BRIGHAM AND WOMEN'S HOSPITAL

Introduction

Brigham and Women's Hospital (BWH) has a long-standing commitment to improving the health status of Boston residents, with a focus on Boston neighborhoods with disproportionately poor health and social indicators, and documented need for comprehensive health and social services. In addition to being the regional leader in preeminent women's health services, BWH is also one of the nation's leading transplant centers, performing heart, lung, kidney, and heart-lung transplant surgery, as well as, bone marrow transplantation. BWH is nationally recognized for clinical excellence in cardiology and cardiovascular disease, immunology, arthritis and rheumatic disorders, joint replacement, and cancer care through the Dana-Farber/Brigham and Women's Cancer Center.

Locally, BWH works in collaboration with many community organizations and government agencies to identify and address social determinants of health and to mobilize community resources to improve health status. BWH and its licensed and affiliated health centers provide primary and specialty ambulatory services to culturally diverse groups of people. Through the BWH Center for Community Health and Health Equity, BWH and its health center partners provide a broad array of community service and community health programs, which are designed to have a measurable, positive effect on the health status of underserved populations.

Mission Statement

The BWH Board of Trustees approved the following community benefit mission statement:

> ***Brigham and Women's Hospital (BWH) is committed to serving the health care needs of persons from diverse communities. The hospital, however, makes a unique commitment to the neighboring residents of Jamaica Plain and Mission Hill, who have some of the most pressing health problems in the state. The hospital, along with its two licensed community health centers, is committed to developing integrated care networks to provide and assure appropriate access to high quality, cost-effective primary care to members of these communities regardless of their insurance status. The hospital also commits to meeting the needs of low-income pregnant women and their families from the communities of Roxbury and Dorchester.***
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> ***In order to address the health needs of its target communities, the hospital must look beyond its walls and seek guidance from the community to implement programs that recognize and address the relationships between health and social problems, including economic and educational issues. The hospital is committed to collaborating with community groups and organizations to***

develop comprehensive programs that respond to the needs of the communities, as identified by the communities themselves, and as suggested by public health and other data. The hospital seeks to improve the health status of residents of the communities by offering health services, continuing and expanding innovative community and school-based programs, and by serving as a resource to the community as a liaison to health careers education and as a possible employer of community residents.

Internal Structure of Community Benefit Programs

The Center for Community Health and Health Equity (CCHHE) at Brigham and Women's Hospital serves as the coordinating department for community health programs and acts as a liaison for community-based organizations and the hospital. First established in 1991, as the Center for Perinatal and Family Health, the CCHHE expanded its focus beyond the needs of pregnant women and changed its name to the Office for Women, Family and Community Programs in 1997. In 2007, the focus expanded once again to explicitly encompass programs that address health disparities, and the name was consequently changed to the Center for Community Health and Health Equity. In FY2008, Health Equity continues to be the key unifying focus of the Center's work and community partnerships.

The mission of the CCHHE is to advance systems of care and community health strategies to eliminate health disparities and elevate the health status of the communities served by BWH. The CCHHE collaborates with hospital departments, including clinical and research areas, and works in partnership with external organizations and community-based groups in addressing the social determinants of individual and community health, including efforts to increase access to equitable health care for all patients throughout the Brigham and Women's /Faulkner Hospitals (BW/F) regardless of ability to pay, and to create an institutional environment that is inclusive and reflects the racial and ethnic identities of communities served.

BWH community health programs focus on improving health equity by addressing the social factors that influence health, such as:

- Fostering social and family support systems
- Enhancing educational and career opportunities
- Improving knowledge of healthy behaviors
- Working with individuals who are victims of domestic violence
- Addressing health care disparities in infant mortality, cardiovascular disease, and cancer
- Providing comprehensive care for women
- Mitigating asthma triggers in schools and in homes
- Through the BWH Division of Social Medicine and Health Inequalities, improving outcomes for underserved individuals with HIV

The hospital, its health centers, and the CCHHE are dedicated to working with community residents and organizations to meet the needs of racially and ethnically diverse and underserved populations, through programs intended to break down barriers to accessing quality, affordable health care and social services. To ensure progress in meeting established goals, the CCHHE develops evaluation plans and regularly collects data on its community health programs. Those data are used to determine program effectiveness and to inform program planning and decision-making. They enable the CCHHE to make accurate assessments of strengths and accomplishments, and to identify opportunities to enhance existing services. Financial support for the CCHHE and its programs comes from many sources, including BWH and Partners, foundation grants, individual donors, and government agencies.

Health Equity Programs

The CCHHE Health Equity programs promote the Brigham and Women's Hospital mission to deliver high quality and equitable care while addressing the social determinants of individual and community health. These programs stem from collaboration with BWH physician, nursing, and administrative leadership to develop targeted strategies for improving care and health outcomes for diverse patient populations in primary care, subspecialties, and the BWH's five centers of excellence in cardiovascular care, cancer treatment, neurosciences, orthopedics and arthritis, and Women's Health.

In 2008, BWH formed the Health Equity Oversight Committee, which comprises BWH physician, administrative, and Board of Trustees leadership, and counsels Brigham and Women's/Faulkner Hospitals and the Center for Community Health and Health Equity toward achievement of the goal of developing multidisciplinary, collaborative approaches to promoting health equity through the elimination of racial and ethnic disparities in health outcomes. The Committee provides strategic direction and oversight of the planning and implementation of the BW/F's efforts to eliminate health disparities through the development of comprehensive interventions that combine research, education and teaching, community outreach and information dissemination.

Health Equity Oversight Committee Charge

- Evaluate the strategy of the BW/F to address the elimination of health care disparities for patients and communities in the Hospital's target service area and ensure integration with the BW/F clinical priorities
- Provide a forum for review and root cause analysis of events or actions affecting diverse patient populations and reviews the BW/F's efforts to ensure the delivery of culturally competent care to all patients
- Evaluate institutional, department and programmatic priorities focused on the provision of culturally competent care
- Review performance relative to the strategic plan and reports progress to the Boards of Trustees

The Brigham and Women's/Faulkner Hospitals use the framework of the Balanced Scorecard to measure organizational effectiveness. In January 2007, the Brigham began collecting data on the race/ethnicity and socioeconomic status of patients, expanding Balanced Scorecard data by these important elements. The CCHHE assists in monitoring Balanced Scorecard measures to develop performance improvement efforts to eliminate observed disparities. The CCHHE also works in collaboration with community-based organizations, community health centers, and government agencies to identify and address barriers to access, and to mobilize community resources to improve health status. The CCHHE is committed to advancing an evidenced-based approach to improving individual and community health status.

The goals of the Health Equity programs are:

- To provide patients, especially those at risk for disparities, access to the highest quality care regardless of ability to pay
- To provide equitable health care to all patients throughout the BW/F system regardless of ability to pay
- To create an institutional environment that is inclusive and reflects the racial and ethnic identities of the communities served
- To elevate the community health agenda as a key priority of BW/F clinical care, teaching, and research mission

City and Statewide Programs

Efforts to Improve the Health of Women

BWH is the state's largest birthing hospital, and plays a unique role in developing and implementing innovative women's health programs. Women's health is viewed as more than a service of primary, obstetric, and chronic care for women's reproductive and other problems. It is also seen as a way to ensure healthy families and thus healthy communities.

Women from low-income neighborhoods who are disadvantaged by their educational status, language, employment, economic status, immigrant status, race, or other personal characteristics face significant barriers to maintaining their health and that of their families. Promoting programs that improve the health of women across the lifespan through health, social support, educational opportunities, and employment reduces these barriers and helps women to care for themselves and their families.

The overall vision for BWH's community health initiatives is driven by a desire to equalize health status and opportunity among underserved populations including women and their families. Concerned about alarming disparities in health among Boston's core urban population, the Center for Community Health and Health Equity's community health initiatives have focused on these populations. Higher infant mortality and low birth weight rates for Black infants, lower rates of adequate prenatal care for Black and Latina women, higher rates of breast and cervical cancer among Black women, higher percentages of Black and Latina adolescents who become mothers, and the impact these

health concerns have on the health of families and children are among the health disparities driving the CCHHE's community benefit focus.

Perinatal Case Manager Program

Established in 1991 as a response to the high infant mortality and low birth weight rates in certain Boston neighborhoods, the Perinatal Case Manager Program (PCMP) seeks to prevent infant deaths and poor birth outcomes by addressing the social and medical needs of pregnant women. The CCHHE provides technical assistance and training for case managers at each of six of the hospital's licensed or affiliated health centers: Brookside Community Health Center, Martha Eliot Health Center, Mattapan Community Health Center, Southern Jamaica Plain Health Center, South End Community Health Center, and Whittier Street Health Center.

Program Components. The case managers provide a variety of services to pregnant women, including:

- Assessment of patients' needs
- Supportive referrals to appropriate social services
- Coordination of patient care with other health center and hospital providers
- Assistance in overcoming barriers to accessing health care and social services
- Education about the need for preventive care and healthy behaviors
- Financial assistance to help patients pay for essential items such as rent, utilities, groceries, layettes, and cribs

Continuing the partnership with Isis Maternity, the PCMP provided childbirth education classes at Southern Jamaica Plain Health Center and the South End Community Health Center. The classes were offered at each health center every other month in English and Spanish, based upon patient attendance. These classes were expanded from a two session class to a six week childbirth preparation series beginning in the late third trimester. The course provided information on nutrition, infant feeding, labor, delivery and postpartum care of the mother and infant. Future plans include expansion of current patient education classes to additional health centers.

To address the impact that lack of transportation can have on the ability of pregnant patients to access adequate prenatal care, CCHHE has developed the Perinatal Transportation Assistance Program (P-TAP). P-TAP provides cost-effective and reliable transportation to pregnant and postpartum women to assist them in getting to and from their perinatal appointments by providing access to MBTA Charlie Cards and/or taxi vouchers to eligible patients. In addition to the six health centers served by the PCMP, four additional health centers affiliated with Brigham and Women's Hospital have access to this resource. Codman Square Health Center, Dorchester House Multi-Service Center, Neponset Health Center, and Uphams Corner Health Centers have formed new relationships with the CCHHE which will provide additional resources to their patients.

During FY2009, the PCMP will undergo its most comprehensive evaluation in over a decade. The evaluation, taking place over several phases, will consist of staff surveys,

key informant interviews, chart review and client focus groups. The Phase I goals of the evaluation include:

- Define and clarify the scope of the Perinatal Case Management Program
- Determine the roles of the Perinatal Case Managers at each of the six health centers
- Assess the accessibility and availability of resources, both internal and external, to case managers to meet the complex needs of PCMP clients

Patient Demographics. During FY2008, the PCMP provided services to 1,172 patients at the six participating health centers. Forty-nine percent of the patients had more than one visit with the case managers. The average number of case manager visits per patient was three. Sixty-seven percent of the patients were newly referred to the PCMP. Eighty-six percent of the patients visited the case managers at the health centers, and two percent of PCMP clients received home visits from the case managers. The majority (67 percent) of patients were Latina, with 20 percent Black, four percent White, three percent Haitian, three percent other, and two percent race/ethnicity not recorded. Forty-nine percent of the patients had MassHealth as their insurance, while the remaining insurers for clients were Neighborhood Health Plan and Healthy Start.

Infant Car Seat Program. The Perinatal Case Manager Program offers an Infant Car Seat program to ensure that any woman who delivers at Brigham and Women's Hospital and who is unable to afford an infant car seat will receive one. Eligible patients must attend a one-hour group training session, which is scheduled a minimum of two times per month, prior to receiving a car seat. Each training session covers the basics of car seat safety, selection of an appropriate seat, and local resources for proper car seat installation. Patients are asked to pay a nominal fee for the seat; however, this fee is waived if patients are unable to pay. During FY2008, 48 women attended the car seat trainings, and 47 of them received an infant car seat.

To ensure the highest standard of care, the PCMP case managers attend workshops throughout the year to stay informed about issues affecting pregnant women. In FY2008, the case managers attended the Massachusetts Law Reform Institute Basic Benefits Training Series, March of Dimes Prematurity Symposium, and the Partners in Perinatal Health Annual Conference. This year, one of the case managers participated in a ten-week Maternal Mental Health Course offered through the Infant Parent Training Institute at Jewish Family and Children's Service. This course examines the influence of maternal mental health and the impact of mental health issues on the parent child relationship. Information from the training will be shared with the other case managers with particular emphasis on incorporating this topic in future staff trainings.

Connecting Hope, Assistance, and Treatment (CHAT) Program

The Connecting Hope, Assistance, and Treatment (CHAT) program helps women with breast cancer that have insufficient income or insurance coverage to pay for necessary services related to their breast cancer diagnosis. Eligible women may receive up to $1,200 per calendar year to help defray the cost of medication, breast prostheses, bras, wigs, compression sleeves, transportation to treatment, childcare during treatment, denture replacement (if due to bone loss resulting from chemotherapy), dressing changes

in a hospice, counseling, and other breast cancer-related expenses. Women who are residents of Massachusetts and who have an individual annual income of $25,000 or less, or a total family annual income of $42,000 or less are eligible for assistance.

