

**APPLICATION FOR DETERMINATION OF NEED  
SUBSTANTIAL CAPITAL EXPENDITURE  
BOSTON MEDICAL CENTER  
DoN APPLICATION # BMCHS-22080908-HE**

**BY**

**BMC HEALTH SYSTEM, INC.  
ONE BOSTON MEDICAL CENTER PLACE  
BOSTON, MA 02118**

**AUGUST 9, 2022**

**BMC HEALTH SYSTEM, INC.**  
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**BMC Health System, Inc.**  
**Boston Medical Center Main Campus Determination of Need**  
**Community Health Initiative Narrative**

I. Community Health Initiative Monies

The breakdown of Community Health Initiative (“CHI”) monies for the Proposed Project at Boston Medical Center (“BMC”) is as follows:

- Maximum Capital Expenditure: \$121,239,760
  - Community Health Initiative: \$6,061,988 (5% of Maximum Capital Expenditure)
  - CHI Administrative Fee to be retained by BMC: \$121,240 (2% of the CHI monies)
  - CHI Money – less the Administrative Fee: \$5,940,748
- 
- CHI Funding for Statewide Initiative: \$1,485,187 (25% of CHI monies – less the administrative fee)
  - CHI Local Funding: \$4,010,004 (75% of CHI monies – less the administrative fee and the Evaluation Monies)
  - Evaluation Monies to be Retained by BMC: \$445,557 (10% of CHI Local Funding)

II. Overview of Community Benefits and the Community Health Needs Assessment Processes

**Background:** The CHI process, including community engagement, prioritization and selection of health needs, and the distribution of funds will be led by the following BMC CHI leadership staff:

- **Thea James, MD, Executive Director of the Health Equity Accelerator, Vice President of Mission and Associate Chief Medical Officer.** As Vice President of Mission, Dr. James works with caregivers throughout BMC. Additionally, she has primary responsibility for coordinating and maximizing BMC’s relationships and strategic alliances with a wide range of local, state and national multi-sector organizations including community agencies, housing advocates, and others that partner with BMC. The goal is to foster innovative and effective new models of care that are essential for patients and communities to thrive and reach their full potential. These models include a focus on the intersections of health and wealth, economic mobility, and other upstream drivers of predictable poor health outcomes. These care models are critical to operationalizing equity in the broadest sense.

In 2020-2021, Dr. James served on the Mayor’s Health Inequities Task Force for the City of Boston, to provide guidance on addressing inequities associated with the pandemic. She also served on the Massachusetts Department of Public Health COVID-19 Health Equity Advisory Group. Dr. James served on the Massachusetts Board of Registration in Medicine from 2009-2012, where she served as chair of the Licensing Committee. She is Director of the Violence Intervention Advocacy Program at BMC and a founding member of the Health Alliance for Violence Intervention. In 2011, she was appointed to Attorney General Eric Holder’s National Task Force on Children Exposed to Violence.

Dr. James’ passion is Public Health both domestically and globally. For several years, she and colleagues worked with local partners in Haiti, and Africa, to implement sustainable healthcare models and ultrasound training. As a member of Equal Health, she was a visiting professor for the first class of Emergency Medicine residents in Haiti at Hôpital Universitaire de Mirebalais and at St. Boniface Hospital in Fond des Blancs.

- **Megan Sandel, MD MPH, Co-Lead Principal Investigator with Children’s Health Watch, Co-Director of the GROW Clinic at BMC, and an Associate Professor of Pediatrics at the Boston University Schools of Medicine and Public Health.** Dr. Sandel is the former Pediatric Medical Director at Boston Healthcare for the Homeless and is a nationally recognized expert on housing and child health. In 1998, she published in collaboration with other doctors at BMC, the DOC4Kids report, a national report on how housing affected child health, the first of its kind, and over the course of her career, Dr. Sandel has written numerous peer reviewed journal articles and papers on this subject. In 2001, she became the first Medical Director of the founding site for medical-legal partnerships, Medical-Legal Partnership-Boston, and from 2007-2016 she served as the Medical Director of the National Center for Medical-Legal Partnership.

Dr. Sandel has served as a Principal Investigator for numerous NIH, HUD and foundation grants, working with the Boston Public Health Commission and Massachusetts Department of Public Health to improve the health of vulnerable children, particularly with asthma. She has served on many national boards, including Enterprise Community Partners, and national advisory committees at American Academy of Pediatrics and the CDC Advisory Committee for Childhood Lead Poisoning Prevention.

- **Petrina Martin Cherry, Vice President of Community Engagement and External Affairs.** Ms. Cherry is a marketing and healthcare executive with over 25 years of experience specializing in marketing strategy, healthcare marketing, and community program development and entertainment marketing. She is highly regarded as a consulting resource across multiple industries in healthcare equity and social determinates of health, diversity and inclusion and branding. In addition to her corporate relationships, Ms. Cherry previously spent fifteen years in entertainment marketing and media training and is an expert at developing brand strategy for celebrities and non-profit organization.

Ms. Cherry excels in helping brands create great ideas and bring them to life through integrated campaigns that leverage online, mobile, and physical brand interactions. Clients and partners rely on her to help them compete more effectively on a global basis by creating and accelerating relationships with customers, employees, partners, media and other influencers. Ms. Cherry also has done significant advocacy work creating community-based programs to bring awareness to Sickle Cell Disease, promote mental health and wellness in inner city communities, reduce recidivism, and influence successful re-entry, and to build equity instead of charity in previously red-lined communities.

Ms. Cherry has shared her expertise on healthcare, building healthier communities, entertainment marketing, criminal justice reform, and building inclusive spaces on numerous panels and to business groups and associations. She was appointed by Mayor Marty Walsh in 2020 to the COVID-19 Health Inequities Task Force and is on the board of trustees for the Urban League of Eastern MA (Emeritus), the Boys and Girls Club of Boston, Vice Chair of the Boston Arts Academy Advisory Board, the Advisory Board of Arts Emerson at Emerson College, and is the Co-Chair of the Women’s Forum for the National Association of Healthcare Executives. She is an active member of the Links Inc. and Delta Sigma Theta Inc. Ms. Cherry holds an Executive MBA from Georgia State University’s J. Mack Robinson School of Business.

- **Gina Patterson Boston Opportunity System (BOS) Collaborative Director:** Gina Patterson is a social impact and public policy leader with significant experience in the government, philanthropic, and nonprofit sectors. After spending over a decade in the government sector, Ms. Patterson is an expert in community social impact and strategic partnerships. She has led key initiatives in addressing violence intervention and prevention policy and programming,

partnership and funding strategies in workforce development and education for youth, and developing innovative initiatives with a focus on equity. In addition, Ms. Patterson has consulted and partnered with nonprofits and foundations on strategy, board development, and diversity and inclusion. Currently, Ms. Patterson is leading a cross-sector collaborative focused on neighborhood revitalization and economic mobility at BMC in partnership with JP Morgan/Chase.

To date, Ms. Patterson has worked with institutions such as the City of Boston, the Obama Foundation, the Sierra Health Foundation, and the Boston Chamber of Commerce. In addition to her extensive social impact and public policy experience, Gina is equally committed to the work of inclusion and equity.

Ms. Patterson holds a Master of Public Administration degree from Columbia University, in New York and a Bachelor of Science degree from Simmons University in Boston, MA.

Together, Drs. James and Sandel, as well as Ms. Cherry and Ms. Patterson work with the Hospital's Determination of Need ("DoN") CHI – Community Advisory Board ("CAB") and will provide oversight to BMC's Community Benefits team for implementation of the CHI.

**CAB Composition and Duties:** In addition to the noted BMC leadership for the CHI, the CAB will assist in the implementation of the CHI and provide oversight to this staff. The CAB is comprised of a diverse group of individuals representing the various sectors required by the Department of Public Health. These Board members bring a wealth of experience to the CHI process – from working with community-based organizations on specific initiatives – to ensuring equity amongst teams, so all perspectives may be heard, CAB members will assure that the BMC CHI process is transparent, focused, equitable, and addresses the critical needs of the targeted communities.

CAB members will be tasked with reviewing the 2019 community health needs assessment ("CHNA"), as well as the soon to be approved 2022 CHNA to better understand the needs of the communities that BMC serves. Based upon primary and secondary data, CAB members will ensure appropriate engagement occurred during the CHNA processes and select CHI health priorities from the noted CHNA priorities. The CAB will be responsible for providing input on the Health Priorities and Strategies Form to the Department of Public Health.

The duties of the CAB, include:

- Review of the CHNA process and input on the CHIP process.
- Selecting the health priorities for the CHI based upon the needs outlined in the CHNA.
- Alignment of the health priorities with BMC's community health improvement plan ("CHIP").
- Ensuring appropriate engagement with residents and patients from BMC's targeted communities both in the CHNA process, as well as in the CHI process.
- Providing input on the Health Priorities and Strategies Form for the Department of Public Health.
- Providing oversight to BMC's CHI leadership team regarding the CHI process.
- Providing oversight to an evaluator that is selected to evaluate CHI-funded projects.
- Review of CHI evaluation reports to understand progress on funded programs.
- Conducting a conflict-of-interest process to determine which members of the CAB will serve on an Allocation Committee.

**Allocation Committee Members Composition and Duties:** The Allocation Committee will be comprised of CAB members who do not have a conflict-of-interest with the distribution of CHI funding.

Additionally, BMC may add social determinant of health (“SDoH”) subject-matter experts, residents, representation from additional community-based organizations, or other appropriate individuals to the Allocation Committee. The Allocation Committee will be charged with the following duties:

- Selecting appropriate strategies for the distribution of CHI funds.
- Providing input on the Health Priorities and Strategies Form for the Department of Public Health.
- Carrying out a solicitation process or an alternative process to distribute CHI funding.
- Engaging technical assistance resources that can support and assist potential applicants for funding with their responses.
- Disbursement of CHI funding.
- Review and analyze reports from funded organizations to determine the impact of the CHI funding.

### **CHNA Processes:**

#### **2019 CHNA Process**

In 2019, BMC conducted a comprehensive CHNA in collaboration with multiple stakeholders including community organizations, health centers, hospitals, and the Boston Public Health Commission. The Boston Community Health Needs Assessment-Community Health Improvement Plan Collaborative (“Boston CHNA-CHIP Collaborative” or “Collaborative”) was formed to undertake the first city-wide CHNA and CHIP for the City of Boston.

Key findings that emerged from the 2019 CHNA include: housing affordability; food insecurity; transportation; healthcare access and utilization; chronic disease; mental health; substance use; violence and trauma; maternal and child health; sexual health; environmental health; education; employment and workforce development; income and financial security; social environment; green space and the built environment; and obesity, nutrition and physical activity. These findings informed BMC’s 2019 Implementation Strategy which served as the Hospital’s roadmap for Community Benefits Programs and Initiatives for 2019-2022. See the CHNA/CHIP Assessment Form and Addendum for additional information.

#### **2022 CHNA Process**

In 2021, the Boston CHNA-CHIP Collaborative began work on its 2022 CHNA (which is projected to be voted upon by the Steering Committee in September). The Collaborative aims to achieve sustainable positive change in the health of residents within Boston by partnering with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. As stated, in 2019, the Collaborative conducted the first large-scale joint citywide CHNA, which then guided the City’s CHIP, a blueprint describing how the Collaborative would focus on collectively addressing the key priorities.

The 2022 Boston CHNA builds upon the 2019 CHNA and takes a “deep dive” into the key priority areas identified in the 2020 CHIP: housing, financial stability and mobility, behavioral health, and accessing services. The 2022 CHNA was conducted during an unprecedented time, including the COVID-19 pandemic and a reckoning with systemic racism. This CHNA focuses on the SDoH and is guided by a health equity lens.

For the 2022 CHNA, existing secondary data were reviewed from national, state, and city sources, including datasets such as the American Community Survey, Boston Behavioral Risk Factor Surveillance System (“BBRFSS”), BBRFSS COVID-19 Health Equity Survey, and vital records, among other sources. For new data collection, key informant interviews were conducted with 62 leaders across

sectors and 29 focus groups were facilitated with 309 residents who have been particularly burdened by social, economic, language, and health challenges. The Collaborative uses the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

Given that this CHNA was conducted during the COVID-19 pandemic, which exacerbated many social and economic inequalities that have been present for generations. The pandemic contributed to a staggering number of COVID-19 cases, deaths, and ongoing health challenges which disproportionately affected marginalized populations. During this same period, there has been a growing national movement calling for racial equity to address racial injustices in the U.S. The growth of this movement has been sparked by the killings of several Black Americans, including George Floyd and Ahmaud Arbery. In 2020, the City of Boston declared racism as a public health crisis, underscoring the City's commitment to dismantle structural racism and recognize historical injustice. This context shaped the assessment approach and content, in that the 2022 CHNA also explores how the pandemic and racial injustices have affected priorities that emerged from the previous CHIP.

The 2022 CHNA has been guided by the Collaborative's shared values of:

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

### *2022 CHNA Community Engagement*

The Collaborative's Community Engagement Work Group (discussed in the CHNA/CHIP Form Addendum) includes 24 members representing a range of organizations, including health centers, local public health, community development, community-based organizations, and hospitals. The Work Group's charge is to provide guidance on the approach to community engagement, input on primary data collections methods, and support with logistics for primary data collection (See Appendix B of the 2022 CHNA for a list of members). The Collaborative's Community Engagement Work Group led efforts to gain insight into community needs and strengths, as well as priorities from community leaders and residents, especially among those individuals where there has been a gap in representation in previous processes. Altogether, the Collaborative facilitated **29 virtual and in-person focus group discussions with a total of 309 residents** who have been disproportionately burdened by social, economic, and health challenges including: youth and adolescents, older adults, persons with disabilities, low-resourced individuals and families, LGBTQIA+ populations, racially/ethnically diverse populations (e.g., African American, Latino, Haitian, Cape Verdean, Vietnamese, Chinese), limited-English speakers, immigrant and asylee communities, families affected by incarceration and/or violence, and veterans. Some focus groups were conducted in languages other than English, including Spanish, Chinese, and Vietnamese. Please see Appendix D of the 2022 CHNA for more details on the community engagement process and qualitative data approach.

