Brigham and Women's Faulkner Hospital

2016

Community Health Assessment and Implementation Plan

BRIGHAM AND WOMEN'S
Faulkner Hospital

Table of Contents

EXECUTIVE SUMMARY 3

BRIGHAM AND WOMEN'S FAULKNER HOSPITAL MISSION STATEMENT 3

COMMUNITY HEALTH AND BENEFITS MISSION 3

KEY FINDINGS SUMMARY 5

OVERSIGHT COMMITTEE FOR COMMUNITY HEALTH AND WELLNESS 6

PURPOSE STATEMENT 6

RESPONSIBILITIES 6

MEMBERSHIP 7

REPORTING RELATIONSHIP 7

ASSESSMENT OF COMMUNITY HEALTH NEEDS, GOALS AND ASSETS 8

PAST COMMUNITY HEALTH ASSESSMENTS 8

METHODOLOGY 8

DEMOGRAPHIC FINDINGS 11

SOCIAL, ECONOMIC, AND PHYSICAL ENVIRONMENT FINDINGS 17

COMMUNITY STRENGTHS AND ASSETS 18

HEALTH BEHAVIORS AND OUTCOMES FINDINGS 19

COMMUNITY PERCEPTIONS 31

ORGANIZATIONAL CHALLENGES 34

ADDRESSING PRIORITY NEEDS 34

2016 IMPLEMENTATION STRATEGY ACTION PLAN 35

CONTACT US 43

APPENDICES 44

APPENDIX 1: 2016 BWFH Quality of Life Survey 44

APPENDIX 2: Community Focus Group Questions 45

APPENDIX 3: Key Informant List 45

APPENDIX 4: Key Informant Interview Questions 46

APPENDIX 5: CURRENT PROGRAMMING 47

EXECUTIVE SUMMARY

BRIGHAM AND WOMEN'S FAULKNER HOSPITAL MISSION STATEMENT

Brigham and Women's Faulkner Hospital (BWFH) strives to attain excellence in patient care services, provided in a learning environment with dignity, compassion and respect. We are dedicated to improving the health and well-being of residents from the areas we serve through our award winning Community Health and Wellness Program. The program serves over 60,000 men, women, children and elderly each year through a wide variety of preventive health education, free health screenings, school partnerships and community outreach.

COMMUNITY HEALTH AND BENEFITS MISSION

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

Background and Priority Communities

The Brigham and Women's Faulkner Hospital (BWFH) is located in the Jamaica Plain neighborhood of Boston. In 2015 BWFH served approximately 85,000 people, of which over 31,000 (37.0%) were residents of Boston. Seventy percent of these residents came from the following 4 neighborhoods, which BWFH defines as its priority neighborhoods:

- Hyde Park – 16%
- Jamaica Plain – 14%
- Roslindale – 20%
- West Roxbury – 20%

In addition, 23% of Boston residents served by BWFH are Medicaid recipients or uninsured.

KEY FINDINGS SUMMARY

In 2016 BWFH conducted a thorough and collaborative community health assessment (CHA). The 2016 CHA is the second assessment since the 2010 Patient Protection and Affordable Care Act, which requires hospitals to conduct an assessment every 3 years. The guidelines for a CHA require both quantitative and qualitative assessments with solicitation from the community. This report will give an in-depth look of the key findings of census, public health and hospital data, including; demographic, environment, lifestyle/behavior, health care access and health outcomes and gaps and strengths of existing resources and services. Additionally, we solicited input from broad interests within the community and those with knowledge and expertise in public health. Feedback from community members was sought through focus groups, community surveys and forums and key informant interviews. Throughout the entire process, there was an overarching focus on uninsured, low-income and minority groups, or those representing these groups.

During this process, several health issues were identified. Physical fitness/nutrition, mental health/substance abuse and chronic disease ranked in the top three of the BWFH Quality of Life survey. Additionally, through both data and community input, we found that cancer, violence, food insecurity, fractured neighborhoods and other social determinants of health, including: education, transportation, housing, poverty and access, were also identified needs in BWFH's priority communities.

- Several barriers to care were identified, which included Work Schedule (36.1%), Transportation (20.3%), and Affordability (18.4%). Hyde Park and Jamaica Plain MD Availability was reported as a top barrier as well at 27.8% and 28.6%, respectively.
- All of the priority neighborhoods except for Hyde Park fare better with regards to fruit and vegetable consumption than Boston overall.
- 56.3% of 2016 BWFH Survey Respondent identified Nutrition and Fitness as a top community health priority.
- Cancer mortality rates in Hyde Park and Roslindale were considerably higher than the other priority neighborhoods as well as Boston overall (Figure 9).
- Heart disease deaths was higher in Hyde Park and Roslindale than Boston. While Cerebrovascular (CVD) Deaths was higher in all priority neighborhoods.
- Among adults, the prevalence of obesity in Roslindale and West Roxbury were higher than Boston.
- 29.1% of 2016 BWFH QOL Survey respondents indicated Heart Disease and Stroke as a top community health issue.
- Food Insecurity in Boston Public Schools was reported as an issue with an estimated 7126, or 21.3% students reporting not enough food or hungry.
- Hyde Park has a larger percentage of its residents with persistent sadness[1] (16.2%) and residents who were notably tense or anxious[2] (23.8%) compared to Boston and the other priority neighborhoods (Figures 15-16).

[1] Persistent sadness among adults was defined as sadness for more than 15 days in the past 30 days.
[2] Being Tense or anxious for more than 15 days in the past 30 days.

- Opioid addiction was a concern by almost all key informants and was brought up by all focus groups as a community health issue.

Based on adequate resources for implementation, community readiness, collaborative opportunities and need, the following priority needs have been identified by BWFH:

1. Chronic Diseases
2. Substance Abuse
3. Food Insecurity, Healthy Eating and Active Living
4. Domestic Violence
5. Social Determinants of Health (Language, Poverty, Education, Access, and Youth Engagement)

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—BWFH VP of Support Services and Clinical Services
- Margaret Duggan, MD—Chief Medical Officer; BWHC Board Member; BWFH Operating Oversight Committee; BWFH Quality Steering Committee
- Jean Flanagan-Jay—BWFH Director, Rehabilitation Services
- Michael Gustafson, MD—BWFH President
- Betty Hanson—Board member emeritus; previous local resident
- Judy Hayes—BWFH VP, Nursing, local resident
- Marion Kelly—Executive Director, West Roxbury YMCA
- Katie Hulett—Community Health and Wellness Coordinator, local resident
- Susan Langill—BWHC, Director, Food Service and Nutrition
- Edward Liston-Kraft—BWFH VP, Professional and Clinical Services
- Sandra Lynch—Former Executive Director of VNA Care Network, Inc.
- Janet McGrail Spillane—Board member emeritus; BWFH Quality Steering Committee; VP, American Cancer Society; local resident
- Cathy Slade—local resident
- Tracy Sylven—BWFH, Director, Community Health and Wellness
- Ronald Warner, MD—Primary Care Physician, Hyde Park

REPORTING RELATIONSHIP

The Oversight Committee for Community Health and Wellness reports to Senior Leadership of Brigham and Women's Faulkner Hospital.

ASSESSMENT OF COMMUNITY HEALTH NEEDS, GOALS AND ASSETS

In 2016, BWFH planned and implemented a Community Health Assessment (CHA) using a collaborative and dynamic approach to review/assess 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 in the target communities of Jamaica Plain, Hyde Park, Roslindale and West Roxbury.

The goals of the 2016 CHA were to:

1. Identify the health needs and assets of our target populations in the neighborhoods of Jamaica Plain, Hyde Park, West Roxbury and Roslindale
2. Engage community members in the process
3. Determine priorities for the next 3 years
4. Develop a plan and implementation strategy

PAST COMMUNITY HEALTH ASSESSMENTS

During FY13 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. BWFH found the following to be priority issues for its target communities: Health and Safety of the Elderly, Cardiovascular Disease (stroke & heart disease) Screening and Education, Diabetes Management Education, Breast & Colorectal Cancer Screening and Education (un- and under-insured), Domestic Violence, Nutrition and Fitness Education, Youth Workforce Development, and Reducing Barriers to Healthcare Access for Underserved and Vulnerable Populations.

METHODOLOGY

Overall Approach

Brigham and Women's Faulkner Hospital's 2016 Community Health Assessment (CHA) values all the factors within its communities that influence health. It is important to incorporate the social, economic, and environmental influences on health outcomes. Data collection for this CHA involved both quantitative and qualitative data to help identify all aspects of the community that impact the health of its priority communities.

During the collection of both qualitative and quantitative data, social determinants of health were large areas of focus. Beyond individual physiology and health-related behaviors, there are other economic, environmental and social factors that influence health. Collectively, we refer to these as social determinants of health (SDOH). Social determinants are societal influences that help to describe the circumstances in which people are born, grow up, live, work and age[3]. Social determinants of health are uniquely experienced by individuals, differentially impacting

[3] CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report on the Commission on Social Determinants of Health. Geneva : World Health Organization, 2008.

health experiences and ultimately contributing to health inequities[4]. Research has identified a wide range of social factors that are associated with differences in health outcomes4:

- Employment
- Access to Healthy food
- Access to Health Care
- Exposure to Violence
- Insurance coverage
- Education
- Access to Health Resources
- Income
- Housing Conditions
- Transportation Options
- Environmental Safety
- Occupational Safety

Source: Healthy People 2020

These social determinants of health impact an individual's life in many specific ways, for example, the quality of education available to them, their ability to find and maintain employment and the type of work (including levels of exposure to occupational hazards), access to safe and stable housing, and access to health care and the quality of those services[5]. The resulting life experiences, in turn, directly influence physical and mental health and contribute to health inequities. Our report describes how many health-promoting resources, such as income, employment, education, and home ownership, are unevenly distributed within our city among those of differing races and ethnicities, socioeconomic status, and geographic locations. Social determinants of health can be described in terms of three broad context areas: economic, environmental, and social.

Quantitative Data

The BWFH CHA uses several secondary data sources to pull information on health indicators, as well as social, economic, and environmental factors in the community. The primary source of the quantitative data is a neighborhood level data analysis from the Boston Public Health Commission as well as race level data obtained from the 2014-15 Health of Boston Report. The Boston Public Health Commission extracts its information from various sources including but not limited to: U.S. Census, Boston Behavioral Risk Factor Surveillance Survey 2013, Massachusetts Department of Public Health, hospital utilization data.

[4] Brennan Ramirez, L. K., Baker, E. A. and Metzler, M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. [Document] Atlanta : Centers for Disease Control and Prevention, 2008.
[5] A Glossary for Health Inequities. Kawachi, I., Subramanian, S. V. and Almeida-Filho, N. 9, s.l. : Journal of Epidemiology and Community Health, 2002, Vol. 56.

Qualitative Data

In the fall of 2015, BWFH conducted a Quality of Life Survey (2016 BWFH QOL Survey). See Appendix 1. Over a 4-week period, the survey was distributed at various community events in BWFH's 4 priority communities. A total of 158 surveys were completed. The data were analyzed in the spring of 2016 using SPSS Version 24.0.

Additionally, both neighborhood focus groups and one-on-one key informant interviews were held to spark thoughtful and insightful conversation to discuss strengths and challenges of sub-sets of the community. Focus groups were compromised of 6-15 participants. These groups were given a basic background to the assessment process and asked a series of questions (See Appendix 2).

> *"Meeting people where they are – in the community"*
> ***-Focus Group Participant***

Key informant participants have increased knowledge of a specific subset of the community or aspect of the community based on their role, experience or insight (See Appendix 3). In one-on-one key informant interviews, the average interview was 50 minutes with a series of questions (See Appendix 4).

Limitations and Considerations

1. Every effort is made in the process to ensure diverse and broad participation in the community
2. QOL Surveys were distributed in both English and Spanish for better access
3. Focus groups were conducted to obtain more in-depth meaningful conversations from a wide sampling of community members
4. Key informant interviews were held to ensure that the perspective of specific sub-groups were represented
5. Consideration of statewide health priorities that are divided into 3 areas of focus:
    - Healthy Living
        - Active Living, Healthy Eating, Tobacco Free Living
        - Chronic Disease Prevention and Control
        - Substance Abuse Prevention, Intervention, Treatment, and Recovery
        - Infectious Disease Prevention and Control
    - Healthy Environments
        - Environmental Risk Factors and Health Injury, Suicide, and Violence Prevention
        - Maternal, Child and Family Health Promotion
        - Infectious Disease Prevention and Control
    - Public Health Systems
        - Health Systems Infrastructure

DEMOGRAPHIC FINDINGS

Population

Between 2000-2010, the population of Boston grew by 4.8% (Table 1). For the BWFH priority neighborhoods, the West Roxbury and Hyde Park populations increased, while Jamaica Plain and Roslindale populations declined.

The 2016 BWFH QOL Survey provided information about access and barriers to health and perceptions of top community health issues from individuals who either live or work in the BWFH priority neighborhoods. In Hyde Park, Roslindale, and West Roxbury the majority of survey respondents live in the designated neighborhood. However, in Jamaica Plain, a considerably larger proportion of respondents work in JP as opposed to living there.

Table 1: Population by Neighborhood and by Gender, 2010

	Boston		Hyde Park		Jamaica Plain		Roslindale		West Roxbury	
Total Population, 2010	617,594	100.0%	30,637	100.0%	37,468	100.0%	28,680	100.0%	30,446	100.0%
Growth Rate, 2000-2010	617,594	4.8%	30,637	1.9%	37,468	-1.9%	28,680	-5.5%	30,446	5.9%
Male	291,879	47.9%	15,713	47.7%	16,925	46.9%	12,616	46.1%	14,423	47.6%
Female	318,063	52.1%	17,248	52.3%	19,128	53.1%	14,771	53.9%	15,870	52.4%

Data Source: US Census, 2010

Racial and Ethnic Diversity

The racial make-up of each priority neighborhood is defined using the categories of the U.S. Census. The Boston population is 47.0% White, and represents the racial majority (Table 2). Similarly, White residents are the largest group in Jamaica Plain, Roslindale, and West Roxbury at 53.6%, 46.7%, and 73.3%, respectively. Unlike the other BWFH priority neighborhoods, Hyde Park has a predominately Black population at 47.3%. Jamaica Plain, Roslindale and Hyde Park also have higher proportions of Hispanic residents than Boston overall.

