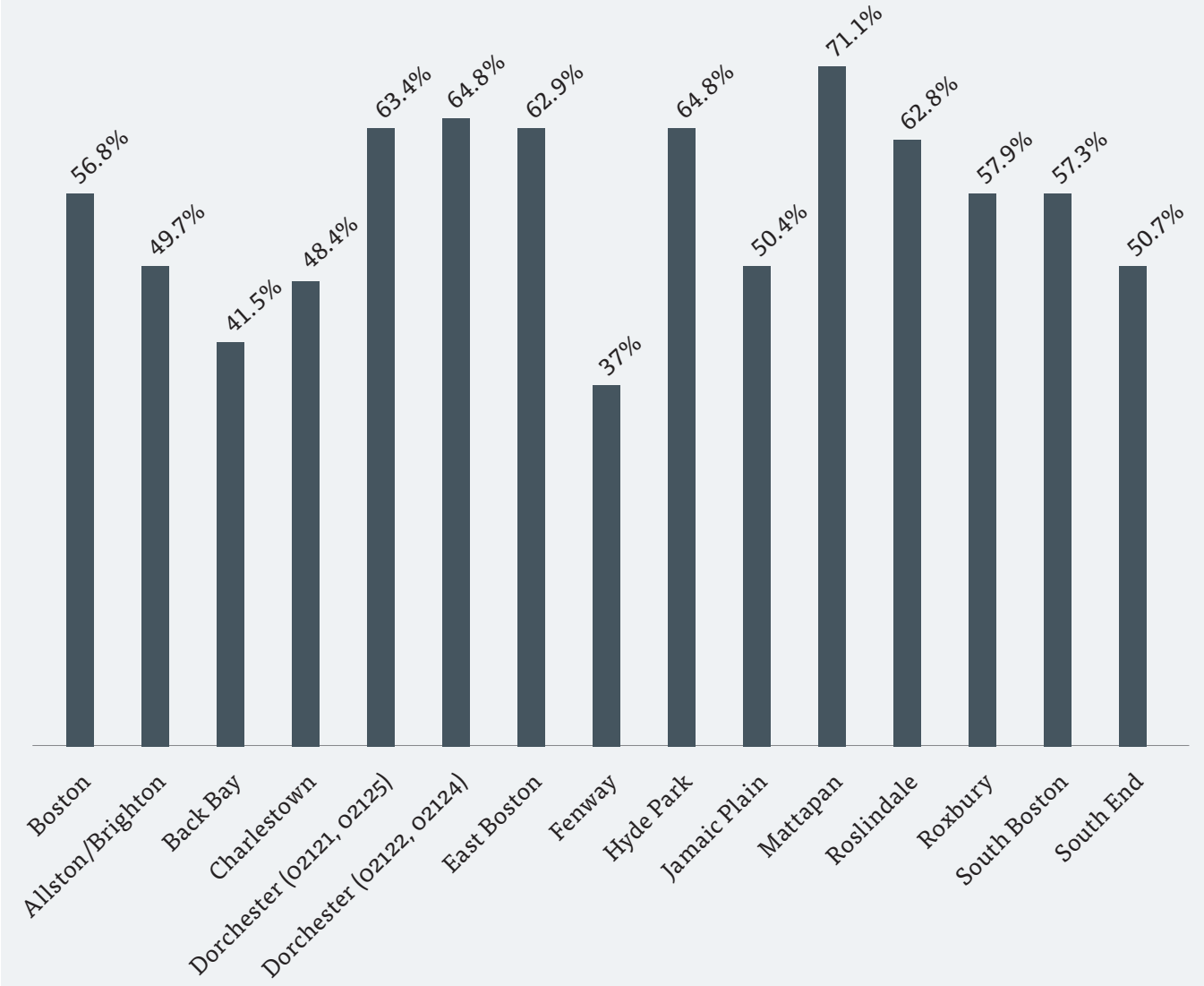
For North Suffolk community violence and safety were a concern in Chelsea and Revere, although there were mixed perceptions. A few focus group participants mentioned that there are certain areas in Chelsea and Revere that many people perceive as unsafe but stated that they don't feel unsafe overall; a couple of elder focus group participants stated that Chelsea feels a lot safer now than it did before. In addition, when asked if they feel safe in their community, one participant said no because of racism and community violence such as shootings. On the North Suffolk community survey, there was a slight difference between non-Hispanic (86%) and Hispanic (82%) when asked if they felt safe in their community.

Obesity and Food Insecurity

Access to fresh and affordable healthy food is a particular problem in some neighborhoods in Boston. While more affluent neighborhoods were described as having substantial access to healthy food, lower income neighborhoods, most commonly communities of color, were described as having few grocery stores and a prevalence of fast food and convenience stores. Quantitative data indicate that nearly one in five Boston residents reported being food insecure, in that it was sometimes or often true that the food they have purchased did not last and they did not have money to get more. Experiences with food insecurity varied by population group. In aggregated 2013, 2015, and 2017 BBRFSS data, Latino (39.1%) and Black (34.5%) residents were significantly more likely than White residents (10.7%) to report being food insecure as were foreign-born residents compared to U.S. born residents. Food insecurity and lack of access to fresh and affordable healthy food is associated with obesity. At the neighborhood level, the percent of adults in Mattapan (71%), Hyde Park (65%), Dorchester (63-65%), West Roxbury (64%), East Boston (63%), and Roslindale (63%) who were obese, or overweight was significantly higher than the rest of Boston.

On the Boston Youth Risk Behavior Survey, one-third of Boston high school youth (33%) reported being obese or overweight in 2013-2017. Similar to patterns for adults, a significantly higher proportion of Latino (37%) and Black (36%) high school youth reported being obese or overweight than White high school youth (23%).

% Adults Reporting Obesity or Overweight, by Boston and Neighborhood, 2013, 2015, and 2017 Combined



DATA SOURCE:
Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2013, 2015, and 2017 combined

In North Suffolk there is great concern around childhood obesity. Many focus group participants and key informants touched upon rising obesity rates in Chelsea and Revere, especially because of easy access to fast food restaurants. Participants mentioned people turn to fast food restaurants when they are hungry because the food is cheaper, and the portions are larger; this particularly helps when trying to feed a family on a budget. This finding was notably present among multicultural populations. Similarly, Winthrop focus group participants mentioned the lack of grocery stores that provide access to healthy foods, as there is only one grocery store in town that is expensive and has a limited variety. In addition to discussing the need to access healthier foods, a couple of focus group participants mentioned that learning healthy eating habits was important to improve the health of the community. In the table on the next page, all grades in the Chelsea, Revere, and Winthrop public schools have a higher percentage of overweight and obese students than Massachusetts.

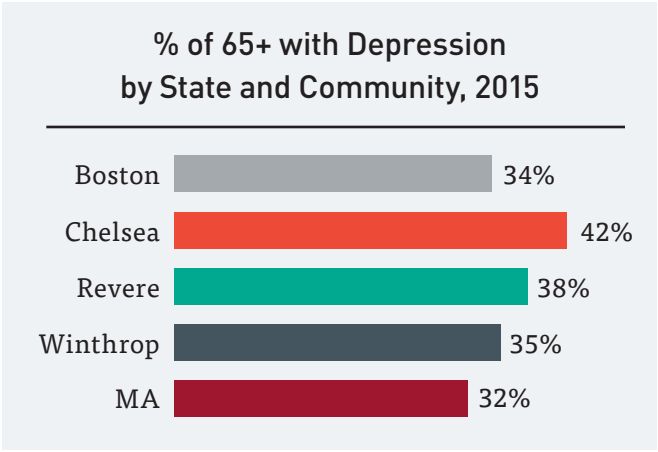
Percent of Overweight or Obese Public School Students				
Grade	Chelsea (2018-19 school year)	Revere (2018-19 school year)	Winthrop (2014-15 school year)	Massachusetts (2014-15 school year)
1st Grade	Revere	42%	35%	28%
4th Grade	Winthrop	52%	37%	34%
7th Grade	Massachusetts	44%	37%	34%
11th Grade	49%	41%	36%	33%

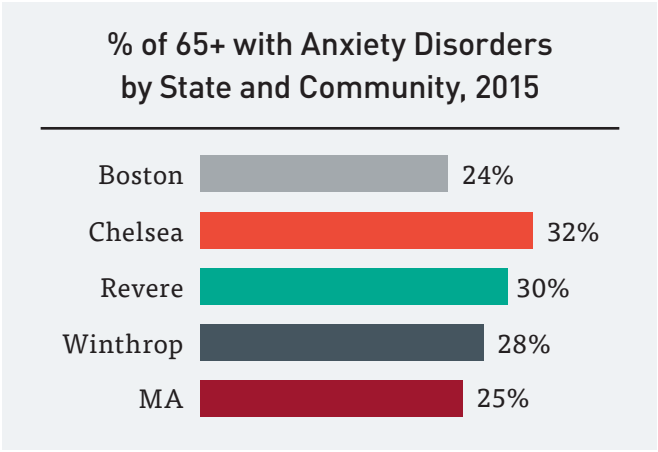
Elder/Aging Health Issues

Only 11% of Boston's population is over 65, compared to 15% for the state. However, nearly 40% of the elderly live alone, compared to Massachusetts (30%). In Boston, stress, anxiety, social isolation, and depression were the most frequently cited mental health challenges among Boston's elderly residents. Participants spoke of co-occurring issues, the most common being hoarding disorder. One key informant explained, "You'll see instances when organizations rally together to clean the home of seniors [who are hoarders]. Then we'll come back 6 months later, and their conditions are right back where they were and it's because they haven't left their house or spoken to anyone in weeks." Thirty-four percent of elders in Boston have depression and 24% have an anxiety disorder. Compared to the state (9%), 20% of Boston elders live below the poverty line.

"You'll see instances when organizations rally together to clean the home of seniors [who are hoarders]. Then we'll come back 6 months later, and their conditions are right back where they were and it's because they haven't left their house or spoken to anyone in weeks."