Collaborative members **conducted key informant interviews with 62 individuals**. These individuals represented a cross-section of sectors to identify areas of action and perspectives on the community. These interviewees included leaders and staff from public health, health care, behavioral health, the faith community, immigrant services, housing organizations, economic development, community

development, racial justice organizations, social service organizations, education, community coalitions, the business community, childcare centers, elected government offices, and others. Please see Appendix E of the 2022 for a list of key informant interviewee organizations.

Additionally, Collaborative members conducted **three 90-minute virtual Community Listening Sessions** in January 2022. A total of **122 community members participated in these sessions**. These sessions occurred mid-way through the CHNA process and provided an opportunity to gather feedback and insights on preliminary data findings and potential priorities at this point in time. During these sessions, Collaborative members shared preliminary themes from focus groups, interviews, and the review of secondary data. The participants discussed their reactions and feedback to these preliminary findings in small groups and identified areas that were their highest priority for action.

To deepen the understanding of issues that were salient to community members, interviewers, focus groups, and community listening session discussion guides used open-ended questions and did not ask about specific topics. Community Engagement Work Group members and their partners conducted the focus groups and interviews, and then summarized the key themes from the discussions they facilitated. These summaries were then analyzed to identify common themes and sub-themes across population groups, as well as unique challenges and perspectives identified by populations and sectors, with an emphasis on diving deep into the root causes of inequities. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. Additional information on the qualitative data collection and analysis process can be found in Appendix D of the 2022 CHNA. BMC uses the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

BMC will submit the Collaborative's CHNA to the Department of Public Health upon approval by the Collaborative Steering Committee.

### III. BMC – Care in the Community Based on the 2019-2022 CHNA Process

Unwavering in our long-standing commitment to address the health needs of our community, BMC has developed programs and initiatives beyond the traditional medical model. Core to fulfilling the Hospital's public health mission and vision for health equity, our Community Benefits Programs and Initiatives aim to improve health outcomes among underserved populations in our community. As the largest safety net hospital in New England, BMC serves a significant number of disadvantaged patients who live in our community. Approximately 57% of BMC's patients are from under-resourced populations. BMC's patients are disproportionately and adversely affected by SDoH. To combat these challenges, through BMC's 2019-2022 CHIP, the Hospital invested in the following community-based programming:

**Investing in Housing:** In 2017, BMC committed \$6.5 million to improving housing for the people and communities that we serve. In partnership with community organizations and government agencies, BMC aims to use housing to help improve the health of some of the most vulnerable children and families, individuals, and elders in our community.

The core of these investments are supportive housing and wraparound services to assist those residents in need of obtaining stable housing. Together, with behavioral health and substance use disorder services and medical care, stable housing can transform health in a community. To that end, BMC has invested in projects such as:

- Supporting the development of healthy local retail to increase access to amenities like food markets and gyms.
- Development of housing support services that emphasize housing stabilization.
- Projects that integrate the housing and healthcare systems for people with unstable housing.

- Community engagement in order to understand and respond to the challenges, barriers, and opportunities facing Boston residents who are encountering displacement and rising costs.
- Investments in developments built near public transportation that prioritize community, environment, and health.

**Nourishing Our Community:** Since 2001, the Preventive Food Pantry and The Teaching Kitchen have addressed hunger-related illness and malnutrition for our low-income patients. Individuals who are food insecure, at risk of malnutrition, or who have other special nutritional needs are referred to the Pantry by BMC, as well as certain physicians or nutritionists who provide “prescriptions” for food to help improve patients’ physical health, prevent future illness, and ease recovery from illness or injury.

The Pantry provides nutritional food prescriptions to approximately 7,000 patients and family members each month, for a total of more than 74,500 Greater Boston residents per year. Each week, the shelves are stocked with nearly 12,000 pounds of food supplies to serve the community.

The Teaching Kitchen complements the work of the Pantry by teaching patients how to cook healthy meals that are medically and culturally appropriate. Their classes aim to help patients prevent and manage chronic diseases such as diabetes, heart disease, chronic pain, cancer, substance use disorder, and more. In addition, classes are offered to BMC and Boston University Medical School employees and students, as well as families of patients and staff and Boston Public School students.

**Breaking the Cycle of Violence:** The Violence Intervention Advocacy Program (“VIAP”) was founded in 2006 and provides specialized services to victims of violence. The program’s violence intervention advocates provide victims and their families with direct services and referrals to outside services, including crisis intervention and stabilization, housing and transportation, legal assistance, education, vocational and life skills development, mental health, employment, and health and wellness. In addition to its presence at BMC, the VIAP model has been disseminated to two other hospitals in Massachusetts.

**Helping Elders Stay at Home:** For more than a quarter century the Elders Living At Home Program (“ELAHP”) has been at the forefront of ending elder homelessness in Boston. Over the last two and a half decades, ELAHP has touched the lives of 2,500 people, not only clients, but their families, care providers, policy makers, public and private funders and students from a variety of disciplines.

The rise in housing prices in Greater Boston has led to fewer people being able to purchase homes, which creates a tremendous demand for rentals. This need for rentals has caused rents to skyrocket. This has also contributed to scarcity in the availability of subsidies, even in housing developments for the elderly and disabled where turnover is greater.

To help combat this problem, ELAHP provides intensive case management services, enhanced by legal support and expertise, to older adults who are at imminent risk of losing their housing and becoming homeless.

**Reaching Out to Patients with Substance Use Disorders:** Project TRUST’s goal is to help anyone who is actively struggling with substance use access to comprehensive and compassionate care without judgement. This program provides addiction treatment resources, harm reduction education and supplies, and navigation to an array of medical services including primary care and urgent care services.

In addition to a drop-in center, Project TRUST runs an outreach team to engage people with substance use disorders in the places that they spend their time. The goal is to reach people who may not be able to – or ready – to come into BMC clinics for treatment, but who can still benefit from BMC services.

#### IV. Prior DoN – CHI Work

In 2013, BMC submitted a DoN to the Department of Public Health to consolidate its two clinical campuses to create a new clinical core at its Menino Campus. Additionally, there was a series of amendments associated with this DoN that required the Hospital to carry out a CHI. Although this CHI was governed by the prior DoN Regulations (in 2017, the Department of Public Health revised the DoN Regulations to require CHI and associated activities), BMC carried out this CHI in general compliance with the new DoN Regulations. Accordingly, BMC conducted a CHI, disbursing monies for specific health priorities and strategies.

**Housing:** In Fiscal Year 2018, BMC launched a multi-year investment in a supportive housing strategy as part of our 2013 DoN and associated amendments. This project was designed as a multi-pronged approach to impact affordable housing and affordable housing with supports in Boston. The following narrative discusses these multi-year commitments.

*Bartlett Station*, a development by Nuestra Comunidad Development Corporation and Windale Developers, is an innovative urban mixed-use development with 323 housing units (market rate and affordable rental) and 46,000 ft of retail, green space and public plaza located in Roxbury's Nubian Square. BMC provided the first year of an operating subsidy for an outreach manager to build relationships and engage with the community in anticipation of the opening of Good Foods Market, a grocery store dedicated to developing retail solutions that work in, and for, food desert communities. In fiscal year ("FY")19, the Bartlett Station expansion added a gym located adjacent to Good Foods Market, removing a barrier to fitness for residents by allowing them to exercise and purchase groceries in the same place. BMC provided an additional operating subsidy in FY20.

The *Waldeck Building*, recently acquired by Codman Square Neighborhood Development Corporation, is a 59-unit distressed property that is located in Fields Corner, Dorchester. Three buildings located on Waldeck Street provide 35 units of permanent supportive housing for individuals with mental health challenges and/or disabilities. BMC provided an operating subsidy in FY20.

*New Franklin* is a housing development located in Franklin Field, Dorchester. BMC is supporting one full-time Community Life Program Coordinator, a new position that serves New Franklin residents and those who live in the surrounding community. The Community Life Program Coordinator also provides supervision and data tracking of this initiative.

*Smith House*, at Madison Park Community Development Corporation, provides 132 apartments for the elderly. BMC is supporting one nurse, and one full-time ELAHP senior care coordinator, a new position located at Smith House, who helps clients maintain a permanent residence and live independently.

BMC supports one full-time service coordinator, a new position at *Madison Park Village's Dewitt Community Center*, whose role is to provide health and wellness programming to residents and community members.

BMC invested \$69,012 in the *Cambridge Health Alliance (CHA)* towards a Community Wellness Advocate at the Manning Apartment Complex. The Community Wellness Advocate provided individualized case management and support to residents of Manning House to improve health outcomes for these residents. BMC also invested in a Community Wellness Registered Nurse as part of



the ELAHP. The RN worked with the CHA and Manning House staff to improve residents' access to services and support and served as the primary liaison between BMC and other health care providers.

BMC invested in the Healthy Neighborhood Equity Fund, a \$22.35 million private equity fund led by the Conservation Law Foundation and the Massachusetts Housing Investment Corporation. This Fund is based on a socially responsible investment model that considers the community, environmental, and health benefits, as well as the financial risks and returns. Boston projects include Treadmark, Ashmont, Dorchester and Bartlett Station, Dudley Square, and Roxbury.

**Additional Housing Efforts:** Additionally, BMC developed and invested in the Innovative Stable Housing Initiative ("ISHI"), a pilot project funded by BMC, Boston Children's Hospital, and Brigham and Women's Hospital through "pooled" resources as part of a DoN – CHI. With a combined investment of almost \$3 million over three years, ISHI's goal is to identify, assess, and fund strategic approaches to increase housing stability for our most vulnerable populations.

The Goals of ISHI are:

- Identify policy, systems, population, and place-based approaches that address displacement and increase housing stability.
- Fund these approaches through an inclusive, participatory grantmaking process where community voice and power are centered.

ISHI acknowledges and values:

- **Racial and Ethnic Equity** as a mechanism of justice and opportunity for People of Color, indigenous communities, and immigrants who have historically, systematically, and intentionally been excluded from systems due to racism, classism, and white privilege;
- **Galvanizing the Power of Communities**, and honoring the voice, shared history, lived experiences, and wisdom of community members;
- **Meaningful and Trustworthy Collaboration** that respects and recognizes differences, leverages expertise, and is accountable to work towards a shared objective, measurable outcomes, and collective action;
- **Flexibility** between innovation and proven solutions, short and long-term investments, grassroots and larger community-based organizations, capacity building and project-based initiatives, as opportunities to invest in real systems change;
- **Working in Solidarity**, side by side with community members most impacted by displacement and systemic inequity, and to use the collective power and privilege in our networks to create lasting Impact.

Through the proposed DoN – CHI, BMC will seek to leverage funds and seek to partner with other hospital systems to amalgamate CHI funding and generate greater impact for CHIs.

**BOS Collaborative:** Finally, BMC participates in the Boston Opportunity System ("BOS") Collaborative. This Collaborative received a \$5 million philanthropic investment from JPMorgan Chase to establish neighborhood-based training strategies for 1,100 residents of color, and fund 250 new and preserved affordable housing units in historically underinvested Boston neighborhoods, including Black and Latinx communities.

BMC, the lead organization, joined partners Boston Children's Hospital, Brigham and Women's Hospital, and Health Resources in Action in teaming up with the City of Boston and community partners (the Dudley Street Neighborhood Initiative and Jewish Vocational Services) to help strengthen recovery

efforts in Boston and address the needs of Black and Latinx communities, which have suffered disproportionately both from the COVID-19 pandemic and generations of disinvestment.

With the support from JPMorgan Chase, the BOS Collaborative is shifting how cross-sector anchor institutions approach place-based hiring, purchasing, and investing, to create enduring opportunities for Boston's Black and Latinx communities. The BOS Collaborative will deploy below-market rate capital to create affordable and permanent supportive housing, adopt new hiring and retention policies that connect residents to better paying jobs at the anchor institutions, and promote state and federal policies that help residents, such as increased state rental vouchers for tenants of acquired properties, or expanded Medicaid funding for onsite supportive services.

## V. New Engagement Strategies

In addition to all of the noted needs assessment and community development work, in 2021, BMC launched its Health Equity Accelerator with “the vision of transforming health care to deliver health justice and well-being.” BMC is reimagining a new approach to accelerate its journey toward health equity and address core issues associated with traditional methodologies. Those involved in the accelerator have found that, to understand and address drivers of racial inequities, [one must] challenge conventional wisdom in multiple ways: (1) revisit conclusions derived from standard statistical analyses; (2) adopt a mindset that if you do not find an inequity, you need to look harder; (3) seek novel insights through primary research with the appropriate mix of patients; and (4) engage with community members to achieve both insights and impact. The BMC accelerator addresses these fundamental issues through focused and multidisciplinary teams that are resourced to be dynamic, to break through convention, and to do things differently.”<sup>1</sup>

Through the Health Equity Accelerator, care teams are seeking to understand how a health system perpetuates health inequities – by looking internally to determine where inequities are present in the patient population, understand the associated drivers, and take accountability.<sup>2</sup> All patients will benefit from this work – as the Hospital seeks to ensure that all patients receive the care and services that they need in the appropriate setting and by a diverse staff. Moreover, the Accelerator allows BMC an additional avenue for engagement with community-based organizations to continue to strengthen partnerships.

The Health Equity Accelerator is an ambitious and aggressive approach to eliminating the race-based health equity gap that exists throughout the healthcare industry in the U.S. For this initiative, BMC is coupling its deep experience in health equity with data-driven clinical insights and community-based research efforts to make healthcare equitable for people of color everywhere. At the core of the Accelerator is a deep commitment to listen to and partner with the community. BMC staff are incorporating multiple mechanisms to engage with patients and community leaders every step of the way. A key part of this effort is launching BMC's Equity Partnership Network (“EPN”), a diverse and engaged group of community leaders who are involved with different BMC Community Advisory Boards. The Accelerator Community Advisory Committee (“ACAC”) is a sub-group of the EPN that provides invaluable guidance to the Accelerator as this group seeks to address inequities – from which health inequities to focus on to how to approach the community on specific topics. Accordingly, EPN and ACAC will be invaluable assets in implementing the CHI and ensuring the Hospital and System are informing the community about CHI efforts. BMC also will explore with these groups additional ways to engage the community – being mindful of fatigue within the community due to the abundance of ongoing engagement.

