



Boston and North Suffolk Regional Community Health Improvement Plan (CHIP)

Massachusetts General Hospital | Brigham and Women's Hospital | Brigham and Women's Faulkner Hospital

Mass General Brigham Boston and North Suffolk Regional Community Health Improvement Plan (CHIP)

In 2022, the Mass General Brigham hospitals in Boston—Massachusetts General Hospital, Brigham and Women’s Hospital, and Brigham and Women’s Faulkner Hospital—participated in two collaborative Community Health Needs Assessments (CHNAs) along with other hospitals, health centers, community-based organizations, community residents, and community stakeholders:

- [Boston CHNA/CHIP Collaborative](#)
- [North Suffolk Public Health Collaborative](#) covering Chelsea, Revere, and Winthrop

The community health needs prioritized in both CHNAs are:

- Housing
- Economic Mobility and Inclusion
- Mental and Behavioral Health, including Substance Use Disorder (SUD)
- Access to Care and Services

The Boston and North Suffolk Collaborative CHIPs defined Goals, Objectives and Strategies to impact these prioritized health needs.

This *Mass General Brigham Boston and North Suffolk Regional CHIP* adopts these Goals, Objectives and Strategies and further outlines additional strategies targeting racial and ethnic health inequities that disproportionately impact communities of color, with a focus on cardiometabolic disease and Substance Use Disorder (SUD) based on the excess deaths attributable to these conditions for Black residents.

Along with the Mass General Brigham system strategies, our Boston hospitals also employ locally directed efforts in support of the Boston and North Suffolk Collaboratives. Additional community health needs may be identified by each hospital’s CHNA and prioritized by its Community Advisory Board.

Taking the strategies defined by the Collaboratives’ CHIPs and combining them with the MGB system and hospital strategies results in a broader spectrum of efforts and initiatives that will more significantly impact community health outcomes.

While the Collaboratives are inclusive of Boston, Chelsea, Revere, and Winthrop, the target communities for our hospitals are:

- Brigham and Women’s Faulkner (BWFH): Hyde Park, Jamaica Plain, Roslindale, West Roxbury
- Brigham and Women’s Hospital (BWH): Dorchester, Jamaica Plain, Mattapan, Mission Hill, Roxbury
- Massachusetts General Hospital (MGH): Charlestown, Chelsea, Revere
- MGB Priority Communities (MGB): Boston, Chelsea, Revere, Lynn, Salem

Each entity is required to define target communities as part of the CHNA process, and efforts may overlap across neighborhoods and communities.

Mass General Brigham Community Health Improvement Strategies

Boston and North Suffolk Priority and Goal	Mass General Brigham Strategies
<p>Housing GOAL: Support safe, stable, healthy, equitable, affordable housing solutions.</p>	<ul style="list-style-type: none"> • Improve access to stable housing for patients and community members through social determinants of health screening and referral to support services, and advocacy.
<p>Economic Mobility and Inclusion GOAL: Close the historic, generational, racial, and ethnic income and wealth gaps.</p>	<ul style="list-style-type: none"> • Create a collective impact model with partner organizations and hospitals to support economic mobility and wealth building for working families and marginalized populations. • Advocate for policies that support economic mobility – e.g., Earned Income Tax Credit expansion.
<p>Mental Health and Behavioral Health including Substance Use Disorder GOAL: Promote mental health and emotional wellness by nurturing resilient communities and building equitable, accessible, and supportive systems of care.</p>	<ul style="list-style-type: none"> • Expand the behavioral health workforce through pipeline programs, scholarships and staff incentives to increase the number of BIPOC and bilingual mental health practitioners in the overall workforce and community health centers. • Support the establishment of five community-based behavioral health centers to facilitate access to Pediatric Behavioral Health Urgent Care. • Establish policies and procedures to provide or enhance trauma informed care. • Expand access to Substance Use Disorder Treatment for Black, Hispanic and non-English speaking individuals. • Advocate for policies that address inequities in mental health and behavioral health.
<p>Access to Care and Services GOAL: Ensure all people have access to coordinated and equitable health and family support services and resources to support overall health.</p>	<ul style="list-style-type: none"> • Provide innovative care models through mobile vans and Neighborhood Empowerment and Engagement Centers (NEERs) offering COVID services, nutrition, physical activity, and mental health programming to reduce hypertension and improve cardiometabolic disease. • Improve food/nutrition security through patient screening and mitigation, increasing SNAP & WIC enrollment and supporting local teaching kitchens.

	<ul style="list-style-type: none"> • Improve Patient Gateway enrollment for MGB patients in Boston and North Suffolk, eliminate restrictions on telehealth services and support policies and programs that help residents access the internet. • Engage BPS schools in healthy eating and exercise education and mental health interventions.
Chronic Disease GOAL: Design strategies and programs to help improve health outcomes for those with chronic disease.	<ul style="list-style-type: none"> • Provide chronic disease prevention and management services to patients and community members through the Mass General Brigham Community Care Van service. • Enroll at-risk residents and patients in digital chronic disease management programs. • Increase access to fresh, healthy food for patients with or at risk for cardiometabolic disease and substance use disorders, including via policy advocacy.