In North Suffolk, there was concern among the elderly and key informants around social isolation, depression, and access to services. Winthrop (17%) and Revere (14%) have higher elderly populations than Chelsea (9%). However, 19% of elders in Chelsea live below the poverty line, compared to Revere (13%) and Winthrop (10%). Additionally, a high number of elders live alone in Chelsea (45%), Revere (34%), and Winthrop (38%) than in Massachusetts overall (30%). In the figures below, elders in North Suffolk communities' have higher rates of depression and anxiety than Massachusetts. Elders also have a harder time with transportation. In focus groups, elders mentioned that the MBTA RIDE needs to improve since many people rely on it to access services, but people end up waiting for it for a long time.





DATA SOURCE: 2018 MA Healthy Aging Community Profile-Tufts Health Plan Foundation, https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/

EVERETT-MALDEN

Mass General has a primary care practice in Everett and therefore collaborated with Cambridge Health Alliance (CHA) and Melrose-Wakefield HealthCare (MWHC) to conduct a joint CHNA of Malden and Everett.

The health systems are piloting a new CHNA framework called THRIVE. THRIVE enables communities to determine how to improve health and safety and promote health equity. It is an approach for understanding how structural drivers, such as racism, influence the social/cultural, physical/built, and economic/educational environments. THRIVE is also a tool for engaging community members and practitioners in assessing the status of community determinants of health, prioritizing them, and taking action to make changes in order to improve health, safety, and health equity. (https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments).

MWHC was in the midst of conducting a 2019 CHNA for the nine communities in its service area, and it provided the data already collected in surveys and interviews, as well as secondary data. Together, the Everett-Malden CHNA collaborative created a short survey and focus group guide to gain a deeper understanding of the priority concerns for these two communities. This short, rapid CHNA process produced 68 surveys and data from four focus groups over three weeks. The process is ongoing as the Everett-Malden's CHNA prioritizes health concerns and prepares its CHIP. Currently, the same familiar regional health concerns are rising to the top for Everett and Malden: housing, economic stability and mobility, behavioral health, and access to care and other services.


GUESS

TOWNS WEST OF BOSTON

Mass General has licensed facilities in four towns north and west of Boston—Concord, Danvers, Newton, and Waltham. Each community has a local health care provider that must also conduct its own CHNA. To avoid over-assessment of residents, Mass General received permission from each health care institution to use their 2018 CHNA data. Mass General supplemented each CHNA by conducting an interview with the current Community Benefit manager of each provider.

The priorities identified in the towns' CHNAs ranged from access to health care, to behavioral health and substance use disorders, aging, cancer, domestic violence, and serving adolescents at risk.

Concord

The town of Concord has a population of 19,271 that is served by Emerson Hospital, a 179-bed institution located in Concord with more than 300 primary care physicians and specialists that serve 300,000 people in 25 towns. Mass General has a satellite Cancer Center at Emerson Hospital. In 2018, Emerson Hospital conducted a CHNA that prioritized the following health needs:

- Lack of transportation options
- At-risk adolescents
- The growing aging population
- Cancer
- Mental health
- Domestic violence

Transportation: Emerson Hospital has very limited accessibility, solely via motor vehicles. There is no public transportation that travels directly through the service area. Highways surround the hospital, and there are few sidewalks.

At-risk adolescents: There are almost 50,000 adolescents living in the hospital service area, about 75% of whom have experienced or witnessed bullying. Concerns about youth mental health issues are high due to stress levels, cyber-bullying, and pressures to fit in.

The growing aging population: About 37,000 people in the Emerson Hospital service area are above the age of 65. This group is expected to increase by 25% over the next five years, making it the fastest growing population in the area. As people age and can no longer drive, there are few options for affordable public transportation. Aging seniors are isolated without nearby family. Their isolation can be accompanied by a decline in mental health and dependency on alcohol or prescription medications, which can lead to falls and broken bones.

Cancer: Cancer is the leading cause of death in Emerson Hospital's service area. Breast and prostate cancer are the two most common cancers locally. The Mass General Cancer Center's joint program with Emerson Hospital brings together experienced cancer specialists, leading-edge technology, and the latest treatment options for Concord-area residents, located right at the hospital.

Mental health: In surveys, middle and high school students revealed that they are worried about peers who might commit suicide. About a fifth of students said that they were told by one of their peers that they were planning a suicide, but did not tell an adult about it. Further, approximately 15% of residents within the service area reported 15 or more days of suffering from poor mental health, an increase from the 2015 CHNA.
In a key informant interview, Emerson Hospital's Manager of Community Benefit and Events discussed these priorities, as well as youth vaping. Emerson is currently working with the high school in Concord to address this issue. The full Emerson Hospital report can be found at: www.emersonhospital.org/EmersonHospital/media/PDF-files/2018-Community-Health-Needs-Assessment.pdf

Danvers

The town of Danvers is a primary service community for the North Shore Medical Center (NSMC), a member of Partners HealthCare and the largest medical provider on the North Shore. NSMC has a hospital in Salem and ambulatory care sites and offices throughout the service area. The Mass General/North Shore Medical Center for Outpatient Care is located in Danvers and offers day surgery, comprehensive cancer services, primary care, and specialty care.

The priorities in the NCMC's 2018 CHNA are:

- Behavioral health.
- Heath care access.
- Health care environment and trust, including culturally sensitive approaches to care.

Behavioral health: Key areas of need identified through the 2018 CHNA included mental health issues (including depression, trauma, and stress); substance use disorders (including use of opioids, alcohol, marijuana, and vaping); co-occurring disorders; gaps in treatment; and stigma.

Health care access: Key areas of need identified through the CHNA included accessibility (transportation, access to after-hours care, access to specialty care); health insurance and cost; and the need for expanded care coordination and navigation services.

Health care environment and trust: The areas of need that were identified included providing culturally-sensitive approaches to care (including training and retaining a diverse healthcare workforce) and providing services in multiple languages.

A key informant interview with the Manager of Community Benefit at North Shore Medical Center indicated these health concerns are still a priority for their services area, including Danvers. The full North Shore Medical Center report can be found at: https://nsmc.partners.org/about_nsmc/commitment_to_community

Newton

Newton is in the service area of Newton-Wellesley Hospital, a 265-bed comprehensive medical center affiliated with Partners HealthCare. Cancer is the leading cause of death in Newton. Breast, colorectal, and lung cancer are the most common cancers in the area. Mass General Cancer Center has a joint program with Newton-Wellesley Hospital that brings together experienced cancer specialists, leading-edge technology, and the latest treatment options for Newton-area residents for care in a facility located right at Newton-Wellesley Hospital.

The priorities identified in Newton-Wellesley Hospital's 2018 CHNA are:

- Mental health.
- Substance use.
- Access to care.

Mental health: Concerns about mental health focused particularly on the elderly, immigrants, and low-income residents. According to youth risk surveys, a higher percent of middle school youth in Waltham, Natick, and Wellesley reported suicide ideation than the average statewide.

Substance use: Opioids were the substance of greatest concern reported in the CHNA, particularly substance use among seniors, as well as use among youth. Participants working with youth reported that vaping has substantially increased in recent years.

Access to care: Access to care was a concern, expressed particularly in connection with cost and insurance, navigating the health care system, behavioral health, cultural competency, and transportation. The Newton-Wellesley Hospital CHNA can be found here: www.nwh.org/about-us/community-health-assessment

Waltham

Waltham is in the service area of Newton-Wellesley Hospital, a 265-bed comprehensive medical center affiliated with Partners HealthCare. Newton-Wellesley's CHNA included Waltham. Mass General also has a large ambulatory care facility in Waltham, offering primary and specialty care.

The priorities listed above for Newton are relevant for Waltham, with one additional priority. A recent review of the data revealed a disparity in high school graduation rates among Waltham students when compared to other communities in Newton-Wellesley's catchment area. While the four-year graduation rate for the other communities (Natick, Newton, Wellesley, and Weston) ranges from 95-99%, the 2016-2017 four-year graduation rate in Waltham was 84% and its dropout rate was nearly twice that of Massachusetts. Furthermore, graduation rates and dropout rates among Hispanic/Latino students and English Language Learners were far worse. The Newton-Wellesley Hospital CHNA can be found here: www.nwh.org/about-us/community-health-assessment

CONCLUSION

In 2018-2019, Massachusetts General Hospital worked actively with community collaboratives in Boston and five communities in the surrounding region to rigorously assess their health needs and identify priorities for reducing health disparities. The process expanded our connections across sectors to achieve shared goals and to address the social and economic factors—the social determinants of health—that have enormous influence over health.

There is substantial congruity in the priorities identified in the participating communities. Across income levels, families are affected by such challenges as behavioral health concerns and substance use disorders. However, there are important differences. Neighborhoods with lower incomes and greater diversity are the most powerfully and negatively affected in these and other areas, particularly housing, education, and access to a broad range of services and supports. At Mass General, our primary focus will be on these communities if we are to successfully work with partners to improve health status and eliminate racial and ethnic disparities across the entire region. This is the next challenge as we create strategies to address these priorities in the Community Health Improvement Plan.

