2020 Community Health Improvement Plan

Boston CHNA-CHIP Collaborative

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Introductory Letter

Dear Community Partners and Residents,

We are pleased to present this 2020 Boston **Community Health Improvement Plan (CHIP)**, produced by the Boston CHNA-CHIP Collaborative. This plan is the product of months of thoughtful work by more than 100 Collaborative members who represent multiple sectors affecting health in the City of Boston. Our CHIP could not have been developed without the leadership and vision of the Steering Committee, Work Groups, and the many residents and community members who engaged, participated, and shared their lived experiences. Thank you!

Using data collected through our Community Health Needs Assessment (CHNA) http://www.bostonchna.org/ we have identified four priorities upon which to focus our collective efforts: **Access to Services; Financial Stability and Mobility; Behavioral Health; and Housing**. We have also identified a central focus of **Racial and Ethnic Health Equity** as a cross-cutting topic that impacts all of these areas. Each priority has a series of objectives, accompanied by metrics and actionable strategies, which provide achievable health improvement for the City of Boston.

In this document, you will learn how the process for planning was conducted and discover key recommendations for action and partnership. You will also be able to identify ways that you and/or your organization might participate in and collaborate on the efforts to improve the health of all who live, work, learn, work and play in Boston.

As we move forward toward implementing this plan, we recognize that change of this magnitude takes concerted effort over time, and that your story builds our story. We urge you to examine the goals, objectives, strategies, and action steps outlined in this plan to determine how you may implement strategies in your own business, organization, or neighborhood to support this effort. Together, we will strive to achieve health equity for all individuals and families in Boston as we lay the foundation for ongoing improvements in our City's public health outcomes.

Thank you again for your ongoing contributions and commitment to this important process.

Sincerely,

Nancy Kasen and Carol Sciortino

Co-Chairs, Boston CHNA-CHIP Collaborative Steering Committee

Executive Summary

Where and how we live, work, play, and learn affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, our community has undertaken a comprehensive community health assessment and planning effort to measurably improve the health of all Boston residents. This effort is led by a nineteen-member Steering Committee in collaboration with a diverse group of partners representing public health, hospitals, federally qualified health centers, community development corporations, community-based nonprofits, municipal agencies, residents, and other key stakeholder groups.

A Community Health Improvement Plan is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.[1] In addition to guiding future services, programs, and policies for these agencies and for Boston overall, this 2020 plan continues to build on learnings and collaborative partnerships from the previous CHIP, led by the Boston Public Health Commission. Both the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) are required deliverables for the Boston Public Health Commission to maintain its national accreditation, which indicates that the agency meets or exceeds rigorous public health standards as determined by the Public Health Accreditation Board (PHAB); in addition, the CHNA and strategies adopted by nonprofit hospitals and federally qualified health centers are required per IRS and HRSA guidelines.

Facilitated discussions from April 2017-February 2018 led to the formation of the Boston CHNA-CHIP Collaborative, and the adoption of a shared Vision, Mission, and Values that provide the strategic framework that supports the CHNA and CHIP:

Vision Statement

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.

Mission Statement

To achieve sustainable positive change in the health of Boston by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of inequity.

[1] As defined by the Health Resources in Action, Strategic Planning Department, 2012

Shared Values and Operating Principles

- **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.

Following the launch of the Community Health Needs Assessment (CHNA), the Boston CHNA-CHIP Collaborative undertook a collaborative planning process to identify the key issues on which to take action. From April 2019 – December 2019, the Collaborative engaged in a multi-stepped process to prioritize needs from the CHNA, refine the definition of each of the priorities, and participate in large, collaborative, day-long planning sessions to develop the 3-year CHIP and the Year One Action Plan.

The central focus of this CHIP is **Achieving Racial and Ethnic Health Equity.** This focus is integrated into the strategies and action steps of the CHIP to ensure that implementation yields outcomes that address the root problems of institutional racism and structural inequities that drive the health disparities we see around race, ethnicity and language in the City of Boston.

Priority Area	Sub-Categories of Focus	Goal
Housing	Affordability, quality, homelessness, ownership, gentrification and displacement	Ensure safe, stable, healthy, equitable, affordable housing solutions for the diverse communities of Boston through a racial equity lens.
Financial Security and Mobility	Jobs, income, employment, education and workforce training	Close the historic, generational, racial and ethnic income and wealth gaps in the city of Boston across the life spectrum.
Behavioral Health	Mental health and substance use	Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.
Accessing Services	Healthcare, childcare, and social services	Ensure all people in Boston have access to coordinated and equitable health and family support services and resources to support overall health.

Overview of the Community Health Improvement Plan

What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, offers a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.[2] A CHIP is an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan.

Boston's CHIP will be implemented over the next 3 years; 2020 – 2022, and contains opportunities for partnership, leverage, and focus to enhance collective impact of initiatives throughout the City. While the CHIP is framed in three years, the Steering Committee and Collaborative understand that these efforts may take more than 3 years to achieve.

How to Use a CHIP

A CHIP is designed to be a broad, strategic framework for community health, and should be modified and adjusted as conditions, resources, and external environmental factors change. The CHIP is broad enough to allow for inclusivity of many community efforts that have similar purpose and intent; it is also specific enough to guide action. The CHIP is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and citizens – can unite to improve the health and quality of life for all people who live, work, learn, and play in Boston. We encourage you to review the priorities and goals set forth in this CHIP, reflect on the suggested strategies, and consider how you can participate in this effort aimed at advancing the health of City of Boston.

Methods

Building upon the key findings and themes identified in the Community Health Needs Assessment (CHNA), the CHIP aims to:

Identify priority issues for action to improve community health
Develop and implement an improvement plan with performance measures for evaluation
Guide future community decision-making related to community health improvement

[2] As defined by the Health Resources in Action, Strategic Planning Department, 2012

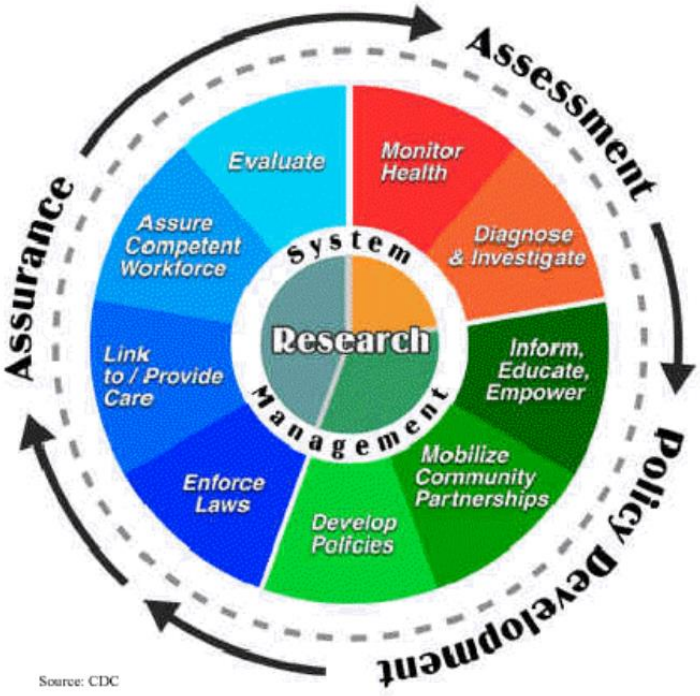
To develop the CHIP, the Boston CHNA-CHIP was the convening organization that brought together community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, such as transportation, mental health, local government, and social services. Following the guidelines of the National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact.

The Cycle of Assessment, Planning, Implementation, and Monitoring/Evaluation

The assessment-planning-implementation-evaluation-reassessment process is a continuous cycle of improvement that seeks to "move the needle" on key health priorities over the course of time. The cyclical nature of the Core Public Health Functions described above is illustrated in Figure 1.

The next phase of the CHIP will involve broad implementation of the strategies and action plan identified in the CHIP, and monitoring/evaluation of the CHIP's short-term and long-term outcome indicators.

Figure 1: The Cyclical Nature of the Core Public Health Functions



Source: Centers for Disease Control and Prevention (CDC), Ten Essential Public Health Services


Core Elements for Successful
Community Health Improvement Planning
• Integration of forces of change/ environmental factors
• Quality Improvement and Sustainability Planning
Phase 4: Reevaluate Refine, & Adjust
Phase 1: Planning
• Leadership Structure
• Outreach to stakeholders
• Define Planning Model
• Priority Setting from assessment data
• Develop goals, objectives, indicators & strategies
Community Health Coalition
• Dashboard
• Quarterly Reporting
Phase 3: Monitoring & Evaluation
Phase 2: Implemen-tation
• Action Planning
• Develop Infrastructure
• Capacity building
• Governance structure
• Resources & Finances

Development of the Community Health Improvement Plan

The formation of the Boston CHNA-CHIP Collaborative (BCCC) began the process of launching the Community Health Needs Assessment and developing the Community Health Improvement Plan. The steps in these processes are outlined below to provide context for the CHIP.

History of the Collaborative

In 2016, the Council of Boston Teaching Hospitals in Boston (COBTH) agreed to actively collaborate on primary data collection that was shared among the hospitals for their respective CHNAs. This effort set a strong foundation for deepening and expanding collaboration in 2017 to include other community stakeholders who also had to conduct community assessments and develop plans to address health-related priorities and disparities.

Facilitated planning discussions with COBTH and key community partners over the course of 10 months from April 2017-February 2018 led to the formation of the Boston CHNA-CHIP Collaborative, and the adoption of a shared Vision, Mission, Values, and Goals that provide the strategic framework that supports the CHNA and CHIP.

Strategic Framework

Vision Statement

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.

Mission Statement

To achieve sustainable positive change in the health of Boston by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of inequity.

Shared Values and Operating Principles

- **Equity**: Focus on inequities that affect health with an emphasis on race and ethnicity;
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- **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

Central Purpose

The Collaborative will achieve its mission by engaging with the community to:

- Conduct a joint, participatory community health needs assessment (CHNA) for Boston every 3 years identifying the social, economic, and health needs and assets in the community;
- Develop a collaborative community health improvement plan (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;
- Monitor and evaluate Collaborative structure and processes to continuously improve effectiveness and results; and
- Ensure that the assessment and planning processes meet IRS, Attorney General, Public Health Accreditation Board (PHAB), Determination of Need (DoN), and Health Resources and Services Administration (HRSA) requirements.

Selection of Priorities for the CHIP

Following the launch of the Community Health Needs Assessment (CHNA), the Boston CHNA-CHIP Collaborative undertook a collaborative planning process on June 26, 2019 to identify the key issues on which to take action.