Table 2: Race and Ethnicity by Neighborhood, 2010

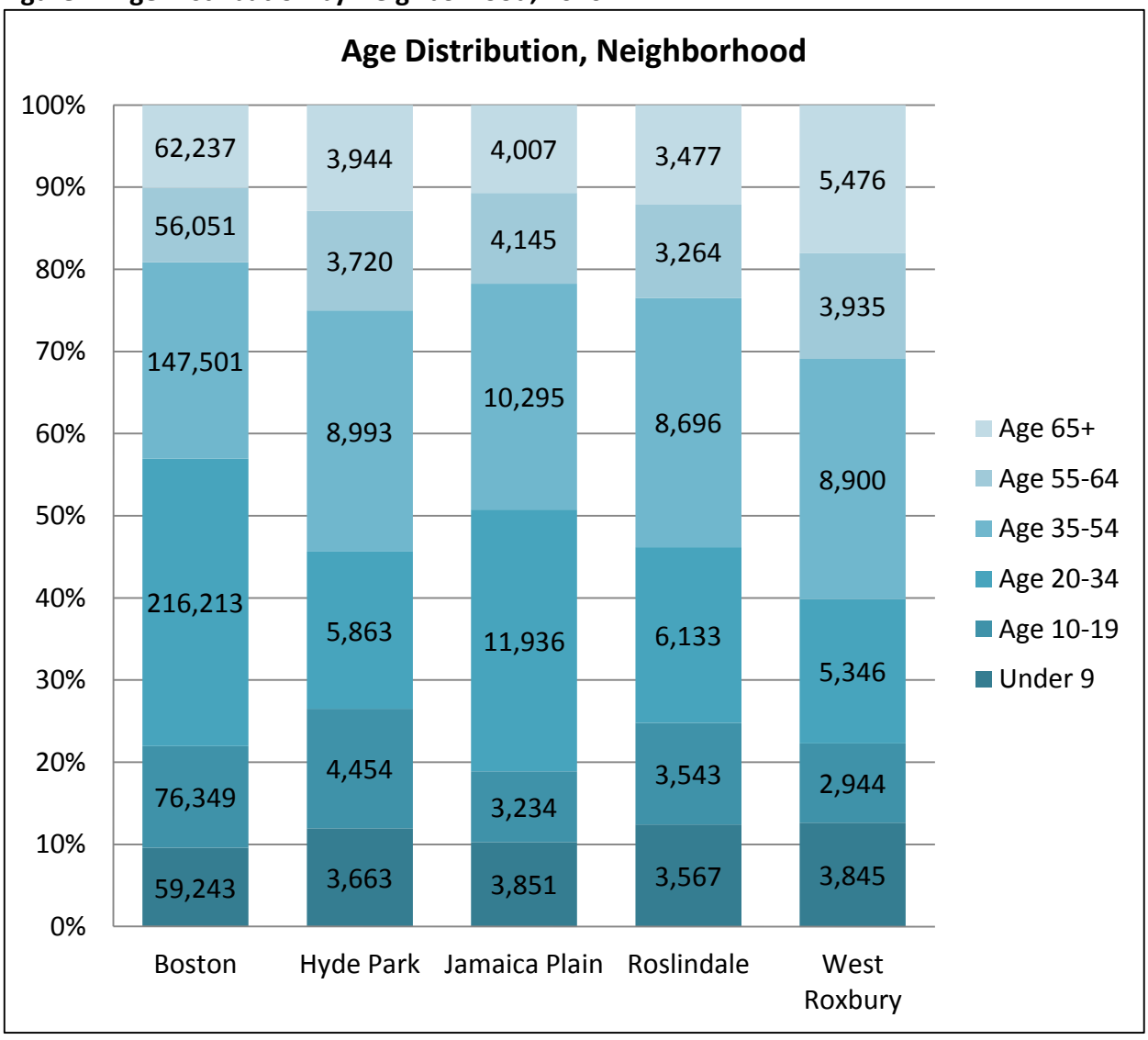
	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
White	47.0%	28.2%	53.6%	46.7%	73.3%
Hispanic	17.5%	19.7%	25.3%	25.9%	8.5%
Black/African American	22.4%	47.3%	13.4%	21.7%	9.7%
Asian	8.9%	1.6%	4.4%	2.7%	6.5%
Other	4.3%	3.2%	3.3%	3.1%	2.1%

Data Source: US Census, 2010

Age Distribution

Across all priority neighborhoods the majority of residents are aged 20-54 (Figure 1). For Boston overall and Jamaica Plain, the largest age group is those aged 20-34 years old, while for Hyde Park, Roslindale, and West Roxbury the largest age group is 35-54 years old.

Figure 1: Age Distribution by Neighborhood, 2010



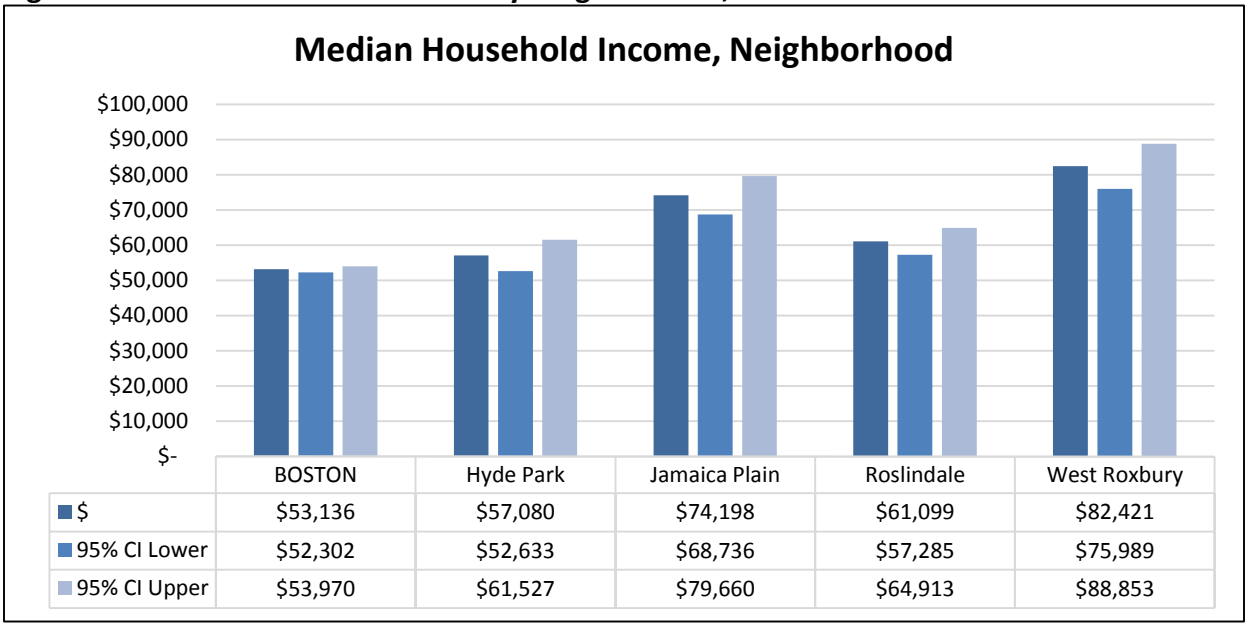
Data Source: US Census, 2010

Income, Poverty, and Employment

Income

The median income for Boston is $53,136. Compared to Boston, all of the BWFH priority neighborhoods have median incomes above the Boston level (Figure 2). However, there are differences in income by race among the neighborhoods (Table 3).

Figure 2: Median Household Income by Neighborhood, 2008-2012



	BOSTON	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
$	$53,136	$57,080	$74,198	$61,099	$82,421
95% CI Lower	$52,302	$52,633	$68,736	$57,285	$75,989
95% CI Upper	$53,970	$61,527	$79,660	$64,913	$88,853

Data Source: Health of Boston Report 2014-2015

For the most part, non-White residents in all of the priority neighborhoods have a lower median income than the neighborhood's overall median income, except for Black residents in Hyde Park and Asian residents in Hyde Park, Jamaica Plain and West Roxbury.

Table 3: Median Household Income[6] by Race and by Neighborhood, 2010

	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
White alone, not Hispanic or Latino[7]	$ 69,107.0	$ 61,002.0	$ 89,865.0	$ 76,117.0	$ 82,015.0
Black or African American	$ 36,654.0	$ 57,475.0	$ 31,786.0	$ 54,690.0	$ 33,397.0
Hispanic or Latino	$ 30,562.0	$ 51,598.0	$ 24,214.0	$ 34,980.0	$ 52,982.0
Asian Alone	$ 39,534.0	$ 61,000.0	$ 75,313.0	$ 42,059.0	$ 111,012.0
Other	$ 44,360.0	$ 55,213.0	$ 31,250.0	$ 35,741.0	$ 61,045.0

Data Source: US Census, 2010

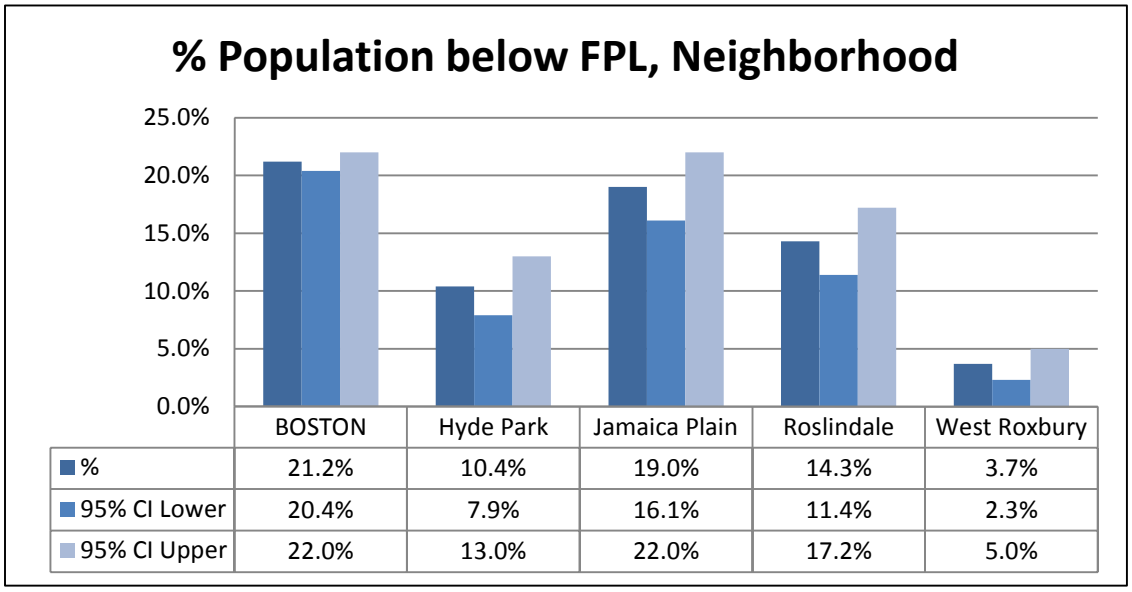
[6] Income (in 2011 inflation-adjusted $$)

[7] Due to data reporting limitation, it is not possible to separate the Hispanic or Latino population from any racial group except for white. As a result, the aggregate number of all races in the table will exceed the total number of households.

Poverty

Compared to Boston at 21.2%, the priority neighborhoods for BWFH all have a lower percentage of households living below the Federal Poverty Level (Figure 3).

Figure 3: Percent of Population Below the Federal Poverty Level by Neighborhood, 2008-2012

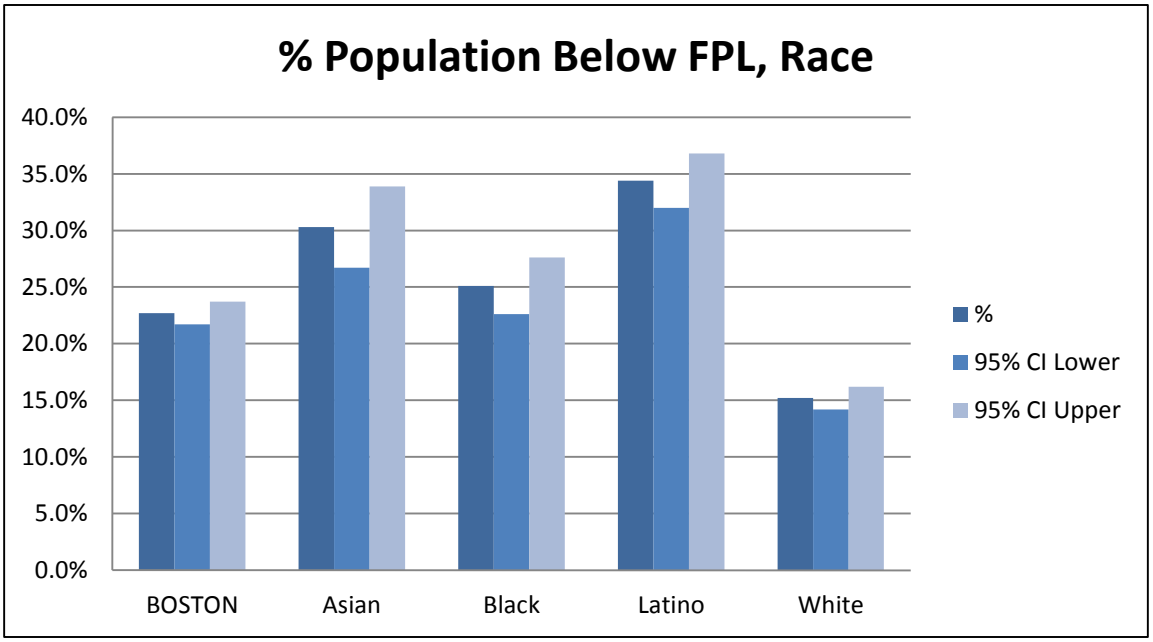


	BOSTON	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
%	21.2%	10.4%	19.0%	14.3%	3.7%
95% CI Lower	20.4%	7.9%	16.1%	11.4%	2.3%
95% CI Upper	22.0%	13.0%	22.0%	17.2%	5.0%

Data Source: Health of Boston Report 2014-2015

When looking at poverty rates by race for Boston, differences are apparent. The proportion of non-White Boston residents living below FPL are as much as twice the rate seen for White residents (Figure 4).

Figure 4: Percent of Population Below the Federal Poverty Level by Race, 2010-2012



Data Source: Health of Boston 2014-2015

Class of Employment

The majority of workers across the neighborhoods are Private for-profit wage and salary workers (Table 4). The second largest class of workers is Private not-for-profit wage and salary workers.

Table 4: Class of Employment by Neighborhood, 2010

Employment	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Private for-profit wage and salary workers	66.3%	58.9%	50.9%	56.1%	58.4%
Private not-for-profit wage and salary workers	17.1%	16.8%	26.0%	22.7%	17.8%
Local government worker	7.1%	11.9%	8.6%	10.7%	10.8%
State government worker	4.4%	5.2%	4.4%	3.9%	4.6%
Federal government worker	1.8%	2.9%	2.2%	1.4%	1.8%
Self-employed - not incorporated	3.3%	3.9%	7.9%	5.3%	6.4%
Unpaid family worker	0.0%	0.4%	0.0%	0.1%	0.2%

Data Source: US Census, 2010

Unemployment

The unemployment rate in Boston decreased from 4.9% in December 2014 to 4.4% as of March 2016[8]. Hyde Park and West Roxbury have notably higher rates of unemployment when compared to Boston's 2014 rate and the other priority neighborhoods (Table 5).