Boston and North Suffolk Collaborative Combined CHIP

HOUSING GOAL: Support safe, stable, healthy, equitable, affordable housing solutions for the diverse communities of Boston through a racial equity lens. Housing concerns of the community included housing affordability, quality, homelessness, homeownership, gentrification, and displacement. Housing is typically the largest household expense, and, for homeowners, housing can be an important source of wealth. For low-income residents, housing instability, the stress of unaffordable housing costs, and poor housing quality increase the risk of adverse health outcomes. Mounting housing concerns in Boston were exacerbated during the COVID-19 pandemic and led to increased displacement of residents.	
OBJECTIVE 1: Support efforts to increase Boston’s supply and production of affordable, safe and healthy housing options and decrease the displacement of low/moderate income residents.	
BCCC CHIP Strategies	Highlighted Hospital Efforts to advance the CHIP Strategies
1. Advocate for public and private funding to support the production of affordable housing.	Across the MGB System: <ul style="list-style-type: none"> • Advocate for and support policies that increase access to and supply of housing affordability.

<p>2. Support efforts to increase resources towards Community Development Corporations and other non-profit developers in order to increase their ability to construct, preserve, and manage affordable housing.</p>	<p>BWFH:</p> <ul style="list-style-type: none"> • Through partnership, support elder residents so that they may stay in their homes and not become displaced with the enhanced home modification and CAPABLE programs. <p>BWH:</p> <ul style="list-style-type: none"> • Invest in community-based organizations engaging in housing stabilization efforts through housing support funds. <p>MGH:</p> <ul style="list-style-type: none"> • Anchor Investment in Chelsea with local community development corporations to preserve affordable housing. • Continue investments in housing through MGH Determination of Need (DoN) funding.
<p>OBJECTIVE 2: Reduce housing insecurity and chronic homelessness by enhancing and supporting City initiatives and systems.</p>	
<p><i>BCCC CHIP Strategies</i></p>	<p><i>Highlighted Hospital Efforts to advance the CHIP Strategies</i></p>
<p>1. Advocate for appropriate housing options for patients upon discharge from hospital emergency departments, inpatient, or post-acute care.</p>	<p><i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i></p>
<p>2. Support policies that prevent evictions and create resources for residents at risk of displacement.</p>	<p>MGH:</p> <ul style="list-style-type: none"> • Advocate and support local public and affordable housing projects through efforts of city-wide coalitions and community engagement (Healthy Chelsea and Revere CARES). • Partner with Boston Housing Authority on advocacy of current Bunker Hill Housing residents’ statuses during and after redevelopment (Charlestown Coalition).
<p><i>Additional Hospital and System Strategies to Advance the CHIP</i></p>	<p><i>Additional Hospital and System Efforts to Advance the CHIP</i></p>

<p>. Support programs and initiatives within our licensed community health centers, practices and programs, to support patients and community members with housing instability.</p>	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Screen individuals for housing insecurity and other Social Determinants of Health in our hospitals and through the Mass General Brigham Community Care Vans. <p>BWFH:</p> <ul style="list-style-type: none"> • Screen and provide resources and information to community members seeking housing assistance through our community SDOH outreach work. <p>BWH:</p> <ul style="list-style-type: none"> • Provide housing advocacy and support through Housing Advocates, Community Health Workers, and Resources Specialist to patients in BWH licensed community health centers, and clinics. • Provide program participants of the Family Partnership Program with housing resources and referrals. • Provide legal representation and consultation on issues of housing to patients and community members through the Passageway Health Law Collaborative (PHLC). <p>MGH:</p> <ul style="list-style-type: none"> • Continue to implement Medical-Legal Partnerships at MGH Chelsea that connect clients to legal advocacy related to public benefits, housing and immigration: Legal Initiative for Care (LINC) and Lawyers for Civil Rights. • Provide supportive services to young children, their families, and youth to ensure development and growth in stable home environments (Early Childhood Home Visitors, Charlestown Family Support Circle). • Screen and provide resources and information to patients and community members seeking housing assistance through Community Health Workers. • Continued partnership with Boston Healthcare for the Homeless Street Outreach program.
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OBJECTIVE 3: Support efforts to increase pathways to independence by helping households in subsidized and affordable housing to stabilize and/or move on to home ownership.	
<i>BCCC CHIP Strategies</i>	<i>Highlighted Hospital Efforts to advance the CHIP Strategies</i>
1. Advocate for additional resources being allocated to support down payment assistance programs targeted toward low-income homebuyers and first-generation homebuyers.	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>
2. Ensure the Boston CHNA-CHIP Collaborative is represented in key housing coalitions and decision-making bodies.	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>
Select Data Measures for Housing	
<ul style="list-style-type: none"> - Number of patients screened for housing instability - Number of referrals made to housing support services - Number of community-based organizations funded to support housing stabilization efforts - Number of bills or policies supported and adopted - Dollars distributed to community-based organizations to support housing stabilization efforts 	

ECONOMIC MOBILITY and INCLUSION

GOAL: Close the historic, generational, racial, and ethnic income and wealth gaps in the city of Boston

Income, work, and education are powerful determinants of health because they lead to financial security and the ability to thrive. It is a challenge to prioritize health when prioritizing survival. Jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access to affordable healthy foods and the ability to afford it), and provide income and benefits to access health careⁱⁱⁱ. In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, healthy food, goods and services that are linked with health, and health care, and contribute to stressful life circumstances that affect multiple aspects of health.