APPENDIX A:

Update on Past Implementation Plans

Mass General last completed Community Health Needs Assessment and Implementation Plans in 2015 and 2016. The 2015 report was a general CHNA in Revere, Chelsea, and Charlestown. The 2016 report focused on youth substance use and mental health issues in Revere, Chelsea, and all of Boston, including Charleston and East Boston. Below are highlights of the work that has been accomplished since 2015 that support MGH's Community Health Improvement Plans (CHIP). For full reports, please see submissions to the Massachusetts Attorney General Community Benefit office. (https://massago.onbaseonline.com/massago/1801CBS/annualreport.aspx)

Priority Area: Substance Use (2015)			
Goal from 2015 & 2016 Implementation Plan	**Description of Activity, Service, or Program**	**Comment on Activity, Service, or Program**	**Progress, Impact, and Outcomes**
Provide "backbone support" to multi-sector coalitions using a collective impact model to make policy, systems and environmental changes to reduce youth substance use and prevent opioid overdoses and deaths. Transform care for those with substance use disorders by reducing stigma and developing a chronic disease management model of care that spans from the community to the bedside.	MGH CCHI supports multi-sector coalitions in the communities of Revere, Chelsea, Charlestown and East Boston. Recovery coaches, who are similar to community health workers for addiction, are assigned to each of our health centers, Boston Health Care for the Homeless, and high utilizers in the ED. They are paired with MGH patients who have been diagnosed with a substance use disorder. The Kraft Center launched the Care Zone Van, a mobile health program in partnership with the Boston Health Care for the Homeless Program, combines harm reduction, clinical services including medication-assisted treatment (MAT), data hotspotting, and mobility to bring addiction services to Boston's most vulnerable residents living with substance use disorder (SUD).	MGH provides staff, space, budget, strategic planning, communications, and evaluation services to sustain the coalitions in order to engage the communities to identify needs and work towards solutions. The Mass General SUDs initiative was designed to improve the quality, clinical outcomes and value of addiction treatment for all MGH patients with SUDs while simultaneously reducing the cost of their care.	In 2016, MGH began a partnership with East Boston Neighborhood Health Center to support the EASTIE Coalition, focused on youth substance use prevention; this support positioned them in 2018 to be awarded a Drug-Free Communities Grant of $125,000 for 5 years. In 2015, Healthy Chelsea expanded its focus to include youth substance use; in 2017 they were awarded a Drug-Free Communities Grant, with same funds as above. In FY2018 the Charlestown community navigator worked with over 202 clients in recovery or struggling with addiction. The Navigator also collaborates with the Charlestown Drug Court; in FY18, 18 people were active. In FY18, 637 patients were served by 9 Mass General Recovery Coaches. In the 6th months before and 6 months after recovery coach engagement, there was a 44% increase in outpatient visits and a 25% decrease in inpatient admissions. The Care Zone van had almost 7,000 contacts in its first year.

Violence and Public Safety (2015)			
Goal from 2015 & 2016 Implementation Plan	Description of Activity, Service, or Program	Comment on Activity, Service, or Program	Progress, Impact, and Outcomes
Support police departments and community organizations in their efforts to reduce violence by advocating for and collaborating on evidence-based strategies. Continue to support MGH-based violence intervention programs.	Mass General and Healthy Chelsea are members of the Chelsea Thrives collaborative, which works to decrease crime and increase feelings of safety in Chelsea. Chelsea Thrives launched the Chelsea HUB, a police-led initiative made up of designated staff from community and government agencies that meet weekly to address specific situations regarding clients facing elevated levels of risk, and develop immediate, coordinated, and integrated responses through mobilization of resources. Through hospital and community programs like HAVEN (Helping Abuse & Violence End Now) and VIAP (Violence Intervention Advocacy Program), we address intimate partner and community violence and assist victims with physical and emotional recovery, empowering them to make positive changes in their lives. In June 2019, Mass General launched the Center for Gun Violence Prevention dedicated to advancing the health and safety of children and adults through injury and gun violence prevention research, clinical care, education and community engagement.		There are 25 participating agencies who come together voluntarily for the Chelsea HUB. To date over 450 family crisis situations have been reviewed resulting in referrals to needed services. HAVEN worked with 652 survivors in FY18. VIAP worked with 74 patients who were victims of community violence. The Center launched a simulation case-based training program for incoming interns, to curb the problem of gun violence in the United States. The Center will continue the efforts of the MGH Gun Violence Prevention Coalition, a multidisciplinary group including MGH nurses, administrators, physicians, social workers and physical/occupational therapists. The group has collaborated closely with several state organizations since 2015 to develop guidance for clinicians to talk to patients about gun safety.

Healthy Eating, Active Living, and Food Insecurity (2015)			
Goal from 2015 & 2016 Implementation Plan	**Description of Activity, Service, or Program**	**Comment on Activity, Service, or Program**	**Progress, Impact, and Outcomes**
Provide "backbone support" to multi-sector coalitions using a collective impact model to make policy, systems and environmental changes to increase access to affordable, healthy foods and physical activity. Screen for and provide resources to patients who are struggling with food insecurity.	MGH CCHI supports multi-sector coalitions in the communities of Revere and Chelsea. MGH Chelsea patients are regularly screened for food insecurity. Those who screen positive meet with a community health worker who will refer the patient to food resources. MGH Chelsea also runs a food pantry 2 days a week.	MGH provides staff, space, budget, strategic planning, communications, and evaluation services to sustain the coalitions in order to engage the communities to identify needs and work towards solutions.	One hundred and twenty (120) participants attended two Chelsea Healthy & Affordable Food (CHAF) summits, strengthening partnerships and formulating action steps. Under the stewardship of Healthy Chelsea, the group is working toward greater coordination with community partners to yield systemic, community-wide solutions that tackle hunger and create greater access to healthy and affordable food. Healthy Chelsea, in collaboration with GreenRoots, is planning to lauch a mobile market in FY2020. Revere CARES, in collaboration with Revere on the Move, supports the Revere Farmers Market, 3 community gardens, and has hosted workshops on bees and composting. 30 youth took a field trip to Natick Community Farms. In FY18, 178 families attended the food pantry at the Health Center, which distributed over 111,618 pounds of food.

Mental Health & Trauma (2015)			
Goal from 2015 & 2016 Implementation Plan	**Description of Activity, Service, or Program**	**Comment on Activity, Service, or Program**	**Progress, Impact, and Outcomes**
Create and support existing community-wide learning collaboratives with agencies and leaders to build trauma-informed communities that promote resiliency in young children and families. Train MGH staff on understanding the effects and recognizing the symptoms of trauma, and ensure staff do not re-traumatize patients. Additionally, ensure that staff are supported to avoid secondary trauma or re-traumatization themselves.	In collaboration with Chelsea Thrives and the Chelsea Police Department, Health Chelsea is working to make Chelsea a trauma-sensitive city with the help of a $1 million grant from the U.S. Department of Justice's Safe and Thriving Communities program. Part of the grant from the U.S. Department of Justice's Safe and Thriving Communities program is to train MGH Chelsea staff in trauma sensitive care.		212 staff from the school, youth serving organizations, and the city participated in 8 trainings in Chelsea designed to build the community's capacity to respond to trauma, increase community resilience, and adopt trauma sensitive practices and policies for the city. See above.

Social Determinants of Health (Housing, Education, Environment) (2015)			
Goal from 2015 & 2016 Implementation Plan	**Description of Activity, Service, or Program**	**Comment on Activity, Service, or Program**	**Progress, Impact, and Outcomes**
Continue to screen and provide connections to resources for MGH patients. Build and strengthen partnerships with community agencies that address the social determinants of health and work towards solutions. Continue to expose and inspire youth to Science, Technology, Engineering, and Math (STEM) subjects, health and wellness, college readiness, and careers by strengthening and growing the MGH Youth Programs.	MGH Chelsea continues to provide the Food for Families program, which screen patients for food insecurity, connects them to resources, and offers a food pantry two days a week. MGH Chelsea partnered with the CONNECT program at the Neighborhood Developers to address housing crises experienced by patients from MGH Chelsea, called the Health Starts at Home program. MGH Youth Programs' mission is to provide youth (grades 3-college) with academic, life, and career skills that will expand and enhance their educational and career options.	We have been able to expand the food pantry from one day a week to two, and hope to expand to more days. With the new Medicaid ACO contract that Partners HealthCare has entered into, there are numerous social services partnerships that will be created to refer patients who screen positive for specific social determinants of health..	In FY18, Food for Families worked with 131 patients, completing 192 SNAP applications. The food pantry also served 178 families and distributed over 111,000 pounds of food. In FY18, more caregivers enrolled in HSAH rated their own health as Excellent or Very Good at the 12-month follow-up than at baseline (40.9% at 12-month follow-up vs. 31.8% at baseline.) In FY18, 1,081 youth (grades 3-college) were served in the MGH Youth Programs across all core and non-core programs. In FY18, 100% of MGH Youth Scholars graduated from high school, 96% matriculated to college, and 73% persisted in college. A total of 92 Youth Scholars Alumni are currently enrolled in college, and as of May 2019, 49 have graduated.

Prevent and reduce adolescent substance use and mental health issues, 2016			
Goal from 2015 & 2016 Implementation Plan	**Description of Activity, Service, or Program**	**Comment on Activity, Service, or Program**	**Progress, Impact, and Outcomes**
Increase job shadowship programs and youth jobs. Enhance adult capacities for informal and formal mentorships and communication with youth. Collaborate with organizations to advocate for age-appropriate youth activities in each community.	In addition to the MGH Youth Programs, each MGH coalition has youth groups that provide shadowships and summer jobs. In 2019, MGH CCHI started a partnership with the Big Brothers Big Sisters of Massachusetts Bay to pilot increasing the number of adult mentors from our communities. The goal is to recruit between 20 and 30 adults.	EASTIE has recently started a Peer Leadership Group with 12 youth in the summer of 2019 37 students the Donald McKay school in East Boston in 7th and 8th grade participated in LifeSkills.	In FY18, MGH Youth Programs provided 250 students with summer jobs. In FY18, MGH Youth Programs provided 250 students with summer jobs. In FY18, Revere CARES, Healthy Chelsea, and The Charlestown Coalitions had a total of 88 students in its youth groups. All of these youth are exposed to careers through shadowships and summer jobs.

Prevent and reduce adolescent substance use and mental health issues, 2016 (Cont'd from p. 57)			
Goal from 2015 & 2016 Implementation Plan	**Description of Activity, Service, or Program**	**Comment on Activity, Service, or Program**	**Progress, Impact, and Outcomes**
Engage youth as part of each community coalition. Increase coping skills of youth and adults to positively manage and reduce stress. Collaborate with schools and organizations to incorporate a curriculum that addresses substance use and mental well-being.	Coalitions in Revere, Chelsea, Charlestown, and East Boston all have robust steering committees with partners from multiple sectors across each community. The coalitions regularly advocate for age-appropriate youth activities. Each coalition has youth groups composed of high school students who learn to advocate for important issues, volunteer at community events, and learn about different public health topics, such as obesity, food insecurity, and substance use. Each coalition supports activities that teach youth what stress does to the body and how it can affect health. The Charlestown Coalition, EASTIE, and Healthy Chelsea all provide LifeSkills curriculum to youth either during school or out-of-school time. Collaborate with schools and organizations to incorporate a curriculum that addresses substance use and mental well-being.		Big Brothers Big Sisters has a assigned an outreach coordinator to work with Healthy Chelsea and The Charlestown Coalitions to recruit mentors. Healthy Chelsea and EASTIE collaborate with local organizations to host annual soccer tournaments. The Charlestown Coalition collaborates with the local YMC to host an annual basketball tournament. In FY18, Revere CARES, Healthy Chelsea, and The Charlestown Coalitions has a total of 88 students in its youth groups. Revere CARES youth hosted a "Self Care Fair" in which 300 students participated in yoga, hip-hop dance, and learned how stress affects the body. The Charlestown Coalition educated 136 youth on the effects of stress on health and ways to manager stress. 37 students the Donald McKay school in East Boston in 7th and 8th grade participated in LifeSkills. 96 students in Charlestown participated in a combined LifeSkills/Stay in Shape program. Healthy Chelsea assisted the Chelsea Public Schools in obtaining a grant from the Mass Attorney General's Office to provide LifeSkills during school time. 30 Revere middle school students participated in the TOPS and Voices curricula.