In the absence of the CHAT program, many participating women would have to choose between paying for items related to their breast cancer treatment and paying for rent, utilities, food, and other basic necessities. Additionally, many of the women in the program travel long distances to get to their treatment in the Boston area, often relying on family and friends for transportation because they are unable to drive after surgery or chemotherapy treatment. The CHAT program provides transportation assistance to patients through cab vouchers. Many women have limited private health insurance, which may not cover, or may cover only partially, the cost of counseling. CHAT resources provide additional coverage for these services. Although the CHAT program targets low-income women, many do not qualify for MassHealth. Medications such as Tamoxifen are expensive and are often not the only medication women are taking for treatment. Additionally, some insurance companies do not cover the cost of other similar medications such as Femara or Arimidex. The CHAT program works with women to identify other sources of payment.

CHAT works closely with vendors such as Lady Grace, the Dana-Farber Friends Boutique, Brooks Pharmacy, New England Medical Fitting, and Women's Health Solutions. As a result of these collaborations, the program is able to refer women to vendors for services. In return, vendors distribute information about the program through newsletters and by displaying applications and a program description at their sites. CHAT also works with providers such as social workers, cancer program patient navigators, resource specialists, and nurses.

Since its inception in FY2001, the CHAT program has provided assistance to 431 women who reside in 135 cities and towns within Massachusetts. In FY2008, the program provided assistance to 131 women, and a total of $42,938 was disbursed. The majority of requests were for transportation (31 percent), compression sleeves (27 percent), and breast prostheses and bras (19 percent). In addition, 15 percent of CHAT clients requested assistance with the purchase of wigs, 11 percent with medication, and one percent with psychological counseling. Nine percent of CHAT participants requested assistance with other items related to their breast cancer treatment such as, bandaging, lymph drainage, and acupuncture to alleviate the side effects of chemotherapy.

Sixty-one women submitted more than one request for assistance. The average age of women who submitted a request was 56 years. The average annual individual income of applicants was $8,318 and the average annual family income was $16,840. Seventy percent of the women served reside in the Greater Boston area, 31 percent in Eastern Massachusetts, 17 percent on Cape Cod, and nine percent in Central and Western Massachusetts. CHAT serves a diverse group of women. Of the 431 women who have received assistance from CHAT to date, 53 are non-English speakers. These non-English speaking women speak Spanish, Haitian Creole, Chinese, Portuguese, Russian, Albanian, Arabic, and Armenian.

To raise community awareness about the CHAT program, outreach is conducted over the Internet, via hotlines, at community events, with vendors, in local and national resource guides, at support groups, and in community health centers, hospitals, and churches. Referrals come from either providers or from patients themselves.

In FY2008, referrals to the program came from 21 sites across the state including hospitals, health centers, medical practices, social service organizations, and vendors providing cancer and mastectomy related services. Relationships have been formed with several support groups serving minority low income women with breast cancer in order to provide them with breast cancer related resources. CHAT Program staff work in collaboration with the Massachusetts Affiliate of Susan G. Komen for the Cure to raise awareness about the CHAT program and participates regularly with CHAT program participants at special events such as the Susan G. Komen Race for the Cure.

Dana Farber/Brigham and Women's Cancer Center Patient Navigation Program

The Patient Navigator program is part a strategic initiative to reduce health care disparities among diverse populations. The program was established to address the needs of a target population of women, at risk for, or diagnosed with breast or cervical cancer, who may enter the care system through either the Dana Farber or Brigham and Women's Hospital.

The goal of the program is to provide access and identify resources for women from diverse backgrounds, whose socio-economic status, limited English proficiency, disability status, or insurance status may be a potential barrier to care. The program, which began in May 2005, offers two patient navigators, bilingual in Spanish, who assist this patient population by identifying and accessing resources for them, providing education about the importance of follow-up care, and offering support through a continuum of health care.

Since the program's inception, the patient navigators have worked with over 527 patients. The patients referred to the program are thought to be at high risk for not remaining within the health care system for a variety of reasons. The patient navigators provide culturally competent support to their patients, educational information, and assist with identifying resources in order to promote the patient's continued access and connection to the health care system.

Women in Action Taking Charge of Their Health (WATCH) Program

The WATCH program provides culturally and linguistically appropriate workshops on breast cancer education for immigrant women from a variety of countries. Bilingual peer health educators facilitate the one-hour workshops, which are held at churches and other community-based organizations.

To train the peer health educators, the CCHHE compiled a breast cancer peer health education manual. The manual covers the roles and skills of a peer health educator, the concept of prevention, the components of breast health, risk factors for breast cancer, basic information about breast cancer, mammography, and the importance of talking with your doctor and getting regular screenings. The manual also contains a variety of workshop exercises and handouts, which have been translated into several languages. The manual and the workshop exercises are suitable for diverse learning styles and are designed for both non-English speaking and English-speaking women with limited literacy skills.

Prevention and Access to Care and Treatment (PACT) Project

The Division of Global Health Equity (previously known as the Division of Social Medicine and Health Inequalities) at Brigham and Women's Hospital is a pioneering initiative in health care that addresses health disparities in resource-poor communities through training, education, research, and service. Founded in 2001, the Division's mission is to reduce disparities in disease burden and to improve treatment outcomes both at home and abroad. It focuses on infectious diseases (including HIV and tuberculosis) and on non-infectious diseases (including coronary artery disease, diabetes, and addiction) and other health problems of major importance to society.

The Division trains doctors and other health care professionals who work both locally and globally, combining their practical experience with research interests to develop new and replicable medical intervention models that advance medical practice and standards of care. The Division functions in close collaboration with the Department of Social Medicine at Harvard Medical School and in partnership with Partners In Health, a non-profit corporation that has developed and implemented a unique health care model which combines social justice and medicine. All three organizations work with community-based groups to foster active local involvement in the planning of efforts to maintain health, particularly in resource-poor communities.

The Prevention and Access to Care and Treatment (PACT) project, a community-based project in urban Boston, is committed to improving health outcomes for underserved individuals with HIV disease. PACT is a joint project of the Division of Global Health Equity at the Brigham and Women's Hospital and Partners In Health.

PACT was founded in response to the growing incidence of HIV among young Black women in the disadvantaged neighborhoods of Roxbury, Mattapan, Hyde Park, and Dorchester, as reported in a 1997 Boston Globe article. In addition, statistics showed that a Black woman living with HIV in Roxbury had a mortality rate 15 times higher than the average White man with HIV in Boston. Alarmed, a group of community residents in the Roxbury area approached Partners In Health (PIH) for help in creating a community-based program to prevent transmission of HIV and improve access to quality services for those already infected with the virus. With funding from the Office of Minority Health, the PACT Project was born.

PIH recruited and trained the first band of the PACT project's community health promoters (CHPs) from the corps of concerned citizens. These community residents, none of whom possessed any medical expertise, were enlisted, trained, and mobilized to become street-based advocates. Drawing on their acquired medical knowledge and their first hand experience as community members, PACT's CHPs have effectively accompanied PACT participants while navigating the complex maze of social and health resources to find solutions to both the physical and social ills of marginalized populations living with HIV/AIDS. PACT health promoters are also trained to deliver a home-based educational intervention. By being welcomed into patients' homes, the health promoters are able to better understand a patient's natural environment. The insights gained and methods of the PACT health promoters in engaging "challenging" patient populations have been extremely effective and instructive to the physicians and students of the PACT project, thereby, creating an open and mutually rewarding learning community. Over the past ten years, PACT has continued to grow and, in collaboration with other agencies and health clinics, has served over 375 HIV-positive individuals from across the city.

The PACT Health Promotion program relies on trained CHPs to improve marginalized HIV patients' access to, and utilization of health and social resources. CHPs engage patients in health promotion and harm reduction activities, including improved medication adherence, increased use of preventive medical services, reduced emergency room visits and hospitalizations, safer and reduced drug use, and increased condom use.

Participants receive services according to three tiers of varying intensity: once monthly, once weekly, or once daily health promotion services. Patients can move between tiers depending on their needs and clinical status. The directly observed therapy (DOT) initiative is the most intensive program and employs DOT specialists to visit ill and non-adherent patients on a daily basis in order to assist them – and observe them – in taking their life-saving HIV regimen. This program is unique in the country and is a central part of a community-based HIV disease management model that is growing in reputation.

Because treatment and prevention are inextricably linked, PACT also houses an HIV and substance use harm reduction program. The Fuerza Latina program, funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a social recovery, leadership development, and community-organizing program designed to address the personal experiences and social context of impoverished Latino men with a history of alcohol and drug abuse. Through Fuerza, these men are trained as peer prevention leaders and conduct HIV and substance abuse prevention activities to reduce drug-related harm in their communities. In 2004, this model was expanded to include Latina women in early recovery from injection drug use, as well as, inner city youth. In 2007, the Fuerza Latina program was integrated into PACT's Health Promotion program to improve harm reduction and drug prevention services to the patients PACT serves.

Goals of the Program. PACT's comprehensive community-based programming aims to achieve three primary goals:

1. To provide harm reduction training and materials, prevention case management, and peer prevention services to high-risk and HIV-positive individuals, including substance abusers and young women

2. To increase access to and utilization of culturally-relevant and respectful health care and social services for those infected with HIV
3. To expand the success of its Health Promotion program by partnering with organizations serving high-risk and HIV-positive individuals that can replicate health promotion services and make the PACT model available to as many individuals as possible

Community-Based Program Components

- ***Health Promotion.*** HIV/AIDS patients in urban areas struggle to obtain consistent access to necessary health care and social services because of complicated institutional structures and a lack of coordinated efforts between agencies. PACT health promoters build personal relationships with HIV/AIDS patients to help them navigate this disjointed system and achieve better physical health and mental well-being. Health promoters visit patients weekly and accompany them to medical and social service appointments. They educate patients about HIV and antiretroviral therapy, provide social support, and collaborate with other agencies to connect patients to existing resources. Health promoters are a critical link between patients and the resources they need to be healthy and contributing members of society.
- ***Directly Observed Therapy***. Some patients are chronically non-adherent to HIV medication due to overwhelming personal and social obstacles and extreme HIV/AIDS-related illness. PACT is the only program in the country to offer these individuals its unique brand of home-based directly observed therapy (DOT) of HIV medications. Patients who receive DOT continue working with their health promoter but are also assigned a DOT specialist who visits their home each day to observe and support them during their pill-taking routine, a complex regimen requiring timeliness and precision in the management of multiple and changing dosages. DOT specialists provide guidance and instruction to prepare patients to eventually self-administer their medicine. PACT clients may move between the health promotion and DOT programs as their adherence to medication, health status, and social and psychological circumstances change.
- ***Harm Reduction.*** The Fuerza Latina program continues to operate. A Harm Reduction Coordinator, two Peer Prevention Leaders, and volunteers from Harvard Medical School and College, conduct street outreach in the Boston area. This team provides one-on-one education to injection drug users and commercial sex workers, enabling them to reduce their risks of HIV infection and other drug-related harm.
- ***Research and Evaluation***. The goals of PACT's programs are to improve the health and quality of life of participants while reducing high-risk behavior and medical costs associated with illness and poor health care. Quantitative data is being collected through questionnaires that assess access to care barriers, mental health, risk behaviors, self-efficacy, and overall program satisfaction. Medical chart reviews and physician reports help track outcomes such as recent opportunistic infections, CD4 and viral load counts, emergency room visits, and hospitalization rates.

  Qualitative data is being collected through focus groups, interviews, and participant observation. These help instruct the design and implementation of responsive and effective interventions, as well as, shed light on the barriers that the poor and

marginalized face in achieving good outcomes. Patient parameters prior to and after entry into health promotion and DOT programs are compared in order to assess change over time.

In the prevention program, relapse rates, outreach data (e.g., number of condoms and bleach kits distributed in the community), and the impact of community mobilization efforts are being tracked. These data are compared against similar programs in the country.

PACT Outcomes

Patient Care

Over the course of the year, six Health Promoters and three and a half Directly Observed Therapy Specialists cared for an average monthly caseload of 90 patients. In 2008, PACT enrolled a total of 24 new patients into the Health Promotion program and discharged 31 from care. Currently, 89 patients are receiving standard health promotion services, and 21 are receiving directly observed therapy. PACT is in the process of increasing capacity by training and hiring new CHPs and increasing patient enrollment.

Patients continued to demonstrate significant improvements in their management of HIV, as demonstrated by decreases in viral load and increases in CD4 counts. Over the course of 12 months in the program, patients' viral load (which quantifies the amount of HIV in the bloodstream) decreased by an average of 58 percent and their CD4 count increased by 66 percent. (CD4 count is a measure of immune system strength: CD4 count <200 cells defines AIDS. Healthy CD4 counts range from 600-1,500 cells.)