Table 5: Unemployment Rate by Neighborhood, 2014

Unemployment Rate (2014)	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Population 16 years and over	4.9%[9]	8.8%	6.5%	11.2%	6.8%

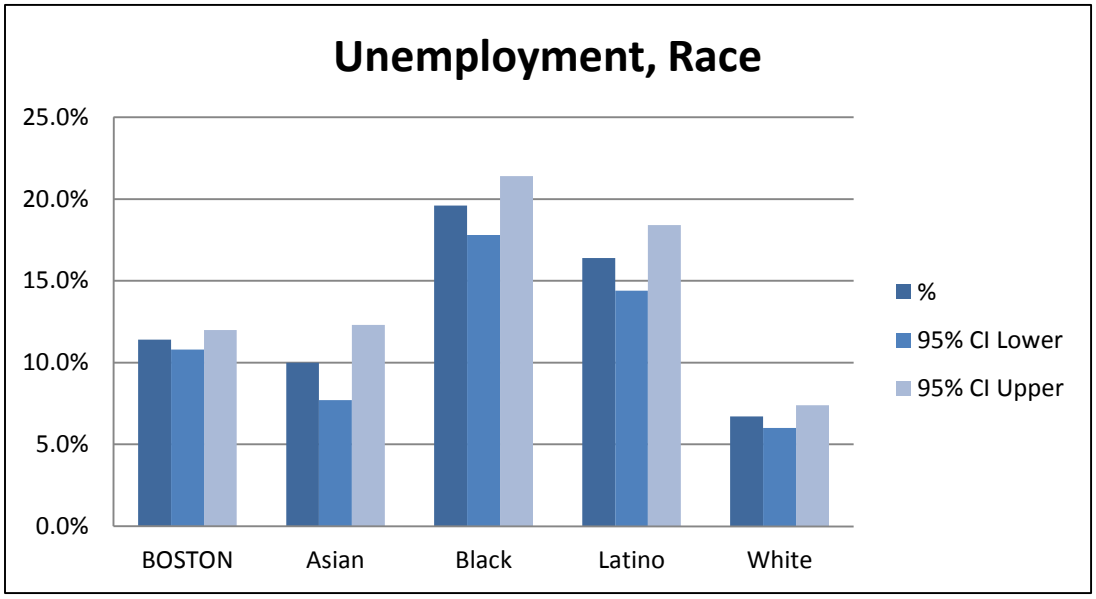
Data Source: US Census, American Community Survey Estimates, 2014.

[8] US Bureau of Labor Statistics, 2014-2016

[9] US Bureau of Labor Statistics, 2014

When looking at unemployment in Boston by race, significant disparities emerge. The rates of unemployment for Black and Hispanic Boston residents are nearly 3 times that of White residents in Boston (Figure 5).

Figure 5: Unemployment in Boston by Race, 2010-2012



Data Source: Health of Boston 2014-2015

Educational Attainment

Educational attainment or graduation rates vary across priority neighborhoods. All of the BWFH priority neighborhoods have more of their residents with a high school diploma or more than Boston overall (Table 6). However, across the priority neighborhoods, there is variation in post high school education attainment levels. Among the priority neighborhoods and compared to Boston, Jamaica Plain has the highest percent of residents with a bachelor's degree or higher, and Hyde Park has the lowest percent of residents with a bachelor's degree or higher.

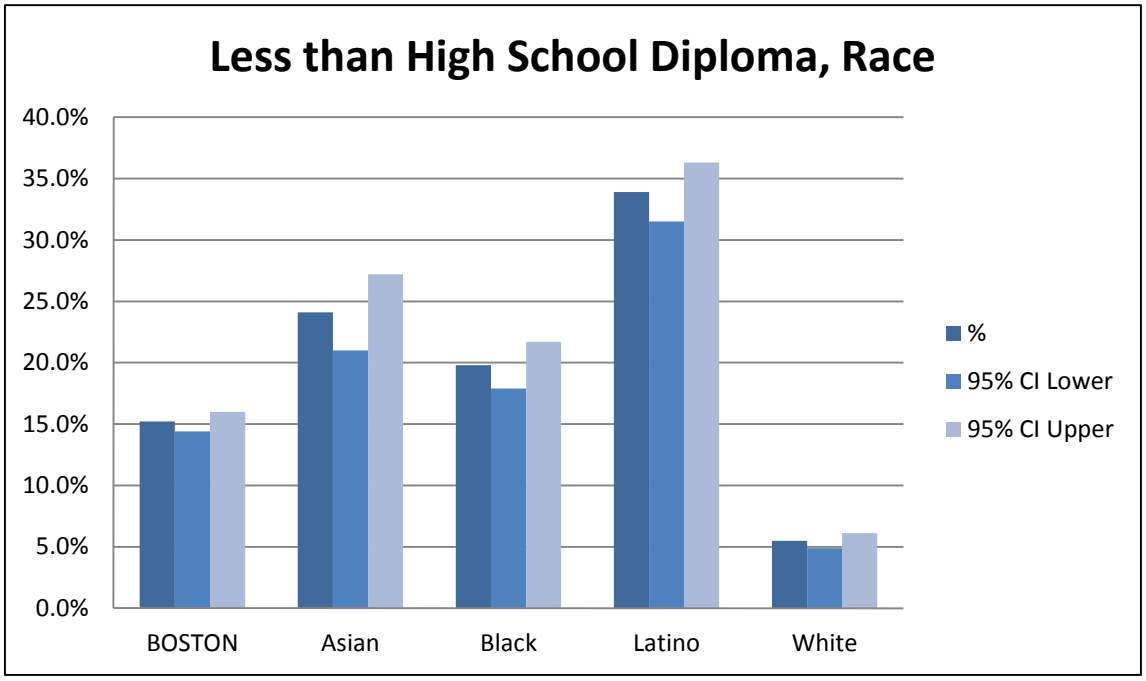
Table 6: Educational Attainment by Neighborhood, 2007-2011

	Boston		Hyde Park		Jamaica Plain		Roslindale		West Roxbury	
Less than High School Graduate	42,638	13.0%	1,657	9.2%	1,787	7.9%	1,473	9.3%	664	3.9%
High School Graduate	69,719	21.2%	5,506	30.5%	2,510	11.1%	3,542	22.3%	3,144	18.4%
Some College or Associate's Degree	63,295	19.3%	5,741	31.8%	3,465	15.3%	3,786	23.9%	3,742	21.8%
Bachelor's Degree or Higher	152,914	46.5%	5,124	28.4%	14,951	65.8%	7,050	44.5%	9,578	55.9%

Data Source: US Census, 2007-2011

When looking at educational attainment in Boston by race, significant disparities emerge. The percent of residents with less than a high school diploma for Black and Hispanic Boston residents is 4-6 times that of White residents in Boston.

Figure 6: Boston Resident with Less than High School Diploma, 2012



Data Source: Health of Boston Report 2014-15

SOCIAL, ECONOMIC, AND PHYSICAL ENVIRONMENT FINDINGS

Housing

The vast majority of housing units in Boston and across the BWFH priority neighborhoods are occupied. However, in Hyde Park and West Roxbury, housing units are more likely to be owner occupied and in Jamaica Plain and Roslindale, housing units are more likely to be renter occupied (Table 7).

Table 7: Housing by Neighborhood, 2010

Housing	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Owner Occupied	33.9%	58.0%	44.4%	50.0%	63.6%
Renter Occupied	66.1%	42.0%	55.6%	50.0%	36.4%
Occupied Units	92.7%	93.8%	94.7%	93.4%	95.7%
Vacant Units	7.3%	6.2%	5.3%	6.6%	4.3%

Data Source: US Census, 2010

Language

Across Boston and all of the priority neighborhoods, English is the primary language spoken at home and Spanish is the second largest language (Table 8).

Table 8: Language Spoken at Home by Neighborhood, 2010

	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
English Only	63.9%	62.1%	64.7%	59.4%	71.7%
Spanish	15.5%	18.5%	21.9%	17.7%	10.7%
Chinese	3.8%	0.6%	2.2%	0.9%	3.0%
French	4.9%	13.7%	2.8%	7.6%	3.3%
Portuguese	2.1%	0.8%	0.9%	0.6%	0.9%
Other	9.9%	4.4%	7.5%	13.9%	10.4%

Data Source: US Census, 2010

Crime and Safety

Within Boston the crime and violence varies by neighborhood, but overall the city's major crime incidents between 2014 and 2015 have decreased from 22,422 to 20,419. Table 9 displays the changes in each of the major crimes across Boston.

Table 9: Major Boston Crime, 2014-2015

Type of Major Crime	2014	2015	Percent Change
Non-domestic aggravated assault	1,868	1,997	6.9%
Domestic aggravated assault	912	857	-6.0%
Commercial burglary	421	445	5.7%
Residential burglaries	2,297	2,128	-7.4%
Other larceny	9,047	8,290	-8.4%
Robberies	1,702	1,544	-9.3%
Auto theft	1,614	1,402	-13.1%
Larceny from motor vehicles	4,242	3,412	-19.6%
Homicide	53	40	-24.5%
Rape and attempted rape	264	207	-21.6%

Data Source: Boston Police Department via The Boston Globe

COMMUNITY STRENGTHS AND ASSETS

Residents cited active community members and neighborhood associations as a strong asset in addressing needs and providing infrastructure. Additionally, community police, hospitals, health centers, businesses, churches, green space and schools were seen as a positive asset to the

area—each contributing to quality of life aspects such as safety, access to health care, convenience and a sense of strong connection to the community. More abstractly, strengths that were mentioned also included strong consumer awareness, high intelligence on how to access care and above average health literacy. The following are some of the currents solutions to some of the needs within the communities:

- Broad range of medical specialties, locally
- Social networks in some communities
- Increase farmer's markets
- Community organizations—YMCA/ETHOS/Rotary/Little League/WIC
- Local programming (screenings and health education in the community)
- Free breakfast and lunch at the schools

HEALTH BEHAVIORS AND OUTCOMES FINDINGS

Coverage and Access

According to data from the 2013 Boston Behavioral Risk Factor Surveillance Survey (BBRFSS) the vast majority of Boston residents and residents of the BWFH priority neighborhoods had health insurance coverage (Table 10). In terms of access to care, Hyde Park had the lowest proportion of adults with teeth cleanings compared to Boston and the other priority neighborhoods and Jamaica Plain had the lowest percentage of adults with routine checkups in the past 2 years compared to Boston and the other priority neighborhoods.

Table 10: Access to Care by Neighborhood, 2013

	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Adults with Health Insurance Coverage 2013	94.0%	95.1%	97.5%	93.1%	98.6%
Adults with Routine Check Up Within Past 2 Years, 2013	89.4%	-	85.5%	-	91.9%
Adults Who Had Teeth Cleaned in Past Year, 2013	70.2%	63.7%	71.8%	91.9%	-

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

Across all priority neighborhoods, 83.2% of BWFH QOL Survey respondents reported using their PCP as their primary source of healthcare. However, despite receiving care and insurance coverage, there were several barriers to care identified, which included Work Schedule (36.1%), Transportation (20.3%), and Affordability (18.4%). Specifically, in Hyde Park and Jamaica Plain, MD Availability was reported as a top barrier as well at 27.8% and 28.6%, respectively.

While the rate of uninsured in Massachusetts is now at historic low levels, roughly 37% of insured Massachusetts residents said they went without necessary medical care in 2015 and this number is significantly higher amongst low-income residents (52% for individuals at or below 138% of the Federal Poverty Level). Trouble finding a provider, trouble getting an appointment in a timely manner and costs were the three main reasons care was not

received.[10] Health insurance premium rates continue to grow year-on-year[11] and as a result, 19% of Massachusetts commercial market members are in high deductible health plans[12] which offer lower premium costs up front in exchange for high cost sharing/out of pocket costs later on.

Upcoming regulatory changes for the Health Safety Net (HSN) (expected June 2016) and MassHealth plan enrollment (due Fall 2016/Winter 2017) will also significantly impact the access low income people have to care. HSN changes will increase cost sharing as well as the administrative burden for patients to prove that they have paid their annual deductible. Given that this fund is to a large extent used by undocumented residents, who are already an underserved population, these changes may further expand health inequities in communities across the state. Changes to MassHealth are proposed to incentivize MassHealth members to enroll with a Managed Care Organization (MCO) plan rather than with the state's own managed Primary Care Clinician (PCC) Plan by reducing the services offered under the PCC Plan. Members in MCO plans would be locked into their plan until the next annual open enrollment period (in line with what Commercially insured and ConnectorCare members must commit to). Further changes to MassHealth may also come in 2017 as the state prepares to launch its MassHealth ACO.

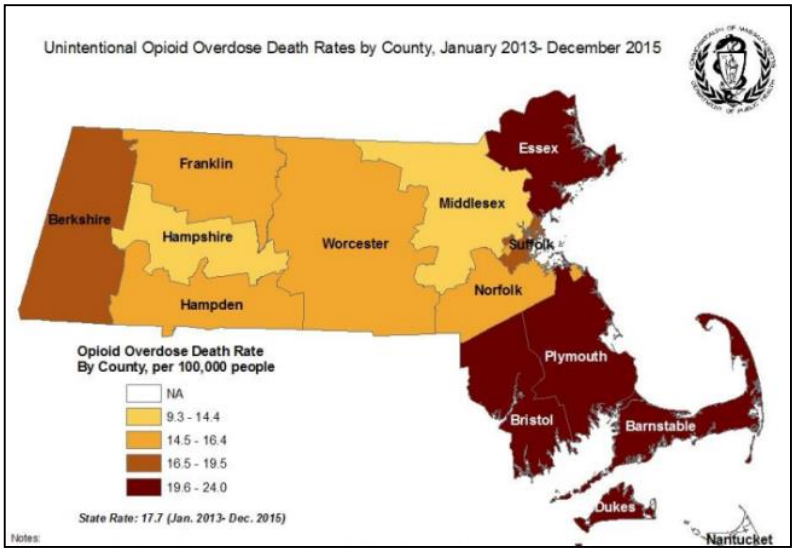
Health Behaviors

Substance Use and Tobacco

Substance abuse involves the excessive use of alcohol or illicit substances (e.g., marijuana, cocaine, heroin, methamphetamine, ecstasy), or the use of licit substances (e.g., prescription drugs such as Vicodin and OxyContin) in a non-prescribed manner to achieve an altered physiological state.