The first step in this planning process was to identify the priorities for the CHIP. Prioritization allows institutions and organizations to target and align resources, leverage efforts, and focus on achievable goals and strategies to address key community needs.

Process and Criteria for Prioritization

In April 2019, the CHIP work group—comprised of representatives from hospitals, health centers, community organizations, and the Boston Public Health Commission—developed prioritization criteria and an engagement strategy for identifying 2-4 priority needs for the Community Health Improvement Plan. Criteria were selected to assess the magnitude of community issues and their impact on the most disadvantaged population groups. The criteria and guiding questions selected are below:

- 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: Are there existing groups across sectors willing to work together on this issue?

Prioritization Process

The prioritization process was multi-stepped and aimed to be inclusive, participatory, and data-driven. During May 2019, several steps were taken to identify the final 2-4 priorities for the planning process, incuding distribution of an online survey, facilitated small group discussions, and synthesis of the results to present nine major topics for large group discussion and selection.

On May 29, 2019, over 100 community residents and organizational staff across a multitude of sectors attended a three-hour evening meeting in Roxbury. This meeting included a brief data presentation on the key findings from the draft CHNA, a description of the prioritization process thus far, and a large group voting process. The goal of the voting process was to identify 2-4 priorities for collaborative planning.

During the voting process, each participant received four dots, to vote for up to four issues among the nine refined topics presented (one dot per issue). The results of the dot voting can be found in Table 36.

After the dot voting process, participants discussed the results to identify the top priorities. Participants suggested combining mental health and substance use into the more inclusive category of behavioral health and to consider integrating education into the category of employment and income/ financial security.

Prioritized Needs and Central Focus for Collaborative Planning

In early June 2019, the Boston CHNA-CHIP Collaborative Steering Committee met to discuss the identified priorities and to brainstorm a cross-cutting/overarching focus to frame future planning.

Further definition and refinement by the Steering Committee and CHIP work group in mid-June resulted in four, final prioritized needs and a central focus outlined bcelow.

Final Priorities

Priority Area	Sub-Categories of Focus
Housing	Affordability, quality, homelessness, ownership, gentrification and displacement
Financial Security and Mobility	Jobs, income, employment, education and workforce training
Behavioral Health	Mental health and substance use
Accessing Services	Healthcare, childcare, and social services

Central Focus

The Central Focus is meant to define and integrate the content of all priority areas for the plan. To do so, we must address the root problems of institutional racism and structural inequities that drive the health disparities we see around race, ethnicity and language in the City of Boston. As such, the central focus of this CHIP is **Achieving Racial and Ethnic Health Equity.** This focus is integrated into the strategies and action steps of the CHIP to ensure that implementation yields outcomes that address this issue.

CHIP Planning Process

From June-December 2019, the Boston CHNA-CHIP Collaborative, in conjunction with key stakeholders and community residents, worked to develop the contents of this CHIP, including goals, measurable objectives, and strategies for each of the four identified priority areas to address collaborative. The CHIP development process commenced with a full-day planning session in late June 2019 to develop the initial output for the goals, objectives, and strategies within each priority area. Further refinement and development of the CHIP took place over the summer and fall, followed by a full-day, action planning session in December, 2019 to identify strategies and action steps for year one implementation.

Relationship Among CHIP and Other Planning Documents

The CHIP is intended to be a strategic blueprint to help coordinate resources and activities to enhance outcomes in defined areas of focus. As such, it is not meant to replace or add on to existing initiatives that are well underway and achieving some success, but to capture work already happening in the City and community that would benefit from focused partnership; align resources and stakeholders in similar efforts to propel the work of the CHIP; and to foster collaboration among a cross sector of community partners who may or may not already be at the same tables.

The following table gives an overview of the symbols used throughout the priority area templates of the CHIP document:

Symbol	Meaning
	Year One Strategies
	Developmental Objective (Need to gather baseline data)
	Long-term strategies that will take more than 3-5 years for implementation

PRIORITY AREA 1: HOUSING (Affordability, Quality, Homelessness, Home Ownership, Gentrification, Displacement)

The intersection of housing and healthcare is most critical for homeless individuals and families, for whom unstable housing is a significant contributor to stable health. Conversely, if this population has housing without access to housing stabilization services, long-term housing stability can be hard to maintain. Therefore, working together towards the production of more permanent supportive housing units is a top priority.

- Lack of affordable housing was a prominent theme that arose across all key informant interviews and focus groups. Participants across geographies consistently shared that the rising cost of living in Boston was a major day-to-day concern. Most participants reported a need for more affordable housing for low and moderate-income levels.
- Several focus group and interview participants noted that high housing costs were particularly difficult for people with low or fixed incomes, such as seniors and residents who work low-wage jobs. Many described the influx of housing developments being built across the city but perceived that the cost of these units was often inaccessible to the average resident. One focus group participant shared, "***The people who live here do not have access to the new apartments coming up in East Boston. How are we supposed to access rents that are $2,000-3,000 and maintain a life?"***

According to participants who identified as low-income, housing costs comprise a large part of spending for their households, leaving few resources for other needs such as health care, medicine, or nutritious food. The notion that children adopt the stressors of rising housing costs was also noted by multiple key informants with experience working with children. One shared, ***"Kids can feel when their parents are stressed because maybe the landlord raised the rent or something broke in the house. They're one situation away from eviction."***

- Overcrowding, housing instability, and homelessness are a few of the themes that emerged in discussions with focus group and interview participants. For example, focus group participants explained that to make ends meet, it was often a necessity to live in multigenerational households, with roommates, or with multiple families.
- Gentrification, generally used to describe the displacement of low-income communities by affluent outsiders, was mentioned across **all** focus groups and interviews and was directly correlated with unaffordable housing costs. Many focus group participants spoke of experiences being "priced out" of neighborhoods
- Homeownership was discussed as a means to acquire wealth and stability; however, it was noted by several key informants that opportunities for homeownership were not equitably accessible. One interviewee shared, "***We live in a culture where many of our Black and Latino kids only know renting. They associate homeownership with White families and something as unattainable for their families."***

While homelessness was described as impacting diverse groups, the experience of trauma was a reported commonality among them. One interviewee illuminated this experience by explaining: ***"Many of our [homeless] parents have also suffered from other traumas including childhood traumas …Once your life spirals, it can be challenging to get out of that, especially if you're walking around with trauma on your back."***

PRIORITY AREA 1: HOUSING (Affordability, Quality, Homelessness, Home Ownership, Gentrification, Displacement)

GOAL 1: Ensure safe, stable, healthy, equitable, affordable housing solutions for the diverse communities of Boston through a racial equity lens.

Affordable Housing Supply/Production/Preservation

OBJECTIVE 1.1: By 2022, increase *above the current baseline*, the city of Boston's supply and production of affordable, safe and healthy housing options.

STRATEGIES

Policy/Advocacy Strategies:

Y1 1.1.1: Advocate to increase the incentives/subsidies for commercial and non-profit developers on density, affordability, efficient, safe and transit-oriented development.

Y1 1.1.2: Advocate for public and private funding to support the production of affordable home ownership opportunities.

Systems Change Strategies:

Y1 1.1.3: Direct resources, including pooled investments, grant, soft-debt loans, below market loans and potential other financial instruments, towards Community Development Corporations and other non-profit developers in order to increase their ability to construct, preserve, and manage affordable housing in their communities.

1.1.4: Work with Department of Housing and Community Development to shorten current State affordable housing subsidy timeline (minimum 2 years of waiting for funding) to accelerate production and preservation of permanent supportive housing for homeless families and individuals.

1.1.5: Invest in the Acquisition Opportunity Program and other creative programs, which protect Boston's rental housing stock from market forces.

Environmental Change Strategies:

1.1.6: Support enforcement of rental registry and housing inspections focused on safety, habitability and health, and educate landlords on code compliance, links between housing quality and health, and available resources.

 1.1.7: Build and retrofit Boston's homes – focusing on Boston's 80,000 units of older housing units – to make them climate-ready through climate resilient housing programs.

1.1.8: Mobilize BCCC partners to end restrictive zoning in neighborhood communities and/or advocate for State benefits to communities contributing to housing production.

PRIORITY AREA 1: HOUSING (Affordability, Quality, Homelessness, Home Ownership, Gentrification, Displacement)	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Number of projects that move through the City and State funding rounds within two years 2. Number of projects supported in an Article 80 review process 3. Number of older housing units improved 4. Number safety code violations cited and enforced 5. Number of units at risk of loss to market conversion preserved 6. Legislation addressing zoning, condo conversions, etc. created or passed	• Department of Housing and Community Development (DHCD) • City of Boston • Department of Neighborhood Development (DND) • Developers • Greater Boston Community Land Trust Network • Boston Housing Authority (BHA) • Department of Public Health (DPH)

Affordable Housing Protection/Anti-displacement

OBJECTIVE 1.2: By 2022, decrease by 25% the current proportion of low/moderate-income residents who are displaced from their homes.

STRATEGIES

Policy/Advocacy Strategies:

1.2.1: Advocate for residential mobility counseling and housing search support.

Y1 1.2.2: Advocate for public policy (e.g. rent control, etc.) that protects individuals against unfair or unlawful evictions and that promotes strategies to maintain housing affordability; particularly for those who spend more than 30% of their income on housing.

1.2.3: Advocate for access to tools, resources and literacy training to address stabilization issues for people in transition (e.g. reintegration from the criminal justice system including CORI and recidivism and immigration).

Systems Change Strategies:

1.2.4: Support the development of electronic eviction database accessible by advocates and the public.

 1.2.5: Expand pool of flexible cash resources to assist residents at risk of displacement.

Y1 1.2.6: Create medical-legal partnerships within appropriate health care or other settings to preserve tenancy, access housing and build income. (cross 1.4 and 2.1)

Y1 1.2.7: Invest in supportive services that are co-located within affordable housing developments (e.g. education, job and skills training, health and wellness, eviction prevention, youth and family services, employment services and career development).