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<sup>1</sup> Mendez-Escobar, et al. *Health Equity Accelerator: A Health System's Approach – Boston Medical Center's Health Equity Accelerator Aims to Eliminate Barriers to Health Equity*, NEW ENGLAND J. MED. CATALYST (2022), available at <https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0115>.

<sup>2</sup> *Id.*

## VI. Timeline for CHI Activities

Upon issuance of a Notice of Determination of Need, the CAB will begin implementing the CHI process. The timeline for CHI activities is as follows:

- Two months post approval: The CAB will begin discussing the Health Priorities for CHI funding.
- Five months post approval: The CAB selects Health Priorities for CHI funds.
- Six months post approval: The CAB conducts a conflict-of-interest disclosure process to determine which members of the CAB will move onto the Allocation Committee.
- Seven to eight months post approval: The Allocation Committee is reviewing options for the transparent distribution of CHI funding, including conducting a solicitation process, or other innovative ways to distribute the monies. The CAB will seek an evaluator to assist BMC leadership and the Community Benefits Team in evaluating the CHI.
- Nine months post approval: a request for proposal ("RFP") or some alternative form of solicitation will occur.
- Ten months post approval: If an RFP is released a Bidders Conference will be held or some form of informational session for other types of funding mechanisms.
- Twelve to thirteen months post approval: RFP responses or materials for alternative funding mechanisms will be due.
- Fifteen to sixteen months post approval: Funding decisions are made, and the disbursement of funds begins.
- Eighteen months post-approval: An evaluator will begin evaluation work on the CHI.

This noted process is longer than the outlined requirements within DoN – CHI sub-regulatory guidelines for a Tier 3 CHI. However, based on BMC's experience with their last CHI – BMC staff feel strongly that the aforementioned timeline is realistic and feasible for the distribution of funding.

## VII. Request for Additional Years of Funding

BMC is requesting additional time to disburse CHI funds. Given that BMC is seeking to potentially pool funding with other health systems and make multi-year investments with CHI funding to sustain programs and certain ongoing initiatives, the System is requesting to disburse funding over a three to five-year period to ensure the best use of funds, achieving the greatest impact within the community.

## VIII. Evaluation of the CHI

BMC is requesting to use 10% of all CHI funding (\$445,557) for evaluation of CHI funded projects. These monies will allow the Hospital to hire an evaluator to provide evaluation activities and assess the impact of CHI programs. Through this evaluation, BMC is seeking to learn best practices from funded organizations, so interventions may be refined and replicated in different geographies. The evaluation team will develop annual reports that will be reviewed by the CAB, and post review, submitted to the Department of Public Health.

## IX. Justification for Administrative Monies

Applicants submitting a Tier 3 CHI are eligible to obtain 2% of the CHI amount for administrative costs. Accordingly, BMC is seeking 2% of the CHI funding (\$121,240) for administrative expenses to carry out the CHI work. First, administrative monies will be used to offset the development of a robust solicitation process. These monies will pay for assistance in developing the RFP or alternative funding mechanism,

technical assistance resources that will be available to community-based organizations as they are completing the CHI process, and publication fees associated with advertising the solicitation process in local papers, as well as other operational costs, such as supplies. Funding also will be used to supplement staff time directed at CHI activities.

X. Stakeholder Assessment Forms

Given that BMC utilized the most recently approved CHNA for this CHI – the Collaborative’s 2019 CHNA – the hospital discussed with DoN – CHI staff that the current CAB does not reflect the group that provided oversight for this CHNA process. Consequently, Stakeholder Assessments by the current CAB would not provide further detail on the engagement that occurred during this process, and are therefore, not required. However, additional documentation around engagement within this process may be provided.

**APPENDIX 5B:**

**FACTOR 6 MATERIALS – CHNA/CHIP SELF-ASSESSMENT FORM & ADDENDUM**



# Massachusetts Department of Public Health

## Determination of Need

### Community Health Initiative

### CHNA / CHIP Self Assessment

Version: 8-1-17

This self-assessment form is to understand the Community Engagement process that has led/ will lead to the identification of priorities for community health planning processes. It is being used to demonstrate to DPH that an existing community health planning process adequately meets DPH standards for community engagement specific to Determination of Need, Community Health Initiative purposes.

This form will provide the basic elements that the Department will use to determine if additional community engagement activities will be required. When submitting this form to DPH, please also submit your IRS Form 990 and Schedule H CHNA/CHIP and/or current CHNA/CHIP that was submitted to the Massachusetts Attorney General's Office. Additionally, the Applicant is responsible for ensuring that the Department receives Stakeholder-Assessments from the stakeholders involved in the CHNA / CHIP process.

**All questions in the form, unless otherwise stated, must be completed.**

Approximate DoN Application Date: 08/09/2022

DoN Application Type: Hospital/Clinic Substantial Capital Expenditure

What CHI Tier is the project? ☐ Tier 1 ☐ Tier 2 ☒ Tier 3

## 1. DoN Applicant Information

Applicant Name: BMC Health System, Inc.

Mailing Address: One Boston Medical Center Place

City: Boston

State: Massachusetts

Zip Code: 02118

## 2. Community Engagement Contact Person

Contact Person: Thea James, MD

Title: Vice President of Mission and Associate Chief Medical Officer

Mailing Address: 840 Harrison Avenue

City: Boston

State: Massachusetts

Zip Code: 02118

Phone: 6174143564

Ext:

E-mail: thea.james@bmc.org

## 3. About the Community Engagement Process

Please indicate what community engagement process (e.g. the name of the CHNA/CHIP) the following form relates to. This will be use as a point of reference for the following questions and does not need to be a fully completed CHNA or implemented CHIP.



(please limit the name to the following field length as this will be used throughout this form):

2019 Boston CHNA-CHIP Process

#### 4. Associated Community Health Needs Assessments

In addition to the above engagement process, please list Community Health Needs Assessments and/or Community Health Improvement Planning Processes, if any that the Applicant been involved with in the past 5 years (i.e. CHNA/CHIP processes not led by the Applicant but where the Applicant was involved?)

(Please see page 22 of the Community-Based Health Initiative Guidelines for reference <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>)

Add/ Del Rows	Lead Organization Name / CHNA/CHIP Name	Years of Collaboration	Name of Lead Organizer	Phone Number	Email Address of Lead Organizer
 	Boston CHNA-CHIP Collaborative	4	Boston CHNA-CHIP Steering Committee		



## 5. CHNA Analysis Coverage

Within the 2019 Boston CHNA-CHIP Process , please describe how the following DPH Focus Issues were analyzed DoN Health Priorities and Focus Issues (please provide summary information including types of data used and references to where in the submitted CHNA/CHIP documents these issues are discussed):

### 5.1 Built Environment

The information provided in Section 5 of this Form is taken from the Boston CHNA-CHIP Collaborative (Collaborative) - 2019 Community Health Needs Assessment (CHNA) (see attached link to view the CHNA; see the Addendum to the CHNA/CHIP Form and the Community Health Initiative (CHI) Narrative.

In 2019, the Boston CHNA-CHIP Collaborative was a new initiative created by a number of stakeholders including community organizations, health centers, community development corporations, hospitals, and the Boston Public Health Commission to assess the health and social determinants of health of Boston residents. This Collaborative aimed to undertake the first large-scale city-wide CHNA and Community Health Improvement Planning (CHIP) process.

The goals of the CHNA were to: 1) systematically identify the health-related needs, strengths, and resources of a community to inform future planning; 2) understand the current health status of Boston overall and its sub-populations within their social context; and 3) meet regulatory requirements for a number of institutions, organizations, and agencies (e.g., IRS requirements for non-profit hospitals, Public Health Accreditation Board (PHAB) for health departments). To support this effort, the Collaborative hired Health Resources in Action (HRIA), a non-profit, public health organization, as a consultant partner to provide strategic guidance and facilitation of the process, collect and analyze data, and develop the report deliverables.

For the 2019 CHNA, the following approach and methods were used: This CHNA focuses on the social determinants of health using a health equity lens. The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are many of the root factors that drive the health inequities that are seen in the U.S. today.

The CHNA used a participatory, collaborative approach that engaged the community through different avenues. Over 100 Collaborative members representing health care, public health, education, community development, social service, and community-based organizations provided input throughout the CHNA process and played an integral role in data collection efforts. Data collection efforts were focused on engaging hard-to-reach populations who are not typically engaged in these processes or represented in the secondary data.

Existing data were drawn from national, state, and city sources, such as the U.S. Census, Massachusetts Department of Public Health, and Boston Public Health Commission, including data sets, such as the Boston Behavioral Risk Factor Surveillance System (BBRFSS). For new data collection, over 91 organizations and 2,500 individuals were engaged in a CHNA community survey (N=2,404) administered online and in-person in seven languages, 13 focus groups with community residents (N=104), and 45 interviews with organizational and community leaders to gauge their perceptions of the community's needs, strengths, and opportunities.

Like all data gathering efforts, there are limitations to the CHNA data. Secondary data have a time lag, and various sources may use different definitions for similar topics. Data may be aggregated across time, geographies, or population groups to provide large enough sample sizes. More granular analysis for specific neighborhoods or ethnic groups within larger racial/ethnic categories is not possible. Primary data, such as the survey and focus groups use a convenience sample which may not be representative of the larger population.

#### Green Space and Built Environment:

Green space and the built environment influence the public's health, particularly in relation to chronic diseases. Urban environments and physical spaces can expose people to toxins or pollutants, affecting health conditions such as cancer, lead poisoning, and asthma. There is compelling evidence that changes in environmental policies can have an impact on children and families. Physical space influences lifestyles: playgrounds, green spaces, and trails, as well as bike lanes and safe sidewalks and crosswalks all encourage physical activity and social interaction, which positively affect physical and mental health. Specifically, lower rates of childhood obesity and decreased levels of stress among adolescents have been associated with safe, accessible green spaces and other built environment elements.

Slightly over 8% of land in Boston is comprised of parks, playgrounds, and athletic fields and about 7% is parkways, reservations, and



beaches. Boston has a walkability score of 81, indicating a “very walkable” community. However, focus group members and interviewees shared that the built environment varies across neighborhoods. Those from Allston/Brighton, Chinatown, and Dorchester perceived insufficient green space across their neighborhoods, which they attributed to the growth in new housing developments. In contrast, interviewees and focus group participants described Jamaica Plain and East Boston as neighborhoods with ample access to green space. Participants also shared additional concerns specific to their neighborhoods, with those from Dorchester, Mattapan, and Chinatown expressing concern about safety in their community open spaces, as well as challenges with rodents, snow removal, and lack of public restrooms.

More information on Green Space and the Built Environment may be found on pages vi, xix, and 69-74.

#### Transportation Information:

Transportation connects people with and between where they live, learn, play, and work. Transportation can promote health by enabling individuals, families, and communities to access resources and opportunities, including employment, health care, education, and other goods and services (e.g., grocery stores, parks). Active forms of transportation, such as walking and cycling, can also be health promoting, reducing the risk of obesity, diabetes, and cardiovascular disease and improving mental health and community cohesion. Transportation can also have health consequences, including traffic-related accidents, air pollution exposure, and sedentary lifestyles linked with less active forms of transportation.

Though many residents who participated in focus groups perceived improvements in transportation in recent years, others expressed concerns about cost, timeliness, and accessibility of public transportation especially for the elderly, those with limited English proficiency, and for residents of neighborhoods who have traditionally had limited access to transportation. Slightly over one-third of Boston residents use a personal vehicle to get to work, and another one-third use public transportation; use of public transportation is particularly high in East Boston and Jamaica Plain. On average, Bostonians spend about 11% of household income on transportation-related expenses. Parking and traffic were mentioned as day-to-day concerns for many community residents. Challenges with public transit and transportation programs, including lack of reliability, difficulty navigating the system, overcrowding, and the need to schedule in advance, can make it difficult to keep medical appointments according to focus group members and interviewees. Efforts such as Go Boston 2030 and bike share programs were seen as positive steps to address the city’s transportation challenges.

More information on Transportation may be found on pages vi, 64-69, and 319.

#### Food Insecurity:

Food insecurity—not having reliable access to a sufficient quantity of affordable, nutritious food—is directly related to financial insecurity. Few Americans meet nutritional guidelines, as indicated by daily consumption of fruit and vegetables. Inadequate financial resources and limited access to healthy, affordable food contribute to these patterns. Food insecurity has substantial negative effects on health: research has shown that people experiencing food insecurity have lower nutritional intakes, increased rates of mental health problems and depression, higher rates of diabetes and hypertension, and worse oral health.

The expense and accessibility of healthy food was a key area of concern shared by focus group participants and interviewees. While more affluent neighborhoods were described as having substantial access to healthy food, lower income neighborhoods, most commonly communities of color, were described as having few grocery stores and a prevalence of fast food and convenience stores. The proportion of Boston adults experiencing food insecurity has declined from 2010 to 2017; however, 17% of residents still experience food insecurity. Black, Latino, and foreign-born residents are far more likely to report being food insecure than White or U.S.-born residents. Nearly 20% of Boston residents receive benefits from the Supplementation Nutrition Assistance Program (SNAP). In focus groups, food assistance programs were described as filling a critical gap for those facing difficulty accessing food. Enhancing food access through expansion of community gardens, food prescription programs, and hours and selections at food pantries was suggested.

Key informant interviews and low-income focus group participants across neighborhoods discussed the challenge of not having enough money to afford food. As one focus group participant remarked, “I’m working three jobs and I can barely afford food; I buy whatever I need to feed my kid and that’s it.” While housing might be the largest cost to a family’s budget in Boston, the cost of food was still challenging for many. As one key informant explained, “A lot of people spend money on food after utilities and health care; whatever is left goes to food.” Focus group participants echoed this sentiment and described having to eat canned or processed food that contain high levels of sodium and low-nutritional value because they felt like that was what they could afford.