In late 2005, PACT received one of the inaugural grants of the Blue Cross Blue Shield Foundation of Massachusetts's initiative, Closing the Gap on Racial and Ethnic Health Care Disparities. Through this three-year grant from BCBSMA, PACT partnered with the infectious disease (ID) clinic at Brigham and Women's Hospital to implement a program designed to reduce racial and ethnic disparities in access to and benefits from HIV/AIDS treatment. One major activity is working with the ID physicians at BWH, who care for over 500 HIV-positive patients each year, on delivering culturally competent care that meets the needs of the marginalized HIV patient population.

Dissemination and Replication of the PACT Model of Care

Over the years, a strong focus on robust data collection and constant quality improvement measures have resulted in a sophisticated intervention that PACT has been working to package as a replicable model that can be implemented in diverse sites across the country. Cities and communities are increasingly interested in the community health worker model and have asked PACT for tools and technical assistance to replicate the PACT model for HIV care among poor and underserved patients. PACT has demonstrated its commitment to disseminating the knowledge gained and materials created throughout the development of the current PACT model through the creation of the new Replication and Adaptation team. Dr. Heidi Behforouz and the Replication and

Adaptation team have been working with the New York Department of Health and Mental Hygiene to adapt the PACT model for HIV care in New York City. Since 2007, when the PACT model was piloted at Lincoln Hospital in the Bronx, two more sites in New York City, the Institute of Family Health and Roosevelt Health Center, have also been building capacity to launch a PACT-like community health worker program. PACT has also partnered with the University of Miami in launching a replication site at Jackson Memorial Hospital in Miami, Florida, in early 2008.

PACT also collaborates with local partners, such as the Boston Health Care for the Homeless Project, AIDS Action Committee of Massachusetts, and Codman Square Health Center to expand its Health Promotion model to the patients that those organizations serve. PACT has worked with its partners to tailor the intervention to the specific needs of the population it is serving.

Furthermore, PACT believes that its Health Promotion program has enormous potential to support any patient struggling to access the health care system and sustain good health. PACT is working to adapt its Health Promotion program for the care of people living with a number of chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, asthma, and emphysema. Of these new disease initiatives, PACT's diabetes project is in the most advanced stage of development. PACT has long recognized that diabetes is yet another chronic disease disproportionately burdening poor and minority communities across the United States. In collaboration with Codman Square Health Center and DotWell, two community health organizations in Dorchester, PACT is integrating its Health Promotion program into their existing diabetes program.

PACT-DotWell Diabetes Initiative

In the city of Boston, diabetes-related deaths increased ten percent between 1999 and 2003 (Boston Public Health Commission, 2005). Within the city, Mattapan, Dorchester, and Roxbury are among the top four neighborhoods for diabetes related deaths (Massachusetts Department of Public Health, 2006). The increasing prevalence of diabetes as a major health concern has gained the attention of DotWell's care providers. The PACT-DotWell Diabetes Initiative has been implemented in response to these concerns, with the ultimate goal of adapting PACT's successful community health worker (CHW)-led HIV health promotion model to diabetes care.

This collaboration will address the needs of the highest-risk diabetic patients of Codman Square Health Center and Dorchester House Multi-Service Center. These patients constitute between 10-15 percent of DotWell's diabetic population and represent those patients who are having difficulty engaging with their health care providers, poorly adhering to their diets and medications, and suffering from macro- and micro-vascular complications associated with poorly-controlled diabetes.

PACT has concluded the planning period for the PACT-DotWell Diabetes initiative at the Codman Square Health Center. The project is currently in a pre-pilot period during

which curricular, program, and evaluation materials and instruments are being developed and tested. Through the testing of these materials the intervention will be refined. Three community health workers will be hired and trained to deliver the intervention, which is scheduled to begin in July of 2009. In the pilot 180 patients meeting high-risk criteria such as elevated blood glucose, the presence of additional cardiovascular risks, and disengagement from the existing care system, will be enrolled into the study. 90 of these patients will be randomly selected to receive the home-based, health promotion intervention with a CHW, and 90 of these patients will be randomly selected to participate in the control group. In addition to the home-based intervention, PACT is also working with the Codman Square Health Center to improve its clinical practice through the use of standardized treatment algorithms, and improved group activities and educational programming. At the end of the year-long intervention and again at the six-month follow-up, outcomes within the two groups, including blood markers, health care utilization patterns, and medication adherence rates, will be analyzed and compared. If the CHW intervention is deemed successful, it will be integrated into DotWell clinics system-wide and offered to other clinics and hospitals for replication.

The PACT-DotWell Diabetes Initiative is not only intended to positively affect health outcomes for participants receiving the intervention, but will also contribute to both DotWell's larger diabetes initiative and the existing body of literature on interventions for diabetes management in high-risk patients.

Jamaica Plain

Boston Asthma Initiative (BAI)

In 1997, the Jamaica Plain community identified asthma and related environmental issues as problems in their community. To address these problems, residents of Jamaica Plain, representatives from community-based organizations, and representatives from Brigham and Women's Hospital, Children's Hospital, and Faulkner Hospital collaborated to develop the Boston Asthma Initiative (BAI).

From the inception of the program, the BAI has sought to address asthma in the schools and in homes, while examining access to and quality of health care for children and adults living with asthma. In recent years, the program has expanded its services to other Boston communities neighboring Jamaica Plain, including Dorchester, Mattapan, and Roxbury. The BAI is a program of Ensuring Stability through Action in Our Community (ESAC), a non-profit organization that serves low- and moderate-income homeowners and promotes stable, integrated neighborhoods. Brigham and Women's Hospital's Center for Community Health and Health Equity provides financial support to the ESAC for the asthma program.

The goals of the BAI are to:

- Identify school children and other household members with asthma and increase their understanding of asthma management

- Identify and address environmental issues contributing to asthma in schools and households
- Increase access to quality health care for asthma treatment and management
- Increase awareness of asthma as a community health problem

The BAI targets:

- Boston elementary school children
- Household members of children with asthma
- Parents, teachers, and school administrators in Boston elementary schools
- Asthma care providers
- Communities impacted by asthma

The Boston Asthma Initiative provides bilingual asthma education services to children and families living with asthma. Services include: home visits, classroom education, assistance to schools in identifying and addressing environmental concerns, public health education, resource guides, and referrals to housing, environmental, and legal agencies.

All of these services are provided free of charge in a culturally competent manner to people living in Jamaica Plain and in the surrounding communities of Dorchester, Mattapan, and Roxbury. These neighborhoods have been identified as having the highest rates of asthma in Boston, disproportionately affecting minorities and children living in these urban environments. The BAI maintains strong ties with community partners (such as the Boston Public Health Commission, Massachusetts Coalition for Occupational Safety and Health (MassCOSH), and the Community Asthma Initiative), health centers, and the Boston Public Schools to sustain a comprehensive health network for children and families living with asthma.

The BAI works across all sectors of a child's life, including the school, home, health center, and community to link services to improve asthma management for all of the families it serves. With a strong emphasis on preventive care, BAI provides families with the knowledge and skills to better manage their child's asthma and to avoid unnecessary and costly trips to the emergency room. BAI does this by increasing families' knowledge of asthma and by empowering them with tools for advocacy and health care decision making.

Home Visiting

The BAI conducts home visits during which clients learn how to reduce or eliminate asthma triggers. Topics covered during home visits include asthma physiology and treatment and medication management. An environmental assessment of the home is also conducted, and information is provided on the role of dust, pets, carpeting, pests, mold and mildew, cigarette smoking, overcrowding, overheating, strong odors, and poor housing in contributing to asthma. During FY2008, the BAI received 206 referrals and conducted 158 home visits.

School Programs

Open Airways for Schools. One of BAI's school-based initiatives is the Open Airways for Schools asthma curriculum developed by the American Lung Association. The curriculum is multicultural and targeted at third through fifth graders. The components of this curriculum include a review of medications, asthma management, physical activity, and asthma trigger modification. The "Open Airways" school program was held in the spring. There were a total of 60 participants in the winter/spring sessions held at the Hennigan Elementary School. Earlier in the year the program was conducted at Trotter School serving 55 students for an annual total of 115 children served during the year.

Environmental committees serviced by BAI staff were maintained in the Hennigan, Trotter, Curley Middle, and Curley Elementary schools. These committees work to identify the environmental triggers for asthma that are present in the school and to create a plan for action and remediation of the triggers.

Boston Asthma Swim Program. In collaboration with the Boston Public Health Commission (BPHC), the BAI provides the Boston Asthma Swim program. Boston Asthma Swim is a curriculum developed by the BPHC that combines swimming with asthma education. During FY2008, two sessions of the Boston Asthma Swim program were held.

Beyond Boston

Indian Health Service

The BWH Physicians' Council, through its Brigham and Women's Outreach Programs (BWOP), is committed to supporting BWH physicians in contributing their skills and time through volunteerism. The goals of the Outreach Program include the development of a program that enables BWH physicians to directly support and enhance patient care delivered at a selected program site, while providing a sustainable, ongoing contribution to supporting an underserved community.

In April of 2008, the BWH Physicians' Council selected the Indian Health Service (IHS) as the site for its outreach program. The significant needs of the IHS underserved community, its location within the United States, and its existing strong ties with BWH all support the goals of developing a successful and sustainable program. Selection of this site followed a competitive application process that included over ten impressive organizations around the world.

The program focuses on creating volunteer opportunities for BWH physicians at the IHS hospitals in Gallup and Shiprock, New Mexico. Gallup is an urban setting and the IHS hospital there offers a wide range of specialized care. The hospital in Shiprock is in a rural setting on the Navajo reservation. Both the 55-bed facility at Shiprock and the 99-bed hospital at Gallup have adequate equipment, medication and supplies, but they are challenged by a shortage of staffing. The Indian Health Service reports a nearly 15

percent vacancy rate in essential clinical positions. The Brigham and Women's Outreach Program physician volunteers are helping alleviate this challenge. BWH physicians have the opportunity to work at these facilities for a minimum of one to two weeks. Ideally, they travel as a group from BWH, providing teaching and patient care with the aim to provide support that contributes to infrastructure and clinical expertise of the IHS. Dr. Phyllis Jen, a senior physician at BWH, leads this effort.

Mission Hill Community Activities

Mission Hill Main Streets (MHMS)

BWH serves as the "corporate buddy" for Mission Hill Main Streets (MHMS). BWH holds a seat on the board of directors of MHMS and in FY2000 made a four-year commitment to provide $10,000 annually. That commitment was extended for two years in FY2004 and the annual contribution was increased to $15,000. In addition to this financial support, the partnership also assists MHMS by providing technical assistance, contributions to support a range of community projects, and promotional support for the organization's activities, as well as, meeting any other responsibilities of being a "corporate buddy." In FY2007, BWH again extended its financial commitment to MHMS for another two years. This extension brings BWH's total financial contribution to $100,000, making the BWH the largest non-profit contributor to any of the city's 16 Main Streets organizations.

Mission Hill/Fenway Food Project

As a founding member of this collaboration in 1984, BWH sponsors biannual canned food drives that benefit the emergency food pantry at the Parker Hill/Fenway ABCD office. In 2008, the 'Spring for a Can' drive netted over 1,000 pounds of canned/dry goods to benefit the neighborhood emergency food pantry.

Mission Hill Youth Collaborative

Mission Hill Youth Collaborative brings together a group of organizations and community groups located in and serving young people in Mission Hill. BWH, as an original member of this group, is committed to working with this collaborative to plan and develop job training opportunities for the youth of Mission Hill, in addition to establishing a seamless network of shared information and programs among those agencies serving youth. BWH has made monetary contributions totaling approximately $60,000 to this organization for the past six years.

Other Mission Hill Support

BWH continues to support programs for the young and old of the Mission Hill neighborhood. The hospital provides annual contributions to support the Mission Hill Little League. It also supports City Councilor Mike Ross's annual softball league, which draws participants who range in age from 16 to 21 years old. In addition to providing

recreation and exercise, the softball games provide an opportunity to offer information on job assistance and health care services.

For the past 20 years, BWH has maintained a discount meals program for Mission Hill seniors. This program allows neighborhood seniors a full meal one Sunday a month in the hospital cafeteria. Additionally, BWH provides a free flu vaccine program for Mission Park residents. This program has been offered for the last 18 years. In May, 2008, the CCHHE coordinated four community based, cardiovascular screening clinics, in conjunction with the opening of the Shapiro Center at 70 Francis St. These screenings combined to evaluate approximately 140 Mission Hill residents for cardiovascular risk.

BWH provides contributions, both financial and in-kind, to many other Mission Hill groups, including Mission Main Tenants Task Force, Roxbury Tenants of Harvard, Mission Main Crime Committee, the Alice Taylor Tenants Task Force, and the Community Alliance of Mission Hill. BWH also pays the bus transportation costs for all of the Mission Grammar School field trips throughout the academic year. In 2008, BWH helped sponsor the fourth annual Mission Hill Road Race, which is hosted by Mission Hill Neighborhood Housing Services and for the thirteenth year in a row, BWH, working with the Mayor's Office of Neighborhood Services, supported the annual Mission Hill Christmas tree lighting ceremony.