APPENDIX B:

Boston CHNA-CHIP Collaborative Steering Committee and Subcommittee Members

Streeting Committee	
Organization	**Name**
Beth Israel Deaconess Medical Center	Nancy Kasen (co-chair)
Boston Children's Hospital	Ayesha Cammaerts
Boston Health care for the Homeless	Denise De Las Nueces
Boston Medical Center	Jennifer Fleming
Boston Public Health Commission	Margaret Reid
Brigham and Women's Faulkner Hospital	Tracy Mangini Sylven
Brigham and Women's Hospital	Wanda McClain
Community representative and Jamaica Plain Neighborhood Development Corporation	Ricky Guerra
Community Labor United	Sarah Jimenez
Dana-Farber Cancer Institute	Magnolia Contreras
Fenway Health	Carl Sciortino (co-chair)
Health Leads	Laurita Kaigler-Crawlle
Madison Park Development Corporation	Jeanne Pinado
Massachusetts Eye and Ear	Erin Duggan
Massachusetts General Hospital	Joan Quinlan
Massachusetts League of Community Health Centers	Mary Ellen McIntyre
Tufts Medical Center	Sherry Dong
Uphams Corner Health Center	Daniel Joo
Urban Edge	Robert Torres

Subcommittee Members:		
Organization	**Name**	**Membership**
American Diabetes Association	Albert Whitaker	Community Engagement- Member
American Heart Association	Cherelle Rozie	Community Engagement- Member
BACH	Jamiah Tappin	Community Engagement- Member

Subcommittee Members (Cont'd from p. 58):		
Organization	**Name**	**Membership**
Beth Israel Deaconess Medical Center	Nancy Kasen	Secondary Data- Member
Blue Cross Blue Shield - Massachusetts	Charlotte Alger	Secondary Data- Member
Boston Children's Hospital	Urmi Bhaumik	Secondary Data- Member
Boston Children's Hospital	Ayesha Cammaerts	Secondary Data- Member
Boston Medical Center	Jennifer Fleming	Community Engagement- Member
Boston Public Health Commission	Dan Dooley	Secondary Data- Co-Chair
Boston Public Health Commission	Margaret Reid	Secondary Data- Member
Boston Public Health Commission	Triniese Polk	Community Engagement- Co-Chair
Bowdoin Street Health Center	Alberte Atine-Gibson	Secondary Data- Member
Boys and Girls Club of Boston	Grace Lichaa	Community Engagement- Member & Secondary Data- Member
Brigham and Women's Hospital	Michelle Keenan	Secondary Data- Member
Brigham and Women's Hospital-Faulkner	Tracy Mangini Sylven	Community Engagement- Member
City Life Vida Urbana	Mike Leyba	Community Engagement- Member
Dana-Farber Cancer Institute	Magnolia Contreras	Community Engagement- Co-Chair & Secondary Data- Member
East Boston Social Center	Gloria Devine	Community Engagement- Member
East Boston Social Center	Lisa Melara	Community Engagement- Member
Fenway Health	Matan Benyishay	Secondary Data- Member
Fenway Health	Sean Cahill	Secondary Data- Member
Harvard School of Public Health	Maynard Clark	Community Engagement- Member
Health Care Without Harm	Jen Obadia	Community Engagement- Member
Health Care Without Harm	Paul Lipke	Secondary Data- Member
MA Department of Public Health	Halley Reeves	Secondary Data- Member
Madison Park Development Corp.	Jeanne Pinado	Community Engagement- Member
Madison Park Development Corp.	Kay Mathew	Community Engagement- Member
Massachusetts Eye and Ear	Erin Duggan	Secondary Data- Member

Subcommittee Members (Cont'd from p. 59):		
Organization	**Name**	**Membership**
Massachusetts General Hospital	Danelle Marable	Community Engagement- Member
Massachusetts General Hospital	Leslie Aldrich	Community Engagement- Member
Massachusetts General Hospital	Sarah Wang	Community Engagement- Member
Massachusetts General Hospital-Center for Community Health Improvement	Kelly Washburn	Secondary Data- Member
Massachusetts General Hospital-Center for Community Health Improvement	Sonia Iyengar	Community Engagement- Member & Secondary Data- Member
Massachusetts League of Community Health Center	Mary Ellen McIntyre	Secondary Data- Member
NAMI – PPAL (Parent/Professional Advocacy League)	Monica Pomare	Community Engagement- Member
Partners Health care	Tavinder Phull	Secondary Data- Co-Chair
Peer Health Exchange	Uchenna Ndulue	Secondary Data- Member
The Family Van	Millie Williams	Secondary Data- Member
The Family Van	Rainelle White	Community Engagement- Member
Tufts Medical Center	Sherry Dong	Community Engagement- Member
Tufts Medical Center	Stephen Muse	Secondary Data- Member
Upham's Corner Health Center	Dan Joo	Secondary Data- Member
Urban Edge	Robert Torres	Community Engagement- Member
Urban Edge	Sahar Lawrence	Secondary Data- Member
Women's Health Unit - BMC	Jennifer Pamphile	Community Engagement- Member

APPENDIX C:

North Suffolk iCHNA Collaborative Steering Committee and Subcommittee Members

Streeting Committee	
Organization	**Name**
City Manager of Chelsea	Tom Ambrosino
Mayor of Revere	Brian Arrigo
Town Manager of Winthrop	Austin Faison
Beth Israel Deaconess Medical Center	Kelly Orlando
Cambridge Health Alliance	Kathy Betts
CAPIC	Bob Repucci
Chelsea Health and Human Services	Luis Prado
Chelsea Board of Health	Dean Xerras
City of Revere SUDI Office	Julia Newhall
East Boston Neighborhood Health Center	Michael Mancusi
Healthy Chelsea	Jennifer Kelly
Massachusetts General Hospital	Leslie Aldrich
MGH Revere	Roger Pasinski
Melrose-Wakefield HealthCare	Eileen Dern
Mystic Valley Elder Services	Dan O'Leary
North Suffolk Mental Health Association	Kim Hanton
The Neighborhood Developers	Rafael Mares
Revere Board of Health	Eric Weil
Revere Cares	Sylvia Chiang
Revere Healthy Communities Initiative	Dimple Rana
Winthrop Board of Health	Susan Maguire
Winthrop Director of Public Health	Meredith Hurley
Winthrop CASA	LeighAnn Eruzione

Subcommittee Members:	
Organization	**Name**
Beth Israel Deaconess Medical Center	Tanya Leger
CAPIC	Bob Repucci

Subcommittee Members (Cont'd from p. 61):	
Organization	**Name**
CAPIC	Kerry Wolfgang
CAPIC	Gladys Agneta
CAPIC	Lee Nugent
Cambridge Health Alliance	Renee Cammarata Hamilton
Cambridge Health Alliance	Jean Granick
Chelsea Board of Health	Dean Xerras
Chelsea Collaborative	Glays Vega
Chelsea Collaborative	Sylvia Ramirez
Chelsea Collaborative	Dini Paulino
Chelsea Police Department	Dan Cortez
Chelsea Thrives	Vicente Sanabria
City of Chelsea	Paula McHatton
City of Chelsea	Tom Ambrosino
City of Revere, SUDI office	Julia Newhall
City of Revere	Robert Marra
Beth Israel Deaconess Medical Center	Tanya Leger
East Boston Neighborhood Health Center	Joanna Cataldo
East Boston Neighborhood Health Center	Brett Phillips
For Kids Only	Briana Flannery
GreenRoots	Roseann Bongiovanni
Healthy Chelsea	Maddy Herzog
Healthy Chelsea	Jen Kelly
Healthy Chelsea	Ron Fishman
Healthy Chelsea	Ryan Barry
Massachusetts General Hospital	Joan Quinlan
MGH Revere	Roger Pasinski
Metropolitan Area Panning Council	Barry Keppard
Metropolitan Area Panning Council	Mark Fine
Metropolitan Area Panning Council	Sharon Ron
Mystic Valley Elder Services	Shawn Middleton

Subcommittee Members (Cont'd from p. 62):	
Organization	**Name**
Mystic Valley Elder Services	Lauren Reid
The Neighborhood Developers	Mary Coonan
The Neighborhood Developers	Vanny Huot
Revere CARES	Sylvia Chiang
Revere Healthy Communities Initiative	Dimple Rana
Revere Resident	Dhriti Dhawan
Winthrop Board of Health	Susan Maguire
Winthrop CASA	LeighAnn Eruzione
Winthrop Resident	Deanna Faretra
WIC	Gisabel Horta
Vitra Health	Romina Wilmot

MASSACHUSETTS
GENERAL HOSPITAL

Center for Community Health Improvement

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Approved by the Mass General Trustee Committee on Community Health on September 16, 2019.

MASSACHUSETTS GENERAL HOSPITAL

CENTER FOR COMMUNITY HEALTH IMPROVEMENT

2019-2020

COMMUNITY HEALTH IMPLEMENTATION PLAN

Executive Summary

Introduction

A Community Health Implementation Plan (CHIP) is a road map to address community-identified public health challenges identified through the Community Health Needs Assessment (CHNA), (www.massgeneral.org/cchi/), both conducted triennially. This report is the 2019-2022 CHIP for Massachusetts General Hospital.