Focus group and interview participants identified seniors and children as being especially vulnerable to being food insecure. Key informants who worked with seniors described mobility and mental health issues that compounded challenges for them to access healthy food. One key informant shared, “Many seniors are homebound and food delivery is one of their only contacts with the outside world.” Those who worked with children explained that food insecurity impacts a child’s stress levels, ability to pay attention at school, lower test scores, and absences.

Quantitative data indicate that over one in five Boston residents reported being food insecure, in that it was sometimes or often true that the food they have purchased did not last and they did not have money to get more. Experiences with food insecurity varied by population group. In aggregated 2013, 2015, and 2017 BBRFSS data, Latino (39.1%) and Black (34.5%) residents were significantly more likely than White residents (10.7%) to report being food insecure as were foreign-born residents compared to U.S. born residents. Food insecurity data by neighborhood, which can be found in APPENDIX I, indicate that Mattapan, Roxbury, Dorchester, and East Boston had a significantly higher percentage of residents than the rest of Boston who reported being food insecure.

More information on Food Insecurity may be found on pages iv, 46-50 and 309.

## 5.2 Education

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Education affects health in multiple ways. Individuals of lower educational attainment generally have less favorable health profiles compared to their counterparts with greater educational attainment. Most directly, education increases economic and social resources. Those with higher levels of education are less likely to experience unemployment and economic hardship and have more social connections than those with lower levels. Those with lower levels of education are more likely to be engaged in jobs that are lower paying or unstable, lack employer-provided health insurance benefits, or that are more risky or unsafe. Research has also found that adults with higher educational levels have higher levels of health literacy, causing them to better comprehend medical instructions, understand medications, and advocate for themselves with health providers than their counterparts with lower educational attainment. Inequities in educational funding and unequal access to key educational resources, including skilled teachers and quality curriculum, are concentrated in low-income communities and communities of color and are interconnected with the unequitable and discriminatory housing and neighborhood policies these same communities experience.

Education was viewed by Boston CHNA survey respondents as a key component of a healthy community. While statistics point to a well-educated community (nearly half of Boston adults have a college degree or more), there are substantial differences across racial and ethnic groups, with a high proportion of White and Asian adults with college degrees or more and far fewer Black and Latino adults. Over a quarter of Latino adults in Boston do not have a high school diploma. Echoing comments shared in focus groups and interviews, data from the Boston Public Schools show that over three-quarters of students are deemed high needs, defined as either being low income, economically disadvantaged, being a current or former English Language Learner, or having a disability. Differences in educational quality and resources across Boston neighborhoods was an issue raised by many focus group participants and interviewees, and were concerns within the same communities experiencing economic, housing, and employment challenges as well.

More information on Education may be found on pages iii and 23-25.

## 5.3 Employment

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Americans spend more than half their waking lives at work. Employment can confer income, benefits, and economic stability, among other factors that promote health. Well-paying jobs enable workers to live in healthier neighborhoods, afford nutritious food, and pay health care related expenses. By contrast, unemployment, underemployment, and job instability not only make it more difficult to purchase goods and services that enhance health, but also have been shown to contribute to stress-related health conditions and poorer mental health.

In 2018, Boston's unemployment rate was 3.0%, according to the Bureau of Labor Statistics. However, when examining unemployment data over the past several years, which can be analyzed by neighborhood and other subgroups, data show that unemployment rates have been significantly higher in Roxbury, Dorchester, Fenway, and Mattapan compared to Boston overall. In focus groups and interviews, those with lower education or fewer skills (especially in technology), immigrants, and those with a criminal record additionally were reported to experience employment challenges. Boston's largest employers are in the health care and education sectors; these sectors have experienced substantial employment gains over the past 15 years, while manufacturing and utilities have experienced decreases. Numerous Boston CHNA survey respondents reported feeling underemployed, wanting higher pay, or desiring greater job satisfaction. Focus group members and interviewees described challenges in getting a secure job, specifically around meeting educational credential requirements, navigating online job application systems, and dealing with CORI criminal background checks.

Additional information on Employment and Work Force may be found on iii, 29-31, and 303.

## 5.4 Housing

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Where people live is integral to their daily lives, health, and well-being. The conditions in the home and neighborhood environment may promote health or be a source of exposures that may increase the risk of adverse health outcomes. Housing is generally the largest household expense. For homeowners, it can be an important source of wealth. However, housing instability and stress of housing affordability have been found to be associated with poorer mental health outcomes and disruptions in work, school, and day care arrangements. Housing instability has been associated with poorer outcomes for children related to risk for developmental delays, being underweight, and lower school attendance. Poor housing quality can have direct negative health impacts such as respiratory conditions (e.g., asthma) due primarily to poor indoor air quality—and can be one of the strongest drivers for asthma-related emergency department visits among children. Housing conditions can also result in cognitive delays in children from exposure to neurotoxins (e.g., lead), and accidents and injuries as a result of structural deficiencies.

The high and rising cost of housing in Boston was a main theme that emerged in discussions with focus group participants and interviewees. Two-thirds (65%) of housing units across Boston are renter-occupied and renter households spend an average of \$1,445 per month on housing. More than half of those in renter-occupied units are housing cost-burdened, meaning they spend more than 30% of their income on housing. More than half of Boston renter households spend 30% or more of their income on housing costs.

A significantly higher proportion of households in East Boston, Fenway, Roslindale, and South Boston are cost-burdened than those in other neighborhoods; additionally, Black home owner and renter households are significantly more likely to spend 30% or more of their income on housing, compared to the Boston average. Assessment participants' perceptions of increasing housing costs are mirrored in the statistics: from 2011 to 2016 median single-family house prices increased across every neighborhood in Boston and the median price increased by 48% in Boston overall. Additional pressures include gentrification, long wait lists for housing assistance programs, and for some, housing discrimination. Overcrowding, homelessness, and poor quality housing were reported to be consequences of a tight and expensive housing market. Housing costs comprise a large and ever-increasing portion of household budgets, interviewees and focus group members report, leaving few resources for other needs such as health care, medicine, or nutritious food. There was general consensus across conversations that more affordable housing is needed in Boston, although quantitative data suggest that the proportion of affordable housing to market rate housing is decreasing.

Additional information on Housing may be found on the following pages: v, 52-63, and 314.

## 5.5 Social Environment

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Relationships are important for physical and mental well-being. At an individual level, social networks spread social behaviors: social support can help encourage people engage in more positive healthy behaviors. By contrast, lack of connectedness has been shown to be linked to depression and is a risk factor for early mortality.

At the community level, the cohesiveness of a community has been shown to be positively related to self-reported health and mortality. Conversely, discrimination as part of one's social environment can have a negative impact on health. Structural discrimination such as segregation, inequitable access to quality education, and disparities in incarceration rates can limit opportunities, resources, and well-being of less privileged groups. Individual discrimination may have high physical and emotional health costs as well. Research suggests that routine discrimination can be a chronic stressor and increase vulnerability to physical illness.

Focus group members and interviewees pointed to examples of strong social networks in Boston, citing cohesion across different immigrant groups and among others who share similar racial, cultural, linguistic and religious backgrounds. Two-thirds of CHNA community survey respondents believed that people in their neighborhoods help each other and three-quarters perceived that they and their neighbors want the same thing for their neighborhoods. Survey respondents also indicated strong civic engagement, as evidenced by high levels of self-reported involvement in community organizations and voting. At the same time, focus group members also mentioned a decline in community social ties, brought on by lack of time and generational differences. Gentrification has likewise changed the "feel" of some neighborhoods, specifically Roxbury, East Boston, and Dorchester. CHNA community survey results and conversations in focus groups indicate that subtle and overt discrimination is an issue in Boston, particularly for immigrants and non-English speakers, LGBTQ residents, and older residents and youth, substance users and the homeless. Institutional racism was discussed in greater detail as being pervasive across the city given discriminatory policies at a systems level, and is described in more detail in the Violence and Trauma section.

Additional information on the Social Environment may be found on the following pages: vi, 74-78, and 323.

## 5.6 Violence and Trauma

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Violence and trauma are important public health issues affecting physical and mental health. People can be exposed to violence in many ways: they may be victims and suffer from premature death or injuries or witness or hear about crime and violence in their community, which can lead to trauma and other mental distress and reduced quality of life. Children and adolescents exposed to violence may experience behavioral problems, depression, anxiety, and post-traumatic stress disorder or show increased signs of aggression; research has also shown violence and trauma are linked to health conditions such as high blood pressure, worse cardiovascular health, immune deficiency and sleep problems.

Violence and trauma were frequent concerns reported by focus group and interview participants. Many focus group members expressed concern about personal safety in their communities, with persons of color and children noted to be disproportionately affected. One quarter of respondents to the CHNA community survey described their neighborhoods as unsafe or extremely unsafe. Black and Latino respondents were more likely than other respondents to describe their communities this way. Intimate partner violence was mentioned in focus groups and interviews, with women of color and non-English speaking immigrants identify as particularly vulnerable. Exposure of children and youth to unhealthy relationships and violence (creates adverse childhood experiences) is also of concern: nearly one in five Boston adults reported experiencing one adverse experience over their lifetime, and one in six reported more than one. Trauma, poverty and, more recently, fear of deportation and family separation is a growing issue. Bullying among youth in Boston has declined over the past few years, although currently one in ten Boston high school students reported that they have been bullied on school property over the past year or have been bullied electronically. Female and LGBTQ students are disproportionately affected by bullying.

Additional information on Violence and Trauma may be found on the following pages: xiii and 172-190.

### 5.7 The following specific focus issues

#### a. Substance Use Disorder

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

According to the National Survey on Drug Use and Health (NSDUH), in 2017 about 19.7 million American adults (aged 12 and older) battled a substance use disorder. Alcohol abuse disorder is the most common, affecting 14.5 million people (74%). About 38% of adults in 2017 battled an illicit drug use disorder; an estimated 2.1 million people (or 28% of those with an illicit drug use disorder) had an opioid use disorder. The impact of substance abuse on individuals, families, and communities is tremendous, including poor health, fraying social structures, abuse and neglect of children, and crime and violence. Substance abuse also has substantial economic cost: abuse of tobacco, alcohol, and illicit drugs is estimated to cost American society more than \$740 billion annually in lost workplace productivity, health care expenses, and crime.

Substance use was considered a priority health issue in many focus group and interview discussions. Participants mentioned a variety of substances including marijuana, prescription drug use, and opioids as being among the most concerning. Co-occurring mental health and substance use issues were frequently discussed among key informants, as well as the interrelationship between trauma, mental health, and substance use. Smoking among adults and youth, as well as e-cigarette and marijuana use among youth, have significantly decreased in Boston; however, there are significant differences by population groups. Notably, LGBTQ adults and youth are more likely to use tobacco, e-cigarettes, and marijuana, compared to heterosexual/non-transgender adults and youth; a similar pattern emerged among the LGBTQ population for alcohol consumption and prescription drug use. The majority of focus group participants and key informants who discussed substance use as a concern identified opioids as a persistent issue in Boston. The rate of opioid overdose deaths in Boston has significantly increased since 2013 and was highest among Latino residents, followed by White residents.

Additional information on Substance Use Disorders may be found on the following pages: xii, 151-168, and 363.

#### b. Mental Illness and Mental Health

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Mental health issues were described as a priority concern across almost all focus group and interviews, and often discussed in connection with trauma and poverty. Stress, anxiety, and depression were the most frequently cited challenges among Boston residents, especially those who identify as LGBTQ, low-income, seniors, children, immigrants, and communities of color. Surveillance and survey data indicate that anxiety and depression are somewhat common across Boston residents, with one in five adult residents reporting that they felt persistent anxiety and one in eight



reporting persistent sadness. Furthermore, the proportion of residents reporting persistent anxiety has increased over time; a higher proportion of females, Latinos, lower income individuals, younger, LGBTQ, and unemployed residents reported persistent anxiety than other groups.

The age-adjusted suicide rate for Boston is 6.7 deaths per 100,000 residents, with the highest rates occurring among White residents, men, and individuals ages 45-64. Concern for mental health issues among children and youth were a prominent theme in focus groups and interviews and this was validated through quantitative data: about one-third of Boston public high school students reported feeling persistent sadness and this has grown substantially over the past few years. The rate of students reporting persistent sadness is even higher among those who identify as Latino, Black, female, and LGBTQ. Nearly one in eight Boston public high school students (12%) has reported seriously considering suicide and 7.6% reported having attempted suicide, with rates for females, Latinos, and those who identify as LGBTQ as higher than for other groups. While statistics indicate that the proportion of people receiving treatment for depression has grown, barriers such as stigma, cultural and linguistic differences, and lack of providers constrain access to services for many residents.

Additional information on Mental Illness and Mental Health may be found on the following pages: xi, 139-148, and 358.

#### c. Housing Stability / Homelessness

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Homelessness was discussed as a concern across focus group and key informant geographies, especially with residents who lived in Chinatown, Downtown, and East Boston. Focus group participants from these neighborhoods perceived that homelessness was on the rise and often related those who were homeless with mental health or substance use issues. However, key informants with expertise in housing indicated that homelessness impacts a diverse range of residents across the city regardless of health status, race, or family makeup. In 2018, there were an estimated 6,188 residents that were counted as homelessness or housing unstable in Boston. It should be noted that these data may not account for residents who are temporarily without a permanent address and are staying with friends or in their car. Among those identified, the majority of homeless residents were staying in emergency shelters (5,427 individuals), followed by transitional shelters (598 individuals), and unsheltered housing (163 individuals). Among this homeless population, four in ten homeless residents identified as Black (45.1%), 36.1% as white, and 17.0% as two or more races. More than 35% identified as Latino (any race). Data of counts over time and shelter bed capacity are provided in APPENDIX I.

Additional information on Housing Stability/Homelessness may be found on the following pages: vi, viii, xx, 13, 52, 59, 61, 62, 63, 88, 89, 93, and 94.