OBJECTIVE 1: Contribute to an ecosystem that prioritizes inclusive economic mobility and increases generational wealth building in disinvested Boston communities.

<i>BCCC CHIP Strategies</i>	<i>Highlighted Hospital Efforts to Advance CHIP Strategies</i>
1. Systematically connect with public and private partners to identify key areas of collaboration to advance the objective.	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>
2. Work with state and local education and training providers to promote career exposure and advancement and educational attainment for Boston residents.	<p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> • Through partnerships, provide opportunities for students to learn about careers (job shadow, career panels, etc.). • Provide employment opportunities for students with a collaboration of multiple partners and offer onsite training and resources to increase job readiness. • Collaborate with Boston PIC and others to replicate youth workforce development programs across Boston and North Suffolk. • Provide a continuum of education, career exposure, and employment programming for young people in partnership with Boston Public Schools (BPS).
3. Partner with and implement key financial education and economic mobility programs to maximize program participation and impact (including providers of financial literacy and saving assistance, small business support and job readiness services for community members experiencing the greatest employment barriers).	<p>BWFH:</p> <ul style="list-style-type: none"> • Through partnerships, offer residents job readiness training, support to address barriers individuals face in getting to work and maintaining a job, and greater access to jobs and interviews through online awareness events. <p>BWH:</p> <ul style="list-style-type: none"> • Through the Stronger Generations Initiative, partner with community-based organizations to support financial literacy and workforce development for young parents. <p>MGH:</p> <ul style="list-style-type: none"> • Collaborate with community partners in Chelsea and Revere to address economic stability and mobility through coordinated municipal workforce development efforts of MassUP Grant (Cross-City Coalition) to increase skilled, benefitted jobs for residents.

	<ul style="list-style-type: none"> Implement the EMPATH (Economic Mobility Pathways) model of financial mobility within the Early Childhood Home Visitors program.
4. Advocate for employers to share current practices and adopt innovative and impactful workforce development and procurement strategies and determine a method to track progress and document impact.	<p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> Participate in series of meetings with various partners to develop year-round youth workforce development programs.
<i>Additional Hospital and System Strategies to Advance the CHIP</i>	<i>Additional Hospital and System Efforts to Advance the CHIP</i>
5. Invest in communities to build trust, address critical social determinants of health, and improve economic mobility.	<p>Across the MGB System:</p> <ul style="list-style-type: none"> Partner with local CBOs to establish a Neighborhood Empowerment and Engagement Resource Center (NEER) in at least 1 Boston neighborhood. Establish a Community-Directed Fund providing grants towards focus areas prioritized by a Community Board. Advocate for and support policies that increase economic mobility and build wealth for working families and marginalized populations. <p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> Continue to be a critical part of the community and participate in the local business and community organizations to better connect and address needs. Increase awareness, promotion, and support of local businesses to support economic vitality by partnering with Main Streets organizations in priority neighborhoods. Screen for SDOH and food insecurity in schools to help address the needs of families. Provide resources and connections on the community van to help families with various SDOH and other barriers.

	<ul style="list-style-type: none"> • Continue to develop partnerships with grassroots community-based initiatives to expand our work on addressing food insecurity, SDOH and other issues. • Engage in supplier diversity committees and strategies to advance procurement of local and diverse business products. • Continue investments in financial and economic mobility and stability programs through MGH Determination of Need (DoN) funding.
OBJECTIVE 2: Develop accessible systems and tools that provide community members with information on job opportunities and career development tools.	
<i>BCCC CHIP Strategies</i>	<i>Highlighted Hospital Efforts to Advance CHIP Strategies</i>
1. Disseminate and broadly promote the Economic Mobility Hub (EMH) App to streamline access to living wage employment and career development and community-based resources.	BWFH/BWH/MGH: <ul style="list-style-type: none"> • Promote and educate residents on the EMH in our community outreach efforts with the mobile van.
2. Identify and advocate for additional support and data tracking needed to ensure quality of user experience of the EMH App.	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>
<i>Additional Hospital and System Strategies to Advance the CHIP</i>	<i>Additional Hospital and System Efforts to Advance the CHIP</i>
3. Adopt innovative workforce development strategies to train low-and moderate-income Boston residents.	BWFH/BWH/MGH: <ul style="list-style-type: none"> • Through partnerships and staff dedicated to resource navigation for patients, provide job training to residents in various areas to obtain access to jobs, as well as ESL classes.
Select Data Measures for Economic Mobility and Inclusion	
- Number of new partnerships (by sector)	

- Implementation of a Neighborhood Empowerment and Engagement Resource Center (NEER) in at least one Boston neighborhood
- Number of community-directed grants awarded
- Number of high school students participating in the MGB Scholars Program
- Key outcomes for MGB Scholars Program participants and alumni, including but not limited to:
 - o High school graduation rate
 - o College matriculation rate (overall and of first-generation college students)
 - o College persistence rate
 - o Number of youth program participants employed at MGB
- Number of bills or policies supported and adopted

MENTAL AND BEHAVIORAL HEALTH

GOAL: Promote mental health and emotional wellness by nurturing resilient communities and building equitable, accessible, and supportive systems of care

Community leaders and residents described trauma, stress, depression, and anxiety as top-of-mind concerns among all populations, but some groups were cited as being disproportionately impacted – such as youth, low-income households, caregivers, elders, and people of color.

