Introduction and Background

Brigham and Women's Faulkner Hospital (BWFH) is a 150 bed non-profit, community teaching hospital located in Jamaica Plain, just 3.4 miles from the Longwood medical area, and across the street from the Arnold Arboretum. Founded in 1900, Brigham and Women's Faulkner Hospital has a long history of meeting the health care needs of the residents of southwest Boston and surrounding suburbs. We offer comprehensive medical, surgical and psychiatric care as well as complete emergency, ambulatory and diagnostic services. Our largest inpatient services are internal medicine, cardiology, psychiatry, pulmonary, orthopedics, gastroenterology and general/GI surgery.

Brigham and Women's Faulkner Hospital provides its patients with some of the most advanced medication safety technology by utilizing a combination of computerized order entry, administration records, infusion pumps and automated drug dispensing machines. In fact, Brigham and Women's Faulkner Hospital now uses a Bedside Medication Verification system, known as bar coding that automatically checks a patient's medical record to ensure that they're receiving the correct medicine and the correct dosage at the proper time.

Brigham and Women's Faulkner Hospital also has full accreditation from The Joint Commission. The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States and their accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Of the many benefits of going to Brigham and Women's Faulkner Hospital is their use of single bed patient rooms. Private rooms have been shown to increase patient satisfaction, reduce the risk of infections and offer more flexibility among practitioners to best treat patients. With more than 1,600 full and part time employees helping to meet the growing demand for medical services, Brigham and Women's Faulkner Hospital and Brigham and Women's Hospital surgical staff are now performing close to 9,000 surgical procedures a year.

Service Philosophy

At Brigham and Women's Faulkner Hospital, our world revolves around our patients and their families who depend on the excellent medical care, commitment to quality and personal attention they have come to expect from us. Our convenient setting, private rooms, patient friendly environment and compassionate and caring staff are just a few of the many aspects of care that patients tell us make a difference. At Brigham and Women's Faulkner Hospital, we strive to treat each patient the way we would like to see a member of our own family treated, and it shows. We consistently receive excellent ratings in patient satisfaction surveys. The
friendly and supportive environment that our patients appreciate also makes Brigham and Women's Faulkner Hospital a rewarding place to work.

**Mission Statement**

Brigham and Women's Faulkner Hospital strives to attain excellence in patient care services, provided in a learning environment with dignity, compassion and respect.

**Teaching**

Highly regarded as one of Boston's most important, community teaching hospitals, our post-graduate medical education is rooted in a long and innovative tradition. Brigham and Women's Faulkner Hospital serves as a training site for students from Tufts University School of Medicine and Harvard Medical School. Its medical, surgical and psychiatry residency programs are integrated with those of Brigham and Women's Hospital. The hospital also serves as a site for training several hundred health care professionals, annually, in the areas of nursing, nutrition, pharmacy, social work, psychiatry, rehabilitation therapies, addiction recovery and more. Our commitment to teaching extends to our employees who benefit from our extensive education and training programs.

**Community Health and Benefits Mission Statement**

(revised version adopted March 10, 2010)

The Board of Directors, Oversight Committee for Community Health and Wellness, hospital administration, and larger hospital community, are all committed to Faulkner’s community health and wellness mission, which is:

- To evaluate the health status of service area neighborhoods of West Roxbury, Roslindale, Hyde Park and Jamaica Plain and respond to identified needs
- To pay particular attention to health and wellness concerns affecting children in local schools, the elderly, women, and diverse populations who may experience health disparities, among others
- To provide a wide variety of free health screenings and immunizations, health education programs, and other services relating to important health issues affecting communities served
- To seek community participation in and feedback about our community benefits efforts, by involving community members in the hospital’s planning and evaluation processes and by keeping the lines of communication open
- To engage in meaningful, active collaboration with a broad range of community residents, schools, service organizations, businesses, government agencies and others, to stay abreast of community needs, and to pool knowledge and resources in addressing those needs
- To periodically review and assess community benefits goals, services, and outcomes to insure that they remain relevant to issues affecting our communities, and to allocate or reallocate community benefits resources, as needed
Oversight Committee for Community Health and Wellness

Purpose Statement

Brigham and Women’s Faulkner Hospital Community Health and Wellness has a long standing commitment to the community to improve access to health care and promote wellness and prevention through education. Being current with data, compliant with guidelines and regulations and maintaining continuous working relationships with the community are all key factors in the success of this work.