#### d. Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes

From the Boston CHNA-CHIP Collaborative - 2019 CHNA:

Chronic disease is both prevalent and costly. Six in ten American adults have a chronic disease and four in ten have two or more. The total costs in the U.S. for direct health care treatment for chronic health conditions totaled \$1.1 trillion in 2016 - equivalent to 5.8 percent of the U.S. gross domestic product (GDP). Although chronic diseases are among the most common and costly health problems, they are also among the most preventable through changes in behavior such as reduced use of tobacco and alcohol and improved diet and physical activity. Two of the most preventable chronic diseases, heart disease and diabetes, accounted for an estimated 715,000 deaths in 2016. As seen across other health issues, many chronic conditions such as heart disease, diabetes, and asthma disproportionately affect communities of color, lower income individuals, and residents of low resourced neighborhoods, the same groups more likely to experience employment, financial, and housing insecurity.

Among focus group and interview participants, diabetes was frequently mentioned as a community concern that impacts both adults and children, followed by pediatric asthma. While there is a low prevalence of diabetes and asthma in Boston (9% and 11% respectively), there were significant differences across the population. Black and Latino residents have a higher prevalence of diabetes and experience higher diabetes-related hospitalization and death rates than White residents. Similar to diabetes, there were disparities in the distribution of asthma across the population, including by race/ethnicity, socioeconomic status, and neighborhood.

Black and Latino adults and children experience significantly higher asthma-related emergency department visits compared to White adults and children. Participants shared that young children living in poverty are disproportionately affected by pediatric asthma as a result of poor environmental factors and/or poor living conditions including exposure to air pollutants, rodents, mold, tobacco smoke, and lead. Also disproportionately affected by diabetes and

asthma are residents of Roxbury and Dorchester, who experience diagnoses and hospitalizations at significantly higher rates than residents in the rest of Boston. Additionally, in 2013-2017, one-quarter (25%) of Boston adults reported being diagnosed with hypertension, one of the most significant risk factors for heart disease and stroke.

#### Cancer:

While cancer is the leading cause of death in the city of Boston, it was not frequently mentioned as a pressing concern among focus group and interview participants. The exception to this was in groups in East Boston and Chinatown. In Chinatown, focus group participants perceived that the high rates of tobacco use impacted cancer rates in their neighborhood. East Boston participants spoke of cancer in the context of environmental concerns; specifically, residents worried about an electrical plant that was being built by the harbor. A few key informants described the need for more supports for caretakers. One shared, "Family members of a cancer patient likely find it hard to think critically about other matters when they are focused on their loved one struggling with such a difficult condition."

When discussing cancer screenings, a few interviewees and focus group participants noted that some of the biggest barriers to cancer screenings included lack of awareness about the importance of screening, discomfort and fear of screenings particularly those considered more invasive such as colonoscopies, inability to take time off work, confusion about changing screening guidelines, and for a few, insurance and transportation issues. Nearly nine in ten women 50 to 74 years of age across Boston (88%) reported receiving a mammogram in the past two years. Of note, compared to their counterparts, Latina women (93%) and immigrants living in the US for fewer than 10 years (97%) were significantly more likely to report receiving a mammogram in the past two years. There was no significant difference by Boston neighborhoods in the percent of women who reported receiving a mammogram in the past two years (data in APPENDIX I).

#### Heart Disease:

Heart disease and stroke were only mentioned by a few key informants, and neither topics emerged as a priority theme in focus groups. The key informants that did mention it perceived that there was a trend of early onset heart disease, with one sharing, "We are seeing a lot of cases of heart disease and COPD in younger populations." Another key informant who worked with seniors identified congestive heart failure as a common issue among the aging population.

Although hypertension was not an issue often discussed by focus group participants, it is the biggest risk factor for heart disease and stroke. In 2013-2017, one-quarter (25%) of Boston adults reported being diagnosed with hypertension (Figure 83). A significantly higher proportion of adults who identified as Black (38%), Latino (26%), aged 35-49 (12%), aged 50-65 (40%), 65 and older (65%), residents living in Boston Housing Authority units (39%), renters on rental assistance (37%), and immigrants living in the US for more than ten years (35%) reported being diagnosed with hypertension or high blood pressure, compared to their counterparts. Additionally, there was a consistent socioeconomic gradient in the prevalence of hypertension: a significantly higher percent of adults with less than a high school education (42%), a high school education (28%), incomes <\$25,000 (34%); incomes \$25,000-\$49,999 (27%), out of work (27%), and other employment statuses (38%) reported a hypertension diagnosis compared with their counterparts of higher socioeconomic status, A significantly lower percent of adults who identified as Asian (16%), renters without assistance (19%), residents with other housing arrangements (19%), immigrants living in the US for less than ten years (10%), and LGBTQ (19%) reported a hypertension diagnosis when compared to the comparison groups.

#### Diabetes:

Diabetes was frequently mentioned as a community concern that had an impact on both adults and children. Many focus group and interview participants discuss diabetes in connection with obesity. For example, participants in East Boston explained that stress often triggers unhealthy coping mechanisms such as unhealthy eating that cause illness. One resident shared, "I work with a lot of women and what I see is a lack of motivation [to exercise]. Moms have to work so much and all of their energy goes to mechanisms to cope like eating poorly; stress often means weight gain." Further, key informants perceived the rise in Type 2 Diabetes symptoms among young children—particularly among Black and Latino children. One interviewee shared, "I'm seeing many of our elementary-aged kids exhibiting early signs of Type 2 Diabetes...the darkening ring behind the neck, blurred vision, and frequent urination. Lots of times parents don't realize that these early symptoms are dangerous." Lastly, a couple of focus group participants from Dorchester described challenges affording insulin, sharing that they often skipped doses to make it last longer. While the prevalence of reported diabetes across Boston was 9% in 2013-2017, there were significant differences in the distribution of diabetes across the population. Compared to their counterparts, a significantly higher proportion of adults who identified as Black (15%), Latino (12%), older (>50 years; 16-23%), Boston Housing Authority residents (18%), renters receiving rental assistance (17%), adults with a high school education or less (12%-18%), immigrants who have resided in the US for more than 10

years (14%) reported a diabetes diagnosis.

Additional information on Chronic Diseases may be found on pages: x, 114-133, and 342.

## 6. Community Definition

Specify the community(ies) identified in the Applicant's 2019 Boston CHNA-CHIP Process

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
<input type="checkbox"/> <input type="checkbox"/>	Boston	including Hyde Park - which is not part of the drop down menu
<input type="checkbox"/> <input type="checkbox"/>	Dorchester	
<input type="checkbox"/> <input type="checkbox"/>	Roxbury	
<input type="checkbox"/> <input type="checkbox"/>	Mattapan	
<input type="checkbox"/> <input type="checkbox"/>	Roslindale	

## 7. Local Health Departments

Please identify the local health departments that were included in your 2019 Boston CHNA-CHIP Process . Indicate which of these local health departments were engaged in this 2019 Boston CHNA-CHIP Process . For example, this could mean participation on an advisory committee, included in key informant interviewing, etc. (Please see page 24 in the Community further description of this requirement <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>.)

Add/Del Rows	Municipality	Name of Local Health Dept	Name of Primary Contact	Email address	Describe how the health department was involved
<input type="checkbox"/> <input type="checkbox"/>	Boston	Boston Public Health Commission	Bisola Ojikutu MD MPH		In 2019 BPHC was a member of the Collaborative. In 2022, BPHC is helping to lead the CHNA/CHIP process and developing the report.

## 8. CHNA / CHIP Advisory Committee

Please list the community partners involved in the CHNA/CHIP Advisory Committee that guided the 2019 Boston CHNA-CHIP Process . (please see the required list of sectorial representation in the *Community Engagement Standards for Community Health Planning Guidelines* <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>) Please note that these individuals are those who should complete the *Stakeholder Engagement Assessment* form. It is the responsibility of the Applicant to ensure that DPH receives the completed *Stakeholder Engagement Assessment* form:

Add/Del Rows	Sector Type	Organization Name	Name of Primary Contact	Title in Organization	Email Address	Phone Number
<input type="checkbox"/> <input type="checkbox"/>	Municipal Staff	City of Boston	Rufus Faulk	Director of the Mayor's Office of Public Safety		
	Education	Boston Public Schools	Eva Mitchell	Chief Accountability Officer		
	Housing	Madison Park Development Corporation	Leslie Reid	Chief Executive Officer		
	Social Services	Youth Guidance Boston	Shawn Brown	Executive Director		
	Planning + Transportation	City of Boston	Andrew Grace	Director of Economic and Strategic Planning		
	Private Sector/ Business	Hyams Foundation	Lisa Owens	Executive Director		
	Community Health Center	Community Care Cooperative (C3)	Phillomin "Philly" Laptiste	Chief People Officer		
	Community Based Organizations	Dudley Street Neighborhood Initiative	John Smith	Executive Director		
<input type="checkbox"/> <input type="checkbox"/>	Local Public Health Departments/Boards of Health	Boston Public Health Commission	Eugen Barros	Division Director of Healthy Homes Division		
<input type="checkbox"/> <input type="checkbox"/>	Community-based organizations	Twelfth Baptist Church	Reverend Willie Broderick, II	Senior Pastor		
<input type="checkbox"/> <input type="checkbox"/>	Private Sector	Taylor Smith Group	Richard Taylor	Chairman		



## 8a. Community Health Initiative

For Tier 2 and Tier 3 CHI Projects, is the the Applicant's CHNA / CHIP Advisory Board the same body that will serve as the CHI advisory committee as outlined in the Table 1 of the Determination of Need Community-Based Health Initiative Guideline (<http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-chi-planning.pdf>)?

☒ Yes ☐ No

## 9. Engaging the Community At Large

Thinking about the extent to which the community has been or currently is involved in the 2019 Boston CHNA-CHIP Process, please choose one response for each engagement activity below. Please also check the box to the left to indicate whether that step is complete or not. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
<input checked="" type="checkbox"/> Assess Needs and Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	See the attached addendum.					
<input checked="" type="checkbox"/> Focus on What's Important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Focus on What's Important" phase.	See the attached addendum.					
<input checked="" type="checkbox"/> Choose Effective Policies and Programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	See the attached addendum.					
<input checked="" type="checkbox"/> Act on What's Important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Act on What's Important" phase.	See the attached addendum.					
<input checked="" type="checkbox"/> Evaluate Actions	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Evaluate Actions" phase.	See the attached addendum.					

## 10. Representativeness

Approximately, how many community agencies are currently involved in 2019 Boston CHNA-CHIP Process within the engagement of the community at large?

91

Agencies

Approximately, how many people were engaged in the process (please include team members from all relevant agencies and independent community members from the community at large)?

2,553

Individuals

Please describe the diversity of the people who have been engaged in the process both within the CHNA/CHIP Advisory Committee and the community at large. Explicitly describe how the process included diverse representation from different groups/individuals with varied gender, sexual orientation, race/ethnicity, disability status, international status and age. Please see page 10 and Appendix A of the *Community Engagement Standards for Community Health Planning Guideline* (<http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>) for further explanation of this.

First, Boston Medical Center's (BMC) Community Advisory Board is representative of the communities that the medical center serves. Board members are diverse in race, ethnicity, and gender and live and work in BMC's neighborhoods. Second, the Boston CHNA-CHIP process included diverse representation from different groups and individuals. This CHNA focused on the social determinants of health using a health equity lens. As previously stated, the influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are many of the root factors that drive the health inequities we see in the U.S. today.

Please describe the type of representation that was/is employed in the community engagement process and the rationale for that type of representation. For more information on types of representation and representativeness, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (<http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>). Please include descriptions of both the Advisory Board and the Community at large.

Deep-rooted community engagement incorporates a mixture of grassroots and grass tops approaches and incorporates different features of engagement. The Collaborative used both of these approaches. Regarding the grass tops approach, the Collaborative ensured sectorial diversity to encourage innovation and provide sufficient representation. Accordingly, diverse groups were part of the data collection and engagement processes to obtain varied diverse perspectives. The grassroots approach also was used when feasible - such as in public meetings for engagement and health priority selection. In fact, over 100 diverse individuals came together to review data and select health priorities.

To your best estimate, of the people engaged in 2019 Boston CHNA-CHIP Process

approximately how many: Please indicate the number of individuals.

Number of people who reside in rural area

Number of people who reside in urban area

Number of people who reside in suburban area

## 11. Resource and Power Sharing

For more information on Power Sharing, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* (<http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>).

*By community partners, we mean agencies, organizations, tribal community, health departments, or other entities representing communities.*

*By Applicant partners, we mean the hospital / health care system applying for the approval of a DoN project*

	Community Partners	Applicant Partners	Both	Don't Know	Not Applicable
Which partner hires personnel to support the community engagement activities?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Who decides the strategic direction of the engagement process?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Who decides how the financial resources to facilitate the engagement process are shared?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Who decides which health outcomes will be measured to inform the process?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 12. Transparency

Please describe the efforts being made to ensure that the engagement process is transparent. For more information on transparency, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines*.

Community engagement processes were carried out in a transparent manner. The Boston CHNA-CHIP Collaborative carried out focus groups, interviews, and surveys with diverse populations throughout Boston. The community survey was translated into numerous languages. Additionally, focus groups and key-informant interviews were conducted with non-English speaking residents in the language of their choice. Community focus groups were open to all community members. Resources to address social drivers, such as child care and translation services were available to reduce barriers to access and attendance.

### 13. Formal Agreements

Does / did the 2019 Boston CHNA-CHIP Process have written formal agreements such as a Memorandum of Agreement/ Understanding (MOU) or Agency Resolution?

- ☒ Yes, there are written formal agreements      ☐ No, there are no written formal agreements

Did decision making through the engagement process involve a verbal agreement between partners?

- ☐ Yes, there are verbal agreements      ☒ No, there are no verbal agreements

### 14. Formal Agreement Specifics

Thinking about your MOU or other formal agreement(s), does it include any provisions or language about:

	Yes	No	Don't Know	Doesn't Apply
Distribution of funds	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Written Objectives	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clear Expectations for Partners' Roles	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clear Decision Making Process (e.g. Consensus vs. Voting)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conflict resolution	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conflict of Interest Paperwork	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 15. Document Ready for Filing

When the document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit. Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the "E-mail submission to DPH" button.