PRIORITY AREA 1: HOUSING (Affordability, Quality, Homelessness, Home Ownership, Gentrification, Displacement)	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Number of residents who are able to uphold their lease obligations and remain housed: rent payments, taking proper care of unit, etc. 2. Amount of funding for residential assistance 3. Number of evictions prevented	• Management companies (e.g. Winn Management, United Housing Management, Maloney Properties, etc.) • City of Boston, Department of Housing and Community Development • Department of Neighborhood Development (DND) • Community partners that provide foreclosure counseling/assistance (e.g. City Life/Vida Urbana, etc.) • Right to the City
Special Populations for Equity	
OBJECTIVE 1.3: By 2022, reduce chronic homelessness by 25% below the current rate by enhancing and supporting City initiatives and systems.	
STRATEGIES Policy/Advocacy Strategies: 1.3.1: Advocate for evidence-based approaches that create permanent supportive housing for the homeless and those with disabling conditions who are high utilizers of emergency services, the criminal justice system, and emergency shelters. 1.3.2: Advocate for creating appropriate housing options for patients upon discharge from hospital emergency departments, inpatient, or post-acute care. Y1 1.3.3: Advocate for additional project-based or mobile vouchers to keep people housed long-term. Systems Change Strategies: Y1 1.3.4: Invest in community and hospital-based strategies (e.g. housing navigators, behavioral health supports and case managers, integrated systems of care and community building) to support community members who are homeless or at risk of homelessness to search, apply for, and preserve housing. (See objective 3.1) Y1 1.3.5: Support policies that incentivize/subsidize developers and small property owners to increase the supply of affordable units using universal design to accommodate the needs of the elderly population.	

PRIORITY AREA 1: HOUSING (Affordability, Quality, Homelessness, Home Ownership, Gentrification, Displacement)	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Number of referrals who secure housing 2. Number of chronically homeless individuals who transition to Permanent Supportive Housing (PSH) and maintain placement for 12 months 3. Number of increased project-based City and State subsidy vouchers available for set-aside units.	• City of Boston Office of Supportive Housing • Community Development Corporations • Social service agencies • Community based organizations
Home Ownership OBJECTIVE 1.4: By 2022, increase pathways to independence by helping 50 households per year in subsidized and affordable housing stabilize and/or move on to home ownership.	
STRATEGIES Policy/Advocacy Strategies: 1.4.1: Support advocacy efforts aimed at enabling sustained and increased affordable home ownership and renting opportunities for local residents, particularly in neighborhoods facing increasing gentrification. Systems Change Strategies: 1.4.2: Increase the number of housing and land trusts. Y1 1.4.3: Support down payment assistance programs targeted toward low-income homebuyers, first-generation homebuyers, and those needing extra assistance to buy a home. Y1 1.4.4: Promote home ownership by investing in community-based organizations that provide homeownership education and counseling, and foreclosure prevention services. 1.4.5: Support income-based programs to assist homeowners and small landlords to preserve affordability, and policies that promote these programs and strategies.	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Number of households who move on to home ownership, and Number of first-time homebuyers under the age of 30 2. Number of at-risk units preserved and existing land/housing trusts supported 3. Number of residents able to retain housing or age in place as a result of investment in service space and wrap-around services	• Community Development Corporations (CDC's) • Social service agencies • Community based organizations • Developers • Community Land Trust Networks (Greater Boston Community Land Trust Network) • DND • DHCD

PRIORITY AREA 2: FINANCIAL STABILITY AND MOBILITY (Jobs, Employment, Income, Education, and Work Force Training)

- Many focus group participants discussed how formal educational requirements for a job are a significant initial barrier. As one resident summarized, ***"I've struggled to get a job. I have more than a decade of experience, but the minimum requirements are always a bachelor's degree, so that disqualifies you for ten jobs right off the bat."***
- Several participants discussed how the high cost of college and other educational opportunities was inaccessible to them, especially if they were working, single parents.
- Challenges navigating technology and dealing with new hiring processes were also identified as a concern. One participant shared, "***It's hard to get job now because everything is online. There're no more walk-in interviews where you can meet someone and give a good first impression."*** CORI checks on criminal records was also an employment concern among some.
- Employment stagnation and not being able to make ends meet were reported as concerns in many focus groups and interviews, with participants indicating that it was one of the root causes of stress in their lives. Participants often attributed these stressors to stagnant salaries, higher costs of living, and difficulty balancing multiple low-wage jobs.

Numerous participants perceived that there is growing economic inequality in communities of color compared to their White counterparts. People noted the gentrification of neighborhoods and rising cost of living was having a disproportionate impact on lower income families and communities of color.

- Financial insecurity was a major theme across many focus groups. Participants talked about the challenges of making ends meet. As one participant noted, ***"Even if rent goes up $50 or $100 a month, it's a lot when your income is not growing."*** In particular, participants talked about challenges with being stuck in low-wage jobs, with little room for advancement, and how that made it difficult to maintain a good quality of life.
- According to key informants and non-English focus group participants, residents who were undocumented and new immigrants were especially vulnerable to financial instability between no documentation, limited power, and the desire to support their families in their country of birth. One undocumented resident shared, ***"The problem is that people have social security numbers- lots of people who don't have papers. And [employers] can pay you very little because they know you can't report them. I get paid $40 a day to work very long days and take care of someone else's kids."***

Multiple focus group participants also described what is known as 'the cliff effect'- when a minor increase in income can cause a swift and total loss of benefits that are often more than the financial raise. One interviewee explained, "***One big obstacle for those we serve is the cliff effect. As [residents] start to increase their income, their benefits drop off. Navigating that is a challenge and there's a real fear around that."***

PRIORITY AREA 2: FINANCIAL STABILITY AND MOBILITY (Jobs, Employment, Income, Education, and Work Force Training)

GOAL 2: Close the historic, generational, racial and ethnic income and wealth gaps in the city of Boston across the life spectrum.

OBJECTIVE 2.1: DEV By 2022, increase *over identified baseline*, the number of opportunities and utilization rates for generating savings (beginning with ability to meet short-term emergency and beyond) and wealth through financial equity options.

STRATEGIES

Policy/Advocacy Strategies:

Y1 2.1.1: Advocate for policies that promote short-term and long-term financial health for lower-income and marginalized populations, including strategies such as increased minimum wage and/or living wage and improved retirement savings opportunities.

Systems Change Strategies:

Y1 2.1.2: Identify and collect baseline data to support the objective.

2.1.3: Establish guidelines and expectations for BCCC vendor partners around respect, dignity and data reporting with respect to their employment practices.

2.1.4: Connect with state and local education and training providers, including trade unions and employer groups to promote career exposure and educational attainment for Boston residents including youth.

Y1 2.1.5: Promote or provide incentives for BCCC organizations to offer opportunities for advancement within and outside of current employment (cross reference with objective 2.4)

Interim Outcomes, Products, or Results	Potential Resources/Partners
1. Data collection method determined	• Finance corporations (e.g. JP Morgan Chase, Bain Capital, Eastern Bank, etc.) • The Boston Federal Reserve Bank's Department of Community Development and Outreach • Boston Ujima Project and other advocacy groups

PRIORITY AREA 2: FINANCIAL STABILITY AND MOBILITY (Jobs, Employment, Income, Education, and Work Force Training)

OBJECTIVE 2.2: By 2022, increase by 10% the number of Boston residents who have a household income above the living wage across communities of color.

STRATEGIES

Policy/Advocacy Strategies:

Y1 2.2.1: Advocate for policies that protect and promote income, educational and economic mobility and stability (e.g. paid FMLA) (cross reference with 2.1.1)

Y1 2.2.2: Fully engage federal, state and local policy makers and relevant public agencies to help them clearly comprehend unintended consequences regulations related to subsidized housing, food, childcare, health, etc. programs related to increased wages or employment outcomes.

Systems Change Strategies:

Y1 2.2.3: Support financial and economic mobility programs (e.g. CONNECT in Chelsea and Uphams Corner neighborhood).

 2.2.4: Advocate for employers and systems to adopt innovative workforce development and procurement strategies.

Interim Outcomes, Products, or Results	Potential Resources/Partners
1. Household income of Boston residents who are people of color and/or immigrants that is above the livable wage	• U.S. Census Bureau American Community Survey • Partners who may be willing to share data with BCCCC • Office of Labor and Workforce Development (Learn to Earn effort) • Center for Social Policy at UMass Boston

OBJECTIVE 2.3: By 2022, increase the number of current, 2019 Boston residents within 50-80% area median income who can afford to stay in Boston to preserve neighborhood cohesion and diversity.

STRATEGIES

Policy/Advocacy Strategies:

Y1 2.3.1: Support transportation advocacy groups to facilitate more progressive, equitable and affordable transportation policies, including effective commuting to/from work for residents from neighborhoods that are underserved by public transit.

Systems Change Strategies:

Y1 2.3.2: Mentor and educate residents in designated neighborhoods interested in wealth building and preserving social cohesion.

PRIORITY AREA 2: FINANCIAL STABILITY AND MOBILITY (Jobs, Employment, Income, Education, and Work Force Training)	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Number of current residents who also work within the City of Boston 2. Number of affordable homes and rental units created and/or sustained 3. Number of increased or improved transit options serving underserved neighborhoods	• U.S. Census Bureau American Community Survey • Longitudinal Employer Household Dynamics (LEHD) • City of Boston • MBTA/Mass DOT/Private transportation firms
OBJECTIVE 2.4: By 2022, increase over *identified baseline*, the number of small and large Boston-based employers who adopt, implement, and model policies and practices to ensure the rights and dignity of people and provide opportunities for advancement. DEV	
STRATEGIES Systems Change Strategies: 2.4.1: Share best practices across diverse types/sizes of employers (learning circle). 2.4.2: Build capacity and partner/collaborate with CBO's, business and other organizations on innovative efforts related to cultural competence/cultural humility training and improving job quality. 2.4.3: Model best practices regarding quality and satisfaction within BCCC institutions. 2.4.4: Partner with unions to build on and advocate for best practices. Y1 2.4.5: Gather baseline data to support this objective.	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Development of business survey	• Greater Boston Chamber of Commerce • Good Jobs Institute • Reinventing Work Initiative at the Boston Federal Reserve Bank • Catapult Initiative through SkillWorks/The Boston Foundation • Boston Ujima Project

PRIORITY AREA 3: BEHAVIORAL HEALTH (Mental Health and Substance Use)

- Mental health issues were described as a priority concern across almost all focus group and interviews, and often discussed in connection with trauma. Stress, anxiety, and depression were the most frequently cited challenges among Boston residents, especially those who belong to underrepresented groups; specific vulnerable groups that were mentioned include: LGBTQ, low-income residents, seniors, children, immigrants, and communities of color.
- In conversations, mental health issues were often discussed in relation to social determinant factors like poverty, employment, and safety. One interviewee summarized, "***Many residents are significantly impacted by untreated mental health, addiction, and untreated chronic conditions. They are at significant disadvantages in terms of the social determinants of health; communities and families that have multigenerational issues around poverty, lack of education, histories of trauma and violence…"*** Additional factors affecting mental health, according to key informants, include unstable housing situations, parental incarceration, and domestic violence.