Opioid abuse specifically, has become a larger issue in the eastern counties in Massachusetts (Figure 7). In 2015, the estimated rate of unintentional opioid-related overdose deaths was 22.6 deaths per 100,000 residents. This represents a 12.4% increase from the

Figure 7: Unintentional Opioid Overdose Death Rates, 2013 –2015



[10] Blue Cross Blue Shield Foundation, "2015 Massachusetts Health Reform Survey", http://bluecrossfoundation.org/sites/default/files/download/publication/MHRS_2015_Summary_FINAL.pdf , Visited 4/13/16

[11] Center for Health Information and Analytics (CHIA) ,"Annual Report Premiums Databook", http://www.chiamass.gov/premiums/, Updated November 2015

[12] Center for Health Information and Analytics (CHIA) ,"The Performance of the Massachusetts Health Care System Series – Massachusetts High Deductible Health Plan Membership", http://www.chiamass.gov/the-performance-of-the-massachusetts-health-care-system-series/#hdhp, Updated November 12, 2015

rate of 20.1 deaths per 100,000 residents in 2014[13]. A person is said to have an addiction to a substance when the nature and intensity of the cravings for the substance contributes to a pattern of unhealthy or self-destructive behaviors in order to satisfy the perceived need for the substance. Individual-level risk factors such as socioeconomic status, family history, incarceration, and stressful life events (e.g., psychological distress, death of a loved one) are associated with drug use[14]. Increasingly, evidence suggests that social factors may contribute to one's decision to initiate drug use and shape other substance use behaviors[15]. For example, the lack of a supportive social network or circumstances related to neighborhood poverty may influence substance use behaviors[15].

Abuse of alcohol or other drugs over time can lead to physical and/or psychological dependence on these substances, despite negative consequences. Substance abuse alters judgment, perception, attention, and physical control[16], which can lead to the repeated failure to fulfill responsibilities and increase social and interpersonal problems[16]. There is a substantial increased risk of morbidity and death associated with alcohol and drug abuse[15]. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include: teenage pregnancy, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), other sexually transmitted infections (STIs), domestic violence, child abuse, motor vehicle crashes, physical fights, crime, homicide, and suicide[16].

Depending on the substance(s) involved, treatment of substance abuse and addiction may include medications, behavioral treatments, or a combination of both. A doctor, substance abuse counselor, or other health professional can determine the right treatment for an individual[17].

All of the BWFH priority neighborhoods had lower rates of binge drinking and smoking among adults compared to Boston (Table 11).

Table 11: Alcohol and Tobacco Use, 2013

	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Binge Drinking[18] Among Adults	25.4%	19.2%	20.0%	25.1%	18.8%
Current Adult Smokers[19]	18.7%	15.8%	14.1%	15.4%	16.1%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

[13] Massachusetts Department of Health. Opioid-related Overdose Deaths Among Massachusetts Residents, May 2016.
[14] Drug Use, Misuse and the Urban Environment. Galea, S., Rudenstine, S. and Vlahov, D. 2, s.l. : Drug and Alcohol Review, 2005, Vol. 24.
[15] The Social Epidemiology of Substance Use. Galea, S., Nandi, A. and Vlahov, D. 1, s.l. : Epidemiologic Reviews, 2004, Vol. 26.
[16] Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Rockville: Substance Abuse and Mental Health Services Administration (US), 2005.5. WebMD. Substance Abuse. Mental Health Center.
[17] National Institute on Aging. Prescription and Illicit Drug Abuse.
[18] Binge drinking is defined as having 5 or more drinks for men and 4 or more drinks for women on one or more occasions in the past 30 days.
[19] Smoked at least 100 cigarettes in your entire life AND Currently smoke cigarettes every day, some days, or not at all.

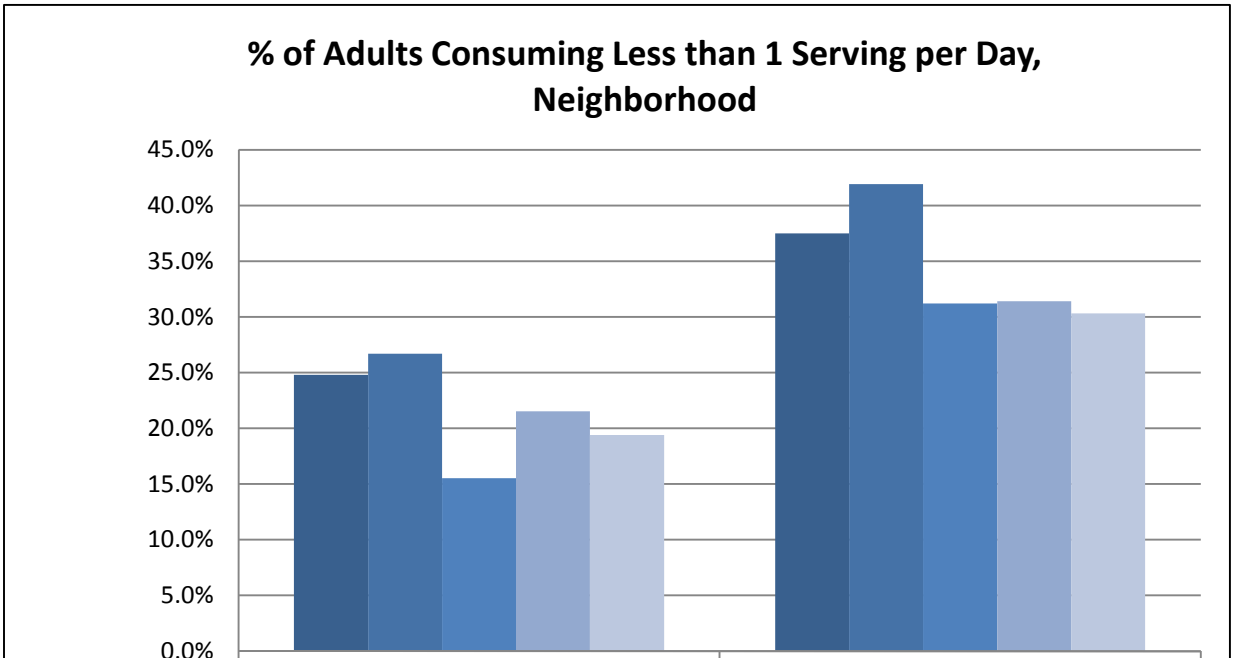
From the BWFH 2016 QOL Survey, 37.3% of all survey respondents indicated addressing alcohol and drug addiction in the community as a top community health issue. The response rate for this issue was significantly higher in Hyde Park and Jamaica Plain where 50.0% and 53.6% (respectively) of respondents indicated this issue.

Vegetable and Fruit Consumption

Vegetable and fruit consumption[20] was measured as the percentage of adults that consume less than 1 serving a day. All of the priority neighborhoods except for Hyde Park fare better with regards to fruit and vegetable consumption than Boston overall (Figure 8).

In addition to data from Figure 8, respondents from focus groups and the BWFH QOL identified nutrition education as an important topic for the community, stating "Nutrition education is very important and I truly believe that the upcoming generation with the right knowledge can make a huge difference."

Figure 8: Fruit and Vegetable Consumption by Neighborhood, 2013



	Vegetable Consumption	Fruit Consumption
Boston	24.8%	37.5%
Hyde Park	26.7%	41.9%
Jamaica Plain	15.5%	31.2%
Roslindale	21.5%	31.4%
West Roxbury	19.4%	30.3%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

[20] Derived by the number of times per day, week or month respondent drank 100% fruit juice, and ate fruit, dark green vegetables, orange-colored vegetables, or other vegetables.

Physical Fitness

Physical fitness was measured by the percentage of adults that meet the Center for Disease Control and Prevention's (CDC) aerobic activity guidelines[21]. All of the BWFH priority neighborhoods had at least 50% of its population of adults meeting the aerobic guidelines for physical fitness (Table 12). Jamaica Plain had a considerably higher amount of its residents that met the CDC guidelines (69.4%) compared to Boston and the other priority neighborhoods.

Table 12: Aerobic Activity for Adults by Neighborhood, 2013

	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Adults who met the CDC guidelines for Aerobic Physical Activity	57.5%	55.6%	69.4%	65.0%	58.6%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

Despite these statistics, 56.3% of 2016 BWFH Survey Respondent identified Nutrition and Fitness as a top community health priority.

Health Outcomes

Cancer Screening and Mortality

Cancer screening is measured by the individual's last visit within the recommended time period (Table 13). While in some priority neighborhoods sample sizes were insufficient to report data, the BWFH priority neighborhoods had higher rates of screening for pap test and mammography than Boston overall. However, for colonoscopy/sigmoidoscopy, Hyde Park and Roslindale rates were lower than Boston overall.

Table 13: Cancer Screenings by Neighborhood, 2013

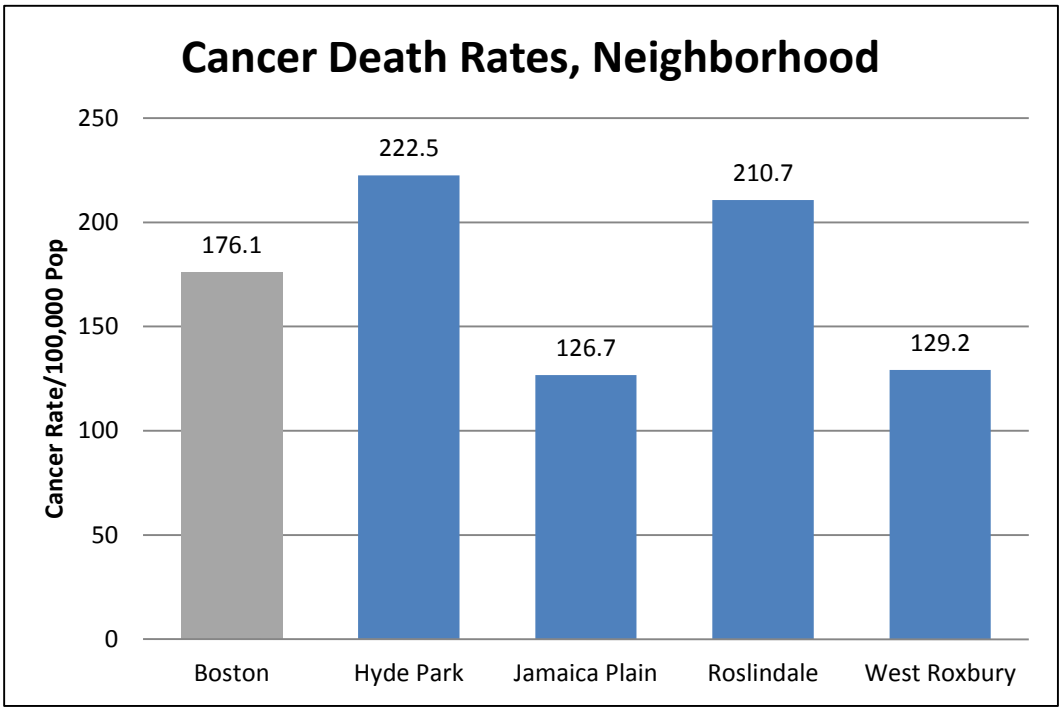
	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Pap Test within past 3 years (Females ages 21-65)	87.3%	91.2%	92.9%	-	93.0%
Mammogram within past 2 years (Females ages 50-74)	89.5%	-	91.9%	-	88.6%
Colonoscopy/Sigmoidscopy in past 5 years (Adults ages 50-74)	64.4%	59.2%	68.5%	63.5%	69.6%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2010-2013 via Boston Public Health Commission Research and Evaluation Office

The overall Cancer mortality rate for Boston 2009-2013 was 176.1 deaths per 100,000 population. As Figure 9 shows on the following page, cancer mortality rates in Hyde Park and Roslindale were considerably higher than the other priority neighborhoods as well as Boston overall.

[21] 150 minutes of aerobic activity in a week or the equivalent

Figure 9: Cancer Death Rates by Neighborhood, 2009-2013



Data Source: Massachusetts department of Public Health Boston Resident Births and Deaths, 2009-2013 via Boston Public Health Commission Research and Evaluation Office

Chronic Diseases

Chronic Diseases are measured by both mortality and prevalence. Compared to Boston and the other priority neighborhoods, Hyde Park had higher rates of mortality and prevalence in many reported categories (Table 14) and all priority neighborhoods experienced higher rates of CVD mortality. Roslindale also experienced higher rates of heart disease mortality. Among adults, the prevalence of obesity in Roslindale and West Roxbury were higher and the prevalence of asthma was higher in Jamaica Plain. In addition, 29.1% of 2016 BWFH QOL Survey respondents indicated Heart Disease and Stroke as a top community health issue.

Table 14: Chronic Diseases by Neighborhood, 2013

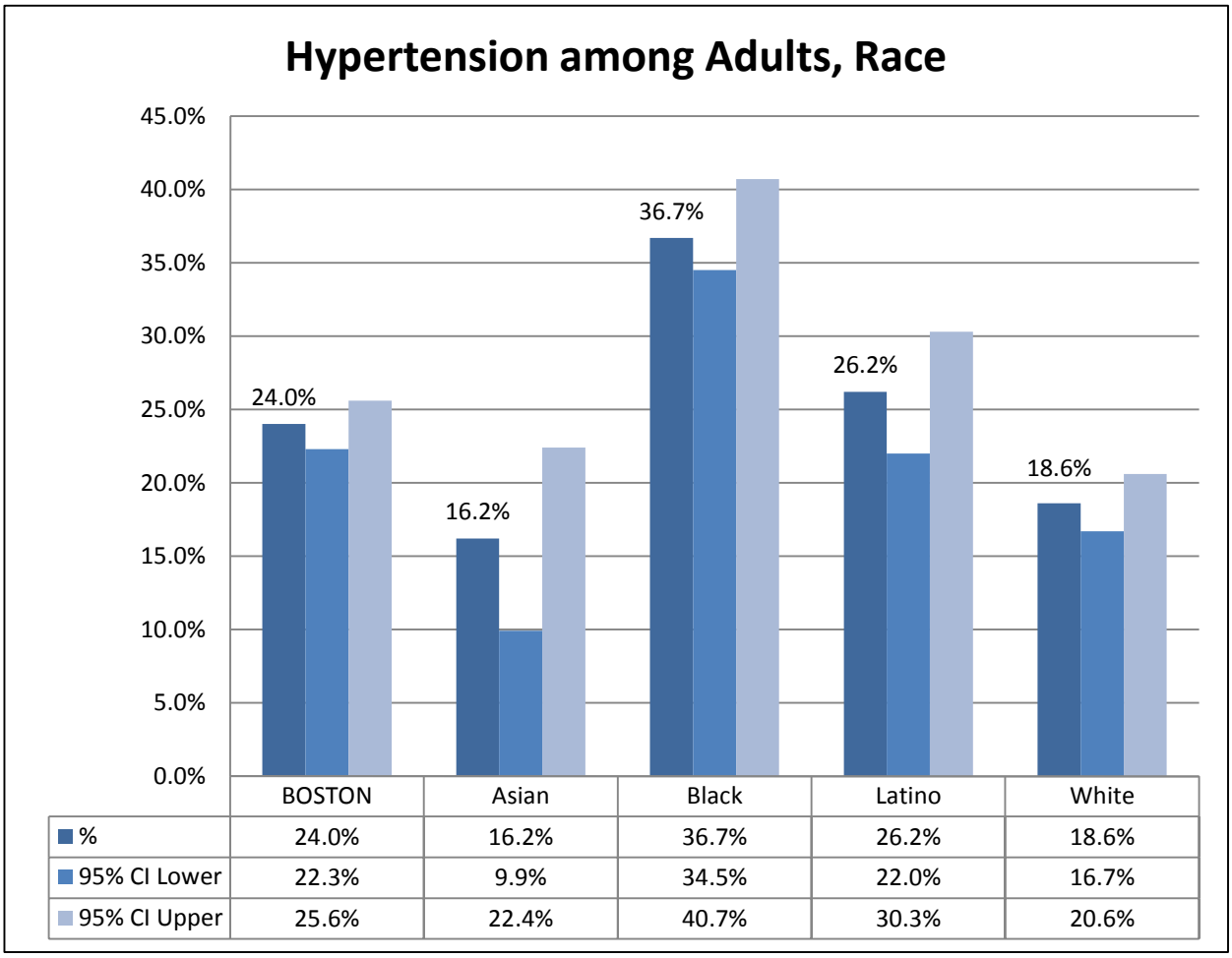
	Boston	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
Heart Disease Deaths (per 100,000)	133.6	186.3	133.6	143.6	112.4
Cerebrovascular (CVD) Deaths (per 100,000)	26.6	31.6	28.3	29.6	32.5
Diabetes Among Adults[22] (%)	8.6%	11.4%	4.2%	8.2%	8.7%
Obesity Among Adults[23] (%)	21.7%	16.3%	15.8%	23.4%	22.2%
Asthma Among Adults (%)	11.1%	13.2%	16.0%	7.2%	12.2%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

[22] Being told by a doctor that you have diabetes; females who have been told they had diabetes only when pregnant and respondents that were told they had pre-diabetes or were borderline diabetic are not included as having diabetes.
[23] Having a Body Mass Index (BMI) equal to or greater than 30.