The BW/F family provided significant support to the Parker Hill/Fenway ABCD in 2008. Our department of Neurosurgery donated $2,500 to help Parker Hill/Fenway ABCD obtain toys and other Christmas gifts for needy families in the Mission Hill area. In addition, BWH provided full dinners for 50 Mission Hill families and our Physician's Organization donated $5,000 to aid low-income families of the Mission Hill area.

In 2008, for the fourth year in a row, BWH contributed $10,000 to the Parker Hill/Fenway ABCD for their annual Summer Works program. These funds allow ABCD to hire ten additional neighborhood youth for summer employment. In addition, BWH provides ten summer job positions to both Roxbury Tenants of Harvard and to Parker Hill/Fenway ABCD (five to each organization). These ten slots allow the hiring of Mission Hill youth to various jobs at BWH.

Youth Programs and School Partnerships

Citywide

Student Success Jobs Program

In response to many of the issues identified through a comprehensive needs assessment, BWH launched the Student Success Jobs Program (SSJP) in 2000. SSJP is an after-school and summer work achievement program that provides internships to underserved students from seven Boston public high schools in Mission Hill, Roxbury and other Boston neighborhoods. SSJP matches students with a mentor within the medical field, provides them with hands-on work experience in the hospital, and enhances their interest

in higher education in health fields. In the summer, the students also may participate in six-week internships in the hospital. SSJP students have a unique opportunity to take part in an innovative learning initiative that establishes tangible links between work and school.

The goals of SSJP are to enable participating students:

- To address the need for proficient and traditionally under-represented populations in health, science, and medical careers
- To enhance high school students' interest in health careers through mentorship by health care professionals
- To support academic progress and post secondary education of participating Boston public school students
- To foster networking opportunities for emerging and under-represented health care professionals with peers and the hospital community

Students are selected for participation in SSJP from the following seven public high schools: Boston Latin Academy, Community Academy of Science and Health, Health Careers Academy, Madison Park Technical and Vocational School, John D. O'Bryant School of Math and Science, New Mission High School, and Parkway Academy of Technology and Health. Each high school that participates in SSJP has an on-site career specialist from the Boston Private Industry Council (PIC) who works with students to both explore their emerging career interests and connect them with employment opportunities. In conjunction with the Center for Community Health and Health Equity's youth programs manager, the school-based PIC career specialists target a pool of interested and qualified students and refer them to SSJP.

The criteria for selection are:

- Presently enrolled in a partnering high school
- Interested in pursuing a health-related career after graduation from high school
- Capable of maintaining a grade point average of 2.5 or better
- Completion of an essay explaining their interest in working at BWH
- Submission of two letters of recommendation
- Demonstration of responsibility, maturity, and strong communication skills while in high school
- Commitment to working ten hours per week during the academic year (summer internships are an optional 25-hour per week commitment)

Student participation in SSJP increased by 92 percent between FY2005 and FY2008, from 25 students in FY2005 to 48 students in FY2008. In FY2008, twenty-eight of those 48 students were new to SSJP, and 20 were returning to the program from the previous year. Forty-four of the students successfully completed the program, each working ten hours per week at Brigham and Women's Hospital from mid-October 2007 through the end of June 2008. In FY2008, there were 18 seniors among the 44 high school students who successfully completed SSJP. All 18 of the seniors registered for the fall semester in a college or university, and all of them chose a health or science major.

In the eight years of the program, 167 students have participated in SSJP. Thirty-three percent of these students were Black, 25 percent Latino, 21 percent African/Caribbean, 15 percent Asian, four percent White, and two percent other. Eighty-five percent were female, and 15 percent male. In FY2009 efforts are underway to increase the percentage of male students in SSJP. Twenty-six percent attended Madison Park High School, 26 percent Boston Latin Academy, 16 percent Health Careers Academy, 15 percent John D. O'Bryant High School, 12 percent New Mission High School, and five percent Parkway Academy of Technology and Health.

Since the 2004-2005 academic year, 55 SSJP students have graduated from high school:

- 98 percent have enrolled in college
- 94 percent are majoring in or intend to major in a science or health field

Volunteer Participation and Mentoring

During FY2008, the SSJP students were assigned to 30 BWH departments, including: Ambulatory Radiology, Blood Control Lab, Center for Fetal Medicine, Center for Community Health and Health Equity, Center for Community Research, Central Transport, Department of Medicine, Computational Biology, Diagnostic Radiology, Division of Rheumatology, Electron Microscopy Lab, Intervention Radiology, Immunology and Allergy, Inpatient Floors, Kessler Health Library, Microbiology Lab, Molecular Diagnostic, Neurology Lab, operating room, Orthopedics, Pathology Lab, Pediatric Oncology, Podiatry Clinic, Post Partum floor, Pulmonary Lab, Radiology Film Library, Renal Division, Renal Pathology, Southern Jamaica Plain Health Center, and Thoracic Surgery.

The SSJP students were each matched with a mentor in the BWH department to which they had been assigned. Mentors met regularly with the students, assigned tasks, answered questions, offered support, and provided guidance on school and career goals. At the end of the year, of the students that responded to this question, 93 percent of the students reported that they met with their mentors at least twice per week, with 37 percent of these students reporting they met with their mentor at least four times per week.

Eighty-six percent of the students rated their relationship with their mentor as excellent or very good. The students also wrote about what they had learned while working with them. Excerpts from two students' letters follow:

> *"In addition to all the great opportunities from being in a lab cutting mice, monkey, and human brains to fully independent research on treatment and prevention for Alzheimer's Disease, SSJP has provided me an everlasting mentor, Dr. Cindy Lemere. I could come to her for anything. My mentor has not only given me great advice in academics, but beyond. I cannot thank her enough."*
> Kevin Le, 12th grader

"During the two years, I had worked in the same department. I can still remember the first day when I found out that I was assigned to the Electron Microscopy Lab. I was confused by the name and thought that lab work was routine. However, as time passed, I became more attached to the lab work as I got more involved.. Under the guidance of Dr. Joel Henderson, I gained knowledge and picked up many tips. I became rich with knowledge because he is such a generous giver and I couldn't possibly ask for more." Mei Cao, 12th grader

The mentors were also asked to provide feedback on their experiences with the SSJP students. Ninety-three percent of mentors who returned their surveys responded that they wanted to work with a student again next year. They were also asked what they found most positive about their SSJP experiences. Some of the mentors' responses included:

"He gave me the chance to use my skills as a teacher to another. I enjoyed teaching my student different aspects of the job and about surgery/science/medicine."

"I have a chance to take part in motivating them both educationally and personally. Watching a young person gain personal confidence a sense of self and an understanding that we are contributing to the education of young people."

"To provide the opportunity to a student to learn about the many different aspects working in a health care setting."

SSJP 2007-2008 Academic Year Program Components

Monthly Seminars

The seminars provided additional opportunities for the students to come together for presentations, discussions, and group activities. Seminar topics included: Banking Basics and Personal Finances, Vehicle Safety, Mental Illness, Nutrition, Reproductive Heath, and The Path to Medical School.

Tutoring

Math and science tutoring sessions were offered twice a week for those students who were experiencing academic difficulties. Seven SSJP students received instruction from the SSJP Academic Tutor in pre-calculus, calculus, chemistry, and biology. The students were required to remain in tutoring until they were able to raise their grades to the SSJP required minimum of B minus.

Newsletter

The SSJP students helped to produce a bi-annual newsletter called the *SSJP Visionary*. The newsletter featured articles written by the students and was distributed to over 300 individuals, including BWH staff, SSJP families, and organizations that have partnered

with SSJP. The newsletter has proven to be an effective way of sharing program updates and activities.

SSJP 2007-2008 Evaluation Results

SSJP evaluation results for FY2008 show that students reported that they had learned the following:

- Hospital Procedures:
  - Sterilization of medical and surgical supplies
  - Learned how to hook an oxygen wire to the unit
  - Where blood or urine goes after it's sent to be tested
  - Prepare patient packets
  - Learned how to stock anesthesia and cardiac surgical carts
  - Learned how to deliver supplies to operating rooms
- Lab Skills:
  - Cell traction
  - Setting up and performing specific numerous experiments for the zebrafish
  - More knowledge about the SCL gene, Myc gene, T-Cell Leukemia, and cells
  - Workers in the lab have to follow specific drills when handling equipment and especially the experimental fish.
  - Proper lab procedures and safety guidelines
  - Handling lab animals
  - Tissue sectioning
  - How to dissect a mouse
  - How to locate the nucleus of a cell that has been stained
  - How to run a PCR (Polymerase Chain Reaction)
  - How to use various chemicals to stain a cell in order to locate
  - How to properly use a microscope
  - How to create your own slides by slicing the tissue yourself
  - Learned how to use pipettes to separate the DNA
  - Find information about patients using LMR / BICS
  - Learned to make food for cells
  - How to put blood into machines that separate cells
  - How to separate lactic acid specimen
  - How to distribute specimen equally
- Patient Interactions:
  - Discharge patients
  - Distribute refreshments to patients and ensure comfort
  - Answered phone system and learned how to schedule appointments

Students were asked if being in SSJP helped them balance various aspects of their life. Eighty-nine percent of students responded that the program has helped them learn how to be more organized. Several students provided more information on their ability to multitask because of being in the program:

"I became more engaged with my own schedule used my agenda everything single moment of my life. I also learned to make sacrifices both in my personal area and academically. SSJP taught me to make realistic decisions and be always on time for an appointment or SSJP meeting."

"I have always been an organized person, but being in SSJP I had a lot more on my plate. Because of this, I was able to manage my time better."

"Prioritizing things was key in staying focused on my internship as well as my personal obligation. I had to decide what things could be rescheduled or missed so that my work would not be interrupted. I also had to not work on days in which I had tests of needed study time on so that my grades were not affected."

College Scholarships

Sixteen of the 18 high school seniors in SSJP applied for and received one-year college scholarships that were offered by the Center for Community Health and Health Equity in FY2008. In March 2008, each student submitted an application form, a transcript of their grades, two letters of support, copies of the college acceptance letters that they had received, and an original essay on what they had learned in SSJP and why they wanted to pursue a health career.

The SSJP Scholarship Selection Committee met in March 2008 to review the application packets. Six students received $4,000 scholarships, four students received $2,000 scholarships, four students received $1,000 scholarships, and two students received $500 scholarships.

Summer Internships for College Students

In FY2008, the CCHHE provided full-time summer internships for 12 college students. Eight of the students were graduates of SSJP and four were enrolled in the PS Health Care Program through the Boston Private Industry Council. All SSJP College Interns are majoring in science and health fields. They began their ten-week internships at Brigham and Women's Hospital in June 2008. The students worked in the following hospital departments: Department of Pharmacy, Center for Surgery and Public Health, Blood Control Lab, Intervention Radiology, OB/GYN Clinic, Center for Women and Newborn, Thoracic Surgery, Division of Immunology and Allergy, Neo-Natal Intensive Care Unit, and a Harvard School of Public Health Pathology Lab.

New Components for 2008-2009

College Preparation

As the goals and expectations of SSJP students have consistently risen since the program's inception, we identified the need for specialized support for seniors to be better prepared for college, and have contracted with an expert in the field to design a

program to strengthen their competitiveness and college applications. This effort in collaboration with MGH's Pro-Tech Program is designed to help students: 1) gain admission to the college that is right for them while learning valuable problem-solving and decision-making skills; and 2) learn how to manage a complex application process that typically involves a range of challenging tasks and varying emotions while achieving their goals. The program began in October 2008, with seniors attending monthly workshops to help them identify potential colleges, prepare college applications, and navigate the financial aid process.

Students also receive individual coaching to research and finalize their college lists, help them strengthen their college essays, complete financial aid applications, and interpret the information received from colleges. The college coach works with students to review their academic and activities records, prepare for college visits, create a timetable of tasks in the application process, and practice for interviews.

Additional Partnering School

During the spring of 2008, administrators from the Community Academy of Science and Health (CASH), a Boston public school located in Hyde Park, contacted SSJP staff to inquire regarding participation in SSJP. After several discussions and a meeting with relevant school staff including the headmaster, CCHHE staff agreed to create a formal partnership with CASH and began accepting CASH students to SSJP as of October 2008.

Alumni Component/Outcome Evaluation

SSJP staff is working with the CCHHE evaluation team in generating a document to track the education and career activities of SSJP graduates. The goal is to annually collect information to better understand the long term impact of SSJP, and to inquire if the program can provide support and networking opportunities to past participants.

Simmons College Intern

During the 2008-2009 academic year, an undergraduate student from Simmons College majoring in public health, completed her practicum requirements in the CCHHE, and worked specifically with SSJP. She oversees the tutoring component, college prep workshop series and work on an alumni component to assist us in tracking SSJP graduates in their educational and career endeavors.