This document is ready to file: ☒

Date/time Stamp: 08/09/2022 10:05 am

E-mail submission to DPH

E-mail submission to  
Stakeholders and CHI Advisory Board

When providing the Stakeholder Assessment Forms to the community advisory board members (individuals identified in Section 8 of this form), please include the following information in your correspondence with them. This will aid in their ability to complete the form:

- A) Community Engagement Process: 2019 Boston CHNA-CHIP Process
- B) Applicant: BMC Health System, Inc.
- C) A link to the DoN CHI Stakeholder Assessment

**Section 9: Engaging the Community at Large – Thinking about the extent to which the community has been or currently is involved in the 2019 Boston Collaborative CHNA-CHIP Process, please choose one response for each engagement activity below. Please also check the box to the left to indicate whether that step is complete or not. (For definitions of each step, please see pages 12-14 in the Community Engagement Standards for Community Health Planning Guidelines [http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines\\_community-engagement.pdf](http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines_community-engagement.pdf)).**

### *Background Information*

In 2019, the Boston CHNA-CHIP Collaborative (“Collaborative”) was a new initiative created by a number of stakeholders including community organizations, health centers, community development corporations, hospitals, and the Boston Public Health Commission to assess the health and social determinants of health for Boston residents. This Collaborative aimed to undertake the first large-scale city-wide CHNA and Community Health Improvement Planning (“CHIP”) process. Boston Medical Center (“BMC”) participated in the Collaborative’s community health needs assessment (“CHNA”) process.

The goals of the CHNA were to:

- Systematically identify the health-related needs, strengths, and resources of a community to inform future planning.
- Understand the current health status of Boston overall and its sub-populations within their social context.
- Meet regulatory requirements for a number of institutions, organizations, and agencies (e.g., IRS requirements for non-profit hospitals and Public Health Accreditation Board certification for health departments).

To support this effort, the Collaborative hired Health Resources in Action (“HRiA”), a non-profit public health organization, as a consultant partner to provide strategic guidance and facilitation of the process, collect and analyze data, and develop the report deliverables.

For the 2019 CHNA, the following approach and methods were used: This CHNA focuses on the social determinants of health using a health equity lens. The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historic oppression of specific groups are many of the root causes that drive health inequities in the United States.

The 2019 CHNA used a participatory, collaborative approach that engaged the community through different avenues. Over 100 Collaborative members representing health care, public health, education, community development, social service, and community-based organizations provided input throughout the CHNA process and played an integral role in data collection efforts. Data collection efforts were focused on engaging hard-to-reach populations who are not typically engaged in these processes or represented in the secondary data.

Existing data were drawn from national, state, and city sources, such as the U.S. Census, Massachusetts Department of Public Health, and Boston Public Health Commission, including data sets such as the Boston Behavioral Risk Factor Surveillance System (“BBRFSS”). For new data collection, over 91 organizations and 2,500 individuals were engaged in a CHNA community survey (N=2,404) administered online and in-person in seven languages, 13 focus groups with community residents (N=104), and 45 interviews with organizational and community leaders to gauge their perceptions of the community’s needs, strengths, and opportunities.

Like all data gathering efforts, there are limitations to the CHNA data. Secondary data have a time lag, and various sources may use different definitions for similar topics. Data may be aggregated across time, geographies, or population groups to provide large enough sample sizes. More granular analysis for specific neighborhoods or ethnic groups within larger racial/ethnic categories is not possible. Primary data such as the survey and focus groups use a convenience sample, which may not be representative of the larger population.

#### *The Boston CHNA-CHIP Collaborative Infrastructure*

To ensure the CHNA-CHIP process was robust with appropriate resources, the Boston CHNA-CHIP Collaborative developed an administrative infrastructure with a Steering Committee comprised of leadership from each of the participating organizations. The Collaborative’s Steering Committee provided strategic direction for the CHNA-CHIP processes. Additionally, the Steering Committee ensured accountability of the work groups, partnering organizations, and HRiA by managing and overseeing work plans. The Collaborative’s Operations Committee addressed issues within the CHNA-CHIP processes and provided direction and oversight to administrative staff. The Collaborative also formed three larger work groups to the Steering Committee (“work groups”), including:

- Community Engagement Work Group: The work group was responsible for developing a sound community engagement strategy to assess the needs and resources of the various neighborhoods within Boston. This work group also provided oversight on the collection of primary data.
- Secondary Data Work Group: This work group provided guidance on secondary data and fostered connections with diverse groups to provide relevant data for the CHNA.
- Implementation Planning (CHIP) Work Group: This work group was responsible for working with HRiA to develop an overall CHIP that selected effective policies and procedures, as well as the health priorities for Boston.

Boston Medical Center staff participated in this infrastructure. Dr. Thea James continues to serve on the Steering Committee for the Collaborative. Moreover, Drs. James and Sandel also Co-Chair certain sub-work groups. Dr. James is the Co-Chair of the Financial Mobility Work Group and Dr. Sandel is the Co-Chair of the Housing Work Group.

#### *Boston CHNA-CHIP Collaborative Mission and Vision*

The vision of the Boston CHNA-CHIP Collaborative is “A healthy Boston with strong

communities, connected residents and organizations, coordinated initiatives, and where every individual has an equitable opportunity to live a healthy life.” To implement this vision, the Collaborative’s mission is “To achieve sustainable positive change in the health of Boston by collaborating with communities, sharing, knowledge, aligning resources and addressing root causes of health inequities.” The Collaborative achieves this mission by engaging with the community to:

- Conduct a joint CHNA for Boston every three years discussing the social, economic, and health needs and assets in the community;
- Develop a collaborative CHIP for Boston to address issues identified as top priority and identify opportunities for shared investment;
- Implement efforts together (where aligned) and track individual organizational activities where appropriate;
- Monitor and evaluate CHIP strategies for progress and impact to continuously inform implementation;
- Communicate about the process and results to organizational leadership, stakeholders, and the public throughout the assessment, planning and implementation time period; and
- Monitor and evaluate the Collaborative infrastructure and processes to continuously improve effectiveness and results.

Given this vision, as well as the required CHNA-CHIP processes outlined in the Department of Public Health’s *Community Engagement Standards for Community Health Planning Guideline*, the Collaborative’s CHNA assessed the needs and resources of Boston’s neighborhoods and focused on what is important through a prioritization process. Additionally, the Collaborative’s CHIP ensures that effective policies and programs are selected to address the health priorities. Finally, BMC may act on what is important by implementing CHNA health priorities through a hospital-based CHIP with feedback from its Community Advisory Board (“CAB”).

The CHNA stages of engagement are outlined below.

- ***Assess the Needs and Resources:***

To assess the needs and resources within the City of Boston, the CHNA-CHIP Collaborative conducted primary and secondary data collection efforts.

### **Primary Data**

Primary Data are new data collected specifically for the purpose of the CHNA. Goals of the Boston CHNA primary data were: 1) to delve deeply into people’s perceptions, lived experiences, challenges, and facilitators around certain issues; and 2) to fill in gaps on specific topic areas or population groups where limited data were available. Primary data were collected using three different methods for the Boston CHNA: a community survey, focus groups, and key informant interviews.

### **Boston CHNA Community Survey**

A community survey was developed and administered over six weeks in February-March 2019. The survey focused on a range of issues related to the social determinants of health; community perceptions; and access to care, and was developed with extensive input from the Community Engagement Work Group and guided by existing validated questions from the field or used in other studies. The survey was pilot tested in late January 2019, and the final instrument was



launched on February 1, 2019, with wider dissemination starting the following week. The survey was administered on-line and via hard copy in seven languages (English, Spanish, Portuguese, Haitian Creole, Chinese, Vietnamese, and Arabic). Extensive outreach was conducted by Collaborative members to disseminate the survey via social media, institutional e-newsletters, e-mails to large networks, waiting rooms, 13 Boston Public Library neighborhood branches, community events, and large apartment buildings. Over 35 organizations assisted with survey dissemination (See APPENDIX D of the CHNA for a list of organizations). Additionally, Healthy Community Champions (an initiative of grassroots ambassadors) conducted targeted survey administration in specific neighborhoods.

### Focus Groups

Thirteen focus groups were conducted with specific populations of interest: 12 focus groups conducted specifically for the collaborative CHNA and one additional focus group conducted by work group members who submitted notes for the CHNA. Focus groups were 90-minute semi-structured conversations with approximately 8-12 participants per group and aimed to delve deeply into community's needs, strengths, and opportunities for the future. Focus groups were conducted with the following population groups, including residents of specific neighborhoods:

- Female low-wage workers (e.g., housekeepers, childcare workers, hotel service workers, etc.)
- Male low-wage workers (e.g., janitorial staff, construction workers, etc.)
- Seniors (ages 65+) with complex, challenging issues (e.g., homebound, medical complications, etc.)
- Residents who are housing insecure (no permanent address or close to eviction)
- Latino residents in East Boston (in Spanish)
- LGBTQ youth and young adults at risk of being homeless
- Immigrant parents of school aged children (5-18 years)
- Survivors of violence; mothers who have been impacted by violence
- Parents who live in public housing in Dorchester
- Chinese residents living in Chinatown (in Chinese)
- Haitian residents living in Mattapan (in Haitian Creole)
- Residents in active substance use recovery
- Additional focus group with notes provided: Chinese residents living in Chinatown

A total of 104 community residents participated in focus groups, representing 13 neighborhoods across the city. Nearly half of focus group participants identified as Black or African American (45%), a third of participants identified as Hispanic or Latino (34%), and 10% identified as White. The majority of participants identified as female (57%), 36% identified as male, and 7% identified as transgender or genderqueer. Additional data on focus group participant characteristics can be found in Appendix F of the 2019 CHNA. Fifteen community and social service organizations located throughout Boston assisted with recruiting participants and/or hosting focus groups (See APPENDIX G within the CHNA for a list of organizations).

### Key Informant Interviews

A total of 45 key informant interviews were completed, six of which were additional interviews submitted by work group volunteers. Interviews were 45-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders and front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and opportunities for future alignment, coordination, and expansion of services; initiatives; and policies. Sectors represented in these interviews included: public health, health care, housing and homelessness, transportation, community development, faith, education,

public safety, environmental justice, government, workforce development, social services, food insecurity, business organizational staff that work with specific population such as youth, seniors, disabled, LGBTQ, and immigrants. See APPENDIX H for a list of key informant interviewees.

## **Secondary Data**

Secondary data are data that have already been collected for another purpose. Examining secondary data helps to understand trends, provide a baseline, and identify differences by sub-groups. These data also help in guiding where primary data collection can dive deeper or fill in gaps. While the secondary data for this CHNA cover a wide range of issues, there is a particular focus to dive more deeply into areas already identified in previous assessments (e.g., housing, transportation, income, employment, education, mental health, substance, chronic conditions and their risk factors, violence and trauma, and access to services), as well as frame the discussion comprehensively around the social determinants of health.

### Data Sources

Secondary data for this CHNA were from a variety of sources, including the BBRFSS, Youth Risk Behavior Survey ("YRBS"), U.S. Census American Community Survey ("ACS"), vital records, Acute Hospital Case Mix Database from the Center for Health Information and Analysis, and a number of other agencies and organizations. See Appendix C of the 2019 CHNA for more technical notes about the most frequently common datasets cited in this report.

### Analyses

All secondary data on birth and death records, BBRFSS, YRBS, and Acute Hospital Case Mix were analyzed by the Research and Evaluation Office of the Boston Public Health Commission. Other data were analyzed by the organizations cited in the data source. Analyses are presented as frequencies (percentages) and rates throughout the report. Data from the ACS and surveillance systems, such as the BBRFSS and YRBS, are presented with confidence intervals (or error bars in the figures), where possible. When statistical significance testing was conducted, it is noted in figures or in text. Specifically, when the word "significantly" is used in the text, it connotes statistical significance ( $p < 0.05$ ). Additional information on confidence intervals and significance testing can be found within the Reporting Notes in this section.

Accordingly, the Collaborative and BMC reached the "Collaborate" level of engagement through all of this work.

- ***Focus on What's Important:***

The Collaborative sought to evaluate the greatest needs of Boston's residents and then develop priorities that the collective group could focus on. To select priorities, a prioritization meeting was held with approximately 125 individuals representing various organizations and communities within Boston.

The health priorities that emerged across communities and were adopted by the Collaborative and BMC include:

- Safe, affordable, and stable housing;
- Economic and financial stability and mobility, including living wage jobs and educational pathways;
- Behavioral health, including substance use disorders ("SUDs") with an emphasis on youth and families; and

- Access to health, social, and childcare services.

BMC through its CHIP sought to implement programs to address these priorities.

For this phase, BMC reached the “Collaborate” level of engagement.

- ***Choose Effective Policies and Programs and Act on What’s Important:***

Given the selected priorities, BMC developed a robust CHIP to implement programming aligned with the CHNA health priorities. This CHIP may be accessed at:

[https://www.bmc.org/sites/default/files/About Us/Commitment to Our Community/field Attachments/FY19-22-Implementations-Strategy.pdf](https://www.bmc.org/sites/default/files/About%20Us/Commitment%20to%20Our%20Community/field%20Attachments/FY19-22-Implementations-Strategy.pdf)

For this phase, BMC reached the “Collaborate” level of engagement.

- ***Evaluate Actions***

The Collaborative consistently evaluates progress on the noted health priorities through review of the CHIP and progress to date. Similarly, BMC also reviews progress with its CHIP to ensure the hospital is meeting its goals.

For this phase, BMC reached the “Consult” level of engagement.

**APPENDIX 5C:**

**FACTOR 6 MATERIALS – COMMUNITY ENGAGEMENT PLAN FORM & ADDENDUM**



# Massachusetts Department of Public Health

## Determination of Need

### Community Health Initiative

### Community Engagement Plan

Version: 8-1-2017

The Community Engagement Plan is intended for those Applicants with CHIs that require further engagement above and beyond the regular and routine CHNA/CHIP processes. For further guidance, please see the *Community Engagement Standards for Community Health Planning Guidelines* and its appendices for clarification around any of the following terms and questions.