OBJECTIVE 1: Increase the number of diverse culturally/linguistically responsive licensed clinical behavioral health workers and community-based behavioral health caregivers.

BCCC CHIP Strategies

Highlighted Hospital Efforts to Advance CHIP Strategies

1. Increase awareness of career pathways, incentives, and supports for individuals from communities of color to join the behavioral health workforce.

Across the MGB System:

- Expand the behavioral health workforce by designing and implementing pipeline and career ladder programs from “high school to grad school”.
- Develop a scholarship program specifically designated to increase the number of BIPOC and bilingual students that become mental health practitioners.

BWFH/BWH/MGH:

- Develop partnerships to provide learning and referrals in the area of mental health and social work.

	<ul style="list-style-type: none"> Promote mental health and substance use disorder careers in our communities and youth programs. Attract and retain clinicians of color through various targeted recruitment efforts through multicultural media outlets.
2. Increase the pool of Community Health Workers and Recovery Coaches with specialized mental health/substance use training who represent low-income, immigrant, LGBTQ+, seniors, and/or communities of color.	<p>Across the MGB System:</p> <ul style="list-style-type: none"> Support the establishment of five community-based behavioral health centers to facilitate access to Pediatric Behavioral Health Urgent. <p>BWFH/MGH:</p> <ul style="list-style-type: none"> Support mental health and substance use disorders work with DoN funds and strategies. Continued support of new and innovated behavioral health workforce.
3. Enhance retention and prevent burn-out of clinical licensed behavioral health workers and community-based behavioral health caregivers from underrepresented communities through worker-informed supports and incentives.	<p>Across the MGB System:</p> <ul style="list-style-type: none"> Provide long term salary supplements for behavioral health staff (MDs, PhD, and NPs) to work in community health centers. Provide scholarships for social work students during their clinical rotations. Develop social work leaders equipped to work with the Latinx and Black communities on sustainable solutions for complex social problems. <p>MGH:</p> <ul style="list-style-type: none"> Work with community health centers to address burn-out among providers and connect work to HRSA Grant: Promoting Resilience and Mental Health Among Health Professional Workforce Grant
OBJECTIVE 2: Increase the number of non-traditional places/settings for children, adults and families to access behavioral health services and resources and support.	
<i>BCCC CHIP Strategies</i>	<i>Highlighted Hospital Efforts to Advance CHIP Strategies</i>
1. Explore funding to place behavioral health specialists in every Boston	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>

<p>Housing Authority and Boston Public School site.</p>	<p>BWFH/ MGH</p> <ul style="list-style-type: none"> • Support mental health and substance use disorder initiatives with DoN funds and strategies.
<p>2. Work with the City and other partners to identify and promote additional therapeutic landscapes (such as parks and other outdoor spaces) for positive mental health experiences.</p>	<p><i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i></p> <p>BWFH/MGH:</p> <ul style="list-style-type: none"> • Support mental health and substance use disorder initiatives with DoN funds and strategies.
<p>Additional Hospital and System Strategies to Advance the CHIP</p>	<p><i>Additional Hospital CAB Approved Enabling Efforts to advance CHIP</i></p>
<p>3. Offer behavioral health counseling, substance use disorders interventions, and harm reduction services to community members, patients, and program participants.</p>	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Expand access to culturally competent SUD treatment and recovery. • Provide substance use disorder treatment on the Community Care Vans. • Expand access to substance use disorder treatment at Mass General Brigham for Black, Hispanic and non-English speaking individuals. • Expand access to substance use disorder treatment at Community Health Centers. • Advocate for and support policies that reduce barriers to care and increase access to treatment. <p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> • Continue to develop work with partners in providing opportunities and programming. for mental health and SUDS for individuals and families using trauma informed interventions. • Provide safe medication information and measures for safe disposal. • Provide resources for those experiencing domestic violence.

	<ul style="list-style-type: none"> • Provide no-cost mental health services for people experiencing and/or witnessing domestic violence, community violence, and trauma. • Provide mental health support to young people participating in youth programs. • Continue to support the MGH Bridge Clinic, a transitional outpatient addiction clinic for discharged inpatients and patients leaving the emergency department not yet connected to outpatient care and expand across communities.
OBJECTIVE 3: Decrease mental health related stigmas by supporting communications about wellness, mental health, and substance use that offer coping skills to individuals, families, and communities and seek early intervention.	
<i>BCCC CHIP Strategies</i>	<i>Highlighted Hospital Efforts to Advance CHIP Strategies</i>
1. Identify opportunities to engage in the City of Boston’s efforts to reduce mental and behavioral health stigma.	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>
2. Work collaboratively with the Boston Public Health Commission to expand the capacity and resilience of community partners and neighborhoods to support response and recovery to mental health and substance use.	<p>BWFH/MGH:</p> <ul style="list-style-type: none"> • Support mental health and substance use disorder initiatives with DoN funds and strategies. <p>MGH:</p> <ul style="list-style-type: none"> • Improve the well-being of communities through commitments of city-wide coalitions (The Charlestown Coalition, EASTIE Coalition) to increase access to mental health services as well as strengthen protective factors and reduce risk factors to prevent substance abuse and negative effects of misuse.
Additional Hospital and System Strategies to Advance the CHIP	Additional Hospital and System Efforts to Advance the CHIP
3. Provide substance use prevention and harm reduction education and early intervention to patients, families, community members, and medical providers.	<p>BWFH:</p> <ul style="list-style-type: none"> • Through our school partnerships, provide early education to youth in BPS for prevention. • Support mental health and substance use disorder initiatives with DoN funds and strategies.