The Oversight Committee works to uphold the Community Benefits Mission through support of the seven priority areas (listed below) of the Community Health and Benefits Department Plan:

Responsibilities:
- Review and evaluate the community mission, plan and programming with respect to the current needs assessment
- Provide input and recommendations to better serve the community health needs
- Facilitate active communication and sharing across all BWFH departments
- Oversee regulatory activity related to the Attorney General, the Massachusetts Department of Public Health, Federal Government, and State of Massachusetts
- Act as a champion for Brigham and Women’s Faulkner Hospital’s community health work and assist to make community connections and foster relationships in the community
- Represent and offer a unique perspective on what the community needs are and how best to meet them
- Oversee and review annual departmental plans for community health and benefit contribution

Membership:
- Marie Louise Kehoe, Chairperson—Board member emeritus; local resident
- Ethan d’Ablemont Burnes—Principal, Manning Elementary School; local resident
- Susan Dempsey—BWHC VP of Support Services and BWF Clinical Services
- Margaret Duggan, MD—Chief Medical Officer; BWHC Board Member; BWF Operating Oversight Committee; BWFH Quality Steering Committee
- Jean Flanagan-Jay—BWFH Director, Rehabilitation Services
- Michael Gustafson—BWFH Chief Operating Officer
- Betty Hanson—Board member emeritus; local resident
- Judy Hayes—BWFH VP, Nursing
- Marion Kelly—Executive Director, West Roxbury YMCA
- Meg Kilmurray—Community Health and Wellness Assistant
- Susan Langill—BWHC, Director, Food Service and Nutrition
- Linda Lauretti, MD—BWFH Primary Care Physician
• Edward Liston-Kraft—BWFH VP, Professional and Clinical Services
• Sandra Lynch—Former Executive Director of VNA Care Network, Inc.
• Vinnie McDermott—BWHC, Chief Financial Officer
• Janet McGrail Spillane—Board member emeritus; BWFH Quality Steering Committee; VP, America Cancer Society; local resident
• Katherine Rowley—retired Boston Public School nurse; local resident
• Tracy Sylven—BWFH, Director, Community Health and Wellness
• Lanny Thorndike—BWHC Board Member
• John Woodard—Board Member emeritus; BWFH Operating Oversight Committee; local resident

**Reporting Relationship:**
The Oversight Committee for Community Health and Wellness reports to the Board of Directors.

**Meeting Frequency:**
The Oversight Committee for Community Health and Wellness meets twice a year for 1 hour.

**Target Communities and Populations**
- West Roxbury
- Hyde Park
- Roslindale
- Jamaica Plain
- Elderly
- Local School Children
- Underserved
- Barriers to healthcare

**Organizational Commitment**
Brigham and Women’s Faulkner Hospital is dedicated to community benefits as a systematic program, rather than a series of isolated community health activities. Through the commitment of hospital leadership, there is a rich internal dialogue that helps to assure sustained financial and human resources commitment. There is a long history of engaging employees, nurturing collaborations with community partners and close involvement in building trust with neighbors.

**Assessment of Community Health Needs, Goals and Assets**
BWFH employs a dynamic and ongoing process to identify and prioritize the community health needs.
Program Design:

- Review of current data and assessments from local, state and national organizations
- Partnership with local community organizations
- In depth and thoughtful dialogue and input from individuals though stakeholder meetings and survey opportunities.

- Development of criteria used to select areas of priority and focus:
  - Estimated effectiveness
  - Are there adequate resources to implement the intervention strategy?
  - Are there existing efforts? If so, how can we best complement or enhance those efforts?
  - Collaborative opportunities with local stakeholders

Program Targeting:

- The targeting of specific program activities is based on the following criteria:
  - Will the intervention fit the needs of the target population?
  - How many people will we reach with the intervention?
  - Is the intervention acceptable by the community?
  - Is the intervention fiscally feasible?

Program Monitoring:

All program activities are tracked by the Community Health and Wellness Department with review from the BWFH Oversight Committee for Community Health and Wellness.

Assessment of Needs and Determination of Priorities

During HFY13 the BWFH Department of Community Health and Wellness undertook a review/assessment of publicly available resources; existing programs; and views from people who represent the broad interest of the community served by the hospital to inform the BWFH community health priorities.