**All questions in the form, unless otherwise stated, must be completed.**

Approximate DoN Application Date: 08/09/2022 DoN Application Type: Hospital/Clinic Substantial Capital Expenditure

Applicant Name: BMC Health System, Inc.

What CHI Tier is the project? ☐ Tier 1 ☐ Tier 2 ☒ Tier 3

## 1. Community Engagement Contact Person

Contact Person: Thea James, MD Title: Vice President of Mission and Associate Chief Medical Officer

Mailing Address: 840 Harrison Avenue

City: Boston State: Massachusetts Zip Code: 02118

Phone: 6174143564 Ext: E-mail: thea.james@bmc.org

## 2. Name of CHI Engagement Process

Please indicate what community engagement process (e.g. the name DoN CHI Initiative associated with the CHI amount) the following form relates to. This will be use as a point of reference for the following questions.

(please limit the name to the following field length as this will be used throughout this form):

2022 BMC Inpatient DoN CHI

## 3. CHI Engagement Process Overview and Synergies with Broader CHNA /CHIP

Please briefly describe your overall plans for the CHI engagement process and specific how this effort that will build off of the CHNA / CHIP community engagement process as is stated in the *DoN Community-Based Health Initiative Planning Guideline*.

See attached addendum.

## 4. CHI Advisory Committee

In the CHNA/CHIP Self Assessment, you listed (or will list) the community partners that will be involved in the CHI Advisory Committee to guide the 2022 BMC Inpatient DoN CHI . As a reminder:

**For Tier 2 DON CHI Applicants:** The CHI Advisory Committee is tasked with helping select DoN Health Priorities based on the CHNA / CHIP unless the Applicant is directed by DPH to conduct additional community engagement. If so, the advisory committee's role is to guide that additional work.

**For Tier 3 DON CHI Applicants:** The CHI Advisory Committee is to select DoN Health Priorities based on, **but not exclusive to**, the CHNA / CHIP. This includes the additional community engagement that must occur to develop the issue priorities.

## 5. Focus Communities for CHI Engagement

Within the 2022 BMC Inpatient DoN CHI , please specify the target community(ies), please consider the community(ies) represented in the CHNA / CHIP processes where the Applicant is involved.

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
<input type="checkbox"/> + <input type="checkbox"/> -	Boston	including Hyde Park - which is not part of the drop down menu
<input type="checkbox"/> + <input type="checkbox"/> -	Dorchester	
<input type="checkbox"/> + <input type="checkbox"/> -	Roxbury	
<input type="checkbox"/> + <input type="checkbox"/> -	Mattapan	
<input type="checkbox"/> + <input type="checkbox"/> -	Roslindale	

## 6. Reducing Barriers

Identify the resources needed to reduce participation barriers (e.g., translation, interpreters, child care, transportation, stipend). For more information on participation barriers that could exist, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>

Upon review of the DoN Community-Based Health Initiative Planning Guideline, specifically Appendix A, BMC CHI leadership and the Community Benefits team will seek to address engagement barriers to maximize participation in CHI activities. Accordingly the following steps will be taken to reduce barriers:

1. For community-facing meetings, Boston Medical Center ("BMC") Community Health Initiative ("CHI") leadership will be thoughtful about the location and accessibility of the venue, childcare needs, the use of interpreters and signers, and transportation challenges that attendees may face. These barriers will be addressed by selecting an accessible venue that is close to public transportation, providing child care services, and having interpreters and signers present to maximize participation.
2. When releasing a request for proposals ("RFP") or an alternative funding mechanism to distribute CHI funding - all materials will be translated into the most common languages for the target communities. Moreover, these materials will be available electronically and via hard copy at the BMC Development Office.
3. BMC CHI leadership will work with the Community Advisory Board ("CAB") to develop alternative funding mechanisms as RFPs are often a challenge for grassroots organizations.
4. Communications regarding CHI activities will be emailed via BMC's various networks including the Equity Partnership Network and other community-based networks.

## 7. Communication

Identify the communication channels that will be used to increase awareness of this project or activity:

BMC CHI leadership will use various methods to update community members, patients, and community-based organizations about ongoing CHI activities. These methods include working with BMC's Equity Partnership Network ("EPN"), a diverse and engaged group of community leaders who are involved with different BMC Community Advisory Boards and the Accelerator Community Advisory Committee ("ACAC"), a sub-group of the EPN that provides invaluable guidance to the Accelerator as this group seeks to address inequities – from which health inequities to focus on to how to approach the community on specific topics. These groups have vast networks that will be kept apprised of the DoN - CHI activities.

Additionally, BMC CHI leadership will continue to communicate with community-based organizations, residents, and patients via community meetings, email distribution avenues - such as coalition listservs, the Hospital's web site and social media platforms, as well as newsletters and other community resources, such as newspapers, blogs, etc.



## 8. Build Leadership Capacity

Are there opportunities with this project or activity to build community leadership capacity?

☒ Yes ☐ No

If yes, please describe how.

BMC is committed to building community leadership capacity. This has been one of the goals of BMC's work with the Innovative Stable Housing Initiative, and this program provides lessons learned in this area to build community leadership capacity.

Furthermore, ongoing efforts of the Boston CHNA-CHIP Collaborative are designed to build community leadership capacity and ensure that diverse perspectives on CHI Health Priorities and Strategies are part of the decision making process. BMC will continue to explore ways that community leadership capacity may be built into this CHI, but at the very least will seek to use lessons learned around building leadership capacity for ongoing CHI initiatives.

## 9. Evaluation

Identify the mechanisms that will be used to evaluate the planning process, engagement outcome, and partner perception and experience:

BMC CHI leadership and the CAB will work with an evaluator to identify appropriate metrics to measure success of the CHI planning process, engagement, partner perceptions and experience and the overall impact of CHI funding. BMC will work with its evaluator to design an evaluation plan to understand the impact of each CHI phase.

## 10. Reporting

Identify the mechanisms that will be used for reporting the outcomes of this project or activity to different groups within the community:

Residents of Color

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to residents of color. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, the Bay State Banner, community-based organizations and coalitions, Boston churches, as well as other avenues that are being explored.

Residents who speak a primary language other than English

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to residents whose primary language is not English. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, the Bay State Banner, community-based organizations and coalitions, Boston churches, as well as other avenues that are being explored, such as through social media, etc.

Aging population

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to the aging population. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, senior centers, community-based organizations and coalitions, Boston churches, as well as other avenues that are being explored, such as social media platforms, etc.

Youth

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to youth. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, to school-based organizations, community-based organizations and coalitions, Boston churches, as well as other avenues that are being explored, such as social media platforms, etc.

Residents Living with Disabilities

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to residents living with disabilities. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, community-based organizations and coalitions, as well as other avenues that are being explored, such as social media platforms, etc.

GLBTQ Community

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to the LGBTQ community. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, community-based organizations and coalitions, as well as other avenues that are being explored, such as social media platforms, etc.

## Residents with Low Incomes

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to residents with low incomes. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, community-based organizations and coalitions, as well as other avenues that are being explored, such as social media platforms, etc.

## Other Residents

BMC leadership will work with the CAB to develop a strategy for reporting CHI outcomes to other residents, such as families with children. This plan will include releasing information, such as press releases, reports, and other materials via the EPN, community-based organizations and coalitions, Boston churches, as well as other avenues that are being explored, such as social media platforms, etc.

# 11. Engaging the Community At Large

Which of the stages of a CHNA/CHIP process will the 2022 BMC Inpatient DoN CHI focus on? Please describe specific activities within each stage and what level the community will be engaged during the 2022 BMC Inpatient DoN CHI. While the step(s) you focus on are dependent upon your specific community engagement needs as a result of your previous CHNA/CHIP work, for tier 3 applicants the CHI community engagement process must at a minimum include the "Focus on What's Important," "Choose Effective Policies and Programs" and "Act on What's Important" stages. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
<input checked="" type="checkbox"/> Assess Needs and Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	See attached addendum.					
<input checked="" type="checkbox"/> Focus on What's Important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Focus on What's Important" phase.	See attached addendum.					
<input checked="" type="checkbox"/> Choose Effective Policies and Programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	See attached addendum.					
<input checked="" type="checkbox"/> Act on What's Important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Act on What's Important" phase.	See attached addendum.					
<input checked="" type="checkbox"/> Evaluate Actions	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Evaluate Actions" phase.	See attached addendum.					



## 12. Document Ready for Filing

When the document is complete, click on "document is ready to file". This will lock in the responses, and Date/Time stamp the form. To make changes to the document, un-check the "document is ready to file" box. Edit the document, then lock file and submit. Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the "E-mail submission to DPH" button.

**This document is ready to file:** ☒

Date/Time Stamp: 08/09/2022 10:04 am

E-mail submission to DPH

## **Addendum to the Community Engagement Plan Form**

### **Section 3: Please briefly describe your overall plans for the CHI engagement process and specify how this effort will build off of the CHNA/CHIP community engagement process as is stated in the Determination of Need (“DoN”) Community-Based Health Initiative Planning Guideline.**

Boston Medical Center’s (“BMC”) CHI engagement process is built upon the engagement work conducted by the Boston Community Health Needs Assessment-Community Health Improvement Plan Collaborative (“Boston CHNA-CHIP Collaborative” or “Collaborative”) for the 2019 and 2022 community health needs assessments (“CHNA”). Below is a discussion of the engagement that occurred during both of these CHNA processes, as well as efforts to further engagement with the community.

#### **CHNA Processes**

##### 2019 CHNA Process

In 2019, BMC conducted a comprehensive CHNA in collaboration with multiple stakeholders including community organizations, health centers, hospitals, and the Boston Public Health Commission. Key findings that emerged from the 2019 CHNA include: housing affordability; food insecurity; transportation; healthcare access and utilization; chronic disease; mental health; substance use; violence and trauma; maternal and child health; sexual health; environmental health; education; employment and workforce development; income and financial security; social environment; green space and the built environment; and obesity, nutrition and physical activity. These findings informed BMC’s 2019 Implementation Strategy which served as the BMC’s roadmap for Community Benefits Programs and Initiatives for 2019-2022. See the CHNA/CHIP Assessment Form and Addendum for additional information.

##### *2019 CHNA – Community Engagement*

In 2019, as part of the Collaborative, BMC participated in the following engagement strategies to access the needs and resources of the community, specifically Boston residents.

First, a community survey was developed and administered over six weeks in February-March 2019. The survey focused on a range of issues related to the social determinants of health (“SDoH”), community perceptions, and access to care and was developed with extensive input from the Collaborative’s Community Engagement Work Group and guided by existing validated questions from the field or used in other studies. The survey was administered on-line and via hard copy in seven languages (English, Spanish, Portuguese, Haitian Creole, Chinese, Vietnamese, and Arabic). Extensive outreach was conducted by Collaborative members to disseminate the survey via social media, institutional e-newsletters, e-mails to large networks, waiting rooms, 13 Boston Public Library neighborhood branches, community events, and large apartment buildings. Over 35 organizations assisted with survey dissemination (See APPENDIX D of the Collaborative’s 2019 CHNA for a list of organizations). Additionally, Healthy Community Champions (an initiative of grassroots ambassadors) conducted targeted survey administration in specific neighborhoods.

Second, thirteen focus groups were conducted with specific populations of interest: 12 focus groups conducted specifically for the collaborative CHNA, and one additional focus group

conducted by work group members who submitted notes for the CHNA. Focus groups were 90-minute semi-structured conversations with approximately 8-12 participants per group and aimed to delve deeply into community's needs, strengths, and opportunities for the future. Focus groups were conducted with the following population groups, including residents of specific neighborhoods:

- Female low-wage workers (e.g., housekeepers, childcare workers, hotel service workers, etc.)
- Male low-wage workers (e.g., janitorial staff, construction workers, etc.)
- Seniors (ages 65+) with complex, challenging issues (e.g., homebound and medical complications, etc.)
- Residents who are housing insecure (no permanent address or close to eviction)
- Latino residents in East Boston (in Spanish)
- LGBTQ youth and young adults at risk of being homeless
- Immigrant parents of school aged children (5-18 years)
- Survivors of violence; mothers who have been impacted by violence
- Parents who live in public housing in Dorchester
- Chinese residents living in Chinatown (in Chinese)
- Haitian residents living in Mattapan (in Haitian Creole)
- Residents in active substance use recovery
- Additional focus group with notes provided: Chinese residents living in Chinatown

A total of 104 community residents participated in focus groups, representing 13 neighborhoods across the city. Nearly half of focus group participants identified as Black or African American (45%), a third of participants identified as Hispanic or Latino (34%), and 10% identified as White. The majority of participants identified as female (57%), 36% identified as male, and 7% identified as transgender or genderqueer. Additional data on focus group participant characteristics can be found in Appendix F of the CHNA. Fifteen community and social service organizations located throughout Boston assisted with recruiting participants and/or hosting focus groups (See APPENDIX G within the CHNA for a list of organizations).

Third, a total of 45 key informant interviews were completed, six of which were additional interviews submitted by work group volunteers. Interviews were 45-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders and front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and opportunities for future alignment, coordination, and expansion of services, initiatives, and policies. Sectors represented in these interviews included: public health, health care, housing and homelessness, transportation, community development, faith, education, public safety, environmental justice, government, workforce development, social services, food insecurity, business organizational staff that work with specific populations such as youth, seniors, disabled, LGBTQ, and immigrants. See APPENDIX H for a list of key informant interviewees for the 2019 CHNA.

### 2022 CHNA Process

In 2021, the Boston CHNA-CHIP Collaborative began work on its 2022 CHNA (which is projected to be voted upon by the Steering Committee in September). The Collaborative aims to achieve sustainable positive change in the health of residents within Boston by partnering with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. In 2019, the Collaborative conducted the first large-scale joint citywide CHNA, which

then guided the City's community health improvement plan ("CHIP"), a blueprint describing how the Collaborative would focus on collectively addressing the key priorities.

The 2022 Boston CHNA builds upon the 2019 CHNA and takes a "deep dive" into the key priority areas identified in the 2020 CHIP: housing, financial stability and mobility, behavioral health, and accessing services. The 2022 CHNA was conducted during an unprecedented time, including the COVID-19 pandemic and a reckoning with systemic racism. This CHNA focuses on SDoH and is guided by a health equity lens.