Immigrants and communities of color were described as especially vulnerable to mental health concerns due to limited English language skills, cultural norms, and stigma related to seeking mental health services. Residents described the need to address issues such as migratory trauma or domestic violence but indicated strong cultural influences at play. In Dorchester, focus group participants perceived that discussing mental health issues was often taboo in Black communities, with one sharing, ***"In the Black community we are raised on, 'what goes on in this house stays in this house'; we aren't seeing no therapist. It's something a lot of us were raised with, but it's crippling us."***

- Substance use was considered a priority health issue in many focus group and interview discussions. Participants mentioned a variety of substances including opioids, marijuana, and prescription drug use as being among the most concerning. Co-occurring mental health and substance use issues were frequently discussed among key informants. Additionally, key informant interviewees discussed the interrelationship between trauma, mental health, and substance use.
- Participants were especially concerned about the impact of substance use disorders on young people. Focus group participants perceived an increase in youth drug abuse, specifically mentioning marijuana, vaping, and prescription pills like Adderall.
- The majority of focus group participants and key informants who discussed substance use as a concern identified opioids as a persistent issue in Boston. Several informants indicated that heroin and Fentanyl use was on the rise, and that these substances were cheap and easily available. Focus group and interview participants reported concerns about used needles littering city streets, playgrounds, and parks.

Participants discussed barriers to substance use treatment including the need for more affordable inpatient and outpatient treatment options, especially for non-English speakers. Long-term support services like sober houses were identified as limited and expensive, with one key informant sharing, ***"I can get someone into detox, but what we don't have enough us is a place for them to get to the next step [of sobriety]." Focus group participants in recovery also reported that cost was a barrier to treatment.***

PRIORITY AREA 3: BEHAVIORAL HEALTH (Mental Health and Substance Use)
GOAL 3: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.
OBJECTIVE 3.1: By 2022, increase the number of diverse, culturally/linguistically competent (a) licensed clinical behavioral health workers and (b) the number of community-based behavioral health caregivers.

STRATEGIES

Policy/Advocacy Strategies:

Y1 3.1.1: Advocate to expand funding for organizations, including community agencies and community-based care providers, to hire community health workers (CHWs) and Recovery Coaches to provide mental health and support services to residents most in need.

Y1 3.1.2: Increase awareness of pathways, incentives, and supports (e.g. educational grants and loan forgiveness), for individuals from communities of color to join the behavioral health workforce.

Systems Change Strategies:

Y1 3.1.3: Partner with health and social service organizations, educational institutions, including Boston Public Schools, professional organizations (like the Association for Psychological Science (APS), etc.), and the Mayor's Office of Workforce Development (OWD) to design and pilot an employment pathway program (workforce development pipeline) to recruit, incentivize, train and place community members of different backgrounds (culture, language, life and lived experience, age, race) in behavioral health careers.

Y1 3.1.4: Increase the pool of CHW's and Recovery Coaches with specialized mental health/substance use training who: represent low-income, immigrant, LGBTQ, seniors, and/or communities of color through coordinated, funded recruitment and training programs, including expanded support for the Community Health Education Center (CHEC), the citywide CHW training resource.

3.1.5: Enhance retention and prevent burn-out of clinical licensed behavioral health workers and community-based behavioral health caregivers from underrepresented communities who work in Boston through worker-informed supports and incentives (e.g. full-time work opportunities and living wages).

 3.1.6: Support the implementation of a training curriculum for staff in school communities, childcare programs, afterschool programs, and other youth-serving organizations on: bias / implicit bias, stigma, cultural humility, mental health, behavioral health, and trauma-informed approaches with referral protocols to link clients with relevant services.

PRIORITY AREA 3: BEHAVIORAL HEALTH (Mental Health and Substance Use)	
3.1.7: Support the implementation of a behavioral health curricula in pre-K-12 schools and appropriate community settings to support teachers and, that includes psychological first aid, trauma informed approaches to working with youth, building resilience and coping skills, social & emotional learning, cultural humility etc.	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Number of new non-clinical staff recruited based on race, ethnicity and language representation 2. Number of new non-clinical staff trained based on race, ethnicity and language representation 3. Number of new non-clinical staff placed 4. Number of individuals who received loan forgiveness 5. Number of health and social service organizations collaborating to implement career pathways	• Mayor's Office of Workforce Development • MassHealth • Boston Public Health Commission Capacity Building and Training Initiative • State Behavioral Health licensure board
OBJECTIVE 3.2: By 2022, increase the number of non-traditional places/settings by 5 sites per year for people to access behavioral services and resources.	
STRATEGIES Systems Change Strategies: Y1 3.2.1: Explore funding to place behavioral health specialists in every BHA and BPS site, including after-school programs, and expand use of Family Partners in pediatric care to support families whose children have mental health and substance use needs. Y1 3.2.2: Increase support for city's neighborhood trauma teams (NTTs) to ensure adequate citywide funding and coverage for behavioral health services available in response to community violence. Environmental Change Strategies: Y1 3.2.3: Explore community-based resources and settings (including social media or app-based technologies) where residents can access information and/or be assessed and referred to the most appropriate level of care. (cross reference with Objective 4.1) Y1 3.2.4: Pilot peer-led and other 'safe spaces' within Boston public schools, places of worship and other community-based settings that offer options to students and families for sharing behavioral health and trauma concerns. Y1 3.2.5: Explore harm reduction programs including open, supervised substance use sites that include integrated behavioral health.	

PRIORITY AREA 3: BEHAVIORAL HEALTH (Mental Health and Substance Use)	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Identification of potential sites	• Opportunity Youth • Boston Public Health Commission – Recovery Service System of Care • Massachusetts Department of Public Health - Project Launch
OBJECTIVE 3.3: By 2022, increase over *identified baseline*, the number of residents who perceive they can influence decisions made by City/State/Federal government that contribute to a more resilient community. DEV	
STRATEGIES Systems Change Strategies: Y1 3.3.1: Gather baseline and improvement data via community surveys. 3.3.2: Use health realization framework in community health centers, CBOs, schools to increase community resilience. 3.3.3: Increase resident engagement in leadership opportunities with city-wide decision-making bodies. 3.3.4: Train and hire diverse community health workers/peers with lived and other expertise to provide support and connect people to services in multiple community and clinical settings. Environmental Change Strategies:  3.3.5: Pilot a 'mental wellness mapping' in communities that meet characteristics of a resilient, pro-mental health community and work with community members to conduct advocacy for successful interventions (e.g. reducing gun violence, having more trees/greenspace, physical activity, etc.)	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Established community survey	• Franciscan Children's • Community Health Centers • Community-based Organizations • Boston Public Schools

PRIORITY AREA 4: ACCESSING SERVICES (Healthcare, Childcare, Social Services)

In discussing access issues and hearing community concerns in these areas we need to consider the community accessing services from many sources, not only as health care patients.

- Focus group and interview participants for the CHNA spoke positively about local health services in Boston, citing close proximity to leading health care institutions.
- The biggest barriers to health care access discussed in the focus groups were: being under-insured; language and immigration status; navigation and care coordination challenges; transportation; and lack of culturally-sensitive approaches to care. A few focus group participants discussed cost barriers in relation to affording medication for chronic diseases, and the challenge of competing costs on a fixed income.
- Very few focus group participants spoke about concerns of being uninsured. A more common theme that emerged in focus group discussions was that many residents reported being **under-insured**—or having insurance coverage that does not adequately cover someone's full health care needs. Many focus group participants, especially those on MassHealth, perceived that there was a limited number of providers, particularly specialists, who accepted their insurance.
- When discussing access to care, a prominent theme across focus groups and interviews was the challenge of **navigating the complex health system**. Focus group members spoke about the struggle understanding healthcare benefits, reporting that they ***"felt lost in the system."*** Seniors were described as especially vulnerable to challenges navigating the health system.
- LGBTQ youth described the need for more LGBTQ-centric care but also stressed the importance of providers taking into considerations the many intersecting identifies that a patient could hold. For example, being a queer-identifying teenager who is also a person of color. As one young person described, ***"We have to face a double whammy with already having the stigma of being LGBTQ and then adding race on top of that makes it even harder."***
- Focus group participants who identified as low income, homeless, or as residents in recovery most frequently cited a need for better dental coverage, citing limited coverage with public insurance. One participant from Dorchester shared, ***"I have so many holes in my mouth because MassHealth doesn't cover any filling or root canals. If you need anything other than a cleaning, it's not going to be covered. It's the bare minimum."***
- For low-income working families, the cost of childcare was described as a substantial barrier to financial security and employment opportunities, especially for single parents. One interviewee summarized, ***"The availability and affordability of childcare, especially for single parents where the vast majority are female-headed households, is almost impossible."***

Key informants who identified as parents also expressed that childcare was especially difficult during the summertime and on school breaks. One shared, ***"[Childcare] is especially bad in the summertime. I want my grandkid to be able to go to the Boys and Girls Club to be with other kids, but even that is $200 a week; I barely make that much."***

PRIORITY AREA 4: ACCESSING SERVICES (Healthcare, Childcare, Social Services)

GOAL 4: Ensure all people in Boston have access to coordinated and equitable health and family support services and resources to support overall health.

OBJECTIVE 4.1: By 2022, build connections and leverage existing systems and platforms to establish one network that coordinates a navigation system for existing CBO's, social service agencies, residents, and healthcare systems, to connect and access information on resources and services.

DEV

STRATEGIES

Systems Change Strategies:

Y1 4.1.1: Establish baseline data.

Y1 4.1.2: Develop an outline for an online, centralized, multi-lingual data-base (patient portal) that can be accessed by clients/patients/families on the services available by various nonprofits and hospitals. (cross reference with strategy 3.2.3)

Y1 4.1.3: Explore systems with e-referrals to allow for better connection and coordination between health care providers and community-based Providers (part of landscape analysis). (cross reference with strategy 3.2.3)

Environmental Change Strategies:

4.1.4: Encourage participation by residents in web-based health applications to facilitate access to services and/or information for patient self-management (e.g. HelpSteps or other).

Interim Outcomes, Products, or Results	Potential Resources/Partners
1. Establish network	• Mass 211, 311 • HelpSteps • Aunt Bertha • Boswell

PRIORITY AREA 4: ACCESSING SERVICES (Healthcare, Childcare, Social Services)

OBJECTIVE 4.2: By 2022, increase *above baseline* the number of flexible, affordable, high quality childcare options for children birth to 8-years old.

STRATEGIES

Policy/Advocacy Strategies:

Y1 4.2.1: Advocate to improve employer efforts and policies to provide childcare resources to their employees and workplace communities, including employer investment in such resources.

Y1 4.2.2: Advocate to expand subsidies for childcare for low income families, including a voucher system and other strategies.