The Mass General 2019 CHNA and CHIP are based on our participation in two first ever collaborative processes in Boston and North Suffolk (Chelsea, Revere, and Winthrop). In each collaborative, participants engaged community organizations, local officials, schools, health care providers, the business and faith communities, residents, and others in an approximately year-long process. The process was tailored to unique local conditions, to better understand the health issues that most affect communities and the assets available to address them.

Boston and North Suffolk have conducted their own CHNAs and CHIPs that can be found here: www.BostonCHNA.org and www.northsouffolkassessment.org. Hospitals are required by regulators (MA Attorney General, IRS) to produce their own CHNA and CHIP, approved by a governing board of the institution. Mass General used the Boston and North Suffolk implementation plans as guidance for its own and engaged content experts to complete the CHIP.

The Priorities

The guiding principle for the Boston and North Suffolk collaboratives is to achieve racial and ethnic health equity. In all communities, social determinants of health emerged as top priorities, as up to 80% of health status is determined by the social and economic conditions where we live and work. Notably, this is the first CHNA ever in which housing and economic issues rose to the top of the list.

The health priorities that emerged across communities and have been adopted as Mass General priorities were strongly aligned and include:

- Safe, affordable, and stable housing.
- Economic and financial stability and mobility, including living wage jobs and educational pathways.
- Behavioral health, including substance use disorders (SUDs) with an emphasis on youth and families.
- Access to health, social, and child care services.

Based on past assessments and historical commitments, Mass General will also continue to address the following priorities:

- Community/intimate partner violence and safety.
- Healthy eating, Active living, and Food Insecurity.
- Elder/aging health issues.
- Chronic disease prevention and management.

The Communities and Strategies

Mass General will continue its commitment and engagement in the communities of Revere, Chelsea, Charlestown, East Boston, and the youth of Boston. Joining with other hospitals through the Conference

of Boston Teaching Hospitals (COBTH) and the Boston CHNA-CHIP Collaborative, Mass General will also engage in the neighborhoods of Boston with the greatest health disparities, notably Roxbury, Dorchester, and Mattapan.

In addition to expanding its work around improving access to care, promoting educational attainment, and partnering with communities to build a culture of health, Mass General will engage in new initiatives that get to the root causes of poor health outcomes. Notable initiatives will include:

Housing

Community-wide Approaches

- *Anchor Investments* – The Partners HealthCare system has already made an initial anchor investment of $1.5 million in partnership with the Local Initiatives Support Corporation (LISC) and the Community Economic Development Assistance Corporation (CEDAC) to preserve 32 units of affordable housing in Chelsea.
- *Permanent Supportive Housing* - The system has also made a $1 million investment in the Mayor's Boston's Way Home plan to build permanent supportive housing for chronically homeless individuals.

We will look to make additional Anchor investments and advocate for public policies that preserve and create affordable housing, such as those in the Massachusetts Principles for Healthy and Affordable Housing.

Patient Approaches

- *Health Starts at Home* – MGH Chelsea participated in an initiative funded by the Boston Foundation to test novel approaches for increasing housing stability and evaluating the impact on health. We screened families in our pediatric practice and referred those who were housing unstable to CONNECT, a partnership of six agencies that works on housing and financial stability. We found that mothers reported significantly less depression and anxiety as a result of the intervention, both connected to better health outcomes for the child. Our partnership recently received a grant from the Kresge Foundation for $320,000 to continue this work.
- *Medical/Legal Partnership* – For 15 years, MGH Chelsea has partnered with the Lawyers for Civil Rights. A lawyer sits in the community health department two days a week and provides services for patients referred by physicians for housing and benefits issues. Each year, the attorney has assisted approximately 100 people to gain, maintain, or improve the quality of their housing.

Our goal is to extend both Health Starts at Home and our Medical Legal Partnership programs to all MGH health center patients.

Economic Security and Mobility

Community-wide Approaches

- *Anchor Institution* – Mass General, along with the Partners HealthCare system, is committed to becoming an Anchor Institution which means we will harness our economic activity in hiring, purchasing, building and investing to benefit low-resourced communities and communities of

color. This is a powerful tool for addressing social and economic determinants of health, such as jobs and economic development.

- *Community Coalitions* – Revere CARES has partnered with the City of Revere, CONNECT, and the Chelsea Collaborative to form the Good Jobs Coalition, and they are receiving technical assistance from the Catapult Lab. Through this coalition, they will develop a comprehensive regional workforce development plan. The Catapult Lab is an initiative of The Boston Foundation, Jewish Vocational Services, and SkillWorks to build the next generation of workforce development solutions.

Patient Approaches

- Partner with Financial Opportunity Centers – CONNECT helps people obtain sustainable living wage jobs and achieve financial health, offering services like financial education and credit building, tax preparation, housing assistance, job search, public benefits, and adult basic education in one location. CONNECT and other organizations like it achieve real results for patients and community members.

We plan to expand our partnerships with financial opportunity centers similar to CONNECT in Chelsea.

Behavioral Health/Substance Use Disorder

Community-wide and Patient Approaches

- We will partner with others to Invest in increasing the pipeline of behavioral health workers who reflect the diversity of the community and in increasing community-based peer support and services to connect residents to behavioral health care. We will build capacity in community-based organizations by training community health workers to provide peer support and we will improve access to existing services.

Conclusion

We are excited to implement this improvement plan with our community and health care partners over the next 3 years and to use our collective voices, resources, and strategies to make lasting and positive health improvements.

Safe, Affordable and Stable Housing

Rationale: Data from the American Community Survey show that at least 50% of renters in Boston and North Suffolk are cost burdened, defined as spending at least 30% of their income on housing. The stresses and pressures created by housing instability and lack of affordability are associated with poor physical and mental health outcomes, as well as disruptions in work, school, and day care arrangements. Poor housing quality can have direct negative health impacts including respiratory conditions such as asthma due to poor indoor air quality, cognitive delays in children from exposure to neurotoxins (e.g., lead), and accidents and injuries because of structural deficiencies.

These effects are experienced most powerfully by people with low or fixed incomes, such as seniors and residents who work low-wage jobs, and those who are undocumented and non-English-speaking.

Goal: Ensure safe, stable, healthy, equitable, affordable housing solutions.				
Objective 1: Advocate for policies and make investments that increase and preserve affordable housing across Greater Boston.				
		Strategy 1		**Strategy 2**
		Direct resources, including but not limited to investments, grant, loans, and other financial instruments, towards community development corporations and other non-profit developers to construct or preserve affordable housing.		**Advocate and support policies that protect tenants, offer rental support, and preserve and increase affordable housing at the local and state level. This includes supporting the Massachusetts Principles for Healthy and Affordable Housing.**
Population(s):		Those experiencing housing instability		People experiencing housing instability or homelessness
Potential New Resources:		• Anchor Investment • Determination of Need Community Health Improvement Funds (DoN CHI)		
Current Initiatives:		• Anchor Investment in Chelsea with local community development corporations to preserve affordable housing • Contribution to Boston's Way Home, the Mayor's initiative to end veteran and chronic homelessness in Boston by creating permanent supportive housing		• Charlestown Coalition advocacy with Boston Housing Authority around status of current Bunker Hill Housing residents during and after redevelopment • Healthy Chelsea advocacy and support for local public and affordable housing projects • Revere CARES advocacy and support for local public and affordable housing projects
Collaborations:		• Local Initiatives Support Corporation (LISC) • Community Development Corporations • Healthy Neighborhood Equity Fund • Boston teaching hospitals		• Other Area Hospitals/Health Systems • Massachusetts Public Health Association
Expected Outcomes:		Increased/preserved affordable housing units		Policies that support safe, affordable housing
Data Source:		Investment/grantee reports		Local and state reports

Objective 2: Implement and expand programs that stabilize or create access to affordable housing for Mass General health center patients.				
	Strategy 1	**Strategy 2**	**Strategy 3**
	Support Medical-Legal Partnerships within the Mass General HealthCare Centers.	**Screen and assess Mass General health center primary care patients for housing instability and connect to partners who provide services including financial and housing counseling.**	**Invest in housing navigation to support MGH inpatients who are chronically homeless to connect with housing resources.**
Population(s):	Patients needing legal advocacy to obtain housing/preserve tenancy	Patients experiencing housing instability	Patients who are chronically homeless or at risk of homelessness
Potential New Resources	Philanthropy	Hospital Investment/philanthropy	Hospital investment
Current Initiatives:	• MGH Chelsea Legal Initiative for Care (LINC), partnership with Lawyers for Civil Rights for housing and benefits • Partnerships with Harvard Law students for immigration status at MGH Chelsea	• Early Childhood Home Visitors • Health Starts at Home (originally funded by The Boston Foundation and now Kresge in partnership with The Neighborhood Developers) • Medicaid ACO Flexible Services • Charlestown Family Support Circle • Healthy Chelsea Family Navigator	ED navigator
Collaborations:	• Lawyers for Civil Rights • Harvard Law School	• The Neighborhood Developers, a community development corporation • CONNECT, a financial services center • CAPIC, an anti-poverty agency	• City of Boston, Mayor's Initiative to End Chronic Homelessness • Housing and shelter providers
Expected Outcomes:	Increased housing stability/access	• Increased housing stability • Improved health outcomes for Health Starts at Home participants	• Increased housing stability • Decreased inappropriate health care utilization • Improved health outcomes
Data Source:	Program data	Program data	Program data

Economic and Financial Stability and Mobility

Rationale: There is significant income inequality in Boston. The median income in Boston is $62,021, but the range is wide— $27,952 in Dorchester to $170,152 in South Boston, and the disparities are significant. Whites have the highest median income ($98,317) while Latinos the lowest ($36,998). In four

neighborhoods—Dorchester, Fenway, Roxbury, and the South End—25-37% of residents live below the federal poverty level. One interviewee summarized, "Real wages have been going down for low income people [for decades]. This is at the heart of all of it: people have no time because they are working four jobs to get the same salary they used to get from one [job]. If you can't rest, how can you be healthy? Some people have to work 70 hours to make ends meet."

In the 2019 North Suffolk Community Survey, 23% of all respondents selected poverty as a top health concern, a marked change from the 2014 and 2015 surveys when poverty was not in the top five. In 2019, 38% of Chelsea survey respondents and 28% of Revere survey respondents identified poverty among their most important health issues. People living in poverty are more likely to have worse health outcomes.