The COVID-19 pandemic has exacerbated many social and economic inequalities that have been present for generations. The pandemic contributed to a staggering number of COVID-19 cases, deaths, and ongoing health challenges which disproportionately affected marginalized populations. During this same period, there has been a growing national movement calling for racial equity to address racial injustices in the U.S. The growth of this movement has been sparked by the killings of several Black Americans, including George Floyd and Ahmaud Arbery. In 2020, the City of Boston declared racism as a public health crisis, underscoring the City's commitment to dismantle structural racism and recognize historical injustice. This context shaped the 2022 CHNA approach and content, in that this assessment also explores how the pandemic and racial injustices have affected priorities that emerged from the previous CHIP.

### *2022 CHNA – Community Engagement*

The Collaborative's Community Engagement Work Group (discussed in the CHNA/CHIP Form Addendum) includes 24 members representing a range of organizations, including health centers, local public health, community development, community-based organizations, and hospitals. The Work Group's charge is to provide guidance on the approach to community engagement, input on primary data collections methods, and support with logistics for primary data collection (See Appendix B of the 2022 CHNA for a list of members). The Collaborative's Community Engagement Work Group led efforts to gain insight into community needs and strengths, as well as priorities from community leaders and residents, especially among those individuals where there has been a gap in representation in previous processes. Altogether, the Collaborative facilitated **29 virtual and in-person focus group discussions with a total of 309 residents** who have been disproportionately burdened by social, economic, and health challenges including: youth and adolescents, older adults, persons with disabilities, under-resourced individuals and families, LGBTQIA+ populations, racially/ethnically diverse populations (e.g., African American, Latino, Haitian, Cape Verdean, Vietnamese, and Chinese), limited-English speakers, immigrant and asylee communities, families affected by incarceration and/or violence, and veterans. Some focus groups were conducted in languages other than English, including Spanish, Chinese, and Vietnamese. Please see Appendix D of the 2022 CHNA for more details on the community engagement process and qualitative data approach (this document will be provided to Department of Public Health – Determination of Need – Community Health Initiative staff upon approval by the Collaborative's Steering Committee).

Collaborative members **conducted key informant interviews with 62 individuals**. These individuals represented a cross-section of sectors to identify areas of action and perspectives on the community. These interviewees included leaders and staff from public health, health care, behavioral health, the faith community, immigrant services, housing organizations, economic development, community development, racial justice organizations, social service organizations, education, community coalitions, the business community, childcare centers, elected government offices, and others. Please see Appendix E of the 2022 for a list of key informant interviewee organizations.

Additionally, Collaborative members conducted **three 90-minute virtual Community Listening Sessions** in January 2022. A total of **122 community members participated in these sessions**. These sessions occurred mid-way through the CHNA process and provided an opportunity to gather feedback and insights on preliminary data findings and potential priorities at this point in time. During these sessions, Collaborative members shared preliminary themes from focus groups, interviews, and the review of secondary data. The participants discussed their reactions and feedback to these preliminary findings in small groups and identified areas that were their highest priority for action.

To deepen the understanding of issues that were salient to community members, interviewers, focus groups, and community listening session discussion guides used open-ended questions and did not ask about specific topics. Community engagement work group members and their partners conducted the focus groups and interviews, and then summarized the key themes from the discussions they facilitated. These summaries were then analyzed to identify common themes and sub-themes across population groups, as well as unique challenges and perspectives identified by populations and sectors, with an emphasis on diving deep into the root causes of inequities. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. Additional information on the qualitative data collection and analysis process can be found in Appendix D of the 2022 CHNA. The Collaborative uses the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

The noted community engagement that was conducted with the residents and community-based organizations of Boston through these CHNA processes is the basis for BMC's community engagement plan for this CHI.

## **CHI – Continued Community Engagement**

Building off of the 2022 CHNA community engagement, and in compliance with the DoN Community-Based Health Initiative Planning Guideline, BMC will continue to conduct community engagement throughout the CHI process. However, given that residents have just been thoroughly engaged in the 2022 CHNA process – BMC CHI leadership will be mindful that engagement should be tempered to certain areas, so Boston residents are not fatigued by additional engagement efforts. Additional CHI engagement will include:

- First, BMC will ensure that its Community Advisory Board ("CAB") includes broad representation from the community to affectively address the DoN Health Priorities outlined in the CHNA. BMC's CAB meets the Department of Public Health's required stakeholder representation – however, BMC also has added residents to its CAB to ensure a community voice is provided when making strategic CHI decisions.
- Second, BMC will continue to work with community organizations that took part in the 2022 CHNA, so these groups may receive updates on the CHI. BMC also will seek to conduct outreach via various means including through work with community-based organizations, as well as various media platforms, including social media. For example, earlier this year, the Hospital launched the Health Equity Accelerator. The Health Equity Accelerator is an ambitious and aggressive approach to eliminating the race-based health equity gap that exists throughout the healthcare industry in the U.S. For this initiative, BMC is coupling its deep experience in health equity with data-driven clinical insights and community-based research efforts to make healthcare equitable for people

of color everywhere. At the core of the Accelerator is a deep commitment to listen to and partner with the community. BMC staff are incorporating multiple mechanisms to engage with patients and community leaders every step of the way. A key part of this effort is launching BMC's Equity Partnership Network ("EPN"), a diverse and engaged group of community leaders who are involved with different BMC Community Advisory Boards. The Accelerator Community Advisory Committee ("ACAC") is a sub-group of the EPN that provides invaluable guidance to the Accelerator as this group seeks to address inequities – from which health inequities to focus on to how to approach the community on specific topics. Accordingly, EPN and ACAC will be invaluable assets in implementing the CHI and ensuring the Hospital and System are informing the community about CHI efforts. BMC also will explore with these groups additional ways to engage the community – being mindful of fatigue within the community due to the abundance of ongoing engagement.

**Section 11: Engaging the Community at Large. Which of the stages of a CHNA/CHIP process will the Boston CHNA-CHIP Collaborative focus on? Please describe specific activities within each stage and what level the community will be engaged during the BMC 2022 CHI. While the step(s) you focus on are dependent upon your specific community engagement needs as a result of your previous CHNA/CHIP work, for tier 3 applicants the CHI community engagement process must at a minimum include the "Focus on What's Important," "Choose Effective Policies and Programs" and "Act on What's Important" stages.**

Below are the methods that BMC will use to meet each of the stages of community engagement, as well as the associated level of engagement for each stage.

#### **A. Assess Needs and Resources**

To assess the needs and resources of the target communities and populations, the Boston CHNA-CHIP Collaborative obtained and reviewed primary and secondary data for the 2019 and 2022 CHNAs. Primary data were obtained via focus groups, interviews, and distribution of a community survey. Secondary data were reviewed to understand the current trends and understand the needs of the community. Collaborative members also conducted three 90-minute virtual Community Listening Sessions, and a total of 122 community members participated in these sessions.

Given the noted engagement activities in the CHNA – BMC met the "Collaborate" level of engagement for the Assess Needs and Resources phase.

#### **B. Focus on What's Important**

To Focus on What's Important, as part of the 2022 CHNA process, the Collaborative held the noted Community Listening Sessions, which led to the prioritization of needs. Since 2020, the Collaborative has been focused on four priority areas (housing, financial security and mobility, behavioral health, and accessing services including health care, childcare, and social services) and implementing the 70 strategies outlined in the Collaborative's 2020 CHIP. Great progress has been made on many of these strategies, while other strategies have not been implemented as extensively given constrained capacity and the current context of the COVID-19 pandemic.

Given the current status of the 2020 CHIP, as well as the current needs within the community, the 2022 CHNA prioritization process focused on:

- Reaffirming the previous priorities and identifying any new issues that have emerged; and
- Prioritizing specific strategies within these major areas that should be lifted up for future action.

To this end, from May – June 2022, the Collaborative conducted a collective prioritization process to solicit community input on the key priorities that should be the focal point of the 2022 CHNA and CHIP. The prioritization process was centered on data from the 2022 CHNA and the current CHIP with an overarching focus of achieving health equity.

### Criteria for Prioritization

For the 2022 CHNA, the Collaborative aimed to use a systemic, engaged approach informed by data to confirm the larger priority areas and prioritize the specific strategies for focus in future planning and implementation efforts. The following criteria were used to help participants prioritize needs and identify strategies to address these needs:

- **Burden:** How much does this issue affect health in Boston?
- **Equity:** Will addressing this issue substantially benefit those most in need?
- **Impact:** Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Is it possible to address this issue given infrastructure, capacity, and political will?
- **Collaboration/Engagement:** Are there existing groups across sectors willing to work together on this issue? Is there an opportunity for engaging these groups?
- **Data:** Do we have data to support this objective and strategy?

### Prioritization Process

The 2022 CHNA – Prioritization Process included a series of activities, and aimed to be inclusive, participatory, and data driven. During May-June 2022, several steps were taken to confirm the larger priority areas and identify strategies for the CHIP process. A total of 62 participants were part of the prioritization process, and activities included the following:

- Three separate 90-minute virtual listening sessions were conducted in late May and early June. In each of these sessions, Collaborative members presented key findings and high-level themes from this current CHNA to provide context for prioritization. Following the data presentation, listening session participants (n=15) were asked to complete an online survey to select priority strategies using provided criteria.
- Based on low participation during the scheduled listening sessions, the survey and a pre-recorded data presentation were sent to all registered participants who did not attend. The survey was open for an additional 24-hours, and an additional 5 respondents completed the prioritization survey.
- To increase participation in the process, Collaborative members attended a Union Capital Boston meeting in June 2022 to gather additional feedback. As part of this meeting, 42 community members participated in a break-out session that included a brief data presentation and dialogue about the prioritization process. These participants discussed which areas most resonated with them and provided feedback on which strategies to prioritize.

- Feedback from this session was incorporated with the earlier survey responses, and these results were posted on the Collaborative's website in multiple languages (Arabic, Cape Verdean, Chinese traditional – Cantonese, Chinese simplified – Mandarin, Haitian Creole, Portuguese, Russian, Somali, Spanish, and Vietnamese) to gather additional community input prior to the late June planning session. The feedback form was shared with the Collaborative Steering Committee for distribution to communities via email.

The noted discussions reaffirmed the four priority areas from the 2020 CHIP:

- **Housing:** focusing on affordability, quality, homelessness, ownership, gentrification and displacement
- **Financial Security and Mobility:** focusing on jobs, employment, income, education, and workforce training which comprised this priority in the past CHIP, and included food security, which emerged as a salient issue in the 2022 CHNA
- **Behavioral Health:** focusing on mental health and substance use
- **Accessing Services:** focusing on healthcare, childcare, and social services

The overarching focus of the CHNA will continue to be used during the planning process for the CHIP – achieving racial and ethnic health equity – recognizing that institutional racism and structural inequities are what drive health disparities. The Collaborative will meet to develop a CHIP that will provide a blueprint to address the aforementioned needs. A 2022 CHIP will be finalized in Fall 2022. BMC will use the Collaborative CHIP to develop its own hospital-based CHIP.

Accordingly, for this phase, BMC reached the “Collaborate” level of engagement.

### **C. Choose Effective Policies and Procedures**

Finalization of the Collaborative's prioritization process will lead to the development of a 2022 CHIP. Once the Collaborative's has developed a CHIP, BMC will work with its CAB to develop a hospital-based CHIP focused on the Hospital's targeted neighborhoods and their specific needs with the noted health priorities. BMC and its CAB will seek to develop and finalize a CHIP by the Winter of 2022/2023. For the BMC-specific CHIP, staff will seek input from the CAB, the EPN and the ACAC around any additional engagement that may be needed with targeted communities.

Accordingly, for this phase, BMC reached the “Collaborate” level of engagement.

### **D. Act on What's Important**

To ensure that BMC is acting upon the noted health priorities, BMC CHI leadership and the CAB will conduct the following activities:

- Hold regular CAB meetings to discuss the health priorities and develop a hospital-based CHIP.
- The CAB will conduct a conflict-of-interest process, so an Allocation Committee may be formed.



- The Allocation Committee will be responsible for the selection of strategies that will be used in the CHIP. Additionally, this Committee will carry out a solicitation process or some other form of transparent process to distribute funds.
- The Allocation Committee will ensure the availability of technical assistance resources, such as a Bidders Conference or meetings to discuss the distribution of funds.
- The Allocation Committee will disburse funds to community-based organizations given the noted solicitation or other transparent processes.
- BMC CHI Leadership, as well as the CAB and Allocation Committee will continue to engage community members and community-based organizations in the CHI process to ensure that community needs are being met and that individuals/organizations have a “voice” in the process.

For the solicitation component of this phase, BMC will reach the “Collaborate” level of engagement. Additionally, for the CHI implementation aspect of this phase, where CHI funds are distributed to organizations and projects implemented, BMC will reach the “Collaborate” level of engagement. Finally, in regard to the conflict-of-interest disclosure process by CAB members, BMC will reach the “Involve” level of engagement.

#### **E. Evaluate Actions**

BMC will work with an evaluator to collaborate with the Hospital on the CHI process. The evaluator will monitor and evaluate funded community-based organizations on an ongoing basis, reporting progress to BMC on CHI activities on an annual basis. Post-review, these reports will be submitted to the Department of Public Health.

For this phase, BMC will reach the “Consult” level of engagement.

**APPENDIX 5D:**

**FACTOR 6 MATERIALS – LINK TO CHNA & CHIP**

**BMC Health System, Inc.**  
**Boston Medical Center Main Campus Determination of Need**  
**Community Health Initiative – Community Health Needs Assessment**

Per instructions from the Department of Public Health, BMC Health System, Inc. is providing a link to its most recent approved community health needs assessment (“CHNA”) and community health improvement plan (“CHIP”) for Boston Medical Center.

CHNA link:

<https://www.bmc.org/sites/default/files/CHNA-less-Graphics-2.pdf>

CHIP link:

<https://www.bmc.org/sites/default/files/About Us/Commitment to Our Community/field Attachments/FY19-22-Implementations-Strategy.pdf>