Data collected and/or reviewed:

- review of MA Dept of Public Health and City of Boston data
  - Health of Boston: A Neighborhood Focus, 2012-2013
  - Massachusetts Dept of Public Health, MAssCHIP
  - Behavioral Risk Factor Surveillance System, 2011 (BRFSS)
  - Youth Behavioral Risk Survey (YRBS)
- Brigham and Women’s Faulkner Hospital’s 2013 Community Survey
  - ~70 respondents
  - 43% of respondents live in one of the BWFH target communities
72% of respondents work in one of the BWFH target communities
○ 18% of respondents were Black and 5% were Hispanic
○ 33% of respondents were under-insured

- community stakeholder interviews
- neighborhood and community meetings

Consideration of statewide health priorities:
- chronic disease
- health disparities
- wellness
- supporting healthcare reform

Consideration of Partners Priorities:
- access
- economic opportunity and workforce development
- prevention

**Summary of Key Findings**

Between 2000 and 2010, Brigham and Women’s Faulkner Hospital’s service area neighborhoods of Hyde Park, Jamaica Plain, Roslindale, and West Roxbury became significantly more diverse. The number of Latino residents in Hyde Park, Jamaica Plain, and West Roxbury increased by 53%, 15%, and 93% respectively, and the number of Black residents grew by 19%, 13%, and 72%, respectively. Jamaica Plain experienced a 12% increase in the proportion of White residents and a 44% increase in the percentage of Asian residents.

The age distribution across the BWFH neighborhoods are similar – roughly 30% of residents are 24 years old and younger, 57% are between the ages of 25 and 64 years old, and 13% are sixty-five years old and up.

In 2010, all of the service area neighborhoods exceeded Boston’s median household income of $58,866.

**Elderly**

- In Brigham and Women’s Faulkner Hospital’s 2013 Community Survey, respondents ranked elderly health as a top priority (i.e. fall prevention).
- Unintentional falls are the leading cause of injury related death and nonfatal injuries among MA residents ages 65+. Fall-related death rates in MA increased 143% between 2002 and 2010, from 17.7 to 43.0 per 100,000.
- In 2010, total hospital charges (ED visits and hospital stays) associated with fall related injuries among older MA residents totaled over $630 million.
• Boston residents ages 60+ were significantly more burdened by all types of cancer, injuries, circulatory system diseases, and respiratory system diseases compared to residents statewide. From 2007-09:
  o the incidence of cancer was 2038.8 per 100k vs. 1802.1 per 100k for MA;
  o the rate of hospital discharges related to injuries was 1862.9 per 100k vs. 1370.9 per 100k for MA;
  o the rate of hospital discharges related to diseases of the circulatory system was 5986.2 per 100k vs. 4342.2 per 100k for MA; and
  o the rate of hospital discharges related to diseases of the respiratory system was 3123.8 per 100k vs. 2312.0 per 100k for MA.\textsuperscript{vii}
• The number of hospital discharges for pneumonia in adults 60+ in Boston exceeded the statewide average from 2007-9 (921.0 per 100k vs. 711.5 per 100k).\textsuperscript{viii}
• Forty-two percent of Boston residents aged 60+ engage in regular physical activity compared to 45% statewide.\textsuperscript{ix}

**Underserved and Barriers to Healthcare**

In Brigham and Women’s Faulkner Hospital’s 2013 Community Survey:
• Ninety-five percent of respondents reported that they were covered by health insurance.
• Ninety-two percent of respondents reported that they had a physical within the last two years.
• Eight-five percent of respondents reported that they received most of their care from a PCP.
• Almost a third of patients cited their work schedule as a barrier to needed healthcare.
• Affordability of services and mental/health substance abuse services were most frequently reported as lacking in the community.

In FY13, BWFH provided services to more than 9,900 public payer patients (Medicaid, Commonwealth Care, and Health Safety Net).
• This represents nearly 12% of the BWFH total patient population.
• Among Boston residents served by BWFH in FY13, 21% were public payer patients.