Here again race proves to be an important factor when looking at health outcomes in Boston (Figures 10-13). Hypertension, diabetes and obesity rates among Black and Latino residents in Boston are nearly (and sometimes more than) twice that seen for White residents and these trends continue for youth obesity rates as well.

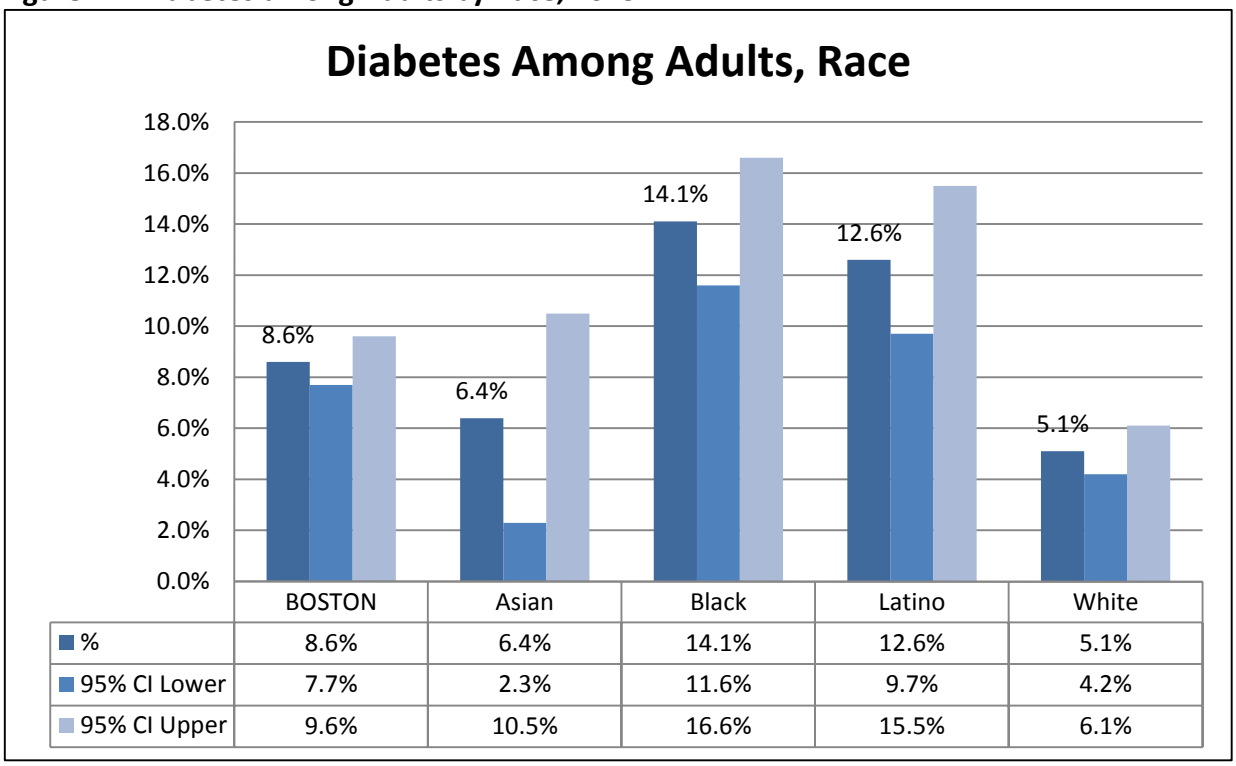
Figure 10: Hypertension among Adults by Race, 2013



	BOSTON	Asian	Black	Latino	White
%	24.0%	16.2%	36.7%	26.2%	18.6%
95% CI Lower	22.3%	9.9%	34.5%	22.0%	16.7%
95% CI Upper	25.6%	22.4%	40.7%	30.3%	20.6%

Data Source: Health of Boston Report 2014-15

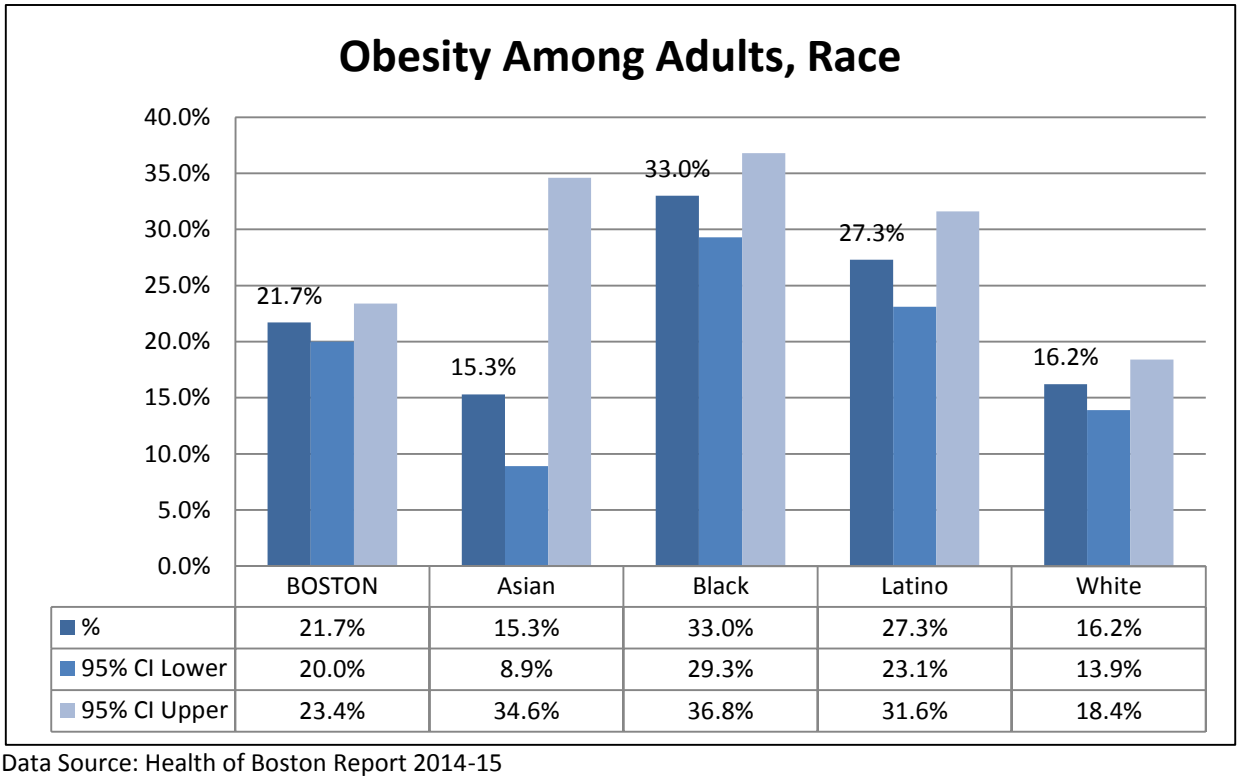
Figure 11: Diabetes among Adults by Race, 2013



	BOSTON	Asian	Black	Latino	White
%	8.6%	6.4%	14.1%	12.6%	5.1%
95% CI Lower	7.7%	2.3%	11.6%	9.7%	4.2%
95% CI Upper	9.6%	10.5%	16.6%	15.5%	6.1%

Data Source: Health of Boston Report 2014-15

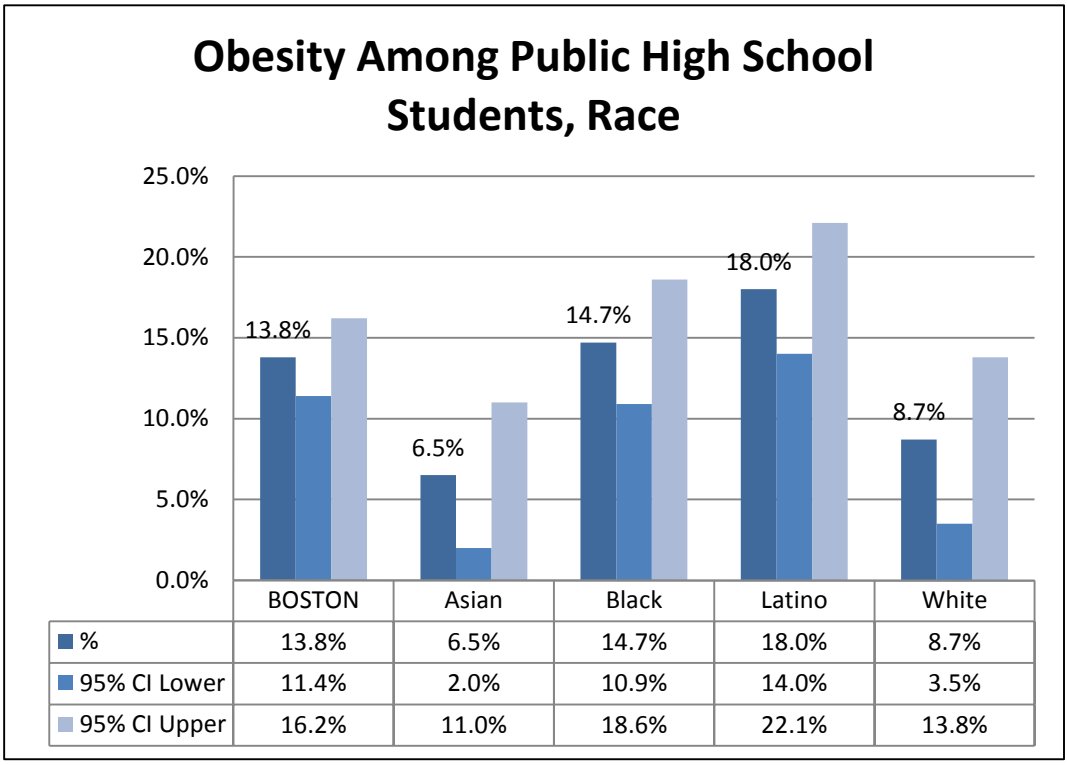
Figure 12: Obesity in among Adults, by Race 2013



	BOSTON	Asian	Black	Latino	White
%	21.7%	15.3%	33.0%	27.3%	16.2%
95% CI Lower	20.0%	8.9%	29.3%	23.1%	13.9%
95% CI Upper	23.4%	34.6%	36.8%	31.6%	18.4%

Data Source: Health of Boston Report 2014-15

Figure 13: Obesity among Public High School Students by Race, 2013



	BOSTON	Asian	Black	Latino	White
%	13.8%	6.5%	14.7%	18.0%	8.7%
95% CI Lower	11.4%	2.0%	10.9%	14.0%	3.5%
95% CI Upper	16.2%	11.0%	18.6%	22.1%	13.8%

Data Source: Health of Boston Report 2014-15

Food Insecurity

Food insecurity is often difficult to identify, and is a result of many other social determinants. Food Insecurity can be identified in many ways, however there are two questions that help to more easily identify food insecure populations[24]:

- Within the past 12 months, were you worried whether our food would run out before we got money to buy more?
- Within the past 12 months, has the food you bought just didn't last and we didn't have money to get more.

Within Massachusetts, 40% of the general population is food insecure with 15% being severely insecure; 20% of household with children are severely insecure; of the general population that are food insecure, only half will seek assistance[25].

Some nutritionists argue that the links between poverty, food insecurity and obesity can be partially explained by the lower cost of foods high in added fats, added sugars or refined grains

[24] The Hunger Vital Sign: A New Standard for Preventative Health," (2014). Children's Health Watch Policy Action Brief.

[25] Ettinger de Cuba, Stephanie; Frank, Deborah A.; Pilgrim, Maya; Buitrago, Maria; Voremberg, Anna; Rollinger, Harris; and Hines, Denise A. (2013) "Food Insecurity among Children in Massachusetts," New England Journal of Public Policy: Vol. 25: Iss. 1, Article 9.

(such as snacks, soft drinks and fast food). These foods tend to be cheaper than nutrient-dense foods (such as fruits and vegetables). Other possible explanations for the links between poverty, food insecurity and obesity include: Psychological stress; a lack of accessible nutrition information among food insecure communities.

In Massachusetts, the average for child food insecurity (combining the two most severe levels of food insecurity among children) in 2011 (most recent data available), according to Feeding America, was 16.5%, higher than the USDA estimate of 12.7%. One of the highest rates within Massachusetts is Suffolk County (18.5%). According to the 2013 Middle School YRBS, there are 16.5% of students in the Boston Public School system that have identified as being at some level of food insecurity. Among The table below (Table 15) displays the large amount of student presenting as food insecure within the Boston Public School System. Household food insecurity is a serious public health concern, particularly for young children.