	<p>BWH:</p> <ul style="list-style-type: none"> • Offer Q.P.R. Suicide Gatekeeper Training to staff, interns, and community members through Stepping Strong Injury Prevention Program. • Provide Narcan training and injury prevention resources and information to community-based organizations and residents at community events. <p>MGH:</p> <ul style="list-style-type: none"> • Support education on substance use prevention through initiatives of the community coalitions (Healthy Chelsea, Revere CARES, The Charlestown Coalition, EASTIE Coalition) and state grants (MassCALL3) and connect community to resources and information on substance use. • Provide Narcan training and injury prevention resources and information to community-based organizations and residents at community events. • Support regional-level substance use prevention efforts (MassCALL3) to promote community engagement and capacity building, comprehensive strategy implementation, and innovation.
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Select Data Measures for Mental and Behavioral Health

- Number of behavioral health providers hired
- Percentage of BIPOC providers hired and/or promoted
- Increase in mental health practitioner program enrollments for BIPOC
- Increase in BIPOC mental health practitioners
- Number BIPOC individuals receiving SUD treatment
- Retention rate of behavioral health providers (for BIPOC providers in particular)
- Provider job satisfaction
- Number of young people receiving mental health support through youth programs
- Number of counseling sessions provided to those experiencing intimate partner/domestic violence
- Number of bills or policies supported and adopted
- Number of workshops and trainings on mental health and substance use
- Number of CHWs trained on how to navigate complex mental health needs

ACCESSING SERVICES

GOAL: Ensure all people in Boston have access to coordinated and equitable health and family support services and resources to support overall health

Residents and community leaders continued to cite numerous barriers to accessing childcare, social services, healthy food and health care including cost, transportation, language access, limited Internet, discrimination and systemic racism, immigration/documentation status, limited culturally appropriate services, and the difficulties in navigating the complex social service and health care systems. Accessing childcare, social services, and health care was identified as a prominent theme and priority area in the previous community health needs assessment and improvement plan. Some aspects of access limitations came up in nearly every conversation in this recent process, and many issues were exacerbated during the pandemic.

OBJECTIVE 1: Partner with community members and organizations to increase awareness and develop innovative outreach models to address persistent health inequities.

BCCC CHIP Strategies

Highlighted Hospital Efforts to Advance CHIP Strategies

1. Support the Boston Public Health Commission's grant to improve the Mass211/ HelpSteps online social service platform to make it easier to find and access services.

MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.

2. Work collectively to increase resident enrollment in the Supplemental Nutrition Assistance Program (SNAP) and identify additional priority areas of collaborative action to address nutrition security in Boston and North Suffolk.

Across the MGB System:

- Maximize SNAP and WIC enrollment for MGB patients in Boston and North Suffolk.
- Support and expand existing commitment to food access, teaching kitchens, and social determinants mitigation.

BWFH/BWH/MGH:

- Continue initiatives that provide greater access to fresh fruit and vegetables for low income/food insecure families and individuals identified.

	<ul style="list-style-type: none"> • Continue partnership with multiple food and nutrition equity community groups to address food insecurity, access, and awareness. • Develop cooking classes for low income/low access residents. • Utilize community van or other mode to continue providing free meals (hot and frozen) and grocery bags to a variety of community partners and locations (BWFH and BWH). • Distribute fresh foods through weekly food distribution program at health centers and community-based organizations. • Continue to serve a multitude of local, city, state and national organizations to address food insecurity. • Provide information and application assistance for SNAP and WIC to residents and patients in the community.
<p>3. Continue and amplify targeted efforts on health education and vaccine outreach focused on Boston neighborhoods and populations with lower vaccination rates, specially related to COVID-19 or other infectious public health concerns.</p>	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Continue to provide needed COVID response through Community Care Vans. <p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> • Provide annual flu vaccine clinics in the community utilizing community partnership and our mobile efforts. • Continue to provide education and information to the community using mobile efforts on COVID, vaccines, boosters, masking and other safety measures. • Provide health education instruction in BPS for elementary aged youth in schools. • Provide flu and COVID-19 vaccines to seniors and residents at annual flu clinic in partnership with housing and human service organization.
<p>4. Identify and pursue opportunities for additional collaborative outreach efforts to address chronic diseases that disproportionately impact people of color and contribute to premature mortality (e.g., heart disease, cancer, diabetes).</p>	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Establish Neighborhood Empowerment and Engagement Centers (NEERs) to bring together screening, nutrition, physical activity, and mental health programming and services to convenient community settings. <p>BWFH:</p>