**Chronic Diseases**

• In Brigham and Women’s Faulkner Hospital’s 2013 Community Survey, respondents identified the following four areas as ones needing to be addressed in the community: fitness/nutrition, mental health/substance abuse, violence, and wellness & prevention.
• In a recent BRFSS survey of service area neighborhoods:
  o Roughly half of residents reported that they engaged in regular physical activity – lower than the Boston average of 57%.
  o On average, 13% of residents reported that they were current smokers.
  o Close to one third of residents in Hyde Park and Roslindale and 16% of residents in JP reported that they were obese.
  o On average 9% of residents reported persistent sadness – though this rate was higher for both Latino and Black residents.
Among youth (Boston BRFSS 2010):

- 74% of Hyde Park youth and 58% of Roslindale youth reported being overweight or obese compared to 56% for youth in Boston overall
- 8% reported having Diabetes compared to 6% for youth in Boston overall
- 50% of Hyde Park youth and 52% of Roslindale youth reported engaging in regular physical activity compared to 57% for youth in Boston overall

- Heart Disease hospitalizations 2005-2011: The rates in Hyde Park and Roslindale were 12.2 and 11.8 hospitalizations per 1,000 residents compared to 11.2 for Boston overall.

- Cerebrovascular hospitalizations (including stroke) 2005-2011: The rate in Hyde Park was 2.8 per 1,000 residents. Higher than the overall Boston rate of 2.5 per 1,000 residents. The rate was highest among Black residents in Hyde Park at 3.5 hospitalizations per 1,000 residents.

- All cause cancer deaths in 2010 were 224.0 per 100,000 deaths and 199.1 per 100,000 deaths in Hyde Park and West Roxbury, respectively, compared to 181.6 per 100,000 deaths in Boston overall.

### Youth Workforce Development

- In Hyde Park, 26% of residents report having a bachelor’s degree or higher compared to 44% for Boston overall.
- The percentage of residents 25 and older with a bachelor’s degree varied amongst the service area neighborhoods (Hyde Park: 26%, Jamaica Plain: 62%, Roslindale: 43%, and West Roxbury: 48%). Jamaica Plain and West Roxbury exceeded the overall Boston percentage of 44%.
- The dropout rate for the 9th-grade Boston cohort (first-time 9th graders in 2007) decreased for the fourth year in a row to 19.6%.
- More than 49% of the Boston Public School Class of 2006 who enrolled in college obtained an Associate’s or Bachelor’s degree within six years. A postsecondary degree is essential for success in Greater Boston’s knowledge economy, where more than half of all job vacancies require at least an Associate’s degree—a percentage that is expected only to grow.
- In Boston, more than 200,000 adults do not have the education and training that they need to secure jobs that will support themselves or their families. In a regional economy where more than half of the job vacancies require at least a 2-year degree, 41% of adults over age 25 lack such credentials or do not have the educational background to attain them.

These key data points and community feedback help to inform and refine the community-based program commitments of BWFH.
• Improve and support healthy behaviors among neighborhood residents (Hyde Park, Jamaica Plain, Roslindale and West Roxbury).
• Educate neighborhood residents about risk factors associated with chronic disease.
• Help residents to improve self-management of chronic disease and associated risk factors.
• Maintain and strengthen existing community partnerships and relationships for continual feedback and input into the community benefits process.
• Forge new community partnerships to help address community needs and disparities.
• Work closely with Philanthropy to raise and secure funds to ensure the sustainability and growth of community benefits programs going forward.

2014-2016 PLAN

1.) Health and Safety of the Elderly
2.) Cardiovascular Disease (stroke & heart disease) Screening and Education
3.) Diabetes Management Education
4.) Breast & Colorectal Cancer Screening and Education (un- and under-insured)
5.) Domestic violence (BWF Passageways) Program
6.) Nutrition and Fitness Education
7.) Youth Workforce Development
8.) Reduce Barriers to Healthcare Access for Underserved and Vulnerable Populations

Plan Outline with Short-Term and Long-Term Goals

1.) Health and safety needs of the elderly
   a. Medication safety
      a. Provide community education about medication safety at various locations.
      b. Offer pharmacy education sessions to elderly participants and or their caregiver to discuss medication management.
      c. Educate community members to the importance of medication reconciliation as it pertains to a hospitalization.
      d. Implement a medication safety call line.
   b. Increasing physical activity
      a. Initiate a weekly walking program for seniors.
      b. Provide information to seniors about the numerous activities in the area for them to be active.
      c. Educate seniors about the importance and benefits of a physically active lifestyle.
      d. Design and offer an exercise program option that can help seniors begin and explore various modalities to physical fitness.
      e. Establish a walking venue for seniors in the winter months.
      f. Partner with the local YMCA’s to increase accessibility.
g. Develop a homebound exercise program with senior housing facilities.