Goal: Promote economic stability and mobility and reduce the wealth gap among residents, staff, and youth.				
Objective 1: Collaborate with and convene organizations to address workforce development, maximize income and benefits, and increase financial literacy and asset building.				
		Strategy 1		**Strategy 2**
		Work with community partners in North Suffolk to develop and implement a community-wide workforce development initiative to increase job stability.		**Partner with and support financial and economic mobility programs to increase financial stability for patients and residents.**
Population(s):		People who are low-income, immigrants and refugees, and/or low-skilled		People who are low-income, immigrants and refugees, and/or low-skilled
Potential New Resources		• Hospital Anchor Investments • DoN CHI • MGH Center for Community Health Improvement		• Hospital Anchor Investments • DoN CHI • CCHI
Current Initiatives:		• Revere CARES is engaged in a workforce development initiative with CONNECT and the City of Revere, with technical assistance through Project Catapult at the Boston Foundation		• Partnership with CONNECT to build economic security • Volunteer Income Tax Assistance (VITA) • Early Childhood Home Visitors using the EMPATH model of financial mobility
Collaborations:		• CONNECT • Jewish Vocational Services • The Neighborhood Developers • Cities of Chelsea and Revere • Chelsea Collaborative		• CONNECT • Budget Buddies • Compass • EMPATH • Other Economic Stability programs
Expected Outcomes:		• Increased income • Increased full-time, benefitted employment		• Increased income • Increased savings
Data Source:		Census Bureau Department of Labor Statistics		Program Data

Objective 2: Develop anchor programs and partnerships to hire, train and promote low to moderate income residents of Boston, North Suffolk and support local businesses.				
		Strategy 1		**Strategy 2**
		Adopt innovative workforce development strategies at MGH to train and develop low-and moderate-income Boston residents.		**Adopt innovative procurement strategies at MGH using Anchor Institution principles to support local minority and women-owned businesses.**
Population(s):		New and Current Mass General Staff who are low and moderate-income residents of Boston and North Suffolk		Local Minority/Women-owned Business Enterprises from Anchor communities
Potential New Resources		Cambridge Street Building Linkage dollars ($1.3M)		Hospital Anchor Investments
Current Initiatives:		• Incumbent worker training (ESOL, GED, etc.) • Partners in Career and Workforce Development		• Partners Purchasing Diversity Initiative • Anchor strategies
Collaborations:		• Cities of Boston, Chelsea, and Revere • Job training agencies		Chamber of Commerce
Expected Outcomes:		Increased employment		Increased revenue into minority/anchor communities through purchasing for locally owned businesses
Data Source:		Program Data		Program Data

Objective 3: Build on existing youth programs to offer opportunities to promote educational attainment, develop leadership skills, and gain career exposure and experience.						
		Strategy 1		**Strategy 2**		**Strategy 3**
		Expand the Mass General Youth Programs (3rd grade through college) to more youth residing in our target communities to support college readiness and explore partnership opportunities for youth not college-bound.		**Provide summer jobs to at least 250 youth every year at Mass General and assist 40 youth in Chelsea, Revere, and Charlestown to find employment with other employers.**		**Strengthen Mass General's Coalition Youth Groups to provide paid internships to develop leadership and advocacy skills to at least 100 youth.**
Population(s):		Youth		Youth		Youth
Potential New Resources		• Philanthropy • Hospital Investments		• Philanthropy • Hospital Investments		• Philanthropy • Hospital Investments
Current Initiatives:		• Mass General Youth Scholars, a program that exposes 1,000 youth grades 3 through college to careers in science and medicine.		• Mass General Youth Summer Jobs Program • Revere Youth Leadership Council • Revere Power of Know Youth Group		• Revere Youth Leadership Council • Revere Power of Know Youth Group • Healthy Chelsea Youth Food Movement Group

				• Healthy Chelsea Youth Food Movement Group • Healthy Chelsea Teen Action Project • Charlestown Turn it Around Youth Group		• Healthy Chelsea Teen Action Project • Charlestown Turn it Around Youth Group
Collaborations:		• Boys and Girls Clubs of Boston • Becoming A Man (BAM) • Accelerated College Experience (ACE)		• Private Industry Council • Cities of Chelsea and Revere		• Revere Public Schools • Chelsea Public Schools • Boston Public Schools
Expected Outcomes:		• Increased college persistence and graduation • Increased career exposure • Increased leadership and advocacy skills		Increased job readiness skills		• Increased career exposure • Increased leadership and advocacy skills • Increased resiliency
Data Sources:		Program Data		Program Data		Program Data

Behavioral Health, including Substance Use

Rationale: The CHNA identified widespread concern about behavioral health challenges among families, friends, and neighbors. Stress, anxiety, and depression were the most frequently-cited behavioral health issues among Boston and North Suffolk residents, especially those who identify as LGBTQ, low-income, women, renters, seniors, children, immigrants, communities of color, and the unemployed. Many community organizations mentioned the need to increase resiliency and healthy coping mechanisms in youth.

Participants discussed the co-occurrence of behavioral health issues with SUDs, including opioid use disorder (OUD) and trauma. Together these challenges are among the leading causes of disability in the U.S. In 2016, unintentional opioid overdose accounted for 69% of all accidental deaths, with rates highest among Latinos, followed by Whites.

CHNA respondents report that access to help is limited by stigma, culture, language, cost, and provider competency in treating communities of color, particularly immigrant communities. They recommended investing in more behavioral health support in public schools, reducing cultural stigma linked to behavioral health services, creating community-based access through peer support, and recruiting behavioral health clinicians who reflect the diversity of the communities. One key informant illustrated these barriers by sharing, “There is far too little access to treatment programs, and those that do exist are not linguistically and culturally competent.”

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.						
Objective 1: Increase the pipeline of culturally appropriate behavioral health workers (licensed and community-based) and increase services in traditional and non-traditional settings.						
		Strategy 1		**Strategy 2**		**Strategy 3**
		Establishing scholarship opportunities for racially, ethnically & linguistically diverse students to obtain education and training for behavioral health roles and recruit behavioral health clinicians who reflect the diversity of the community.		**Pilot programs or partner with existing organizations that train community health workers in community-based settings to provide support and connect community members to behavioral health care.**		**Partner with school systems, health centers, and youth- and family-focused programs to provide resiliency curriculum and behavioral health support.**
Population(s):		Culturally and linguistically diverse students seeking behavioral health careers		Residents of Roxbury, Dorchester, Mattapan, Chelsea, Revere, Charlestown, East Boston		Boston, Chelsea, Revere, Winthrop public school students, parents, faculty
Potential New Resources		• System Investment • Governor’s health care legislation • DoN CHI		• System Investment • DoN CHI • IRIS Database		• System Investment • Philanthropy • DoN CHI

Current Initiatives:						Chelsea and Revere School-Based Health Centers
Collaborations:		Local colleges		• Massachusetts Department of Mental Health • North Suffolk Mental Health Association • Other behavioral health agencies		• Public schools • Community organizations • Mass League of Community Health Centers
Expected Outcomes:		Increased number of diverse behavioral health workforce in Boston		• Increased alternative pathways to an array of community based BH services • Increased access to services • Increased knowledge on trauma and resources available		• Improved access to care • Increased resilient communities and youth
Data Sources:		Program Data		Program Data		Youth Risk Behavior Survey
Objective 2: Support multi-sector community coalitons to convene stakeholders to identify and advocate for policy, systems, and environmental changes to increase resiliency, reduce youth substance use, and prevent opioid overdoses and deaths.						
		Strategy 1		**Strategy 2**		**Strategy 3**
		Building Community and Organizational Capacity - Increase the capacity of communities and organizations to respond to the behavioral health needs of youth and families by convening municipalities, organizations, and residents to identify opportunities to support a culture of health.		**Advocate for policies - Create or amend policies that support youth resiliency and decrease or mitigate factors that lead to substance use.**		**Educate - Continue to provide opioid overdose prevention and harm reduction education to those struggling with addiction, families, and medical providers in Greater Boston and provide substance use prevention education and early intervention, particularly around marijuana, vaping, and opioids to parents and youth.**
Population(s):		Community residents Community organizations		Community youth and families		People with substance use disorders Community youth and families
Potential New Resources		Philanthropy		• Philanthropy • Grants		Philanthropy
Current Initiatives:		• Healthy Chelsea Coalition • The Charlestown Coalition • EASTIE Coalition • Revere CARES Coalition		• Healthy Chelsea Coalition • The Charlestown Coalition • EASTIE Coalition • Revere CARES Coalition		• Healthy Chelsea Coalition • The Charlestown Coalition • Revere CARES Coalition • MGH Vaping initiative

		• SAPC Regional Grant • Boston Substance Use Prevention Collaborative		• MGH Vaping initiative • Boston Substance Use Prevention Collaborative		• EASTIE Coalition • Boston Substance Use Prevention Collaborative
Collaborations:		Multiple community and municipal agencies		Multiple community and municipal agencies		Multiple community and municipal agencies
Expected Outcomes:		• Increased resources received in the communities • Increased stakeholders involved • Increased policy or system changes		• Increased youth resiliency • Decreased substance use • Increased mental health indicators		• Reduction in opioid overdoses and deaths • Reduction in hospitalizations • Increase in treatment admissions
Data Sources:		Program Data		Youth Risk Behavioral Survey		Program Data Data from Mass DPH on opioid deaths, treatment admissions, hospitalizations
Objective 3: Reducing stigma for those with substance use disorder and support the MGH chronic disease management model of care that spans the continuum of care from inpatient to the community.						
		Strategy 1				**Strategy 2**
		Sustain and expand Substance Use Disorders initiative across the hospital and MGH health centers.				**Sustain and expand mobile addiction program, identify areas at high risk for overdose, provide harm reduction services and initiate MAT for people with SUDs.**
Population(s):		MGH patients with SUDS				Those with a substance use disorder on the streets with a focus on opioids
Potential New Resources		Philanthropy/grants				MA DPH RFP to spread to 2 to 3 additional communities
Current Initiatives:		• Mass General SUDs Initiative – ACT (inpatient), Bridge, Hope (pregnant and new moms), Primary Care SBIRT screening, SUDs screening in Behavioral Health, jails				Kraft Center for Community Health mobile addiction services van
Collaborations:		• City of Boston • Nashua Street Jail • Boston Health Care for the Homeless Program • South Bay House of Corrections				• Boston Health Care for the Homeless Program • Boston Public Health Commission's AHOPE Program • Grayken Center for Addiction Medicine at Boston Medical Center • GE Foundation • Bridge Over Troubled Waters • RIZE Massachusetts

				• MA Department of Public Health
Expected Outcomes:		• Decreased addiction severity • Reduction in length of stay and 30-day readmission to the hospital • Decreased overdose, particularly in the post-incarceration period		• Lower mortality from opioid overdose • More engaged in treatment • Harm reduction results in fewer medical complications of addiction
Data Sources:		Program Data		Program Data City & State Overdose Data

Accessing Services (Healthcare, Childcare, Social Services)

Rationale: Across focus groups, interviews, and surveys CHNA respondents expressed satisfaction with their health care; the Boston Behavioral Health Risk Factor Surveillance System (BRFSS) survey results show that 80% of respondents identify at least one personal doctor. Nevertheless, they described barriers to care including language, navigating the health care system, understanding health care benefits, transportation, a lack of culturally sensitive approaches to care, and immigration status. In particular, CHNA participants spoke about the fear in undocumented or mixed status families that prevent family members from seeking care. CHNA respondents also cited long wait times for appointments (44%) and a lack of evening and weekend services (38%) that limit access to health care.