Table 15: Boston Public Schools Food Insecurity Data, 2013

	Elementary	K-8	K-12
Number of Homeless Students	947	940	3
Number of students who "Always or Most of the time went hungry during the past 30 days because there was not enough food	767	834	5
Total number of students who "Always, Most of the time, or Sometimes went hungry during the past 30 days because there was not enough food in their home"	2636	2867	17

Data Source: 2013 Middle School YRBS

Children may be particularly affected by hunger and food insecurity. They may experience adverse health and development attributable to the inadequate quality and quantity of foods and to overall family stress. According to the Children's HealthWatch, we know that there are damaging effects in the following areas:

- Brain and cognitive development in the perinatal period (0-3 yrs)
- School readiness in preschool years (0-5 yrs)
- Learning, academic performance and educational attainment during school years (6-17 yrs)
- Physical, mental, and social development, growth and health throughout childhood (0-17 yrs)
- Psychosocial functioning and behavior, and mental health during school years (6-17 yrs)
- Child health-related quality of life, perceived functionality, efficacy and "happiness/satisfaction" during school years (6-17 yrs)
- Some, not yet clear associations with obesity throughout childhood (0-17 yrs)

Domestic Violence and Intimate Partner Violence

Domestic violence and Intimate Partner Violence (IPV) are largely an underreported among communities across the state. According to statistics from Jane Doe Inc. (JDI), between 2003 and December 31, 2012, JDI identified 266 victims of domestic violence related homicides and an additional 74 domestic violence homicide perpetrator deaths in Massachusetts. Due to the nature of this health issue, outcomes are difficult to measure. The Center for Disease Control and Prevention has linked several other health issues to DV and IPV (Figure 14).

Figure 14: Health Conditions Linked to Domestic Violence/Intimate Partner Violence, 2012

- Asthma
- Bladder and kidney infections
- Circulatory conditions
- Cardiovascular disease
- Fibromyalgia
- Irritable bowel syndrome
- Chronic pain syndromes
- Central nervous system disorders
- Gastrointestinal disorders
- Joint disease
- Migraines and headaches
- Anxiety
- Depression
- Symptoms of post-traumatic stress disorder (PTSD)
- Antisocial behavior
- Suicidal behavior in females
- Low self-esteem
- Inability to trust others, especially in intimate relationships
- Fear of intimacy
- Emotional detachment
- Sleep disturbances
- Flashbacks
- Replaying assault in the mind
- Engaging in high-risk sexual behavior
- Using harmful substances
- Unhealthy diet-related behaviors

Data Source: Jane Doe Inc., 2012

According to a survey release by The Avon Foundation for Women in 2012[26], many Americans know victims of domestic violence or sexual assault but do not address the issue or take action to help victims. About 60 % of Americans know a victim of domestic violence or sexual assault, but only 42 percent of victims said they received help when they came forward. Additionally, 80% of respondents said they believe domestic violence is a problem, but only 15 percent think it is a problem among their friends.

While more detailed and local data is a challenge to collect, Boston Police reported 857 reports of domestic aggrevated assault and 207 reports of rape. Due to concerns around privacy, the BWFH Passageway: Domestic Violence Intervention program that assists patients and employees who are unsafe, controlled, threatened or hurt by current or former imtimate partners, made over 275 visits to individuals in 2015.

Mental Health

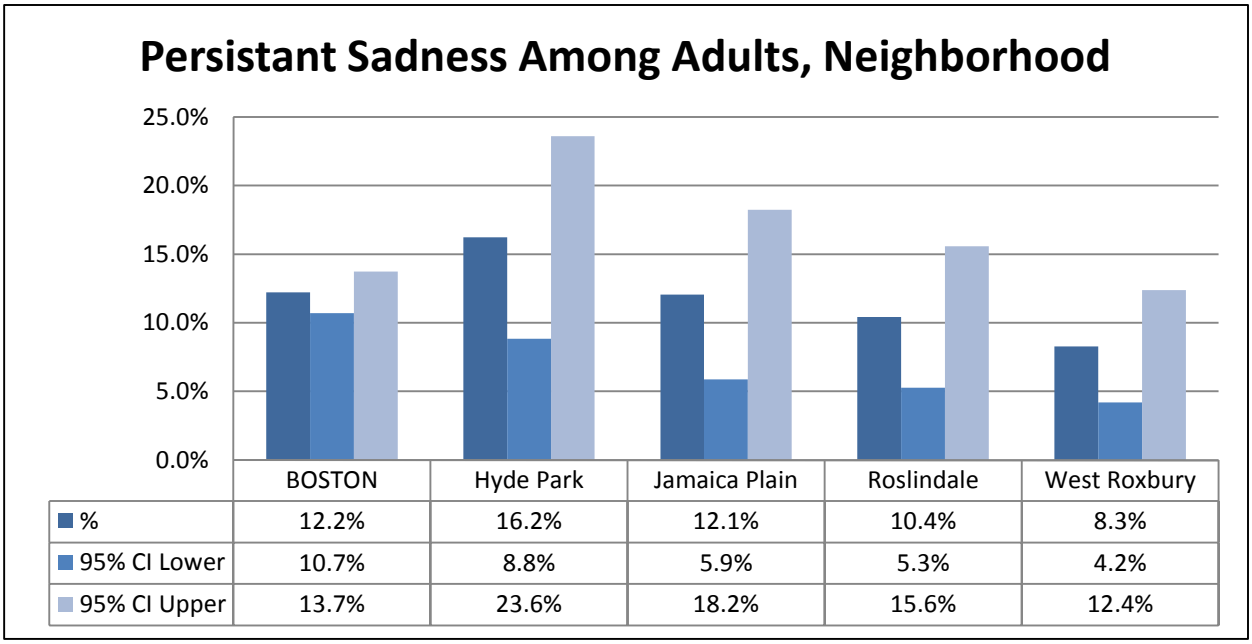
Mental health was measured by telephone survey respondent self-report. Hyde Park has a larger percentage of its residents with persistent sadness[27] (16.2%) and residents who were

[26] The Avon Foundation for Women NO MORE Domestic Violence and Sexual Assault Survey, 2012.

[27] Persistent sadness among adults was defined as sadness for more than 15 days in the past 30 days.

notably tense or anxious[28] (23.8%) compared to Boston and the other priority neighborhoods (Figures 15-16).

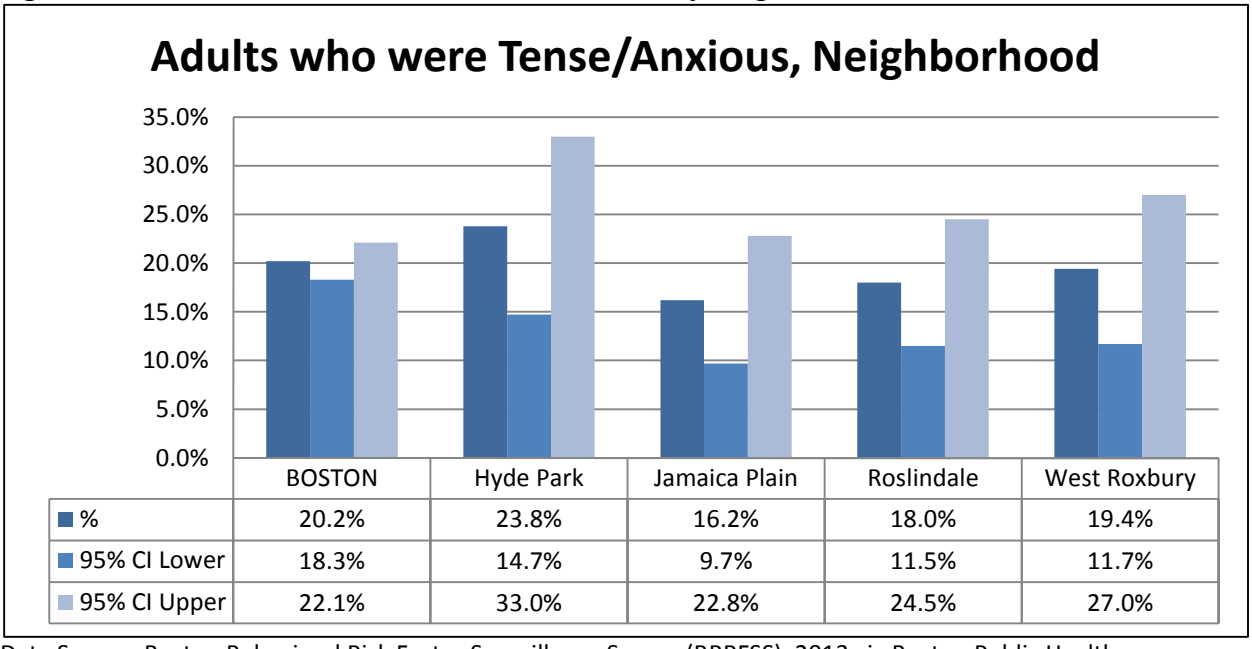
Figure 15: Persistent Sadness among Adults by Neighborhood, 2013



	BOSTON	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
%	12.2%	16.2%	12.1%	10.4%	8.3%
95% CI Lower	10.7%	8.8%	5.9%	5.3%	4.2%
95% CI Upper	13.7%	23.6%	18.2%	15.6%	12.4%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

Figure 16: Adults who were Tense and/or Anxious by Neighborhood, 2013



	BOSTON	Hyde Park	Jamaica Plain	Roslindale	West Roxbury
%	20.2%	23.8%	16.2%	18.0%	19.4%
95% CI Lower	18.3%	14.7%	9.7%	11.5%	11.7%
95% CI Upper	22.1%	33.0%	22.8%	24.5%	27.0%

Data Source: Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), 2013 via Boston Public Health Commission Research and Evaluation Office

[28] Being Tense or anxious for more than 15 days in the past 30 days.

COMMUNITY PERCEPTIONS

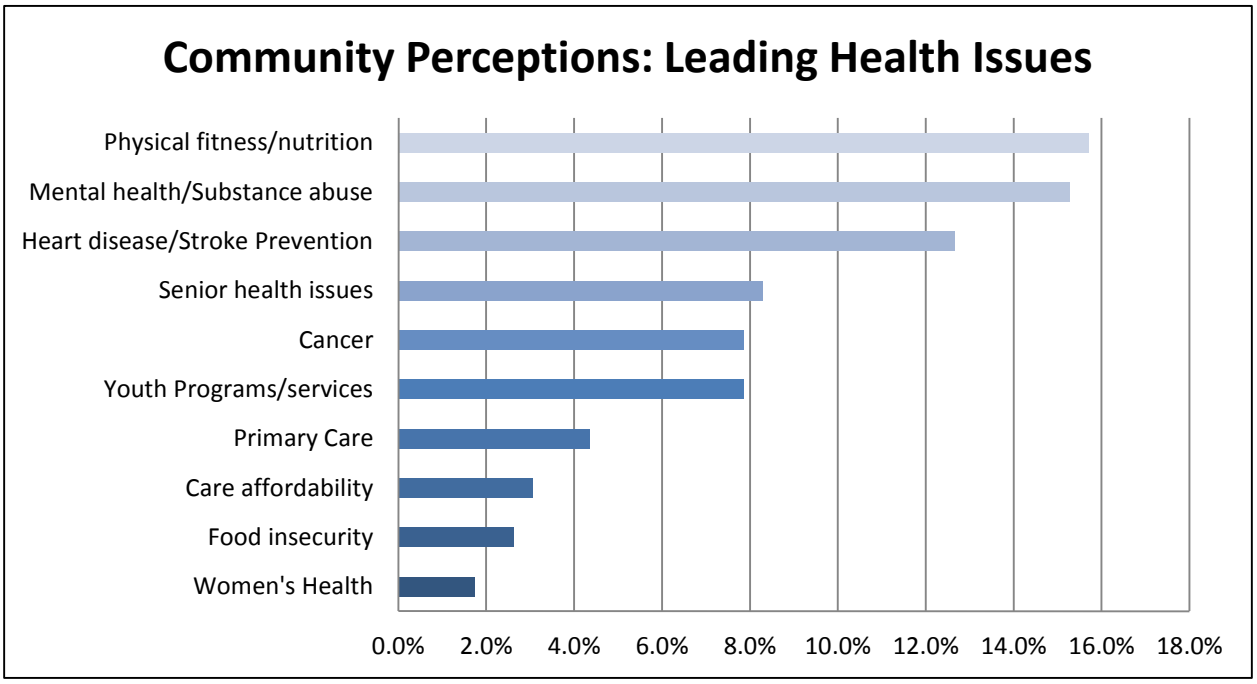
Quality of Life Survey

In the 2016 BWFH QOL Survey, community perceptions on current health issues were gathered through a series of questions. The process was designed to engage community residents through a widely distributed survey. Surveys were distributed in English and Spanish.

- 158 respondents
- 70% of respondents live in one of the four target neighborhoods (Hyde Park, West Roxbury, Jamaica Plain, Roslindale)

Figure 17 displays the top 10 health issues as perceived by residents in priority neighborhoods.

Figure 17: Community Perceptions on Leading Health Issues, 2016



Data Source: The 2016 Brigham and Women's Faulkner Hospital Quality of Life Health Survey

Key Informant Interviews: Major Challenges

Key informants cited the following as the most pressing issues in the community:

- Obesity/nutrition/eating habits/food costs/food access
- Diabetes/heart disease
- Opioid addiction—perceived risk is less prominent
- Poverty/lack of affordable housing
- Transportation
- Young adult/teen gap/trauma
- Elderly—connecting to services
- Need for health education on nutrition, medication, diabetes

Community Focus Groups: Major Themes

Community focus groups were conducted in the following neighborhoods with representation from all of the priority neighborhoods: Roslindale, Mattapan, and Jamaica Plain. There were major themes in each focus group that were unique to the community, and others that were common across all the neighborhoods.

Roslindale

Challenges discussed were that there seems to be a divide in the community and lack of community cohesion. There are "old families" and "new families" that do not agree on how the neighborhood should function—citing race as a large part of the divide. Additionally, the perception is that many agree on what the issues are, but disagree on how to approach them and therefore nothing gets done. The largest issues identified were:

- Opioid addiction crisis
- Pedestrian safety
- Income diversity
- Race and cultural barriers
- Youth needing positive role models
- Drug and substance abuse education
- Nutrition education
- Parents need support on youth-related issues
- Transportation, most notably for seniors

The group cited solutions in:

- Work from ETHOS with seniors
- Police working with youth
- Brigham and Women's Faulkner Hospital's involvement with community groups and health education.
- "Meeting people where they are" and constant communication with residents is most important

Mattapan (with many Hyde Park residents in attendance)

The following issues were raised:

- Cancer: There is a large amount of residents that spoke on knowing someone who had either died or survived cancer. There were two cancer survivors in the meeting that spoke on not having support outside of their family and friends throughout the course of their illness and treatment. In addition, it was brought to our attention that there were 2-3 small streets on which every man died of prostate cancer. They communicated that there were these concentrated areas of cancer in the community.
- Diabetes: Many of the residents emphasized that it's become very common for people to have diabetes, and it has become a very recent issue.
- Nutrition and Food Label Literacy: Residents communicated that there is a desire to eat better, but there is no nutrition education. In addition, there isn't education on reading and interpreting food labels.

- Space for Activity: Residents communicated that there is a need for both inside and outside space for physical activity, and for youth to have programming.
- Youth and Young Adults: There needs to be more than just after school programming because there are individuals ages 18-24 that need help getting employment or becoming positively engaged with the community.
- Crime and Violence: Residents communicated that crime and violence is a major issue, and majority of the crime going on is usually involving young adults between the ages of 18-24.