c. Influenza and Pneumococcal vaccines
   a. Provide free and accessible vaccines at a number of convenient locations where seniors frequent.
   b. Educate the community on the importance of getting a influenza or pneumococcal vaccine.
   c. Secure enough vaccine for the demand in the community.
   d. Establish protocol to identify appropriate pneumococcal vaccine candidates and reporting mechanism to primary care physicians to eliminate revaccination.
   e. Identify methods to vaccine independent living homebound seniors in the local community.
   f. Maintain a collaborative Core Measure Improvement Team to review Pneumonia readmissions.

d. Falls prevention
   a. Participate in the Master Trainer program for a Matter of Balance.
   b. Recruit and train Matter of Balance Lay Leader Coaches to help establish the program.
   c. Launch the Matter of Balance course in the community.
   d. Promote the program to physicians, stroke team and support group as a source of referral
   e. Create a home modification checklist and or tool kit for self administration.
   f. Establish a comprehensive home inspection and modification program to evaluate and correct a senior’s risk of falling in the home.
   g. Organize a gait testing program for evaluation of a seniors risk to fall.
   h. Offer free vision and hearing screening programs for seniors.
   i. Educate seniors and caregivers about the many facets that contribute to the risk of falls.

e. Community Group Involvement
   a. Maintain a leadership role in various community groups.
   b. Participate in pertinent committee established initiatives.
   c. Collaborate with local agencies and groups to address the healthcare needs of seniors.
   d. Work in conjunction with community stakeholders to ensure minimal service overlap and reduce gaps in services.

f. Safe Transitions
   a. Provide guardianship process to needy elderly patients to ensure the safe transfer to appropriate care.

Arthritis
   a. Help to engage senior adults with arthritis in the recommended amount of physical activity through our walking and exercise programs
   b. Provide education about arthritis to the senior population
2.) Cardiovascular disease (stroke & heart disease) screening and education

a. Stroke
   a. Maintain an active hospital based Stroke Committee to ensure the highest level of care for stroke patients.
   b. Establish a stroke support group for stroke survivors and or their caregivers.
   c. Educate the community on stroke.
   d. Raise awareness of stroke signs and symptoms.

b. Cardiovascular Disease (BP, CHO, Glucose)
   a. Maintain a collaborative Core Measure Improvement Team for the prevention of CHF readmission.
   b. Educate the community about heart disease and diabetes.
   c. Provide screening programs to help residents identify and or monitor risk factors such as cholesterol levels, glucose and blood pressure.

3.) Diabetes education

a. At staff level, obtain diabetes education certification from American Association of Diabetes Educators.

b. Develop a diabetes education program based on the AADE7 self care behaviors
   i. Healthy eating: making healthy food choices; understanding portion sizes; learning the best times to eat; learning the effect food has on blood glucose; reading labels; planning and preparing foods; understanding and coping with barriers and triggers, etc.
   ii. Being active: regular activity for overall fitness; weight management; blood glucose control; improve BMI; enhance weight loss; control lipids, blood pressure and reduce stress.
   iii. Monitoring: daily self-monitoring of blood glucose to help assess how food, physical activity and medication affect levels.
   iv. Taking medication: help patients to be knowledgeable about medications they are taking, including its action, side effects, efficacy, toxicity, prescribed dosage, appropriate timing and frequency of administration, effect of missed or delayed dose, instruction for storage, travel and safety.
   v. Problem solving: address barriers, such as physical, emotional, cognitive and financial obstacles and developing coping strategies.
   vi. Healthy coping: help to identify individual’s motivation to change behavior then helping set achievable behavioral goals and guiding patient through obstacles.
   vii. Reducing risks: assist individuals in gaining knowledge about standards of care, and prevention to decrease risks, including; smoking cessation, foot
inspections, blood pressure monitoring, self monitoring of blood glucose and personal care records.

c. Improving diabetes management for African Americans
d. Implement a comprehensive diabetes program for identified community members.

4.) Breast & colorectal cancer screening and education for un- and under-insured

a. Breast Health Care Access Program
   a. Provide free screening mammography to women without insurance
   b. Provide all follow up care to women in the breast health care access program
   c. Educate women about the importance of breast self exams and early detection
   d. Provide support groups and programs for survivors such as YMCA Pink Program and ACS Look Good Feel Better

b. Colorectal Health Care Access
   a. Provide free colonoscopy to those without insurance
   b. Provide all follow up care required to those in the program
   c. Increase the program to meet the demand of the number of participants
   d. Educate people about colorectal cancer and the importance of regular and timely screening