Goal: Ensure all Mass General patients have access to coordinated and equitable health and family support services and resources to support overall health.				
Objective 1: Increase the capacity of health services to provide culturally and linguistically relevant care and expand access to those services.				
	Strategy 1	**Strategy 2**	**Strategy 3**	**Strategy 4**
	Increase the capacity of Mass General community health centers and other health care organizations to reduce barriers to care for patients through community health workers, navigators, and other outreach programs.	**Reduce barriers to timely cancer screening and follow-up cancer care through culturally appropriate navigation and innovative programs.**	**Support families with children up to age 5 to develop nurturing relationships and healthy child development.**	**Continue to work with Partners HealthCare Center for Population Health to support implementation of community health workers across the system to support patients in the Medicaid Accountable Care Organization.**
Population(s):	Patients with complex health and social needs	High-risk community health center patients who need cancer screening or care	Families with children under 5 with complex health and social needs	ACO patients with complex health and social needs
Potential New Resources	• Hospital Investment • Grants • Philanthropy • State and Federal Funding	• Hospital Investment • Philanthropy • Grants	• Hospital Investment • Philanthropy • Grants • State and Federal Funding	• Hospital and System Investment • Medicaid ACO
Current Initiatives:	• MGH Chelsea Community Health Improvement Team Programs	• Cancer Navigation Program • Trefler Program for Cancer Care Equity • Implementation Science Center for	• MGH Revere Healthy Steps • MGH Revere Parents as Teachers • MGH Chelsea Healthy Families America	• Partners CHW Collaborative • MGH CCHI and health centers

		• Revere & Chelsea School-Based Health Centers • MGH Community Health Associates • Boston HealthCare for the Homeless Program		Cancer Control Equity (ISCCCE) • Komen Foundation Cancer Navigation Program		• MGH Chelsea Healthy Steps • Healthy Chelsea Early Childhood Network	
Collaborations:		Numerous community organizations		• Harvard T.H. Chan School of Public Health • Massachusetts League of Community Health Centers • 31 community health centers across MA		• MA Department of Public Health • Healthy Families America • Raising a Reader • EMPATH • Chelsea/Revere Family Network	MA Department of Public Health
Expected Outcomes:		• Increased arrival rates to appointments • Increased medical compliance • Increased care coordination • Increased funding to deliver equitable, culturally relevant care		• Increased arrival rates to appointments • Increased timely cancer screenings • Increased early detection of cancer • Increased follow through in cancer care • Increased adoption of proven-effective interventions for cancer screening and prevention in community health settings • Increased equity in cancer care and outcomes		• Decreased child abuse and neglect • Increased parent-child attachment • Child(ren)achieving developmental milestones • Increased connection to care and community resources • Decreased maternal depression	• Number of CHWs • Number of trainings
Data Sources:		Program Data		Program Data		Program Data	Program Data

Objective 2: Assist older and disabled adults who live in three buildings near Mass General in Boston's West End and Beacon Hill in maintaining independence as they age in place by identifying social and health related needs and providing nursing, social work, and resource intervention.		
		Strategy 1
		Ensure seniors and disabled adults in three buildings near hospital have access to coordinated health and support services and resources to support overall health and age in place.
Population(s):		Low-income older and disabled adults who live in three local buildings
Potential New Resources		Cambridge Street DoN CHI
Current Initiatives:		Connect to Wellness, an outreach team of nurse, social worker, and resource specialist who spend a day a week in each building offering individual and group services
Collaborations:		Preservation of Affordable Housing, Rogerson Communities, HallKeen
Expected Outcomes:		• Reduced inappropriate utilization for MGH patients • Better chronic disease management • Connection to supportive benefits and resources • Preserve tenancy and build social connection
Data Sources:		Program Data

Community/ Intimate Partner Violence and Safety

Rationale: In Boston, community violence was the most frequently discussed type of violence in focus groups, namely in the neighborhoods of Dorchester, Mattapan, Roxbury, Chinatown, and East Boston. When Boston CHNA survey respondents were asked how safe they considered their neighborhoods to be, 25% described their neighborhood as unsafe or extremely unsafe. Twice as many respondents from Roxbury (50%), Mattapan (49%), and Dorchester (45%) described their neighborhood as unsafe or extremely unsafe. One in five Boston CHNA survey respondents described gunshots in the neighborhood (22%) and feeling unsafe when alone on the street at night (19%) as serious problems.

There is very little quantitative data available on interpersonal or domestic violence. In 2018, the Boston Police Department served a total of 1,921 restraining orders, ranging from 386 in Roxbury and 368 in Mattapan to 2 in Charlestown. However, it is well known that intimate partner violence is underreported.

Goal: Promote policies, systems, and programs to achieve safety in communities and homes.				
Objective 1: Reduce injuries and deaths related to violence and promote safety in the home and in the community through clinical care and education, community engagement, advocacy, and research.				
		Strategy 1		**Strategy 2**
		Provide intimate partner and community violence intervention programs to Mass General patients and community residents.		**Prevent firearm-related violence and promote safety in the homes and communities of the patients we serve.**
Population(s):		Patients experiencing intimate partners violence (IPV) and/or community violence		Patients and communities affected by gun violence
Potential New Resources		Philanthropy		Philanthropy
Current Initiatives:		• HAVEN, for those experiencing intimate partner violence • VIAP, for survivors of community violence • PACT, for child witnesses to violence		Center for Gun Violence Prevention
Collaborations:		• Boston Police Department • Chelsea Police Department • Many other community organizations		• Boston Police Department • Chelsea Police Department • Many other community organizations
Expected Outcomes:		• Increased access to resources • Increased arrival rates to appointments • Decreased trauma • Increased resiliency		• Increase in number of physicians and other health professionals trained in screening for weapon safety in the homes and counseling in gun safety
Data Sources:		Program Data		Program Data

Healthy Eating, Active Living, and Food Insecurity

Rationale: Access to fresh and affordable healthy food is a growing problem in some neighborhoods in Boston and North Suffolk communities, with lower income neighborhoods, most commonly communities of color, having few grocery stores and a high prevalence of fast food and convenience stores. Data indicate that nearly one in five Boston residents reported being food insecure, meaning that they ran out of food and funds to purchase more over the course of the month. Experiences with food insecurity varied by population group. In aggregated 2013, 2015, and 2017 BBRFSS data, Latino (39.1%) and Black (34.5%) residents were significantly more likely than White residents (10.7%) to report food insecurity as were foreign-born residents compared to U.S. born residents. Food insecurity and lack of access to fresh and affordable healthy food is associated with obesity. At the neighborhood level, the percent of adults in Mattapan (71%), Hyde Park (65%), Dorchester (63-65%), West Roxbury (64%), East Boston (63%), and Roslindale (63%) who were obese or overweight was significantly higher than the rest of Boston.

Goal: End hunger and reduce obesity in Boston and North Suffolk.				
Objective 1: Increase healthy eating and active living by advocating for systems changes, increasing opportunities for physical activity, and providing healthy food resources to patients and community residents.				
		Strategy 1		**Strategy 2**
		Support policy, systems, programs, and environmental changes to increase access to affordable, healthy foods and physical activity in communities and school environments.		**Screen for and provide resources to patients who are struggling with food insecurity.**
Population(s):		Community residents		Patients who are experiencing food insecurity
Potential New Resources		Philanthropy DoN CHI		Philanthropy Grants
Current Initiatives:		• Healthy Chelsea Initiatives: Holiday School Food Project, School Food partnership, Hunger Network, and advocacy work • Revere on the Move Farmers Markets and Food Economy work • Stay in Shape program to educate youth on healthy eating and active living • BOKS Program, physical activity before school		• MGH Chelsea Food for Families • MGH Chelsea Food Pantry • MGH Revere Food Pantry • First 1,000 Days • Shopping Matters • Stay in Shape
Collaborations:		• Cities of Chelsea and Revere • Greater Boston Food Bank • Chelsea public schools • Other community organizations		• Greater Boston Food Bank • Other community organizations
Expected Outcomes:		• Increased healthy eating, especially among youth • Increased physical activity		Decreased food insecurity
Data Sources		Program Data Youth Risk Behavior Survey		Program Data

Chronic Disease

Rationale: Data show that cancer, SUDS, asthma, diabetes, and other chronic diseases are drivers of mortality in Boston and North Suffolk communities. There are significant racial and ethnic disparities in these conditions that result in higher mortality rates. For example, the age-adjusted mortality rate per 100,000 is higher in Chelsea (963.8), Revere (734), and Winthrop (928.7) than the Massachusetts rate (668.9). Likewise, Charlestown (758.2), Dorchester (737), East Boston (759), Hyde Park (840.4), and Roxbury (769.9) are higher than Boston's age-adjusted mortality rate per 100,000 (702.5).