Jamaica Plain

Team Mita: Working for the Health of the Community

Team Mita develops youth leadership skills through peer-led community health improvement initiatives providing interactive, youth-led health education workshops, while also engaging in youth-led anti-violence organizing. The Team Mita peer leaders, who are between the ages of 14 and 18, and reside in the South Street Housing development, receive extensive training on a number of topics such as sexual health,

emotional wellness, nutrition, asthma, job readiness, resume writing, communication, mediation and other violence prevention techniques, environmental justice, and community organizing.

The peer leaders are expected to do outreach to a minimum of 12 youth groups annually. The peer leaders have developed workshops on gender roles, STD prevention, teen pregnancy and contraceptive methods, and healthy and unhealthy relationships. Each workshop, which is intended to encourage provocative discussions and insights, is accompanied by a short video clip, developed and edited by the peer leaders. Additional workshops on domestic violence prevention, sexual harassment, and, most recently, on media literacy, communication, and conflict resolution have been created by the program participants.

Team Mita empowers the peer leaders to make healthy choices for themselves, while they educate others their age on how to make healthy choices. By the end of FY2008, the peer leaders reported that they:

- Engaged in healthy behaviors because of their increased understanding of health topics
- Promoted and supported the healthy choices of others as measured by their ability to lead health education workshops for their peers
- Were able to resolve conflicts as measured by their participation in Youth Unscripted training
- Used community organizing skills as measured by their participation in community-wide initiatives
- Learned about cultural competency as measured by their participation in ongoing diversity trainings

The peer leaders' skills are evaluated using the Massachusetts Work-Based Learning Plan (MWBLP), and the teens must progress from a rating of "needs improvement" to a rating of "competent" or "proficient" in at least five skill areas. Along with the program coordinator, the peer leaders evaluate themselves twice a year and have developed a number of their own evaluation criteria specific to the health education goals of the program. All of the FY2008 peer leaders made progress on the MWBLP evaluations.

The peer leaders offer workshops to at-risk youth in Boston, including other peer leadership programs and community centers. Since December 2003, a total of 25 young people have been Team Mita peer leaders. In FY2008, 70 young people attended 21 trainings conducted by the peer leaders. Since it began, Team Mita has reached over 324 young people and conducted 60 trainings.

Artist in Residence

Beginning in FY2005, Team Mita sponsored an "Artist In Residence" who works with the teens to develop a media project. In FY2008, the teens worked with Lisa Dush, PhD, from Storybuilders, a digital storytelling group. The peers did intensive digital

storytelling training and completed six stories focused on violence in the home and community. Team Mita is now working with Michael Cermak, a Boston College PhD candidate, to develop an interactive website that will show the youth investigating and explaining the local food system. This website can be used to educate the community and for future classroom use.

Health Careers Ambassadors Program (H-CAP)

Team Mita continues to collaborate with the Hyde Square Task Force (HSTF) and their Health Careers Ambassadors Program (H-CAP) that was piloted at the Southern Jamaica Plain Health Center (SJPHC) in FY2004 to provide job shadowing and health careers education. All six of the peers are introduced to the different departments at SJPHC and learned about a variety of health careers. As participants in H-CAP, they receive college preparatory and evening tutoring support through the HSTF and meet one day a week with other H-CAP interns to learn about health topics and to work on a service project. In FY2008, the peer leaders created a documentary on community violence called "Looking for Peace One Block at a Time". The peers show the documentaries to various groups and facilitate discussion that promotes peace in Boston.

Youth Unscripted

The peer leaders continue to work with Urban Improv in the Youth Unscripted Program. In FY2008, Youth Unscripted continued to meet at English High School with over 45 participants. Ten youth were hired by Urban Improv over the summer as a youth theater troupe and performed for summer camps and other youth groups.

The South Street Youth Center

The mission of the South Street Youth Center (SSYC) is to provide a safe, educational and engaging space during out of school time for young residents of South Street development. Through its broad-based programs, participants learn a happy, healthy, resilient attitude toward life that will help sustain them through adulthood.

Staffing

The SSYC is staffed by a full-time Director, a part-time Program Coordinator, an average of three to four volunteers a week and six middle school peer leaders who call themselves the Colossal Peace Crew (CPCs).

Programming and Collaborations

SSYC offers after-school programming Monday through Thursday for first through eighth grades and every other Friday for middle school youth. The Youth Center's programming focuses on providing choices for its young participants. There is a wide range of enrichment activities available, as well as, educational opportunities. Normal rotation of planned activities includes art, cooking, experiments, and outdoor games.

Daily, the youth have choice time when they can explore the resources at the SSYC—books, games, computer time, foosball, individual art projects, and interacting with the adults present.

Due to new collaborations the programming has increased for both the after school and middle school programs. The SSYC collaborated with several organizations this fiscal year including: Boston Police's E-13 office, Representative Liz Malia's office, Team Mita, The Medical Foundation's Healthy Girls Healthy Women Program, Northeastern University, Originations, Slightly Askew, The Food Project, Patty the Garden Girl, Curtis Hall, and Hyde Square Task Force. These collaborations have provided workshops, as well as, greater access to resources for SSYC. The FY2008 workshops include sexual health, nutrition, African and Latin dance and hip-hop classes, farming tutorials and gardening demonstrations. SSYC has benefited from other collaborations that have provided resources and on-going activities for after-school programming such as weekly dance classes, weekly gym time at Curtis Hall and a plethora of craft supplies. The remaining collaborations have provided volunteers to help continue our programming and train our staff.

Attendance

Another area of success for FY2008 is the overall increase in youth participation at the center. This was due to an increase in staffing (a part-time Program Coordinator was hired to staff the center when it is open) and more targeted outreach to new families in the South Street community. Participation has increased from an average of 19 youth per day to 24 per day, an increase of nearly 32 percent.

Academics

The youth center specifically targets younger youth in first through fourth grades for homework assistance and strongly encourages reading with the youth who speak a language other than English at home. As outlined below, only 15% of our youth report attending other after-school programs, most of whom report attending an athletic activity. As a result, the SSYC becomes one of the primary supports for youth to complete homework and work towards greater success in school.

	Report regularly completing homework at SSYC	Report receiving help from SSYC Staff or Volunteers	Report grade improvement when homework completed at SSYC	Report participation in other out-of-school time programs
FY2007	61%	61%	n/a	4%
FY2008	76%	91%	92%	15%

Mission Hill

ScienceWorks

For 12 years, the Center for Community Health and Health Equity has offered volunteer and summer job opportunities to eighth grade students. Participation in the summer

program ScienceWorks begins in the spring term of the school year when students receive their volunteer assignments in hospital departments. The volunteer assignments allow students to explore potential summer work sites and begin to learn job skills and prepare for their summer work experiences. Students who successfully complete their volunteer assignments are placed in paid summer jobs in departments throughout the hospital. Skills gained by the students through their paid and volunteer work include punctuality, professional dress and behavior, ability to complete tasks, verbal and written communication skills, problem solving, and use of technology.

During FY2008, 20 eighth grade students from the Tobin School, Roxbury Preparatory Charter School, and Mission Grammar School participated in ScienceWorks. In addition to volunteer opportunities and summer jobs, ScienceWorks also has an academic component, which features a series of afternoon seminars designed to educate the students about the human brain.

Volunteering

ScienceWorks started in June 2008 with a two-week volunteer opportunity. Students were placed in hospital departments and were expected to volunteer in those departments for ten hours per week. Participating departments included: Center for Community Health and Health Equity, Center for Women and Newborns, Central Transport, Materials Management, Operating Room, Kessler Health Library, Radiology, and Receiving and Distribution.

Summer Jobs

Seventeen of the 20 of the students successfully completed their 20-hour volunteer commitment and became eligible for the summer jobs portion of the program. These students worked at their summer jobs for approximately 20 hours per week during July and August.

The ScienceWorks students were asked to complete a pre-questionnaire upon entering the program and a post-questionnaire upon completion. Eighty-six percent of the students reported that their relationship with their supervisor was excellent or very good.

The students also listed skills that they had acquired through participation in their ScienceWorks summer jobs. Those skills included learning how to use a scanner for documents, filing, operate a busy answering telephone system, prepare exam rooms and to stock supply rooms. Students also provided feedback on life skills that they acquired through ScienceWorks: becoming organized, being focused, becoming more mature, improving communication, arriving prepared to work, taking initiative, learning to interactive with adults in a professional environment, and being responsible and trustworthy.

Studying the Human Brain

In FY2008, ScienceWorks offered a series of five three-hour science lessons on the

human brain that were held at Brigham and Women's Hospital. The lessons were developed and taught by Dr. L. Todd Rose, Ph.D., of the Mind, Brain, and Education program at Harvard University:

- Lesson 1: Human Brain Overview
- Lesson 2: Limbic System: Primary and Secondary Emotions
- Lesson 3: Learning and Memory
- Lesson 4: Personality
- Lesson 5: Senses and Perception

During these lessons, the students learned about neurons, the brain stem, and the hypothalamus. They discussed the physiology of moods and emotions and how the mind acquires, stores, and retrieves information. One week after each lesson, a test was administered to the students to determine how much information they had learned and retained. The students were also required to write and submit research papers on neurology. Their paper topics included the following: memory, laughter, physical and emotional controls in the brain, fear, medulla oblongata, the hemispheres of the brain, the five senses, how art affects the brain, inhibitory control, sleep and dreams, and multiple intelligences.

Health and Science Clubs

Since they were first offered in FY2006, the Health and Science Clubs have provided science learning opportunities to over 200 students in the fourth, fifth, sixth, and seventh grades at three schools and one community center in Mission Hill. In FY2008, the CCHHE coordinated Health and Science Clubs at Maurice J. Tobin School and Mission Grammar School. A total of 67 students participated.

The Clubs provided an informal learning environment in which students worked with one another in small groups led by hospital employees on science experiments and listened to presentations by guest speakers. The relaxed yet structured atmosphere of the Clubs

Test Topic	Number of Questions	Mean Score
Test 1: Human Brain Overview	5	4.5
Test 2: Limbic System: Emotions (primary and secondary)	5	4
Test 3: Learning and Memory	6	5
Test 4: Personality	6	4
Test 5: Senses and Perception	5	4.5

promoted teamwork and produced cooperative learning experiences that increased science knowledge. The Clubs also familiarized students with new health careers and showed them what types of education and training are necessary to pursue specific health career paths. A total of 30 Brigham and Women's Hospital employees were recruited to serve as classroom volunteers and as guest speakers for the Health and Science Clubs.

The volunteers were recruited from 17 BWH departments and were trained to use the Boston Public Schools' Youth Explorations in Science (Y.E.S.) curriculum, which aligns to the national science frameworks, enhances and reinforces the Science and Technology for Children and the Full Option Science System curricula (other BPS curricula), and

addresses educational standards for engineering and technology. The Y.E.S. curriculum is also aligned to the science Massachusetts Comprehensive Assessment System (MCAS).

The 29 participating fourth grade students from the Tobin School worked on eight Health and Science Club projects: sound waves, the food chain, periscopes, electronic circuits, properties of matter, flotation and density, paper chromatography, and laws of motion. Six guest speakers presented to the students on nutrition, radiology, exercise, what it is like to be a nurse, and respiration. The CCHHE helped to organize a field trip to the Museum of Science for the students and their parents.

The 38 participating fourth and fifth grade students at the Mission Grammar School also worked on eight Health and Science Club projects but covered oil spills rather than the food chain. Eight guest speakers visited the school to talk to the students about nutrition, neurology, radiology, respiration, and nursing. CCHHE also arranged for the students to go to the Museum of Science for an all-day field trip.

Before and after the first four projects, students take a pre and post test to evaluate how much they already knew about the subject and how much they learned from the projects. Students then take a pre and post test before and after the next set of four projects. Each pre- and post-test consisted of an average of 12 questions about four science projects. The test questions were formulated in collaboration with the participating science teachers. The following table shows the impressive increase in pre- and post-test scores.

Health and Science Clubs
FY2008 Average Percentage Increase in Pre- and Post-Test Scores

School and Grade	Fall	Spring
Tobin Grade 4	20% increase	28% increase
Mission Grammar Grade 4	24% increase	34% increase
Mission Grammar Grade 5	11% increase	32% increase

When the participating science teachers were asked to rate the benefits of the Health and Science Club, teachers rated it as "Excellent", while 95 percent of the participating students wanted to do more science projects.

When asked what they learned from the Health and Science Club, students responded:

> *"I learned to eat healthy, exercise and watch what I eat. That health is very important"*
>
> *"I learned about electricity. It was fun!"*
>
> *"I learned that I can figure out anything."*

Pen Pal Program

In FY2007, the CCHHE started a Pen Pal Program linking 46 elementary school students in Mission Hill with BWH employees. In FY2008 the program more than doubled to 108

second and third grade students at Mission Grammar School and the Tobin School. Students were matched with 109 hospital employees. The pen pals wrote and exchanged eight letters, as well as, an introductory "Meet Me" form.