Y1 4.2.3: Advocate to pass legislation to fund early childhood education including childcare.

Systems Change Strategies:

 4.2.4: Support the development of coordinated networks of home-based childcare providers specializing in accommodating the nonstandard schedules of the health care workforce.

Interim Outcomes, Products, or Results	Potential Resources/Partners
1. Number of childcare providers in workplaces 2. Percent of flex funds for social network care 3. Percent of affordable after-hour childcare	• Massachusetts Contingency Plan (MCP) • Childcare organizations • Early Education for All campaign • Care That Works (carethatworks.org)/ Independent Women's Project • SEIU1199 • Jamaica Plain Neighborhood Development Corporation • Community Labor United

PRIORITY AREA 4: ACCESSING SERVICES (Healthcare, Childcare, Social Services)	
OBJECTIVE 4.3: By 2022, increase *above the established baseline*, the number of trained health, educational, and family support service staff that provide culturally and linguistically relevant care across Boston. DEV	
STRATEGIES Policy/Advocacy Strategies: 4.3.1: Identify advocacy efforts to increase peer and community-based outreach support services and address limitations and barriers for refugee, immigrant, and non-English speaking communities. Systems Change Strategies:  4.3.2: Increase business development opportunities to support and grow culturally/linguistically supportive child-care programs.  4.3.3: Identify funding and incentives (e.g. loan repayment programs, grants) to increase provider capacity and retention (e.g. training and support with licensure, hiring and retaining culturally/linguistically competent workers, interpreter services and tools for language access). 4.3.4: Identify, disseminate and coordinate training materials, resources and expertise focused on identifying, and resolving cultural barriers to accessing services.	
Interim Outcomes, Products, or Results	**Potential Resources/Partners**
1. Identified data source	• Birth to 8 Coalition

Are You a Missing Partner? How to Use the Boston CHIP

Part 1: General Levels of Action

WHAT CAN YOU DO AS A RESIDENT OF BOSTON?

Become an Educator!

Educate your family, your friends, and your coworkers about important public health issues. Inform anyone you can get to listen about the possibilities outlined in this Community Health Improvement Plan. This document is for all of us to use together.

Take Action/Get Involved!

Whether you hold a neighborhood meeting about a community garden or present the idea of a walking school bus to a group of parents – remember that every effort makes a difference toward improving the health of our community. Inspire change!

Here are some simple steps on how to get involved and make a difference:

1. Pick up the phone and start making some calls. Maybe mental health is the issue that you care most about. Go back to the report, look at the key contacts and start reaching out. Find out how you can support the agencies that are involved in making sure this plan gets carried out.
2. Maybe neighborhood safety is most important to you and your family. Attend your neighborhood watch meeting or if your neighborhood does not have an established watch, visit a nearby meeting and get the information you need to establish your own neighborhood watch.

This guide was not developed to sit on a shelf and collect dust in the offices of the agencies involved in putting it together and supporting it. This guide should be on your kitchen table or on your bedside table.

Part 2: Suggestions by Community Sector

The Boston CHIP is not a plan solely for hospital or government action. It is a plan for the entire community -- all those institutions, organizations, and individuals with a stake in a healthy population. Their efforts from numerous sectors of the community will be necessary to achieve the long-term and intermediate goals related to the CHIP. Suggestions for how different sectors of the community can use the CHIP are listed below:

Health Care Systems

- Plan for Non-Profit Hospital Community Benefits initiatives
- Plan for DoN initiatives
- Incorporate recommendations into organizational strategic planning
- Lead your organization and the health care industry in responding to the health needs of the community

Health Care Professionals

- Identify important health issues and barriers that exist for your clients and use recommended practices to make changes
- Share the information in this plan with your colleagues
- Lead your peers in advocating for actions that will improve the health of the community

Health Plans

- Educate employers and other health insurance purchasers about the benefits of preventive health care and responding specifically to the health needs of the community

Legislators and Policy Makers

- Understand and promote priority health issues in the community
- Adopt policies that align with health improvement needs and recommendations in this plan

Government Agencies

- Understand and promote priority health issues in the community
- Identify barriers to health in the community and make plans for action
- Invest in programs, services, and policy changes that will support the health needs of the community

Community Planning and Transportation Agencies

- Identify health challenges and recommendations in this plan that relate to community planning and development
- Work with health officials and government agencies to employ the recommendations in the course of planning and building areas of new and re-development

Employers/Businesses

- Understand priority health issues and recommendations in this plan and how they apply to your workforce
- Change your work environment and augment your benefits plans to support healthier employees
- Educate your management team and employees about the link between employee health and work productivity

Community-Based Organizations

- Understand and promote priority health issues among the audiences and stakeholders you serve
- Align activities and outreach efforts with health improvement needs and recommendations in this plan
- Advocate for changes that improve health when interacting with policy makers and legislative officials

Faith-Based Organizations

- Understand and promote priority health issues among the community members you serve
- Talk to members about the importance of wellness and connect them with resources
- Create opportunities for your organization and members to take action to support the recommendations in this plan

Philanthropy

- Understand and promote priority health issues among the communities you serve
- Support the health issues and recommendations in this plan when considering allocation of funding resources

Child & Adolescent Education

- Understand and promote priority health issues and recommendations in this plan and incorporate them as educational lessons in health, science, social studies, and other subjects
- Create opportunities to take action at schools to support the recommendations in this plan that impact students, faculty, staff, and parents

Higher Education

- Understand and promote priority health issues and recommendations in this plan when designing research studies or projects with the community
- Incorporate the health priorities, barriers, and solutions as educational lessons for students in health, science, education, sociology, and community service subjects
- Create opportunities to take action at institutions to support the recommendations in this plan that impact students, faculty, and staff

Tell Us About Your Efforts!

The Boston CHNA-CHIP Collaborative wants to know how you use the recommendations and information in this plan. Please contact us to share your stories!

www.bostonchna.org

Acknowledgements

The dedication, expertise, and leadership of the following agencies and people made the 2020 Boston CHIP an engaging, and substantive plan that will guide our community in improving the health of Boston residents:

Steering Committee

Shari	Nethersol	Boston Children's Hospital
Johnny	Charles	Dorchester Bay Economic Development Corporation
Magnolia	Contreras	Dana-Farber Cancer Institute
Denise	De Las Nueces	Boston Health Care for the Homeless
Sherry	Dong	Tufts Medical Center
Erin	Duggan	Massachusetts Eye and Ear
Ricky	Guerra	Jamaica Plain Neighborhood Development Corporation
Thea	James	Boston Medical Center
Sarah	Jimenez	Community Labor United
Daniel	Joo	Uphams Corner Health Center
Nancy	Kasen*	Beth Israel Deaconess Medical Center
Wanda	McClain	Brigham and Women's
Mary Ellen	McIntyre	Massachusetts League of Community Health Centers
Vivien	Morris	Mattapan Food and Fitness Coalition
Jeanne	Pinado	Madison Park Development Corporation
Joan	Quinlan	Massachusetts General Hospital
Margaret	Reid	Boston Public Health Commission
Carl	Sciortino*	Fenway Health
Tracy Mangini	Sylven	Brigham and Women's Faulkner Hospital

*Co-Chairs

Steering Committee Alternates

Leslie	Aldrich	Massachusetts General Hospital
Jennifer	Fleming	Boston Medical Center
Michelle	Keenan	Brigham and Women's Hospital
Darlene	Lombos	Massachusetts Community Labor United
Stephen	Muse	Tufts Medical Center
Ayesha	Cammaerts	Boston Children's Hospital

Former Steering Committee Members

Laurita	Kaigler Crawlle	Health Leads
Jamiah	Tappin	Boston Alliance for Community Health (BACH)
Robert	Torres	Urban Edge

Working Groups

Work Group Name	Participants	Sectors
Operations Committee	Nancy Kasen, *Co-Chair* Carl Sciortino, *Co-Chair* Tish McMullen, *Coordinator*	Hospital Community Health Center Hospitals
CHIP Working Group	Joan Quinlan, *Co-Chair* Margaret Reid, *Co-Chair* Ricky Guerra, *Co-Chair*	Hospital Public Health Community Representative
Communications Working Group	Ayesha Cammaerts, *Co-Chair*	Hospital
Community Engagement Working Group	Danelle Marable Jamiah Tappin Jeanne Pinado Jennifer Fleming Leslie Aldrich Magnolia Contreras, *Co-Chair* Nancy Kasen Robert Torres Sarah Wang Sherry Dong Tracy Sylven Triniese Polk, *Co-Chair*	Hospital Community-focused PH organization Community Development Hospital Hospital Hospital Hospital Community Development Hospital Hospital Hospital Public Health

Work Group Name	Participants	Sectors
Data Working Group	Alberte Altine-Gibson	Hospital
	Alec Lebovitz	Hospitals
	Ayesha Cammaerts	Hospital
	Bret Philips	Community Health Center
	Charlotte Alger	BCBS of MA
	Dan Dooley, *Co-Chair*	Public Health
	Daniel Joo	Community Health Center
	Danelle Marable	Hospital
	Denise de Las Nueces	Public Health
	Erin Duggan	Hospital
	Grace Lichaa	BGCB
	Halley Reeves	State
	Helen Ayanian	Public Health
	Joanna Cataldo	Community Health Center
	J Pantoja	Regional Planning
	Kelly Washburn	Hospital
	M Benyishay	Community Health Center
	Magnolia Contreras	Hospital
	Margaret Reid	Public Health
	Mary Ellen McIntyre	Community Health Centers
	Michelle Keenan	Hospital
	Millie Williams	Medical School
	Nancy Kasen	Hospital
	Paul Lipke	Environmental Health
	Sahar Lawrence	Housing
	Sean Cahill	Community Health Center
	Shari Nethersole	Hospital
	Sonia Iyengar	Hospital
	Stephen Muse	Hospital
	Tavinder Phull, *Co-Chair*	Hospital
	U J Undulue	Nonprofit WF Development
	Urmi Bhaumik	Hospital

Consultant Advisors/Facilitators

Health Resources in Action, Inc.

Coordinators

Council of Boston Teaching Hospitals (COBTH)

Appendices

Appendix A: Glossary of Terms

Acquisition Opportunity Program: A City of Boston initiative that: *protects the City's rental housing stock from market forces by:*

- creating affordable housing for Boston residents who can't afford market-rate rents
- funding developments that have more restricted units, or have units restricted to lower incomes, and
- fighting the forces of gentrification. We work to make sure tenants' apartments don't become unaffordable over time.

Area Median Income: The income levels are percentages of that **AMI** number: any household income at or below **80**% of the **AMI** is considered "low-income"; above **80**% and up to 120% of the median income is considered "moderate- income."