	<ul style="list-style-type: none"> • Provide free screenings to community members at partnership sites to address heart disease and diabetes. <p>BWH:</p> <ul style="list-style-type: none"> • Through Connecting Hope, Assistance, and Treatment (CHAT) Program, provide stipends, resources and support to low-income patients for services related to their breast cancer diagnosis. • Offer "Home Hospital" care to acutely ill adults in their homes. • Provide free cancer and memory screenings, resources, and information to patients and during community outreach events. <p>MGH:</p> <ul style="list-style-type: none"> • Offer on-site health and social services to residents in three apartment buildings near MGH campus through the Connect to Wellness program.
<p><i>Additional Hospital and System Strategies to Advance the CHIP</i></p>	<p><i>Additional Hospital and System Efforts to Advance the CHIP</i></p>
<p>5. Increase the capacity of community health centers and other health care organizations to reduce barriers to care for patients through community health workers, navigators, and other outreach programs.</p>	<p>BWH/MGH:</p> <ul style="list-style-type: none"> • Support Community Health Workers and Resource Specialists in screening patients for SDOH and making referrals and connections to appropriate resources and services. • Strengthen Community Health Worker (CHWs) workforce to support patients who have multiple health issues and barriers to care who often are immigrants or refugees, have limited English proficiency, little social support and/or are not familiar with the US medical system to help create and accomplish goals and increase their connection to primary care. • Offer health education and support programs for community members with specific health and social needs at Community Health Centers and community organizations.

	<ul style="list-style-type: none"> • Provide a wide variety of health equity programs through the Health Promotion Center at Southern Jamaica Plain Health Center designed from a racial justice lens. • Provide access to care at MGH in partnership with The Boston Health Care for the Homeless Program to ensure access to care for homeless men, women, and children in Boston.
6. Expand access to Digital programs to at-risk community residents.	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Enroll at-risk residents in digital chronic disease management programs. • Increase Patient Gateway enrollment for MGB patients in Boston and North Suffolk. • Advocate for and support policies that increase access to affordable broadband and devices and eliminate restrictions on telehealth services.
7. Invest in school-based initiatives.	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Expand the number of BPS schools participating in initiatives like Stay in Shape and BCH Neighborhood Partnerships to provide more students with healthy eating and exercise education and mental health interventions. <p>BWFH/MGH:</p> <ul style="list-style-type: none"> • Continue school partnerships that provide wellness education, programming, food insecurity initiatives, health eating programs, school support, staff support and interventions. • Provide primary care and services in mental health, nutrition, health education, substance abuse prevention, violence prevention, and assistance with health insurance enrollment to all students at School-Based Health Centers at Chelsea High School and Revere High School.
OBJECTIVE 2: Increase the number of flexible, affordable, high quality childcare options for children birth to 8-years old.	
<i>BCCC CHIP Strategies</i>	<i>Hospital Efforts to Advance CHIP Strategies</i>
1. Advocate to improve employer policies and investments towards providing	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>

childcare resources to their employees and workplace communities.	
2. Advocate to increase City, State, and Federal funding to expand access to high quality early education and childcare.	<i>MGB hospitals will support and advance the Boston CHNA-CHIP Collaborative activities for this strategy.</i>
OBJECTIVE 3: Increase the number of trained health, educational, and family support service staff that provide culturally and linguistically relevant care across Boston.	
<i>BCCC CHIP Strategies</i>	<i>Highlighted Hospital Efforts to Advance CHIP Strategies</i>
1. Work with the City and larger service provider organizations to increase peer and community-based outreach support services for refugee, immigrant, and non-English speaking communities. Ensure the Boston CHNA-CHIP Collaborative is represented in key housing coalitions and decision-making bodies.	MGH: <ul style="list-style-type: none"> Develop a CHW-based mental health program through the MGH Center of Immigrant Health to increase access to mental health services for MGH patients who prefer languages other than English, including newly arrived immigrants.
<i>Additional Hospital and System Strategies to Advance the CHIP</i>	<i>Additional Hospital and System Efforts to Advance the CHIP</i>
2. Provide culturally and linguistically relevant care to MGB patients.	Across the MGB System: <ul style="list-style-type: none"> Develop language-concordant clinical content available in the top 6 non-English languages read by MGB patients – Spanish, Portuguese, Haitian Creole, Russian, Arabic, Traditional Chinese.
<i>Select Data Measures for Accessing Services</i>	
<ul style="list-style-type: none"> - Number of patients screened for SDOHs - Number of patients screened for food insecurity - Number of referrals made - Number of people served with the BHCHP - Number of food assistance referrals and SNAP applications completed - % Increase in SNAP/WIC enrollment - Increase in food pantry utilization 	

- Number of teaching kitchen activities
- % Increase in Patient Gateway enrollment
- Number of clients actively engaged in NEERs
- Number of participants attending education/support programs
- Number of students receiving care at school-based health centers
- Number of preventative screenings conducted, and treatment services provided through Community Care Van efforts
- Number of individuals provided digital access supports
- Number of BPS participating in initiatives like Stay in Shape; corresponding changes in knowledge around healthy eating and active living
- Number of bills or policies supported and adopted
- Reduce racial disparities in health outcomes particularly for hypertension, cardiometabolic disease and SUDS

MGH & BWH Priorities

VIOLENCE AND TRAUMA

Goal: Promote policies, systems, and programs to achieve safety in communities and homes.