Each participating BWH employee was given a manual outlining the guidelines of the program, providing information on second and third grade reading levels, explaining the letter sending schedule and protocols, and describing the selected subjects to write about. The BWH Pen Pal Program was incorporated into the grade two and three literacy curriculum with much enthusiasm and success. Teachers noted that the BWH Pen Pal Program facilitated teaching reading and writing and noted the students' excitement and enthusiasm when reading and writing letters.

In January 2008, the pen pals met for the first time in the students' classrooms. Adult pen pals got tours of the classroom, read books, worked on a project and got their picture taken with their student pen pal in a photo booth. All pen pals received copies of the photos, and the students were given grab bags filled with stationery kits and pencils to encourage their continued interest in writing. In June 2008, the pen pals were able to meet again in person at Brigham and Women's Hospital. During breakfast, the pen pals enjoyed a science demonstration by Mad Science, and had their photos taken together in a pen pal photo booth. All pen pals were given copies of the photos and students received "Healthy Summer" grab bags filled with safe and active summer activities and nutritional information for them and their families. The events were a great success with lots of hugs and smiles from adults and children alike, which clearly demonstrated that the pen pals were very excited to meet face to face.

The program was successful in facilitating reading and writing skills among students. Participants (students and teachers) at schools reflected positively on their experience in the program. Ninety-three second and third grade students responded to an end of the year program evaluation survey. When asked how much fun was it to get a letter from a BWH pen pal, 93 percent of students said it was "very fun." Further, when asked how much fun was it to write to a BWH pen pal 87 percent of students said it was "very fun." Also among student respondents 97 percent said they wanted to receive/read more letters and 91 percent said they wanted to write more letters. To further infer students' excitement in the program, all teachers at the participating schools who also completed an end of the year program evaluation survey said that they have seen an improvement in their students' enthusiasm in reading and writing due to the program. Among teacher respondents, all gave an "excellent" rating to the benefits of the pen pal program to their students and school.

Brigham and Women's Hospital - Maurice J. Tobin School Partnership

For 18 years, Brigham and Women's Hospital and the Maurice J. Tobin School in Mission Hill have been working in a unique relationship between an academic medical center and an urban public elementary and middle school which began with a former principal's request for assistance from the hospital to make improvements to the physical plant of the school and provide nutrition education for students. Today, the connections

between the two organizations have influenced the environments of both, and the partnership has made an impact on the Tobin students.

The overall goal of the partnership is to support the academic mission of the school by increasing parent, family, community, and hospital involvement in students' learning. With the established link between educational attainment and health status, this partnership was created to support the hospital's mission of improving the health status of the Mission Hill community. Family involvement has been shown to be a critical element in student achievement, therefore, the joint programming aims to reach out to families and assist them in becoming active participants in their children's education. Other elements of the program are designed to engage hospital employees in students' education.

The Tobin-Brigham Family Support Program

Three parenting partners and the Tobin Family Support Center coordinator staff the Tobin-Brigham Family Support program. The parenting partners are employed by BWH and work at the school under the supervision of the Tobin Family Support Center coordinator. With guidance from the coordinator, the parenting partners implement literacy initiatives to involve families in their children's education and build relationships between students and adults. The components of the Family Support program include the Family Support Center, Full-Service School Model, Parent Council, Brigham Book Buddy Program, and Brown Bag Food Distribution/Adopt-a-Family Program.

The Family Support Center

The Family Support Center provides a central and visible place in the school where parents know they are welcome, where they can receive information about the school and about community resources, and where they can make connections with other parents. Two of the parenting partners, one of whom is bilingual, have office space in the Family Support Center. A second bilingual parenting partner is based in the school's main office, where she is available to families entering or calling the school. Spanish language capacity is very important, since a majority of Tobin students are Latino, and Spanish is the primary language spoken in their homes. In November 2008, a Grandparents' Support Group was created to assist families where grandparents are the guardian or primary caregiver of a student at the Tobin School. A group of 11 grandparents attended the first meeting and are the leaders of the group. Subsequent meetings and activities are being planned for the rest of the school year.

Full-Service School Model

In January 2005, the Tobin School and Brigham and Women's Hospital began to explore the feasibility of developing a full-service school model, which would enable the Tobin School to offer a broader, more coordinated network of before-school and after-school programs for children and parents. As a result of these initial discussions, a task force was convened in FY2006 to undertake a more thorough planning process.

The task force was comprised of the Principal, three teachers, the Student Support Services coordinator, the school psychologist, the Tobin Family Support Center coordinator, a parenting partner, two representatives from the CCHHE, and two representatives from after-school programs. After a series of meetings, the task force assembled a comprehensive proposal for the implementation of an extended school model, which focused on the following major areas:

- Community Resource Assessment
- Health Services
- Learning Assessment and Evaluation
- Mental Health Services
- Out-of-School Time
- Family and Community Engagement

The Tobin Family Support Center staff is responsible for carrying out the family and community engagement segment of this proposal. In FY2007, they selected a curriculum, ordered materials, and conducted outreach in preparation for English as a Second Language (ESL) classes to be offered at the Tobin School. The classes continued in FY2008 with six parents attending classes. They held fall and spring Open Houses to introduce new parents to the school. Eighty-five parents attended the fall Open House in September 2007, and 55 parents attended the spring Open House in March 2008. The parenting partners also organized two bake sales by parents, an apple picking field trip for families, and movie nights for children and parents. Also, in the fall of 2008 the first Grandparents group was established to support the growing numbers of grandparents that act as the primary caretaker of Tobin School students.

Parent Council

In the fall of 2007, the Tobin School Parent Council was organized, and elections were held for Parent Council officers. A total of eight Parent Council meetings were held over the course of the year, and an average of six parents attended the meetings, which were coordinated by the Tobin Family Support Center staff who created the agendas, outreached to parents, secured childcare during meetings, and facilitated the meetings. The Parent Council is an important way that parents can be consistently involved in the school, make their voices heard, and influence school policy.

Brigham Book Buddy Program

The Brigham Book Buddy Program, since its inception in 1994, has been implemented in partnership with the Maurice J. Tobin School in Mission Hill. The Tobin is a Kindergarten to eighth grade school, with 83 percent of the students coming from families qualified for free or reduced lunch. The Massachusetts Department of Education places the Tobin School in the "Needs Improvement" category in English Language Arts (ELA). In addition, a high percentage of students in the lower grades received a warning or a failing grade on the ELA portion on the state MCAS test.

Each month, hospital employees volunteer their time to the Brigham Book Buddy program by visiting Tobin School kindergarten through fifth grade classrooms and reading aloud to students. The Brigham Book Buddies read books selected by the classroom teachers and, at the conclusion of each reading session, they present the books to the students for their classroom libraries. The goals of the program are to improve students' reading and listening skills, connect the students with health care professionals who serve as role models, and promote the literacy objectives of the school. During the 2007-2008 school year, the Book Buddies read to 188 students in 11 classrooms and donated 77 books to the school.

The program was successful in facilitating reading and listening skills among students in K to five grades at the Tobin. Participants (students and teachers) at schools reflected positively on their experience in the program. Of 109 children who either completed a survey or were questioned by their class teacher, almost all, 99 percent said they wanted to read more books, hear more books read out to them, and wanted a Brigham Book Buddy in their classroom again. Also among student respondents, 92 percent said that it was "very fun" to have a Brigham Book Buddy in their classroom and 89 percent said it was "very fun" to have books read out to them. To further infer students' interest in the program, all teachers who completed an end of the year program evaluation survey said they have seen an improvement in their students' enthusiasm in reading and listening as a result of the program. Further, all teachers gave an "excellent" rating to the benefits of the Brigham Book Buddy program to their students and school.

Brown Bag Food Distribution/Adopt-a-Family Program

The Greater Boston Food Bank provides food through the Massachusetts Emergency Food Assistance Program (MEFAP), which supplies nutritionally adequate meals to low-income families. The parenting partners distribute these meals twice a month to families at the Tobin School. In FY2008, there were 19 days during which food was distributed to needy families, and an average of 25 families participated each time. Additionally, through the Adopt-a-Family program, Brigham and Women's Hospital employees donate gifts during the holiday season to some of the school's most needy families.

Longwood Medical Area (LMA)

Partnership with Health Careers Academy

In FY2008, the CCHHE provided grant support to the Health Careers Engagement project at Health Careers Academy (HCa), a Horace Mann Charter School that prepares students in the ninth through twelfth grades for careers in the health sciences. The goals of the Health Careers Engagement project are to promote student knowledge of health care professions and work sites, increase the number of HCa students who enter college programs designed to prepare them for health careers, and expand the number and variety of internships and other workplace learning experiences that are available to HCa students.

During the 2007-2008 school year, the Health Careers Engagement Project organized a guest speaker series for ninth and tenth grade students at Health Careers Academy. Twenty health care professionals presented to the students about the following fields: dentistry, emergency medicine, health care administration, health law, internal medicine, molecular research, nursing, obstetrics/gynecology, pharmacy, physical therapy, psychology, public health, radiology technology, social work, and surgical technology. Additionally, the ninth and tenth grade students made ten site visits to health work sites across Boston and 84 eleventh and twelfth grade students received internship placements with 68 percent internships in the health care field. Eighty-five ninth, tenth and eleventh grade students were given job shadowing opportunities at health care organizations and 65 students in the tenth and eleventh grades received summer placements in health-related academic enrichment and work experience programs.

Of the HCa students who graduated in 2008, 30 (46 percent) intend to pursue careers in health care and to major in health or science fields. In addition to the 20 students who intend to pursue nursing, the fields in which these students have expressed interest include: pre-medicine, biology, biochemistry, psychology, pharmacy, and speech pathology.

The Gateway Program: A Partnership with the John D. O'Bryant School of Mathematics and Science

The O'Bryant Gateway to the LMA is an educational partnership between the John D. O'Bryant School of Mathematics and Science in Roxbury and multiple institutions in the Longwood Medical and Academic Area (LMA), including BWH. The O'Bryant School is one of Boston's three examination-based public high schools, and it is unique among the exam schools in its mission to prepare Boston students to succeed in careers in science and technology.

At the O'Bryant School, the O'Bryant Gateway program provides a four-year high school pathway that focuses on career opportunities in medicine, biomedical science and the health professions. To prepare students to enter these highly competitive fields, the program fosters high academic achievement by providing the students with a supportive learning community, out-of-school time academic supports, and year-round enrichment opportunities.

In June 2008, the O'Bryant Gateway to the LMA completed its first year of classes, and 48 of the students in the program advanced to the tenth grade. In addition, 50 new ninth grade students joined the program, bringing the cohort of students enrolled in the program to 98 in September 2008. The sophomore students look forward to a rigorous science-based academic school year that will include an action research project, hospital rounds, a speaker series, a career networking event, and a college access event. The program continues to maintain strong support and commitment from the LMA institutions that include Brigham and Women's Hospital, Beth Israel Deaconess Medical Center, Children's Hospital, Dana Farber Cancer Center, Emmanuel College, Harvard Medical School, MASCO, Simmons College, and Wentworth College.

Violence Screening, Treatment and Prevention Programs

Passageway at Brigham and Women's/Faulkner Hospitals and the Health Center Domestic Violence Initiative

In May 1997, Brigham and Women's Hospital (BWH) launched Passageway, a domestic violence intervention program developed by the Center for Community Health and Health Equity (CCHHE). A hospital-wide domestic violence advisory committee identified the need for a program to develop and support coordinated, safe domestic violence interventions within BWH and in the community. The program model is based on an empowerment philosophy and is rooted in the grassroots history of the battered women's movement.

In developing Passageway, the CCHHE created a program that would both incorporate the perspectives and experiences of women and assist the hospital in integrating screening for abuse and domestic violence interventions into routine health care. In the fall of 2004, the hospital expanded Passageway to its community sites at Faulkner Hospital and Southern Jamaica Plain Health Center.

Passageway has become a leader in integrating domestic violence advocacy services and training for health professionals into the health care system. While women's shelters and domestic violence hotlines continue to provide critical emergency services for victims, placing domestic violence advocacy services within the health care setting offers additional avenues for help and for earlier intervention and prevention. Victims who may not be ready to access shelters or hotlines may still seek health care. As health care professionals become skilled in routinely screening for and identifying domestic violence, victims may benefit in numerous ways. First, the act of domestic violence screening is itself an intervention and informs patients that health care providers care about their safety and well-being. Second, the screening process and availability of an on-site domestic violence program offer victims access to services in a private setting. If a patient discloses abuse, their health care provider can refer them immediately to Passageway for safety planning and ongoing support. Third, employees can find easy access to assistance within their workplace.

Passageway strengthens the health care system's response to domestic violence and improves the safety, health, and well-being of individuals and families experiencing domestic violence through its four program components:

- **Comprehensive Advocacy Services** for patients and employees who are abused
- **Training/Education** for multidisciplinary health care providers and hospital employees
- **Community Collaboration** to ensure a strong network of services to address domestic violence within and beyond the health care setting

- **Evaluation** to support the continuous improvement of care for domestic violence victims and effective training and education programs for health care professionals

Since its inception, Passageway has responded to over 7,000 requests for advocacy services and trained nearly 10,000 health care providers and staff. In addition to working with individual clients, Passageway provides survivor support groups in both English and Spanish.