5.) Domestic violence (BWF Passageways) Program

a. Advocacy for patients
   a. Implement structure for MSW internship at Passageway at Faulkner for 2010-2011 academic year
   b. Increase capacity at Brigham and Women’s Faulkner Hospital’s campus to respond to the needs of victims of domestic abuse

b. Education and training programs at the hospital and in the community
   a. Create and implement strategic plan to provide outreach and training to hospital departments on an annual basis to promote provider awareness and access to Passageway program
   b. Sustain visibility for domestic violence issues at Faulkner Hospital

b. Community awareness and activities
   a. Explore opportunities for collaboration with ETHOS towards the goals of creating support groups for older women who have experienced intimate partner violence
   b. Establish linkages with community agencies and providers to strengthen the gaps in services for underserved populations.

d. Evaluation
   a. Maintain contact logs for direct services to victims
b. Track referral sources by department to identify areas for continued training and education

c. Monitor screening rates for DV in ED and on medical floors; identify opportunities for outreach and training for staff

d. Document the specific needs for further expansion of domestic abuse programming on-site at Faulkner

6.) Nutrition and Fitness Education

a. Nutrition/Fitness Education

a. Work with partner schools on Wellness Committee that would include school staff, parents and community stakeholders.

b. Educate youth and residents about the importance of a physically active lifestyle.

c. Educate youth and residents about the importance of healthy eating.

d. Work with BPS and the school nutrition staff to help implement healthier food options for kids.

e. Provide various fitness and nutrition programs to increase the opportunity for residents to get hands on experience in health and wellness

f. Support residents in a fitness program for the purpose of lowering BMI

g. Support residents in a nutrition health coach program model for the purpose of increasing consumption of healthy, fresh foods and bettering health

h. Provide education to the school staff and parents of the school community about healthy nutrition and fitness.

i. Implement a cardiovascular exercise program that would engage youth and families in physical fitness and promote a physically active lifestyle.

j. Increase the number of school classroom visits by BWFH staff to help promote the goal of health and wellness at the schools.

k. Develop a summer wellness promotion program to keep kids and their families connected and on-track with their healthy lifestyle.

l. Increase awareness about consumption of sugar sweetened beverages to relationship to obesity and diabetes.

7.) Youth Workforce Development

a. Partner with BPIC for summer jobs program

a. Provide a work opportunity to BPS students for the summer

b. Allow students to explore various aspects of healthcare through the Summer Jobs Program

c. Provide enrichment workshops during the summer to help the students hone and develop skills in areas such as interviewing, resume writing, etc.

b. Nursing & allied health job shadow
a. Provide an opportunity for students interested in nursing to participate in a nursing specific job shadow day
b. Increase the pipeline of nursing students for the Partners system
c. Career panels and general job shadow days
   a. Provide a look into healthcare for youth that allows them to learn numerous aspects of the field
d. Take an active and leadership role in planning for the future of Workforce Development in Boston/Massachusetts
   a. Member of Boston Partnership for Youth Career Awareness and Pipeline Programs
   b. Member of Youth Equity Campaign of Jamaica Plain
   c. Develop a path so that students can be tracked and guided from a young age through college or training program
d. Increase the number of students that are exposed to the Workforce Development programs at BWFH
e. TOPS-Training Opportunity Program for Students
   a. Continue to provide a work program for special needs students of the Mildred Avenue Middle School
   b. Increase the program to the Curley School

8.) Reduce barriers to healthcare access for underserved and vulnerable populations

a. Provide interpreters for non-English speaking patient and deaf and hard of hearing patients for all services at the BWFH campus
   a. Make better connections with providing interpreters upon discharge for at home care instructions
b. Provide Continuity of Care
c. Reduce barriers to health care for those who are underserved and or disadvantaged
   a. Provide free parking or transportation services to needy patients
   b. Provide patient financial counselors to help with enrollment in public assistance programs
d. Provide translation services for materials of non-hospital services at the BWFH campus
   a. Offer more languages for materials
   b. Continue to evaluate the needs and utilization
e. Leadership and active involvement in JP Tree of Life coalition
   a. Work to identify and address various health concerns for vulnerable populations
   b. Work closely with JP community members and leaders

ii Ibid.

iii Ibid.

iv MA Dept of Public Health, MassCHIP 2013

v Ibid.

vi Ibid.

vii Ibid

viii Ibid.

ix Ibid.


xi Ibid.

xii Ibid.

xiii The Boston Foundation

xiv Ibid.

xv Ibid.