Goal: Design strategies and programs to help improve health outcomes for those with chronic disease.		
Objective 1: Ensure high-risk patients with chronic disease (Diabetes, HIV, Hep C, Asthma, SUDs) receive access to coordinated health and support services, assistance with social determinants, medications, and other resources to better manage their disease.		
		Strategy 1
		Improve the health of high-risk patients with chronic disease through culturally appropriate navigation, resources, and supports.
Population(s):		High-risk community health center patients with diabetes, asthma, SUDS, Hep C, HIV
Potential New Resources		• Hospital Investment • Philanthropy • State and Federal Funding
Current Initiatives:		• Comprehensive Community Health Workers • MGH Chelsea Pediatric Asthma Program • Hepatitis C Navigation Program • HIV/AIDS Medical Case Management Program • Diabetes CHW pilot • Mass General SUDs Initiative (see Behavioral Health) • Adult and Pediatric integrated Care Management Programs (iCMP) • Live Tobacco Free
Collaborations:		• City of Boston • Mass League of Community Health Centers • Many other organizations
Expected Outcomes:		• Increased arrival rates to appointments • Decreased disease burden • Increased medication adherence • Increased care coordination • SDOH's addressed
Data Sources:		Program Data

Current Mass General Programming by Priority Area

Current Program	Safe & Affordable Housing	Financial & Economic Stability and Mobility	Behavioral Health, including Mental Health and Substance Use	Access to Care	Community Violence & Safety	Obesity & Food Insecurity	Elder/Aging Issues	Chronic disease with cancer, diabetes focus
Boston Health Care for the Homeless Program (BHCHP) at MGH				✓				
Boston Substance Use Prevention Collaborative			✓	✓				
Cancer Navigation Program				✓			✓	✓
Charlestown Coalition			✓		✓			
Charlestown Family Support Circle		✓	✓	✓				
Charlestown Turn it Around Youth Group		✓	✓		✓			
Chelsea High School Based Health Center			✓	✓	✓	✓		
Chelsea Immigrant and Refugee School Program			✓	✓	✓			
Chelsea Teen Action Project Youth Group		✓	✓					
Chelsea Youth Food Movement		✓				✓		
Comprehensive Community Health Worker Program	✓	✓	✓	✓		✓	✓	✓
Connect to Wellness	✓			✓			✓	
EASTIE Coalition			✓	✓	✓			
Healthy Chelsea Coalition		✓	✓	✓	✓	✓		
Healthy Chelsea Early Childhood Network				✓				
Helping Abuse and Violence End Now (HAVEN)				✓	✓			
Hepatitis C Program			✓	✓				✓
Living Tobacco Free			✓	✓				✓

Current Program	Safe & Affordable Housing	Financial & Economic Stability and Mobility	Behavioral Health, including Mental Health and Substance Use	Access to Care	Community Violence & Safety	Obesity & Food Insecurity	Elder/Aging Issues	Chronic disease with cancer, diabetes focus
Mayor's Way Home Investment	✓							
MGH Chelsea Food for Families				✓		✓		
MGH Chelsea Health Starts at Home	✓	✓	✓	✓				
MGH Chelsea Healthy Steps Program				✓				
MGH Chelsea Healthy Families America	✓	✓	✓	✓	✓			
MGH Chelsea Legal Initiatives for Care (LINC)	✓	✓		✓				
MGH Chelsea Medical Interpreter and Community Health Workers				✓				
MGH Chelsea Pediatric Asthma Program				✓				✓
MGH Chelsea Police Action Counseling Team (PACT)				✓	✓			
MGH Chelsea Refugee Health Assessments			✓	✓				
MGH Vaping Initiative				✓				
MGH Youth Programs & Youth Scholars		✓	✓					
Office Based Addiction Treatment Program			✓	✓				✓
Revere Adolescent Health Initiative			✓	✓	✓	✓		
Revere CARES Coalition		✓	✓			✓		
Revere Family Planning Program				✓				
Revere Health Leadership Council		✓	✓					
Revere Healthy Steps for Young Children	✓	✓	✓	✓	✓	✓		

Current Program	Safe & Affordable Housing	Financial & Economic Stability and Mobility	Behavioral Health, including Mental Health and Substance Use	Access to Care	Community Violence & Safety	Obesity & Food Insecurity	Elder/Aging Issues	Chronic disease with cancer, diabetes focus
Revere High School Based Health Center			✓	✓	✓	✓		
Revere on the Move		✓				✓		
Revere Parents as Teachers	✓	✓	✓	✓	✓	✓		
Revere Power of Know Afterschool Clubs		✓	✓					
Revere Youth Zone			✓	✓		✓		
SAPC Regional Substance Abuse Prevention Collaborative			✓					
Stay in Shape Program			✓	✓	✓	✓		
Trefler Cancer Care Equity Program				✓			✓	✓
Violence Intervention Advocacy Program (VIAP)				✓	✓			

Collaborators

Name	Description	Communities
Accelerated College Experience (ACE)	Teaches students to take ownership of their academic experience by setting their own high standard of personal and academic excellence as measured by achieving a GPA of 3.0 or higher in college.	Greater Boston
Becoming a Man	Helps young men of color navigate difficult circumstances that threaten their future.	Boston
Boston Health Care for the Homeless Program	Provides or assures access to the highest quality health care for all homeless individuals and families in the Greater Boston area.	Greater Boston
Boston Private Industry Council (PIC)	An organization that strengthens Boston's communities and its workforce by connecting youth and adults with education and employment opportunities that align with the needs of area employers.	Boston
Boston Public Health Commission's AHOPE Program	City of Boston's harm reduction program offering needle exchange and naloxone education and distribution.	Boston
Boston's Way Home	A City of Boston initiative to end chronic homelessness.	Boston
Boys and Girls Clubs of Boston	Provides safe and affordable places for children and teens during out-of-school time.	Greater Boston
Bridge Over Troubled Waters	Provides effective and innovative services to runaway, homeless and high-risk youth, helps youth avoid a lifetime of dependency on social services, guides youth towards self-sufficiency, and enables youth to transform their lives and build fulfilling, meaningful futures.	State-wide
Budget Buddies	Provides financial coaching for women with low-income.	Greater Boston
Chelsea/Revere Family Network	A state funded child and family support program serving families with children from the prenatal stage up to eight (0-8) years old.	Chelsea, Revere
Chelsea Collaborative	Empowers residents to enhance the social and economic health of the community and its people; and to hold institutional decision makers accountable to the community.	Chelsea, Revere
Community Action Programs, Inter City (CAPIC)	A private, non-profit corporation designated to identify and eradicate the root causes of poverty in Chelsea, Revere and Winthrop.	Chelsea, Revere, Winthrop
Compass Working Capital	Provides financial coaching for people with low-income.	Greater Boston
CONNECT	CONNECT offers the services of five agencies working to improve the financial mobility of low-income families.	Chelsea, Revere
EMPATH	Provides financial coaching for people with low-income.	Greater Boston
GE Foundation	The philanthropic organization of GE committed to transforming communities and shaping the diverse workforce of tomorrow.	State-wide

Name	Description	Communities
Grayken Center for Addiction Medicine at Boston Medical Center	Offers innovative treatment, education, and research programs.	State-wide
Greater Boston Food Bank	The largest hunger-relief organization in New England and among the largest food banks in the country.	Greater Boston
HallKeen Management	Property management company for affordable multi-family, assisted living, and mixed-use properties	Greater Boston
Harvard Law School	Provides volunteer law students to fight discrimination through legal action, education, and advocacy.	Greater Boston
Harvard T.H. Chan School of Public Health	Brings together dedicated experts from many disciplines to educate new generations of global health leaders and produce powerful ideas that improve the lives and health of people everywhere.	State-wide
Healthy Families America	One of the leading family support and evidence-based home visiting programs in the United States. We believe early, nurturing relationships are the foundation for healthy development.	Nation-wide
Healthy Neighborhood Equity Fund	Provides capital and strategy to invest in affordable housing.	State-wide
Jewish Vocational Services (JVS)	Empowers individuals from diverse communities to find employment and build careers, while partnering with employers to hire, develop, and retain productive workforces.	Greater Boston
Lawyers for Civil Rights	Fosters equal opportunity and fights discrimination on behalf of people of color and immigrants through legal action, education, and advocacy.	State-wide
Local Initiatives Support Corporation (LISC)	Provides capital and strategy to invest in affordable housing.	Nation-wide
MA Department of Public Health	Promotes the health and well-being of all residents by ensuring access to high-quality public health and healthcare services, and by focusing on prevention, wellness, and health equity in all people.	State-wide
Mass League of Community Health Centers	Promotes population health equity for all through leadership and programs supporting community health centers and members in achieving their goals of accessible, quality, comprehensive, and community responsive health care.	State-wide
Massachusetts Department of Mental Health	The State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages; enabling them to live, work and participate in their communities.	State-wide
Massachusetts Public Health Association	A statewide membership organization that promotes a healthy Massachusetts through advocacy, education, community organizing, and coalition building.	State-wide
Nashua Street Jail	Jail located in Boston for pre-trial detainees.	Suffolk County

Name	Description	Communities
North Suffolk Mental health Association	Providing mental health services to individuals, and especially children, in relatively under-served communities.	Revere, Chelsea, Winthrop, Boston
Preservation of Affordable Housing	A national nonprofit organization whose mission is to preserve, create and sustain affordable, healthy homes that support economic security and access to opportunity for all.	Nation-wide
Raising a Reader	Helping families with children from birth to age eight develop, practice and maintain home literacy habits essential for school and life success.	Nation-wide
RIZE Massachusetts	An independent nonprofit foundation working to end the opioid epidemic in Massachusetts and reduce its devastating impact on people, communities, and economy.	State-wide
Rogerson Communities	Provides housing and health care for elders and low-income individuals and families.	Greater Boston
South Bay House of Corrections	A jail in Suffolk County.	Suffolk County
The Neighborhood Developers	A community development corporation that preserves and builds affordable housing and builds the social connectedness of residents.	Chelsea, Revere, Everett

MASSACHUSETTS GENERAL HOSPITAL

CENTER FOR COMMUNITY HEALTH IMPROVEMENT

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