Comprehensive Advocacy Services and Consultation

Passageway provides free, voluntary, and confidential services to patients and employees who are experiencing domestic violence. Services include risk assessment and safety planning, crisis intervention, individual counseling, support groups, referrals, intervention with complex systems (e.g., health care, courts, employers), assistance in accessing resources, and education to victims/survivors in understanding their rights and options. Passageway advocates offer consultation to health care providers and hospital staff regarding screening practices, safety planning, and other issues impacting patient and employee safety. During FY2008, Passageway responded to a total of 967 Brigham and Women's and Faulkner Hospital patients and employees experiencing domestic violence.

Demographic information on individuals served follows:

Gender of Passageway Clients

Gender	Number	Percent
Female	943	97%
Male	24	3%
Total	**967**	**100%**

Race of Passageway Clients

Race	Number	Percent
Asian	15	1.6%
African American/Black	262	27.0%
White	238	24.6%
Latino	374	38.7%
Native American	4	0.4%
Other	16	1.7%
Unknown/Unrecorded	58	6.0%
Total	**967**	**100%**

Age of Passageway Clients

Age Range	Number	Percent
17 or Under	12	1.2%
18 to 19	41	4.2%
20s	267	27.2%
30s	228	23.6%
40s	201	20.8%
50s	109	11.3%
60s	36	3.7%
70s	13	1.0%
80+	5	1.0%
Unknown/Unrecorded	55	6.0%
Total	**967**	**100%**

Primary Language of Passageway Clients

Language	Number	Percent
English	736	76.1%
Spanish	197	20.4%
Other	16	1.7%
Unknown/Unrecorded	18	1.8%
Total	**967**	**100%**

Passageway has a collaborative intervention model that includes domestic violence advocates, nurses, physicians, social workers, mental health providers, and other health care providers. Domestic violence intervention is provided at the academic medical center campus, community hospital, and health centers. The intervention model is flexible and tailored to individual needs. Services include safety planning, crisis response, counseling, education, outreach, support groups, medical advocacy, legal assistance, and referrals.

Passageway's advocates come from diverse backgrounds reflecting the populations served. The advocates offer services in English and Spanish and use hospital interpreters for all other languages. In FY2008, the Passageway advocates recorded 16,163 service contacts on behalf of all individuals assisted. The details of the service contacts are listed below:

Passageway Service Contacts

Type of Service	Number	Percent
Direct Contact with Individuals:	**4,197**	**26%**
Advocacy/Counseling	1,530	9.5%
Phone Contact	2,638	16.3%
Support Groups	29	.2%
Indirect Advocacy:	**3,726**	**23%**
Outreach and Client Follow-Up	3559	22%
Administrative	167	1%
Consultation and Collateral Contact:	**8,240**	**51%**
With a BWH Provider	6,448	39.9%
With a Community Provider	1,792	11.1%
Total	**16,163**	**100%**

This year's data represents an 11 percent increase in individuals served as compared to FY2007.

The Passageway Health-Law Collaborative

The Passageway Health-Law Collaborative is a unique legal services program within a health care domestic violence program. By conducting a full legal assessment for victims, Passageway helps victims to move beyond legal crises and identifies ways that lawyers can be proactive in their assistance with issues such as health care proxies, disabilities, insurance, access to systems and rights, housing and tenant problems, financial issues, guardianship and permanency planning for children, and others. In FY2008, the project assisted 151 victims of domestic violence through full legal representation, brief legal assistance, and consultation services. In addition, legal services partners offered monthly law clinics at Passageway to provide direct consultation and assistance to clients.

Health Center Domestic Violence Initiative

Established in 1999, the Health Center Domestic Violence Initiative is a collaborative among Passageway and Brookside, Whittier Street, and Martha Eliot Health Centers. Each health center has a domestic violence advocate supported by community benefit funding and administered through Passageway. Currently, advocates from the health centers and Passageway meet quarterly to improve communication and continuity of care for patients and to participate in resource sharing and trainings.

The Initiative's aim is to ensure consistent and safe domestic violence interventions across the health care system and increase access to support for women experiencing domestic violence. This year, there was an emphasis on advocacy practice standards and

resource sharing among the advocates. Advocates met bi-monthly to review practice issues and debrief about high-risk cases.

In FY2008, advocates at Brookside, Whittier Street, and Martha Eliot Health Centers assisted 215 women who were coping with domestic violence, and they reported 1,137 service contacts. The demographics of race/ethnicity and age are listed below:

Race/Ethnicity of Health Center Domestic Violence Initiative Clients

Race/Ethnicity	Number	Percent
African American/Black	29	13.49%
White	4	1.86%
Haitian	2	.93%
Hispanic/Latina	180	83.72%
Asian	0	0%
Unrecorded	0	0%
Total	**215**	**100%**

Age of Health Center Domestic Violence Initiative Clients

Age	Number	Percent
Under 18	4	1.86%
18 to 19	4	1.86%
20s	38	17.67%
30s	69	32.09%
40s	44	20.47%
50s	23	10.70%
60s	16	7.44%
70 and Above	0	0%
Unrecorded	17	7.9%
Total	**215**	**100%**

Training/Education for Health Professionals

This year, Passageway trainings focused on providing opportunities for in-depth training with social workers across the system. Passageway provided individual orientation sessions for social workers, training for on-call Emergency Department social workers, and training for social workers at Dana Farber Cancer Institute in addition to an annual training session for BWH MSW interns. In total, 45 social workers (including nine MSW interns) were trained. Faulkner Hospital training efforts focused on the Nursing Department and provided training on Passageway services and domestic violence intervention for 110 members of the Nursing Department, including RNs, PCAs, and Unit Coordinators.

In June 2008, Passageway participated for the first time in the BWH Housestaff Orientation, providing information and education about Passageway services to 250 incoming residents.

In addition to providing formal training, the program reached about 450 additional health care professionals through outreach and domestic violence awareness efforts. Over 200 staff participated in a hospital event with special guest speaker Diane Patrick in October called "Honoring Survivors: A Service to Reflect on the Impact of Domestic Violence." Additionally, informational tables at BWH, Faulkner Hospital, and Southern Jamaica Plain Health Center offered opportunities for staff to get information and materials on Passageway services.

Community Collaboration

Passageway has continued to provide leadership in a number of community collaborations, including the Domestic Violence Council of the Conference of Boston Teaching Hospitals and SAGE – Boston, working to end abuse among older women and elders, and the NASW Committee on Domestic Violence and Sexual Assault. Each of these groups meet monthly with active participation with other area hospitals and over 30 community agencies represented. This year, Passageway participated and provided educational materials in the Massachusetts State House's Health Fair with the Domestic Violence Council.

Passageway collaborates with a Boston-based, citywide health program that provides home care to people living with HIV and AIDS to reach those who are most vulnerable and in need. The program offers case consultation at a community program to provide staff with a place to discuss complex domestic violence situations that raise concerns about immediate safety for victims and for outreach workers. Passageway staff conducted two hours of intensive staff training in FY2008, and offered ongoing opportunities for domestic violence case consultation.

Passageway staff participated in other events, community projects, and conferences to strengthen collaboration, including:

- Healthy Roslindale Coalition
- Southern Jamaica Plain Health Center – Community Health Fair
- Jewish Domestic Violence Coalition
- Boston Regional Domestic Violence and Sexual Assault Providers Group
- Relationship Violence Action Council
- Jane Doe, Inc. Executive Directors Retreat
- Jane Doe, Inc., White Ribbon Day
- MA Public Health Advisory Working Group
- Department of Social Services – Hospital Working Group
- Boston Public Health Commission – Advocates Networking Group

Evaluation

Passageway developed and maintains a comprehensive database for tracking and analyzing services and for continuous quality improvement. The database enables Passageway to document the growth of the program and to identify clinical areas and departments that make referrals to the program. This information guides program development and training priorities.

Passageway administers a yearly survey to hospital staff with the goal of identifying areas for program improvement. Last year's survey was targeted towards BWH social workers, in an effort to gather their perspectives to inform future educational forums and programming and to enhance collaborative interventions. This survey generated 31 responses, which represents a 69 percent response rate. Passageway learned about key clinical practice questions and about how to focus training efforts (e.g., more content on mandatory reporting and how to intervene with abusers who may accompany victims in the health care setting). The survey findings continue to inform the hospital-wide domestic violence steering committee's activities for the year.

In an effort to assess how to better serve survivors of intimate partner abuse over age 50, Passageway facilitated a focus group in 2008 with volunteers who identified as survivors in this age group.

Passageway developed a survey tool in English and Spanish to use with women who received assistance from the Passageway Health Law Collaborative. Distribution began in the summer of 2007 and is ongoing. Feedback from women will be used to enhance the program's services. Additionally, in FY2008, an exit interview tool for collecting more in-depth information about client satisfaction was created and piloted.

Health Centers

Brookside Community Health Center

Background

Brookside Community Health Center was originally established as the Brookside Park Family Life Center in 1970, a "grass roots" program with a five year funding grant through the Model Cities Program. This grant was made in response to a proposal drafted and developed by a group of community residents, organized to address the health care needs of Jamaica Plain. The proposal clearly expressed a defined set of needs, identified in a community needs assessment, for accessible affordable health care that addressed the social and medical needs of families.

The group of local residents established itself as the center's Consumer Policy Board functioning under a set of by-laws drafted to govern the Board and its actions. The Board outlined the health center plan and hired the first staff members. The Board continues to

function as an engaged set of consumers and advisors who work directly with the health center's Executive Director and staff. The 16-seat board requires that 12 of the seats be filled by consumers who are elected annually by health center clients.

In 1974, the Brookside Community Policy Board signed an affiliation agreement with the Peter Bent Brigham Hospital and became part of the Ambulatory and Community Services Department, operating under the Hospital's License. The hospital, now the Brigham and Women's Hospital (BWH), and a founding member of Partners HealthCare System, Inc., has continued to work closely with the health center staff and Board to provide high quality services that meet the needs of the community.

Throughout its 38-year history, the health center has evolved and grown in order to meet the needs of its patients and improve the health status of the community. In 1970, after initially opening for business in a school classroom, the health center moved to four house trailers and then into a renovated parish hall basement. By 1975 the health center had settled into its current location, originally a manufacturing building leased by BWH in 1974 for 20 years from the City of Boston. The building, a one story, 27,700 sq. ft. space, was renovated in 1975 with funding from a federal government program to meet the health center needs. The building is fully handicapped accessible and on public transportation routes. The health center shared space in the building with N.I.C.E, a community-run day care program, until the summer of 1999. At that time, the Day Care relocated to a new building of its own, allowing the health center to increase its capacity and offer services in an updated and fully refurbished space.

In December of 2000, BWH purchased the property from the City of Boston. Long-planned, and much needed, renovations, including a complete overhaul of the building's infrastructure systems, were completed in May of 2003. The increase in space supported improved working conditions for staff and the delivery of high-quality care to clients. In 2006, BWH purchased two adjacent vacant lots that are to be incorporated into the health center's driveway to address the problem of substantially limited parking. As the demand for services continues to grow, a review of the clinical areas is needed in order to prepare the growing service demand and continue to ensure access. This challenge is one that continues into the coming year.

Despite the changing needs and demands, Brookside's board and staff remain committed to its mission, "*to provide high quality, family-oriented, comprehensive health care, with a focus on serving the low income population of our community, regardless of ability to pay.*"

In order to meet this mission, services are provided through four direct care departments, Medical, Dental, Family Services, and WIC/Nutrition. Each of these departments is made up of a multidisciplinary team of staff. The Medical Department provides primary care in pediatrics and adult medicine, OB/GYN care, family planning, and Pulmonary services for both adults and pediatric patients. The Dental Department provides comprehensive preventive and restorative services, as well as, endodontic, periodontic, and orthodontic services to adult and pediatric patients. The Family Services Department provides

behavioral health, social services, Substance Abuse Counseling, Domestic Violence Advocacy Support, HIV health education/ prevention, and Parenting Education and support. The WIC/Nutrition Department provides nutritional assessment and counseling to adults and pediatric patients, lactation support, as well as, a supplemental food support program. An on-site laboratory, managed by Brigham and Women's Hospital's Laboratory Administration, provides services to all departments. All services provided have been developed and expanded in direct response to the presenting needs of the health center's populations. Across all departments, there are a total of 114 staff, making up 94.68 full time equivalent (FTEs) positions, including physician staff.

Each clinical department conducts an active teaching program, approved annually by the Community Policy Board. The intent of these programs is to provide an opportunity for future clinicians to experience a learning environment that is culturally appropriate and responsive to the needs of the community it serves. Each department organizes its program in a manner meant to support the primary focus of its practice while protecting against any interference with patients' access to their primary care providers.

Given the health center's focus on family, the staff of the health center has organized various cross-departmental teams for case reviews and family support planning. The goal of these teams is to ensure a holistic approach to family centered care.