Chronic homelessness: **Chronic homelessness** is used to describe people who have experienced **homelessness for** at least a year — or repeatedly — while struggling **with a** disabling condition such as a serious mental illness, substance use disorder, or physical disability. Chronically homeless as defined by the City of Boston: 365 days homeless either in one episode or in four episodes in the last three years. Disablity that is indefinite and impairs ability to live independently.

Code Compliant: MA State Sanitary Code, Chapter 11, details minimum standards of fitness for human habitation.

Cultural competency: Given the complexity of multiculturalism, it is beneficial to understand **cultural competency** as a process rather than an end product. From this perspective, competency involves more than gaining factual knowledge — it also includes our ongoing attitudes toward both our clients and ourselves.

Cultural humility: is one construct for understanding and developing a process-oriented approach to competency. Hook, Davis, Owen, Worthington and Utsey (2013) conceptualize cultural humility as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]"

https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility

Harm Reduction**:** Harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.

Health realization (HR): is a resiliency approach to personal and community psychology first developed in the 1980s by Roger C. Mills and George Pransky, and based on ideas and insights these psychologists elaborated from attending the lectures of philosopher and author Sydney

Banks. HR first became known for its application in economically and socially marginalized communities living in highly stressful circumstances (see *Community Applications* below).

HR focuses on the nature of thought and how it affects one's experience of the world. Students of HR are taught that they can change how they react to their circumstances by becoming aware that they are creating their own experience as they respond to their thoughts, and by connecting to their "innate health" and "inner wisdom."

HR also goes under the earlier name of "Psychology of Mind" and most recently "Three Principles" understanding.

Housing Instability: Housing instability has no standard definition. Moving 3 or more times in 1 year, often called “multiple moves,” has been associated with negative health outcomes in children (HP 2020)

Launch Model: The Massachusetts LAUNCH model is focused on integrating a “power team” of an early childhood mental health clinician and a family partner with lived experience in a pediatric primary care setting. LAUNCH staff support families in addressing sources of stress, and partner with families and pediatricians to promote children’s social–emotional wellness.

Livable Wage: The living wage in Massachusetts for one adult is $13.96 per hour or $29.66 per hour for one adult and one child (Livingwage.MIT.edu/states/25). The living wage in Boston for one adult is $14.70 per hour or $30.63 per house for one adult and one child. (https://livingwage.mit.edu/metros/14460)

Mobile voucher: The tenant-based voucher, known as mobile, is assigned to the participant and is valid for any housing unit that meets program standards.

Resilience: is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences.

The road to resilience - American Psychological Association

https://www.apa.org/helpcenter/road-resilience

'Safe space': refers to an environment within which a person can contribute or participate in education, counseling, or care without any discrimination, harassment, or bias

Stigma**:** The **stigma** associated with **mental illness** can be divided into two types: social stigma, which involves the prejudiced attitudes that others have around mental illness; and self-perceived stigma, which involves an internalized stigma that the person with the mental illness suffers from. Both are very real.

Understanding the Stigma Around Mental Illness - Verywell Mind

https://www.verywellmind.com/mental-illness-and-stigma-2337677

UPK System: Universal Pre-kindergarten (**UPK**) is a program specifically designed for four-year-olds not eligible for kindergarten. The program has a strong emphasis on early literacy and early numeracy to help prepare children for kindergarten.

Project-based voucher: The **project-based voucher** (PBV) program is one part of the HCV program. It helps pay for rent in privately owned rental housing, but only in specific, privately-owned buildings or units. That means that if you get a **project-based voucher**, you don't get to choose the unit you live in.

Residential mobility counseling: Mobility counseling is assistance for people using tenant-based government housing subsidies who are interested in moving to areas that offer greater opportunities in terms of school performance, personal safety, employment, and other benefits. Counseling can include assistance with credit repair, help identifying potential units, and information about neighborhood amenities.

Appendix B: CHIP by the Numbers

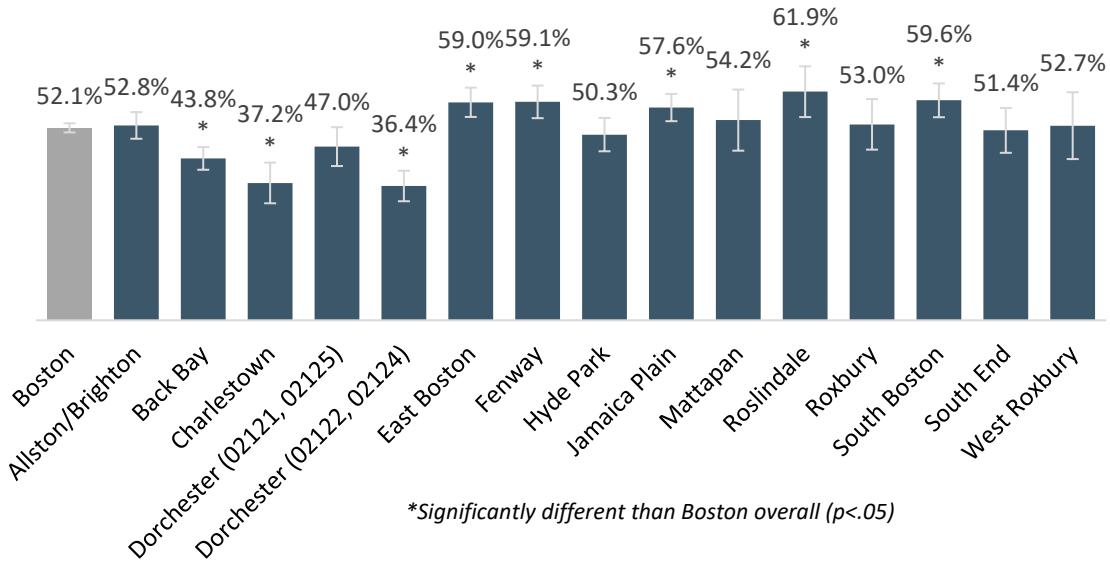
	CHIP Total	Year One
Priorities	4	4
Objectives	14	14
Strategies	70	37

		PA 1: Housing	PA 2: Financial Stability & Mobility	PA3: Behavioral Health	PA4: Accessing Services
Objectives	CHIP Objectives	4	4	3	3
	Year One Objectives	4	4	3	3
Strategies	CHIP Strategies	25	16	17	12
	Year One Strategies	11	9	10	7

Appendix C: Priority Area Data Placemats

CHNA DATA PLACEMAT: Housing (including affordability, quality, homelessness, ownership, gentrification, and displacement)

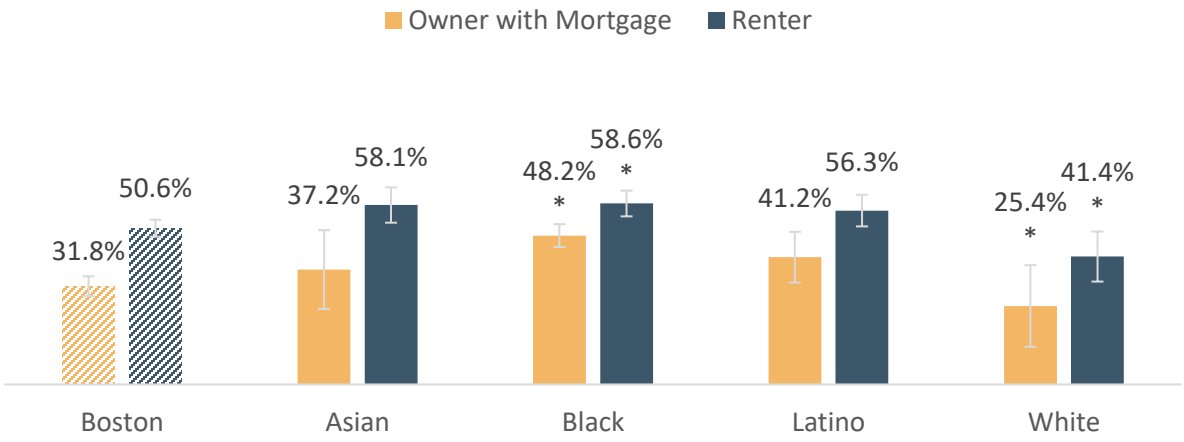
Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, among Renters, by Boston and Neighborhood, 2013-2017



DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

NOTE: Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown

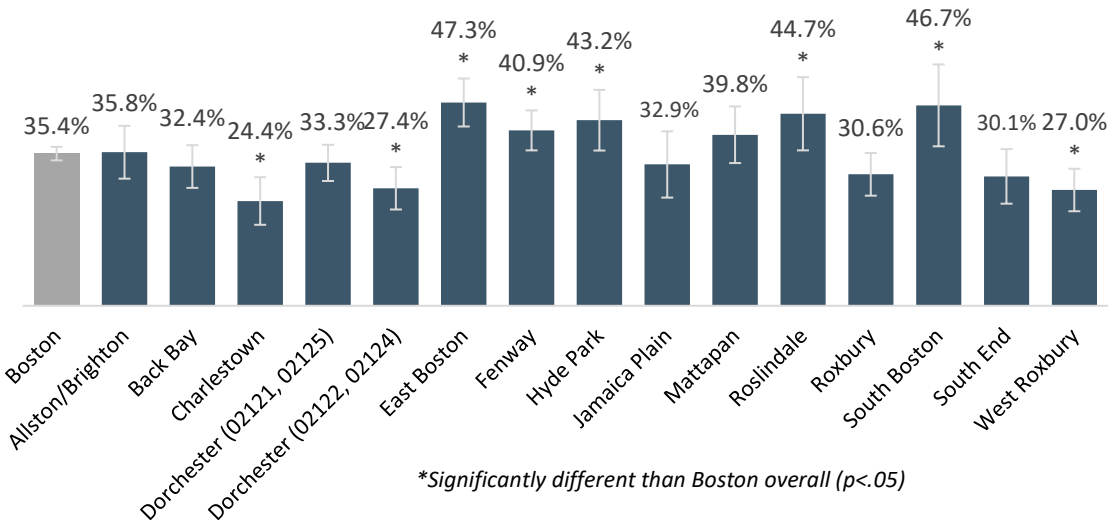
Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, by Housing Tenure, by Boston and Householder Race/Ethnicity, 2017