The group cited solutions in:

- Residents communicated that they want more meditation, yoga, and stress/trauma support programs
- Need cancer support groups because none currently exists
- Need real estate and space that the community can use on a consistent basis.
- Better outreach, communication, and collaboration with the hospitals so interventions or programs like youth employment programs are known by everyone in the community.

Jamaica Plain

The following issues were raised:

- Mental health: Insufficient accessibility of mental health and substance abuse services and those services that are available are too high cost.
- Housing: High cost of housing/lack of affordable housing
- Community safety concerns: tied to drug activity that is visible and that people who are drug dependent/homeless and have "no where to go")
- Transportation: insufficient transportation and unreliability of transportation, particularly noted for seniors. The impact for residents traveling to health care appointments was noted.
- Resident Engagement: there are definitely residents who are working hard to improve things in the community, but it was noted that a lot of community members feel disillusioned and lack hope
- Insufficient Programming/places to gather: more programming needs to be established for young people, particularly after middle school years. Need more programs/places for seniors, including some less structured, drop in opportunities. The significant need for physical spaces for gathering/activity in JP was noted

The group cited solutions in:

- Improved transportation (especially for seniors)
- Strategies to build trust and sense of community connection
- Use peer to peer empowerment models so people can learn from someone who has the same experience

- More holistic and comprehensive approach to wellness is needed (importance of understanding people in their social and family context)
- Supports for families that have children with disabilities
- Hospitals should Increase presence in the community ('embed' services where people live or congregate) and increase coordination of services and community awareness of programs
- Support residents and CBOs that **are** leading community change – they need more support and we can build on these efforts
- Hospitals need to work together to avoid duplication and increase coordination. It would be good if people had a 'go to' person at hospitals that people can contact when they have needs

ORGANIZATIONAL CHALLENGES

BWFH is working with communities on domestic violence, substance abuse and youth engagement. While many of the initiatives involved in these priority areas overlap and have an impact on neighborhood violence and mental health, they are not directly addressed through our community health priorities due to limited resources and available expertise. BWFH will look for opportunities to collaborate with local agencies to be a part of the conversation to address these unmet needs.

ADDRESSING PRIORITY NEEDS

Criteria for Prioritization Areas:

- Community need: review of current data and assessments from local, state and national organizations
- Collaborative opportunities: overview and evaluation of partnership with local community organizations
- Community interest and readiness: in depth and thoughtful dialogue and input from individuals though stakeholder meetings, focus groups and survey opportunities
- Estimated effectiveness and impact
- Adequate resources for implementation

Priority Health Needs

The following needs have been identified as the priority needs to be addressed by BWFH:

1. Chronic Diseases
2. Substance Abuse
3. Food Insecurity, Healthy Eating and Active Living
4. Domestic Violence
5. Social Determinants of Health (Language, Poverty, Education, Access, and Youth Engagement)

2016 IMPLEMENTATION STRATEGY ACTION PLAN

Priority 1: Chronic Disease **Engage community partners and hospital clinicians to focus chronic disease prevention and education efforts, including heart disease, stroke and diabetes.**		
Objective: By September 2019, increase awareness of chronic disease management and prevention through education and screenings.		
Outcome Indicators:	**Target**	**Stretch**
• Number of educational/screening programs	40	60
• Number of participants/encounters in programming events	1500	2000
Strategies	**Timeline Year 1, 2, 3**	**Resources**
1.1.1 Stroke • Educate the community on stroke signs and symptoms and the importance of getting to the hospital • Provide a stroke support group for stroke survivors and or their caregivers • Maintain an active hospital based Stroke Committee to ensure the highest level of care for stroke patients.	1, 2, 3	Hospital and clinical staff, YMCA, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing
1.1.2 Cardiovascular Disease • Educate the community about heart disease and diabetes • Provide screening programs to help residents identify and or monitor risk factors such as cholesterol levels, glucose and blood pressure • Participate in awareness and education campaigns • Maintain a collaborative Core Measure Improvement Team for the prevention of CHF readmission.	1, 2, 3	Hospital and clinical staff, YMCA, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing
1.1.3 Diabetes • Develop and implement a diabetes education program based on the AADE7 self-care behaviors ▪ 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. ▪ Being active: regular activity for overall fitness; weight management; blood glucose control;	1, 2, 3	Hospital and clinical staff, YMCA, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing

improve BMI; enhance weight loss; control lipids, blood pressure and reduce stress. ▪ Monitoring: daily self-monitoring of blood glucose to help assess how food, physical activity and medication affect levels. ▪ 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. ▪ Problem solving: address barriers, such as physical, emotional, cognitive and financial obstacles and developing coping strategies. ▪ Healthy coping: help to identify individual's motivation to change behavior then helping set achievable behavioral goals and guiding patient through obstacles. ▪ 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. • Provide awareness campaign and screening and education events		
Monitoring/Evaluation Approach: • Communications data and tracking • Attendance and registration sheets • Meeting the standards for a certified DPH Stroke Center • Track and evaluate CHF readmissions		

Priority 2: Substance Abuse **Provide education, support and services for those community members struggling with substance abuse addiction.**		
Objective: By September 2019, provide community education, support and services for substance abuse addiction.		
Outcome Indicators:	**Target**	**Stretch**
• Number of educational/screening programs	20	40
• Number of participants/encounters in programming events	200	400

Strategies	Timeline Year 1, 2, 3	Resources
2.1.1 Education and Awareness • Assemble a community coalition to address substance abuse • Educate the community about substance abuse • Educate youth about the dangers of drugs, alcohol, tobacco and nicotine devices • Develop clinical provider education forum • Provide Narcan training program for the community • Distribute Narcan kits and education to users and families in the ED • Provide a Recovery Day for awareness and de-stigmatize and celebrate recovery milestones • Offer a variety of support groups for community members and their families struggling with addiction	1, 2, 3	Hospital and clinical staff, YMCA, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing
2.1.2 Adopt MHA Emergency Department Guidelines (Link Here) • Development of processes for substance use screening, brief intervention, and referral to treatment for patients both at risk for developing substance use and patients who actively have substance use disorders • Consultation with the Massachusetts Prescription Monitoring Program (PMP) before writing an opioid prescription • Utilization of health information exchange systems to share Emergency Department visit history with other ED treating providers • Coordination of care processes for patients with high utilization of ER services due to substance use • Emergency Department visit notifications to patient's primary care or primary opioid prescriber after visit for acute exacerbations of chronic pain • No replacement prescriptions for controlled substances that are lost, destroyed, or stolen or doses of methadone for patients in methadone treatment programs unless specific criteria met • No prescriptions for long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches, and methadone • Mandatory patient counseling on proper usage,	1, 2, 3	Hospital Emergency Department, Leadership and Medical Staff, Massachusetts Hospital Association

storage, and disposal of opioids when prescribed by Emergency Department staff • Limiting day supply of opioid analgesics for serious acute pain written by Emergency Department Staff, to no more than five days		
2.1.3 Other Support • Provide space for addiction recovery support groups free and open to the community	1, 2, 3	Hospital based
Monitoring/Evaluation Approach: • Communications data and tracking • Attendance and registration sheets • Track and monitor ED statistics of overdoses • Track distribution of Narcan kits		

Priority 3: Food Insecurity, Healthy Eating and Active Living **Provide food resource and screening, nutrition and fitness education and programming to support the needs of the community.**		
Objective: By September 2019, provide youth, adults and families the education, support and programming needed to foster good health and wellbeing.		
Outcome Indicators:	**Target**	**Stretch**
• Number of educational/screening programs	40	60
• Number of participants/encounters in programming events	1500	2000
Strategies	**Timeline Year 1, 2, 3**	**Resources/Partners**
3.1.1 Food Insecurity • Educate providers and staff about utilizing food insecure screening questions • Identify food insecure populations through use of the screening tool • Work with EPIC/IT system to include screening tool as part of the patient medical record • Provide resources to identify and access food pantries and low cost food options • Partner with local YMCA, Food Truck, Boston Public Schools and others to screen BPS families and provide food backpack program to those in need (See *Appendix 5*) • Work with school staff in the use of a share table	1, 2, 3	Hospital and clinical staff, YMCA, Fresh Truck, Boston Public Schools, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing

3.1.2 Healthy Eating • Support residents in a nutrition health coach program model for the purpose of increasing consumption of healthy, fresh foods and bettering health • Increase awareness about consumption of sugar sweetened beverages to relationship to obesity and diabetes • Work with BPS and the school staff to help implement healthier food options • Continue to offer school partnerships monthly tasting of health foods with recipes • Educate community residents about the importance of healthy eating • Provide nutrition programs to increase the opportunity for residents to get hands on experience in how to make healthier food choices and understand nutrition	1, 2, 3	Hospital and clinical staff, YMCA, Fresh Truck, Boston Public Schools, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing
3.1.3 Active Living • Educate youth and residents about the importance of a physically active lifestyle • Support community in a fitness program Implement a cardiovascular exercise program that would engage youth and families in physical fitness and promote a physically active lifestyle • Work with school partners to increase physical activity during the school day	1, 2, 3	Hospital and clinical staff, YMCA, Fresh Truck, Boston Public Schools, local community agencies, parents, residents, youth, local housing developments, community centers and elder housing
Monitoring/Evaluation Approach: • Communications data and tracking • Attendance and registration sheets • Monitor school policies and implementation • Evaluate and track food insecure screening tool • Evaluate use of food resources		

Priority 4: Domestic Violence (BWHC Passageways) Program **Provide advocacy, education, awareness and training programs for the issue of domestic violence.**		
Objective: By September 2019, increase advocacy, education and awareness for the issue of domestic violence.		
Outcome Indicators:	**Target**	**Stretch**
• Number of educational/screening programs	10	20
• Number of participants/encounters in programming events	500	800
Strategies	**Timeline Year 1, 2, 3**	**Resources**
4.1.1 Education • Provide outreach and training to hospital departments on an annual basis to promote provider awareness and access to Passageway program • Provide education and awareness to community on domestic violence	1, 2, 3	Hospital and clinical staff and community partners
4.1.2 Advocacy • Implement structure for MSW internship at Passageway at Faulkner • Continue increasing capacity at Brigham and Women's Faulkner Hospital's campus to respond to the needs of victims of domestic abuse	1, 2, 3	Hospital and clinical staff and community partners
4.1.3 Awareness • Sustain visibility for domestic violence issues at Brigham and Women's Faulkner Hospital • Work on creating stronger connections with community providers responding to the needs of survivors of sex trafficking and community violence to enhance our response to survivors of multiple forms of interpersonal violence.	1, 2, 3	Hospital and clinical staff and community partners
Monitoring/Evaluation Approach: • Maintain contact logs for direct services to victims • Monitor screening rates for DV in ED and on medical floors; identify opportunities for outreach and training for staff • Document the specific needs for further expansion of domestic abuse programming on-site at Brigham and Women's Faulkner Hospital • Track referral sources by department to identify areas for continued training and education • Monitor community needs and respond and partner as appropriate		

Priority 5: Social Determinants of Health (Language, Poverty, Education, Access) **Provide support and services that reduce barriers that exist in our community.**		
Objective: By September 2019, provide a variety of support and programming that help to reduce barriers in the community.		
Outcome Indicators:	**Target**	**Stretch**
• Number of participants/encounters	15,000	17,000
Strategies	**Timeline** **Year 1, 2, 3**	**Resources**
5.1.1 Language • Provide interpreters for non-English speaking patient and deaf and hard of hearing patients for all services at the BWFH campus, including the private physician offices for seamless care for patients • Make better connections with providing interpreters upon discharge for at home care instructions • Provide translation services for materials of non-hospital services at the BWFH campus	1, 2, 3	Hospital and clinical staff and community partners
5.1.2 Poverty • Provide free parking or transportation services to needy patients • Provide patient financial counselors to help with enrollment in public assistance programs • Provide guardianship process to needy elderly patients to ensure the safe transition to appropriate care	1, 2, 3	Hospital and clinical staff and community partners
5.1.3 Education • Continue to provide health education programming at local schools to supplement education and resources available for students • Provide students with hands on experiences in health education both in the classroom and at the hospital campus • Provide enrichment workshops for youth to hone and develop skills in life skills areas such as interviewing, resume writing, presentation skills and finance • Take a leadership role at partnership schools in the areas of health education to continue to advocate greater access and time for the subject • Provide cancer prevention education to specific	1, 2, 3	Hospital and clinical staff, BPS, youth, parents, community partners

	priority neighborhoods with low screening utilization and high cancer rates		
5.1.4	**Access** • Offer a job shadowing experience in both general placement and a nursing specific placement opportunity • Collaborate with BPIC on a competitive and enriching experience that allows students to explore various aspects of healthcare through the Summer Jobs Program • Take an active and leadership role in planning for the future of Workforce Development in Boston/Massachusetts • Offer career panels for youth to hear about health care careers and offerings • With community partners, develop youth groups to engage participants in community work and resources • Work with community partners to better understand and address access issues • Continue to provide free breast health care access screening program to those patients without health insurance access • With patient financial counselors and social workers, assist needy patients with accessing resources for health insurance, housing and other needs and barriers • Provide local resource information and better connect community to available services	1, 2, 3	Hospital and clinical staff, Boston Private Industry Council, BPS and community partners
Monitoring/Evaluation Approach: • Communications data and tracking • Attendance and registration sheets • Monitor use of interpreter services • Monitor use of translation services • Track health education needs of schools			

CONTACT US

We welcome comments and questions regarding this report. Please contact us at Brigham and Women's Faulkner Hospital at Community Health and Wellness:

Tracy Mangini Sylven, MCHES, CHC
Director, Community Health and Wellness Department
Phone: 617-983-7451
Email: tsylven@partners.org

APPENDICES

APPENDIX 1: 2016 BWFH Quality of Life Survey

(distributed in English and Spanish)

2015-2016 Community Survey

BRIGHAM AND WOMEN'S Faulkner Hospital

Please complete the following survey.
Your input is valuable and all responses are kept confidential.

1.) Please indicate, if you live /work (or both) in one of the following neighborhoods:

LIVE	WORK
☐ Jamaica Plain	☐ Jamaica Plain
☐ Hyde Park	☐ Hyde Park
☐ Roslindale	☐ Roslindale
☐ West Roxbury	☐ West Roxbury

2. Where do you find out about local community events/ services?

- ☐ Newspaper
- ☐ On-line (Patch, social media, etc)
- ☐ word of mouth/neighbors
- ☐ community board
- ☐ Other or make a suggestion: _____

_____

3.) Where do you get most of your health care services? (CHECK ONE)

- ☐ Primary Care Physician
- ☐ Walk in or Urgent Care Center
- ☐ Hospital Emergency Room
- ☐ Community Health Center
- ☐ Other: _____

4.) What are barriers to healthcare for you and your family? (CHECK ALL THAT APPLY)

☐ Transportation	☐ Work Schedule
☐ Child care	☐ Distance
☐ Language	☐ Availability of Doctor
☐ Cannot Afford to Pay	☐ Lack of Insurance

☐ Other (describe): _____

5.) Of the following health priorities, please check any/all that are needed in your community:

- ☐ Elder health programs
- ☐ Health education in the schools
- ☐ Youth work opportunities and training
- ☐ Heart disease and stroke education
- ☐ Address alcohol and drug addiction in the community
- ☐ Provide free health screenings for those without insurance
- ☐ Nutrition and fitness program
- ☐ Help families with lack of food
- ☐ Other (please be specific): _____

_____

6.) Please identify the TOP 2 health issues that you feel should be a priority focus for Brigham and Women's Faulkner Hospital in 2016-2018:

1. _____

_____

_____

2. _____

_____

_____

7.) Please provide any other input you would like to contribute to this topic:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time.