The health center is open Monday, Tuesday and Thursday 8:00 am - 7:00 pm, Wednesday 9:30 am - 7:00 pm, Friday 8:00 am - 5:00 pm, and Saturday 8:30 am - 12:00 pm. To ensure access for patients, each clinical department offers same day appointments for all services. Each department in the health center is open on several statewide holidays, offering routine appointments and urgent care access in all clinical areas. As an extension of this commitment to access, a physician backed on-call system for pediatric and adult medicine is in place 24 hours a day, 365 days a year. Dentists, midwives and mental health staff are also available for phone consultation whenever the health center is closed.

Brookside services are available to all residents and workers of Jamaica Plain, as well as, residents of surrounding Boston neighborhoods. Over the past several years, due to the increasing housing costs facing many patients, a growing number of patients now reside in the greater Boston metro areas, but continue to receive their care at Brookside. The center is easily accessible by public transportation and the building is fully accessible to the handicapped.

All services are offered bilingually in English and Spanish. In addition, staff members are available as translators in Haitian, Creole, German, Russian, and Polish.

FY2008 Accomplishments

FY2008 was Brookside's 38th year of service to the community, a remarkable achievement and a testament of the high regard in which the health center is held by patients and funders. It is also a reflection of the changing health care environment within

the state that is now committed to expanding access to high quality, affordable health care for all, something Brookside has been dedicated to since it opened its doors. In that environment, throughout the year, the health center responded to the needs of those who sought assistance and adapted services and programs to ensure that needs were met and successful outcomes were achieved. This dedication is a reflection of Brookside's outstanding staff, a rare group of highly skilled and deeply committed people. There were a great number of achievements, all of which are long-lasting and important. These achievements are the direct result of staff efforts and the equally dedicated supporters. These include the health center's Community Policy Board, the Leadership and Friends of Brigham and Women's Hospital, Partners HealthCare, and our community partners.

Highlights of accomplishments include:

- Due to the outstanding commitment and hard work of every member of the health center staff, completed a record setting year of service, providing 70,422 patient visits, registered 1,218 new clients and reached a total of 10,908 unduplicated users, ensuring high quality patient care with a continued focus on coordination and collaboration to achieve successful patient outcomes.
- Generated $8.8M in patient revenues, despite significant clinical provider vacancies over the course of the year and managed operating expenses to end the year at just 0.6 percent over budget despite skyrocketing costs of energy and other major supply lines.
- Successfully recruited and filled two new budgeted Primary Care Physician vacancies, expanding capacity and opening this service to new patients after a two year close.
- Despite staff vacancies and absences, Family Services Department, offering mental health, social services, Substance Abuse Counseling, and Domestic Violence Support, maintained their open access policy and no wait list, ensuring patients timely access to essential care.
- Brookside's Jamaica Plain WIC Program continued to be recognized as the highest ranked WIC Program in the state for its outstandingly high quality of care, including highest rates of breastfeeding and immunizations of its recipients.
- Financial Counselors met with 6,929 individuals to provide information on health care access and entitlement programs. They successfully completed close to 700 application submissions to the state for enrollment of families in Mass Health, Commonwealth Care and other state supported programs.
- Implemented Comprehensive Behavioral Health Screenings for all children up to the age of 21 and for all women of reproductive age.
- Dental Department successfully recruited a General Dentist and Periodontist (joining staff at the beginning of FY2009) to replace vacancies from this fiscal year.
- In collaboration with Dana-Farber and the American Cancer Society, conducted three on-site Mammography Screening days at Brookside, becoming the health center with the highest rate of screenings offered
- Successfully completed the rigorous application process to seek Certification by the American Diabetes Association (ADA), which will allow the development of expanded services for the growing Diabetic population served at the health center.
- WIC Program Assistants issued over $1.7M in WIC Checks to participants, ensuring

their access to healthy and nutritious foods.

- Significantly reduced Claims Denials and Free Care claims due to efforts of Financial Counselors and Practice Secretaries to ensure accuracy of health care coverage information.
- With support form the MA Department of Public Health, initiated new efforts to reduce tobacco use in primary care patients.
- Successfully recruited a Program Manager/ Nurse Practitioner for the Teen Health Center at English High School
- Urban Youth Sports Coordinator worked in a variety of areas to increase on-site support to children.
- Expanded existing staff resources by converting Medical Record Clerk positions to Practice Secretary and Financial Counselor to increase support to clinical departments and patients.
- Maintained highly successful teaching programs in a broad array of clinical disciplines in Medicine, Nursing, Dental and Behavioral Health departments. Also participated in several administrative internship programs including the Americorps-sponsored Health Corps Internship and the Health Career Connection Programs.
- Maintained working groups with staff from Partners Finance to address claims processing issues, increase revenues, reduce errors and patient complaints.
- Continued a partnership with Children's Hospital's Neighborhood Partnership Program as we continued to focus on the mental health needs of children in our community.
- Increased external grant funding to $ 1,111,566, an increase of $182,851 or 19.7 percent over FY2007.
- Despite major changes to health care regulations and entitlement programs, continued to provide outstanding support to patients, increasing the number receiving financial and administrative assistance with applications for Medicaid and Free Care while increasing on-site cash collections and reducing rejections and denials of processed claims.
- In collaboration with two other Jamaica Plain Health Center and community residents, initiated a Rapid Response team to support the community in the face of violent incidents.
- Continued participation in BWH/Faulkner and Partners Psychiatry Department's Substance Abuse Team to identify initiatives to enhance patient outcomes and develop programs to meet their needs.
- Maintained extended service hours in all clinical departments, increasing utilization and diversifying patient base by offering increased access to the working families of the community.
- Took active role in the CHEERS program, as a member of the Board, as well as, participation in several task forces and exploring initiatives and community-based research projects.
- Completed restructuring of external handicap ramp to ensure access to all patients, staff, and visitors.
- Continued important projects to support the work and mission of the health center. These include: Urban Youth Connection Project, offering the increased resource of a

on-site coordinator working with providers to increase information on physical fitness programs and develop programs to address issues of obesity in youth; the Partners In Asthma Care Program, which offers the services of an on-site RN Case Manager to support the needs of asthmatic patients; and Reach Out and Read Program, providing free, age-appropriate books for all children seen for well-child visits.

Southern Jamaica Plain Health Center

Background

One of the health centers operating through the license of BWH, Southern Jamaica Plain Health Center (SJPHC), has been serving the community for 35 years. Starting as a well-child clinic in Jamaica Plain's Curtis Hall area and then moving to a Centre Street storefront, SJPHC moved to a beautiful modern facility at its current Centre Street location in 1998. The health center now serves over 10,000 patients with its comprehensive services of adult medicine, pediatrics, women's health, mental health/substance abuse services, cardiology, dermatology, nutrition, and podiatry. SJPHC's mission is to provide personal, high quality health care with compassion and respect to a diverse community. Health center providers include nine internists, five pediatricians, an obstetrician/gynecologist, midwives and nurse practitioners in women's health, a podiatrist and cardiologist, dermatologists who are part of the BWH Dermatology staff, and social workers, psychologists and psychiatrists in the mental health/substance abuse department. A bi-lingual staff of five nurses provide and coordinate services to patients. Patients made more than 45,000 sick and health maintenance visits last year, taking advantage of the health center's accessible schedule and 24-hour on-call service.

The health center augments its medical and mental health services with health education, case management, screening programs (blood pressure, diabetes, mammography, cholesterol), a Mind/Body Center that includes T'ai Chi and yoga, and a child literacy program. In addition, the health center has a long history of providing substance abuse treatment services to patients, families, and the community. Health center staff also work collaboratively with residents of the local South Street public housing development to promote the health of public housing residents.

The patient population of the health center is quite diverse, both ethnically and economically, reflecting the community in which it is situated. Approximately 52 percent of the patient population is Latino, 15 percent Black, and 33 percent White. The health center attracts many patients who have recently emigrated from the African continent, Asia, and the Caribbean Islands. Seventy-five percent of the health center staff is bilingual in Spanish to serve the patient population.

All of SJPHC's physicians are on staff at Brigham and Women's Hospital and are faculty of Harvard Medical School. All SJPHC providers are credentialed with the major managed care companies; financial assistance is available in the form of MassHealth, Children's Medical Security, and Free Care/Sliding Fee.

FY2008 Accomplishments

- SJPHC remains a major resource for access to care for the populations most at need in Jamaica Plain and surrounding communities: immigrant, Spanish-speaking, and low-income residents. The patient population has grown from 4,600 patients to over 10,000 patients since the move to the new facility in December 1998.
- Collaborating with JP Tree of Life and residents of the South Street public housing development, the tenth year of a community-building project was successfully completed, and funding was obtained for the next year of the project, with BWH/Partners HealthCare community benefit support as the lead funder. SJPHC is providing supervision to the Teen Peer Leadership Program. During the past year, the teen program continued to develop. The teens worked collaboratively to address violence within the community and to promote sexuality education. An afterschool program for younger children proves homework help and educational activities. A middle school component was added to the afterschool program to address the needs of sixth to eighth graders for positive activities after school.
- The Pediatric Department continued its participation in the Reach Out and Read program and was very successful in securing over 1,000 books for SJPHC's pediatric patients. Young patients receive a book each time they come for their well-child visits.
- SJPHC participated in major community activities such as the Jamaica Plain World's Fair and the Wake Up the Earth Festival.
- SJPHC received staff grants for health education from the Massachusetts Department of Public Health and for case management from the Boston Public Health Commission.
- The health center provided prenatal care to 160 women, and continues to be a major source of care in the community, particularly for Latinas.
- The SJPHC Community Advisory Board, made up of ten members, continued to provide input from patients and community members about SJPHC's services and programs.
- The health center participated in citywide Emergency Preparedness activities through the Boston Public Health Commission, establishing and clarifying roles of health center and staff in the event of an area-wide emergency.
- SJPHC was one of the core members of a community-wide effort to address youth violence. A Jamaica Plain Trauma Response Team was organized in 2008 and provided community responses to seven episodes of violence, primarily homicides.
- SJPHC provides families whose children are cared for at the center with assistance in enrolling their children in summer camp and enrichment programs. This is particularly geared toward families who would not otherwise have the resources or knowledge to enroll their children in these programs. The SJPHC Community Advisory Board and the Friends of Brigham and Women's Hospital provided funds to assist families with application fees and partial tuition where needed. Over 150 families took advantage of the program.

Access to Care

BWH is one of the largest providers of Health Safety Net care to people without means to pay for health care in the Commonwealth. In FY2008, nearly $40 million worth of care was provided to more than 3,000 patients. More than one-third of these patients came from the communities of Dorchester, Mattapan, Jamaica Plain, and Roxbury. At the same time, the hospital treated nearly 5,000 patients insured under Commonwealth Care.

BWH is also a major provider of health care for patients on Medicaid, providing more than $161 million worth of care to approximately 25,000 patients in FY2008. Nearly half of those patients were from Jamaica Plain, Dorchester, and Roxbury.

Measuring the Commitment

One way to measure BWH's commitment to the community is by the amount spent on health care services and programs. The following table calculates this in two different ways: first, according to the guidelines promulgated by the Attorney General's office and second, according to a broader definition, which considers additional components of spending or revenue loss.

Components of FY2008 Community Commitment
(in $ Millions)
Compiled According to the Attorney General Guidelines

Community Benefit Programs		
Direct Expenses		
	Program Expenses	4.0
	Health Center Subsidies (Net of HSN Care)	10.4
	Grants for Community Health Centers	2.7
Associated Expenses		N/A
DoN Expenses		0.6
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	1.9
	Doctors Free Care	4.8
Hospital Health Safety Net (HSN) Care		15.2
Corporate Sponsorships		0.5
Total per AG Guidelines		40.1

Components of FY2008 Community Commitment
(in $ Millions)
Compiled According to a Broader Definition

Community Benefit Programs		
Direct Expenses		
	Program Expenses	4.0
	Health Center Subsidies (net of HSN and Payer Losses)	4.8
	Grants for Community Health Centers	2.7
Associated Expenses		N/A
DoN Expenses		0.6
Employee Volunteerism		N/A
Other Leveraged Resources		
	Grants Obtained	1.9
	Doctors Free Care	4.8
Hospital Health Safety Net (HSN) Care		20.9
Bad Debt (at Cost)		
	Hospitals	4.7
	Doctors	7.3
Medicaid Loss (at Cost)		
	Hospitals	26.2
	Doctors	14.3
Medicare Loss (at Cost)		
	Hospitals	74.2
	Doctors	43.5
Unreimbursed Expenses for Graduate Medical Education		2.3
Corporate Sponsorships		0.5
Linkage/In Lieu/Tax Payments		2.2
Total Broader Definition		214.9

Note: Where N/A is reported, it should be noted that although amounts are not available for reporting, Partners hospitals, health centers, and physicians provide substantial contributions.

Depending upon the definition used, BWH contributed between three and more than 12 percent of patient care-related expenses to the community in FY2008.

Contact Information

For questions about this report, or for more information about BWH's community benefit activities, please contact:

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