DATA SOURCE: U.S. Census, American Community Survey 1-Year Estimates, 2017

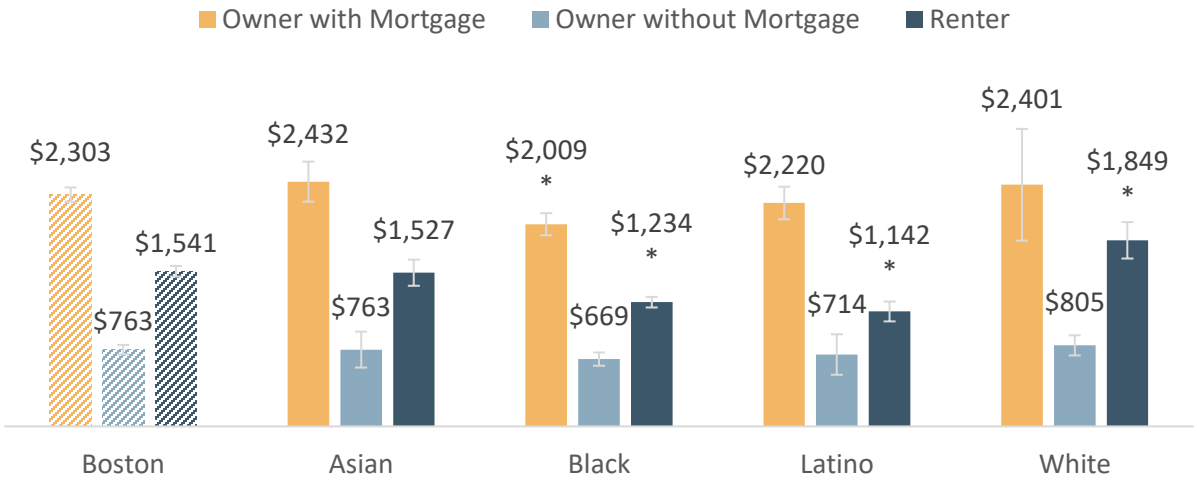
NOTE: Asterisk (*) denotes race/ethnicity estimate was significantly different compared to the Boston estimate ($p < 0.05$)

Percent Housing Units Where 30% or More of Income Spent on Monthly Housing Costs, among Owners with Mortgage, by Boston and Neighborhood, 2013-2017



DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

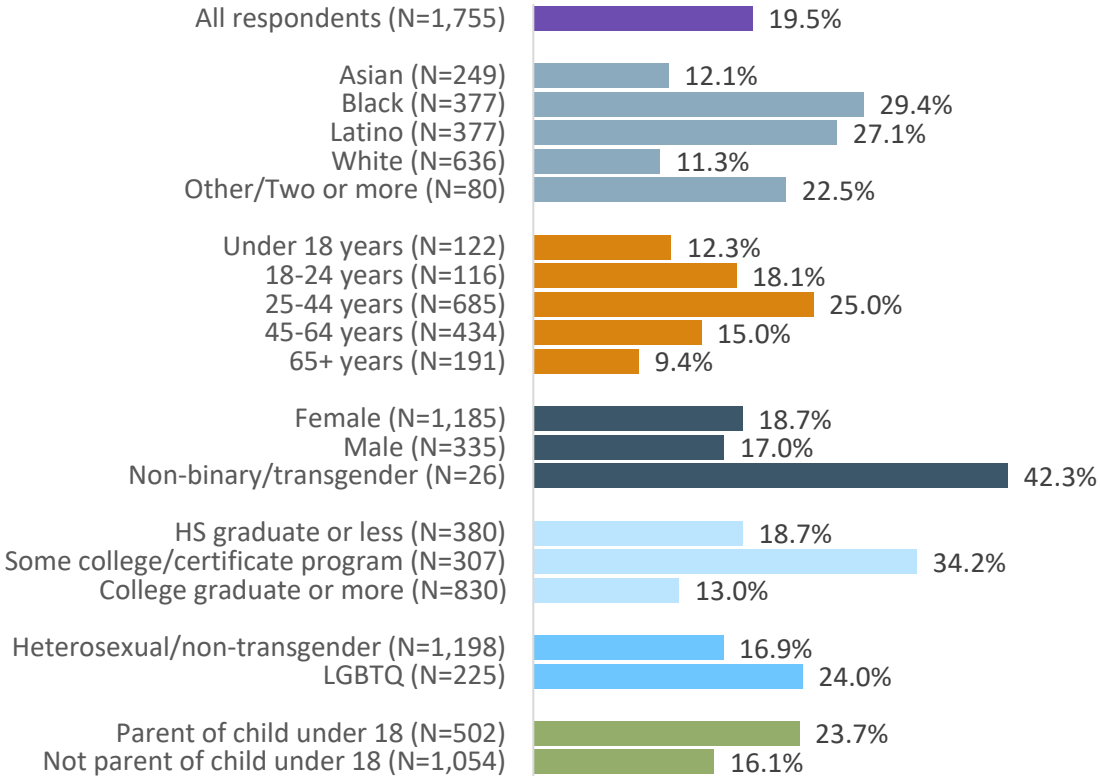
Median Monthly Housing Costs, by Boston and Race/Ethnicity, 2017



DATA SOURCE: U.S. Census, American Community Survey 1-Year Estimates, 2017

NOTE: Asterisk (*) denotes race/ethnicity estimate was significantly different compared to the Boston estimate ($p < 0.05$)

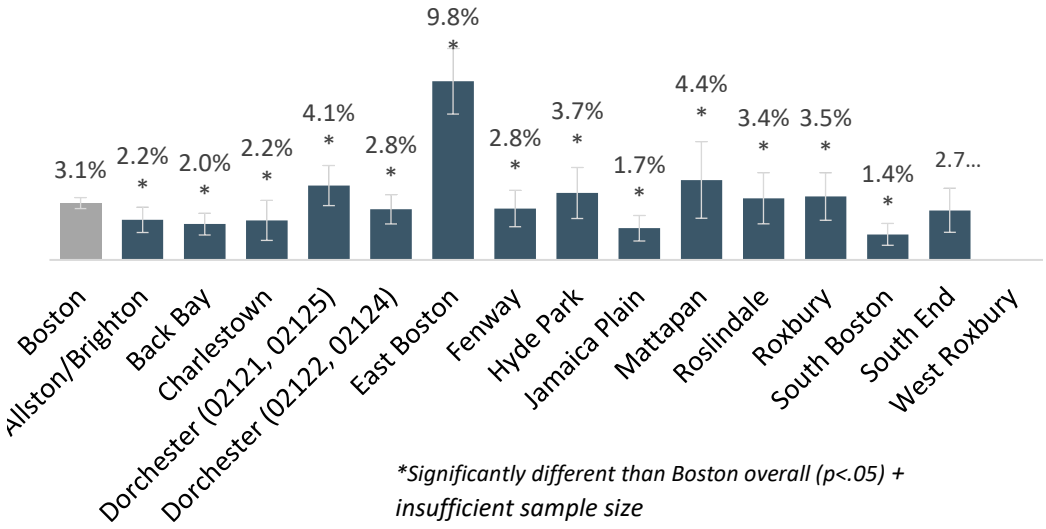
Percent Boston CHNA Survey Respondents Reported Having Trouble Paying Rent/Mrotgage, by All Respondents and Selected Indicators, 2019



DATA SOURCE: Boston CHNA Community Survey, 2019

NOTE: Chi-square analyses were conducted and there were statistically significant differences within the following groups ($p < 0.05$): race/ethnicity, age, gender identity, educational attainment, sexual orientation, and parent status

Percent Housing Units Experiencing Overcrowding, by Boston and Neighborhood, 2013-2017



DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017; Household overcrowding defined as more than one person per room

Total Number of Homeless Individuals Living in Boston, by Race, Ethnicity, and Shelter Type, 2018

	Sheltered				
	Emergency Shelter	Transitional Housing	Unsheltered	Total	Percent of Total
American Indian or Alaska Native	13	4	0	**17**	**0.3%**
Asian	45	3	5	**53**	**0.9%**
Black	2,566	188	36	**2,790**	**45.1%**
Native Hawaiian or Other Pacific Islander	38	3	0	**41**	**0.7%**
White	1,913	251	70	**2,234**	**36.1%**
Multi-race	852	149	52	**1,053**	**17.0%**
Total	5,427	598	163	**6,188**	
Latino	2,079	103	8	**2,190**	**35.4%**
Not Latino	3,348	495	155	**3,998**	**64.6%**
Total	5,427	598	163	**6,188**	

DATA SOURCE: U.S. Department of Housing and Urban Development, Continuums of Care, HUD 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Sub Populations, 2018

NOTE: Safe Haven programs are included in the Transitional Housing category

Total Number of Homeless Households Living in Boston, by Household Type and Shelter Type, 2018

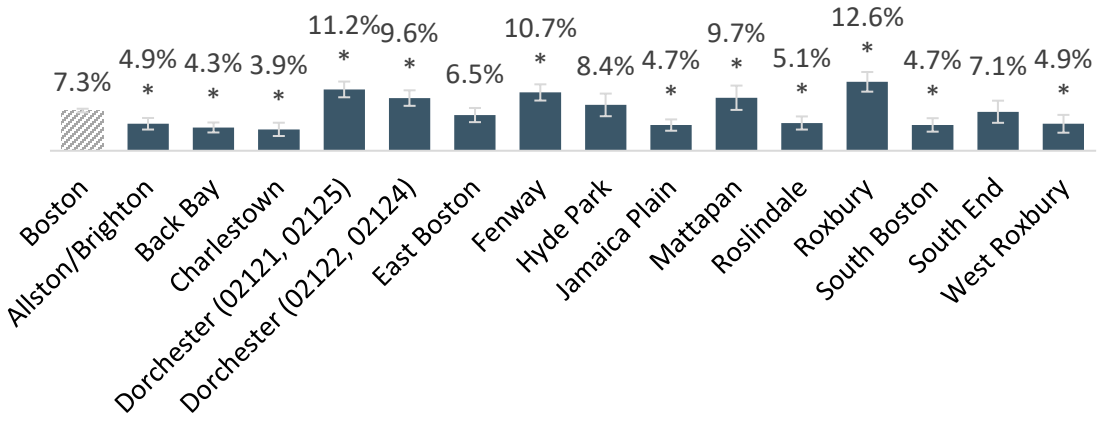
	Sheltered		Unsheltered	Total	Percent of Total
	Emergency Shelter	Transitional Housing			
Households without Children	1,806	407	163	2,376	67.4%
Households with at least one adult and one child	1,075	46	0	1,121	31.8%
Households with only children	28	2	0	30	0.9%
Total	2,909	455	163	3,527	

DATA SOURCE: U.S. Department of Housing and Urban Development, Continuums of Care, HUD 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Sub Populations, 2018