TO EMAIL YOUR SURVEY, PLEASE SEND TO:
tsylven@partners.org

TO MAIL YOUR SURVEY, PLEASE SEND TO:
Brigham and Women's Faulkner Hospital
Attention: Tracy Sylven
Community Health and Wellness
1153 Centre Street
Boston, MA 02130

APPENDIX 2: Community Focus Group Questions

- What do you see as the most pressing health and wellness issues in your community today?
    - Would you say things have gotten better, worse or pretty much the same from a few years ago?
    - When speaking about specific health issues, would you say cancer is of concern in the community? If so how much?
- What resources and/or supports currently exist in your community to address barriers to health and wellness for residents? What is working well?
    - Are adequate services available to support people who have survived cancer?
- What would be helpful in your neighborhood to address the most pressing health and wellness issues affecting your community?
    - What do you think would be helpful to specifically meet the needs of people who have survived cancer?
- What is important for hospitals to know so we can work collaboratively with residents and local community organizations?

APPENDIX 3: Key Informant List

Internal Key Informant Interview Participants

- Michael Gustafson, MD – President BWFH
- Edward Liston-Kraft – VP, Professional and Clinical Services, BWFH
- Susan Dempsey, VP, BWFH
- Judy Hayes, Chief Nursing Officer, BWFH
- Linda Burgoon, Director of Clinical Program Development, BWFH
- Lois Lobon, MD, Chief of Emergency Medicine, BWFH
- Barbara Pierson, Manager, Patient Financial Services, BWFH
- Aspasia Bakolas, Counselor, Patient Financial Services
- Alex Kaufman, Manager Surgical Quality Data, Department of Patient Safety, Quality, Infection Control and Accreditation, BWFH
- Mary Ray Mazaka, Director, Social Work, BWFH
- Eileen Joyce, Senior Clinical Social Worker, BWFH
- Colleen Monaghan, MD, Family Medicine Physician, BWFH
- Claudia Rodriguez, MD, BWPO Physician, Department of Psychiatry and Addiction
- Brenda Falk, Practice Manager, Department of Psychiatry and Addiction, BWFH
- John Fromson, MD, Chief of Psychiatry, BWFH

External Key Informant Interviews

- John Lewis, MD, Medical Director, BWFH Community Physicians
- Ron Warner, MD, Hyde Park Physician, BWFH Community Physicians
- Jennifer Obadia, New England Coordinator, Health Care Without Harm, Healthy Food in Health Care Program

- Lillyana Hebbert, Elder Care Collaborative
- Marion Kelley, Executive Director, YMCA of Greater Boston, West Roxbury
- Ethan D'Ablemont Burnes, Principal, Manning Elementary School, Jamaica Plain
- Tara Raposa, Assistant Director, School to Career, Boston Private Industry Council
- Berto Sanchez, Manager, City-Wide Overdose Prevention, Boston Public Health Commission

Other Key Informant Interviews

- Monica Valdes Lupi and Gerry Thomas, Executive Director, Boston Public Health Commission
- John Drew, ABCD (Central Office)
- Dr. Atiyah Martin, Chief Resiliency Officer, City of Boston Resiliency, Anti –Violence efforts
- Dr. Monica Bharel, Commissioner, Mass. Department of Public
- Chris Norris, Executive Director, Metropolitan Boston Housing Partnership Housing
- SJPHC and Brookside

APPENDIX 4: Key Informant Interview Questions

- What do you consider as some of the strengths of the community?
- What do you consider some of the challenges of the community?
- What do you consider as the most pressing health and wellness issue in the community today?
- For the resources and support that currently exists in our community to address health and wellness, what is working well?
- What do you consider the needs of the community that are not being sufficiently addressed and what do you feel they are not being addressed?
- What would be helpful in the community to address the most pressing issues?
- What is important for the hospital to know so we can work collaboratively with resident and local organizations on these concerns?

APPENDIX 5: CURRENT PROGRAMMING

Food Insecurity Work in BPS Schools

BWFH Backpack Fresh Food Program

In 2014, the BWFH team began work on a food insecurity program with the J.P. Manning School, in Jamaica Plain; a whole school team worked together with BWFH to identify 25 food insecure families in the school. Families were identified through a variety of methods, including through teachers and staff, the nurse, principal, lunch room monitors and by calls from the families. The two questions that are asked to help identify food insecurity are:

1. Within the past 12 months we were worried whether our food would run out before we got money to buy more.
2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

BWFH in partnership with the Fresh Truck provides a grocery bag of fresh produce to each of the 25 identified families every week. The cost of the bags is $8-10 per family per week. In addition to the fresh fruits and vegetables in the bag, starting in September 2016, there will be information sheets on some of the items in the bag. How to store, clean and prepare the items, as well as simple recipes will be included on the sheets. The bags also act as another vehicle to get information home to this needy population. BWFH has used the bags to send fliers on free programs, screenings, health fairs and how to access various resources.

The goal of the program is to expand the fresh fruit and vegetable backpack program, beginning with elementary schools, to other Boston Public Schools through the use of the Wellness Champion Initiative. Through this, schools will be able to opt into the program via their wellness champion representative beginning in September 2016. Upon entrance into the program, they will receive instruction on how the program works and one-on-one assistance with implementation. Implementation will include addressing areas such as identifying needy families, communicating with sensitivity, privacy and confidentiality in distribution and coordination of delivery. All instruction and assistance will be done by Tracy Sylven of BWFH at no additional cost to the program expenses.

There is little data on this topic gathered specifically by BPS, but we know from broader reports and data that there are significant food insecurity issues in Massachusetts and especially those families with children (see below resources).

Currently, we are seeking funding for the program to launch. The only expense to the program remains to be the cost of food with bags ($8-10 per family). Funding will dictate how many schools/families are allowed in the program.

Mental Health Services at BWFH

Brigham and Women's Faulkner Hospital (BWFH) Department of Psychiatry is the largest clinical psychiatry site in the Brigham / Faulkner system. Our clinical staff includes psychiatrists, psychologists, social workers, occupational therapists, and certified alcohol and drug counselors. We evaluate and treat a broad range of patients especially those with complex,

interconnected medical problems who are treated by Brigham Faulkner physicians. In addition to providing expert care to individuals with mood, anxiety, psychotic and substance use disorders, we have subspecialists who concentrate on behavioral therapies and community psychiatric issues.

BWFH Psychiatry offers medication, individual, couple, and group psychotherapy with an emphasis on skills-based training such as cognitive-behavioral therapy. Other talking or behavioral therapies may be recommended. Whenever possible, we will provide ongoing care after the initial evaluation. How-ever, patients with more straight forward psychiatric illnesses who are medically well may be referred to community providers for ongoing care.

As part of our academic mission, BWFH Psychiatry is involved in training the next generation of clinicians. We are a training site for the Harvard Longwood Residency Training Program, Harvard medical students, psychology, social work, nursing, and occupational therapy students. These trainees are a valued part of our multidisciplinary team and are closely supervised by our experienced providers. We are also increasingly working side-by-side with researchers, and may offer you opportunities to participate in clinical studies. Clinicians who are involved in teaching and research provide you the most evidence-based, state-of-the-art care possible.

Our Psychiatry programs include:

- 2 South - 24 bed locked inpatient psychiatric unit for patients 16 and older.
- 6 North - 8 bed inpatient detox - primarily for alcohol and benzodiazepine withdrawal, co-led with medicine
- Psychiatric Partial Hospital Program
- Consultation Liaison Service
- Outpatient General Psychiatry Clinic
- Outpatient Buprenorphine Practice
- Evening Treatment Group Program for Substance Abuse
- Dual Diagnosis Partial Hospitalization Program
- Vivitrol Clinic

NAMI CEO Pledge

http://ceos.namimass.org/

At Brigham and Women's Hospital and Brigham and Women's Faulkner Hospital, supporting people with health issues – both physical and mental – is at the heart of our mission. That's why we're proud to announce that we've signed the ***CEOs Against Stigma*** pledge to promote the mental health of everyone – patients, families and staff – here at BWH and BWFH.

Mental illness is the single greatest cause of lost productivity at workplaces across the country, largely because people affected by mental illness fear the stigma associated with sharing and seeking help. We're going to take positive steps to create a stigma-free work environment.

Statistics about the prevalence of mental illness are telling: A recent survey conducted by the National Alliance on Mental Illness of Massachusetts (NAMI Mass.) found that one out of every five adults in Massachusetts will experience mental illness this year. Most of these people struggle in silence in their workplace, afraid to disclose the truth. Only 27 percent of survey respondents would advise someone with a mental illness to share their difficulties with a co-worker.

The ***CEOs Against Stigma*** campaign aims to overcome silence and isolation by guaranteeing a positive and effective environment for everyone who works at BWH and BWFH.

For this effort to succeed, we need the help of every employee. Here are some ways you can make a difference:

- Learn the truth about mental illness.
- Visit the NAMI Mass website on CEOs Against Stigma: ceos.namimass.org
- Reach out to co-workers who you suspect might be struggling with mental illness and find ways to listen and help.
- If you encounter mental health issues yourself, please reach out to our Employee Assistance Program. We want to support you.

It's up to all of us to create a mentally healthy work environment. Our pledge is to encourage communication and responsibility—to provide a work environment that is healthy and stigma-free. Let's do it together. Thank you.

Sincerely,

BWHC President Betsy Nabel, MD

BWFH President Michael Gustafson, MD

CEOs AGAINST STIGMA

A NAMI Mass campaign

CEO's Against Stigma

Workplace Pledge

As a ***CEO Against Stigma,*** I am committed to the mental health and wellbeing of everyone who works here. With the assistance of the National Alliance on Mental Illness – Massachusetts (NAMI Mass), I will encourage communication and understanding to foster a stigma-free workplace.

I will **EDUCATE MYSELF** and other top executives within my organization about mental illness and best practices in the workplace. I will show **PERSONAL LEADERSHIP** by sending a memo to all of my employees, stressing the importance of eliminating stigma.

I will bring NAMI **"IN OUR OWN VOICE"** (IOOV) presentations into our workplace to increase further understanding and empathy about mental illness.

I will encourage open dialogue about mental illness among employees to promote a **STIGMA-FREE WORKPLACE** and will provide helpful information for employees and managers so they are better informed.

I will examine employee **HEALTH AND WELFARE BENEFITS** to ensure the availability of effective benefits for mental illness and addiction.

I will make sure any **EMPLOYEE ASSISTANCE PROGRAM** (EAP) is welcoming to all with mental health issues and effective in providing assistance to them.

I agree to participate with NAMI Mass, through linked websites and media awareness, in **EDUCATING THE PUBLIC** about how to move beyond stigma.

Michael Gustafson MD

CEO signature

MICHAEL GUSTAFSON MD

Please print name and company here

OCTOBER 7, 2015

Date

Addiction Recovery Services at BWFH

The Addiction Recovery Program at BWFH offers a comprehensive array of clinical services for individuals seeking recovery from alcohol and other drug addiction. Each patient seeking recovery from alcohol and other drug addiction is different. At the Brigham and Women's Faulkner Hospital Addiction Recovery Program, we recognize every patient as an individual who deserves to be treated with dignity, care and respect.

We believe addiction is a treatable disorder, and that care provided by compassionate professionals in an environment of support and mutual respect heightens patients' self-esteem and promotes medical, emotional, spiritual and social recovery. Our goal is not only to promote abstinence and recovery from chemical dependency and its effects, but also to assist patients in achieving the highest level of human potential. Further, we offer the patient's family and friends' information on how to support the patient and how to care for themselves at the same time.

"The purpose of the kit is to save someone's life, it's not to solve the opioid problem."

-Dr. Luis Lobón, MD, MS
Chief of Emergency Medicine

The program's experienced team of doctors, nurse practitioners and nurses are specially trained in addiction recovery treatment. To aid patients' withdrawal and recovery, the treatment team stays abreast of and applies the latest breakthroughs in addiction medicine. Clinical staff members also provide patients with information about HIV, smoking cessation, nutrition and general health issues.
Our advanced-practice addiction counselors provide patients with a wide range of specific techniques for successful recovery. These techniques can include hypnotherapy, meditation, exercise, cognitive and spiritual approaches to recovery and 12-step and other self-help methods. Counseling staff also educates patients through discussion groups, lectures.

The Outpatient Suboxone Practice for Opioid Addiction is designed to help patients struggling with opioid addiction. Examples of opioids include heroin, percocet, vicodin, oxycodone, oxycontin, morphine, MS Contin, and methadone. The process begins with an initial medical evaluation which is done to determine if patients are appropriate for our suboxone program. Next, a suboxone induction is scheduled. Following a successful suboxone induction, the patient enters into a Weekly Maintenance Group for at least 12-weeks. Weekly groups have a psycho-educational approach aimed to increase safe copings skills to prevent the return to active use. All patients are required to attend a 45 minute group facilitated by an addiction social worker in addition to a weekly suboxone medication management appointment with one of our board certified addiction psychiatrists. Individual therapy is available and highly encouraged for all of the patients in the suboxone practice. Following the completion of the weekly maintenance group, patients transfer into a monthly maintenance group for ongoing addiction education and support while receiving suboxone maintenance therapy.

Nowhere is the opioid crisis more apparent than in the Emergency Department where healthcare providers treat patients for overdose on a daily basis. This is true at Brigham and Women's Faulkner Hospital where patients present in the ED each day with signs of overdose

on opioids or opioids mixed with other substances. In these cases, the goal is not necessarily to help patients treat their addiction, it's to save their life in a time of crisis. Beginning in 2016, a new program at BWFH provides these patients and their families with the tools they need to treat an overdose at home with nasal naloxone in an effort to save a life in the event of a future overdose. Now, when a patient who has overdosed is stable and ready to be discharged from the ED at BWFH, they are offered a nasal naloxone to take home with them.

The kits include educational materials for patients and their families, as well as instructions for use. In less than a month, the program proved to be lifesaving. One of the first patients to go home with a nasal naloxone kit returned to BWFH's ED after being treated at home for another overdose with nasal naloxone. The treatment worked and his life was spared.

In addition to the treatment programs offered at BWFH, there are several recovery and self-help meetings offered on an on-going basis. These groups not only support the patient, but family and friends can participate to assist with a successful recovery.