Violence and trauma are critical public health concerns that impact all aspects of health and wellness, which continue to be a reoccurring theme with residents and community leaders in the CHNA. The COVID-19 pandemic created conditions intensifying violence and trauma with a disproportionate impact on communities of color and other marginalized groups. Community leaders and residents described trauma as one of the top-of-mind concerns and internal stakeholders drew attention to elevated experiences of violence and trauma for patients, residents, and communities during the pandemic.

OBJECTIVE 1: Provide an integrated and effective response to those experiencing violence and trauma and build system capacity to provide trauma-informed care in our communities.

Hospital and System Strategies to Advance the CHIP

Highlighted Hospital and System Efforts to Advance the CHIP

<p>1. Provide advocacy and support to patients and community members who experience human trafficking, domestic, sexual, and/or community violence.</p>	<p>Across the MGB System:</p> <ul style="list-style-type: none"> • Provide trauma support using a community-based approach to foster recovery and healing from all sources of post-traumatic stress, including exposure to violence, poverty, and racism. <p>BWH/MGH:</p> <ul style="list-style-type: none"> • Provide advocacy, safety planning, psychoeducation, and supportive counseling for community members and patients through Passageway/HAVEN, Adelante, Jamaica Plain Neighborhood Trauma Team/Charlestown Coalition’s Trauma Response Team, and Violence Recovery Program/Violence Intervention Advocacy Program.
<p>OBJECTIVE 2: Promote safety in the home and in the community through clinical care and education, community engagement, advocacy, and research.</p>	
<p><i>Hospital and System Strategies to Advance the CHIP</i></p>	<p><i>Highlighted Hospital and System Efforts to Advance the CHIP</i></p>
<p>1. Collaborate with key community partners to participate in community events and offer supportive violence prevention education to residents and patients in high-risk environments.</p>	<p>BWH/MGH:</p> <ul style="list-style-type: none"> • Connect patients experiencing community violence to resources and support via the Violence Recovery Program advocates. • Participate in city-wide Neighborhood Trauma Team network and community safety meetings to coordinate resources and support for communities and residents impacted by violence. • Continue and expand collaboration between community-based organizations and Jamaica Plain Neighborhood Trauma team, to develop and participate in community-led events and activities. • Provide trauma responses assistance through immediate care, ongoing support, and access to resources through the Charlestown Trauma Team. • Offer BWH Stepping Strong Injury Prevention Program <i>Stop the Bleed</i> training and additional training provided by the MGH Charlestown Trauma Response team to community members and organizations. • Participate in community-led events and activities to offer resources through city-coalitions with deep roots in neighborhoods: Healthy Chelsea

	Coalition, The Charlestown Coalition, EASTIE Coalition, and Revere CARES Coalition.
Select Data Measures for Violence and Trauma	
<ul style="list-style-type: none"> - Number of patients supported by Violence Intervention and Prevention Programs - Number of consultations and training sessions for providers and hospital staff - Number of trainings for community-based organizations - Number of partnerships with community-based organizations - Number of community events in which staff participated - Increase in patients and community members reporting feeling safe 	

CHRONIC DISEASE / PHYSICAL HEALTH	
Goal: Design strategies and programs to help improve health outcomes for those with chronic disease.	
Data show that heart disease, cancer, and other chronic diseases are drivers of mortality in Boston and North Suffolk communities. There are significant racial and ethnic disparities in these conditions that result in higher mortality rates. Residents and community residents underscored how preexisting conditions worsened during the pandemic, including chronic conditions that are difficult to manage, conditions that remained undiagnosed, and chronic conditions linked with trauma.	
OBJECTIVE 1: Ensure high-risk patients with chronic disease receive access to coordinated health and support services, assistance with social determinants, medications, and other resources to better manage their disease.	
<i>Hospital and System Strategies to Advance the CHIP</i>	<i>Highlighted Hospital and System Efforts to Advance the CHIP</i>

<p>1. Enable easier access to care for chronic diseases in MGB priority communities.</p>	<p>Across the MGB System</p> <ul style="list-style-type: none"> • Provide chronic disease prevention and management services to patients and community members through the Mass General Brigham Community Care Van service. • Enroll at-risk residents in digital chronic disease management programs. • Target CHW programming to patients with uncontrolled hypertension. • Expand programs to increase access to fresh, healthy food for patients with or at risk for cardiometabolic disease and substance use disorders. <p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> • With partners, offer a phase 4 community-based program for patients with unmanaged BP, pre-diabetes, obesity or overweight (including education, fitness training, monitoring, goal setting, nutrition classes and demos). • Provide fitness and movement classes for elderly and those isolated or without access. • Develop a CHF program for low income discharged patients with the goal of addressing their nutrition and nutrition education after diagnosis. • Provide resources and education for blood pressure and diabetes in the community, utilizing our partnerships and mobile work. • Grow partnerships with community organizations to help community members access prevention activities and connections to fitness training and monitoring. • Partner with community-based organizations and media outlets to provide information on chronic diseases to community residents. • Engage obese or at-risk for obesity pediatric population in community health centers' Fitness in the City program, providing community resources and information about healthy foods. • Provide emergency assistance to community health center patients and staff in need of transportation or other immediate needs.
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<p>2. Provide education, prevention and screening to better address chronic disease in target populations.</p>	<p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> • In partnership with several community sites and partners, provide prevention screening and education for cardiovascular disease/diabetes/obesity especially in neighborhoods identified as having higher than average rates of chronic disease and mortality.
<p>3. Identify and pursue opportunities for additional collaborative outreach efforts to address chronic diseases that disproportionately impact people of color and contribute to premature mortality (e.g., heart disease, cancer, diabetes).</p>	<p>BWFH/BWH/MGH:</p> <ul style="list-style-type: none"> • Continue to work with many partners on collaborative efforts to address chronic disease prevention, management and education.
<p>Select Data Measures for Chronic Disease / Physical Health</p>	
<ul style="list-style-type: none"> - Avg daily visit volume for Mobile Care Vans - Number of enrollments in digital chronic disease programs - Change in chronic disease control metrics - Number of at-risk individuals receiving nutrition supports - Number of screenings at community sites - Change in chronic disease control metrics, particularly around hypertension and cardiometabolic disease 	

Additional MGH Priorities

The MGH has separated, and highlighted Food & Nutrition Insecurity and Substance Use Disorders as unique priorities (separate from Mental Health and Access to Care) given the specific needs across Boston and North Suffolk. Below are strategies we will be initiating in the years ahead to address these important issues.

<p>FOOD & NUTRITION INSECURITY</p>
<p>Goal: End hunger and increase healthy eating in Boston and North Suffolk.</p>
<p>OBJECTIVE 1: Increase healthy eating and active living by advocating for systems changes, increasing opportunities for physical activity, and providing healthy food resources to patients and community residents</p>

<i>Hospital and System Strategies to Advance the CHIP</i>	<i>Highlighted Hospital and System Efforts to Advance the CHIP</i>
<p>1. Support policy, systems, programs, and environmental changes to increase access to affordable, healthy foods and physical activity in communities and school environments.</p>	<ul style="list-style-type: none"> • Provide curriculum-based health education (Stay in Shape) on healthy eating and active living among school youth in MGH Health Center-served communities of Charlestown, Chelsea and Revere. • Promote community participation through Revere on the Move’s Farmers Markets. • Sustain internship programs like Youth Food Movement to empower high school and middle school students to advocate for higher quality food in their school. • Support school programs by hosting FoodCorps Service Members embedded in early learning centers and elementary schools to increase awareness around gardening and preparing healthy food among young children in Chelsea. • Foster partnership between Healthy Chelsea, Chelsea School Food Services, Chelsea Public Schools and Northbound Ventures to improve school meals in the district. • Support food relief efforts through the Hunger Network to educate and raise funds for local pantries and soup kitchens and in collaboration with City of Chelsea, expand food assistance taskforce.
<p>2. Screen for and provide resources to patients who are struggling with food insecurity.</p>	<ul style="list-style-type: none"> • Refer patients and families with food insecurity to Food for Families that connects patients with local and federal food resources such as SNAP benefits (formerly known as Food Stamps), the WIC (Women, Infants, and Children) Program, food pantries, and community meal sites. • Distribute fresh foods through weekly food distribution program at health centers and community-based organizations.
<p>Select Data Measures for Food & Nutrition Security</p>	
<ul style="list-style-type: none"> - Number of youth engaged in workshops/programs - Number of patients screened for food insecurity - Number of food assistance referrals and SNAP applications completed 	

- Number of public-school students participating in initiatives like Stay in Shape
- Number of teaching kitchen activities
- Increase in SNAP/WIC enrollment
- Increase in food pantry utilization
- Increase in changes of youth knowledge around health eating and active living
- Number of bills or policies supported and adopted
- Youth and families reporting a decrease in worrying about food insecurity

SUBSTANCE USE DISORDERS

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.

OBJECTIVE 1: Support multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to increase resiliency, reduce youth substance use, and prevent opioid overdoses and deaths.

Hospital and System Strategies to Advance the CHIP

Highlighted Hospital and System Efforts to Advance the CHIP

1. Provide opioid overdose prevention and harm reduction education to those struggling with addiction, families, and medical providers in Greater Boston and provide substance use prevention education and early intervention, particularly around marijuana, vaping, and opioids to parents and youth.

- Support education on substance use prevention through initiatives of city-wide coalitions (Healthy Chelsea, Revere CARES, The Charlestown Coalition, EASTIE Coalition) and state grants (MassCALL3) and connection to community resources and information on substance use.
- Support community-level substance use prevention efforts through grant funds (MassCALL3) to promote community engagement and capacity building, comprehensive strategy implementation, and innovation.

2. Support clinical initiatives developed in response to community needs that are designed to improve the quality, clinical outcomes, and value of addiction treatment for patients with SUDs.

- Continue to support the Bridge Clinic to provide patients with necessary addiction treatment for their SUDs while awaiting to connect with community resources and outpatient care.
- Assist patients with access to treatment, provide emotional support, advocacy for legal issues, assistance with housing, transportation, GED

	<p>programs, and education on overdose prevention through recovery coach program.</p> <ul style="list-style-type: none"> • Launch mobile van sessions in underserved communities to better engage patients of color.
<p>Select Data Measures for Substance Use Disorders</p>	
<ul style="list-style-type: none"> - Number of workshops and trainings on substance use - Number of BIPOC patients engaging in Bridge Clinic - Number of patients Recovery Coaches supported - Increase in changes of youth knowledge around substance use - Reduction in opioid overdoses and deaths - Reduction in hospitalizations - Increase engagement in treatment 	