NOTE: Safe Haven programs are included in the Transitional Housing category

CHNA DATA PLACEMAT: Financial Security and Mobility (inclusive of employment, income, education, and workforce training)

Percent Population 16 Years and Over Unemployed, by Boston and Neighborhood, 2013-2017

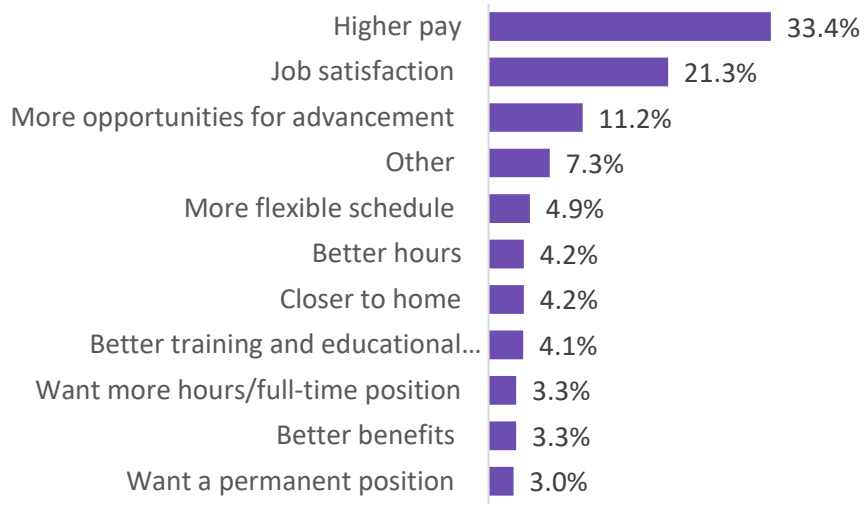


DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

NOTE: Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Percentage out of population 16 years and over in the civilian labor force; Significance testing compared to Boston overall

NOTE: Asterisk (*) denotes estimate was significantly different compared to the Boston estimate ($p < 0.05$)

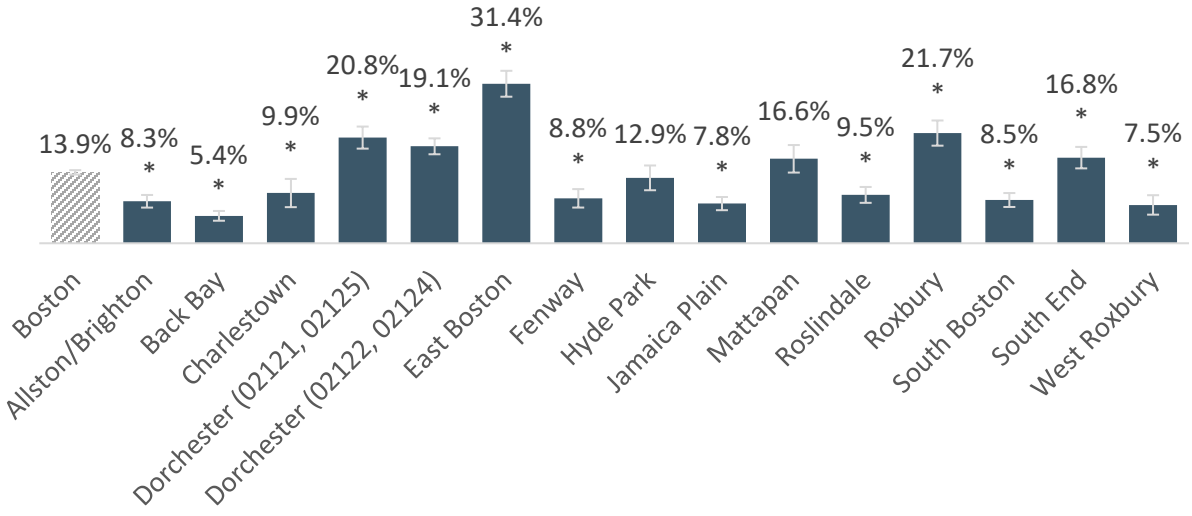
Percent Boston CHNA Survey Respondents Looking for New Job Reporting Primary Reason for Looking for a New Job (N=978), 2019



DATA SOURCE: Boston CHNA Community Survey, 2019

NOTES: Data arranged in descending order; Percentage calculations exclude respondents who selected "not looking for a new job"

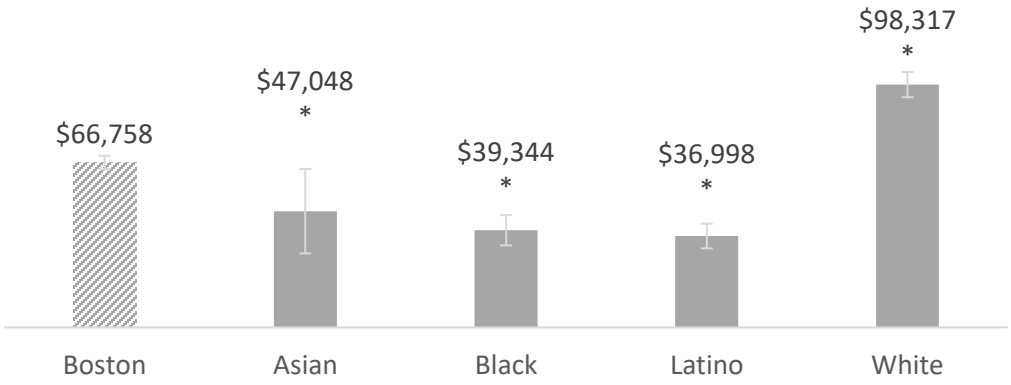
Percent Population 25 Years and Over with Less Than High School Diploma, by Boston and Neighborhood, 2013-2017



DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

NOTE: Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Asterisk (*) denotes neighborhood estimate was significantly different compared to the Boston estimate ($p < 0.05$); Error bars show 95% confidence interval

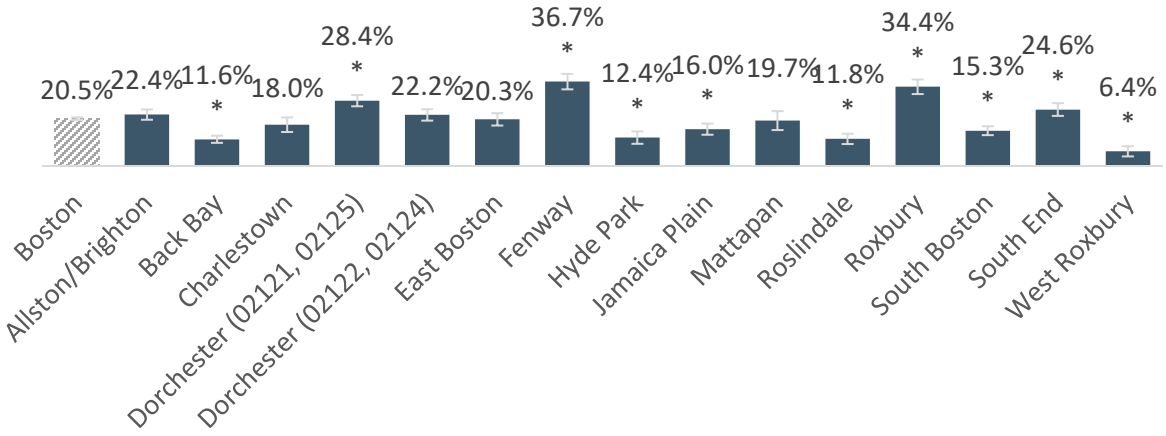
Median Household Income, by Boston and Race/Ethnicity, 2017



DATA SOURCE: U.S. Census, American Community Survey 1-Year Estimates, 2017

NOTE: Asterisk (*) denotes race/ethnicity estimate was significantly different compared to the Boston estimate (p < 0.05); Error bars show 95% confidence interval

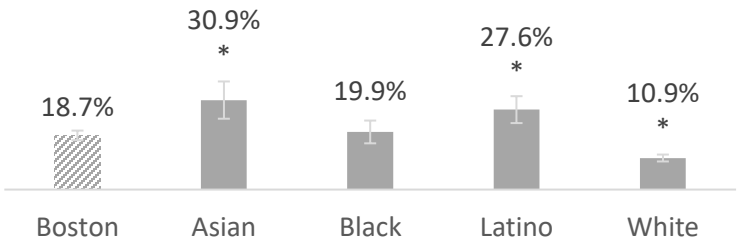
Percent Population Living Below Poverty Level, by Boston and Neighborhood, 2013-2017



DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

NOTE: Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Asterisk (*) denotes neighborhood estimate was significantly different compared to the Boston estimate (p < 0.05); Error bars show 95% confidence interval

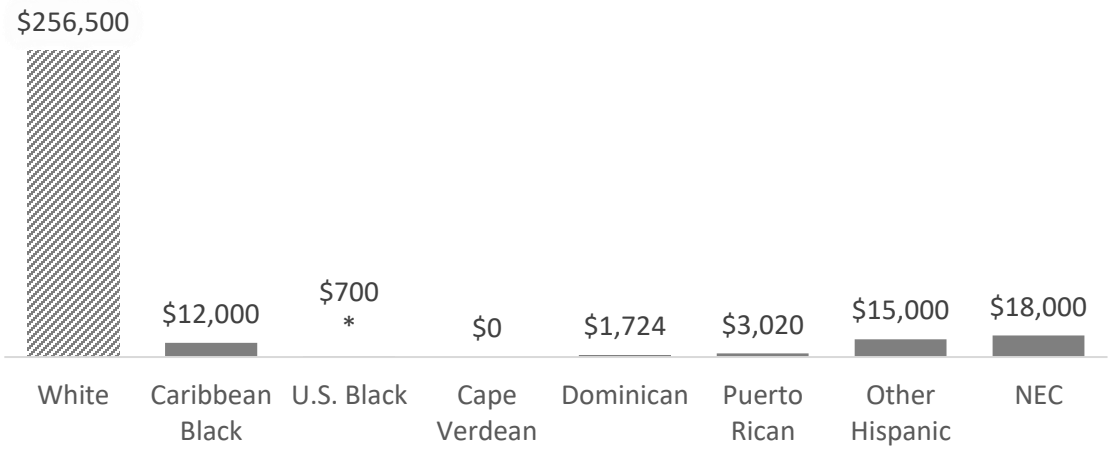
Percent Individuals Below Poverty Level, by Boston and Race/Ethnicity, 2017



DATA SOURCE: U.S. Census, American Community Survey 1-Year Estimates, 2017

NOTE: Asterisk (*) denotes race/ethnicity estimate was significantly different compared to the Boston estimate (p < 0.05); Error bars show 95% confidence interval

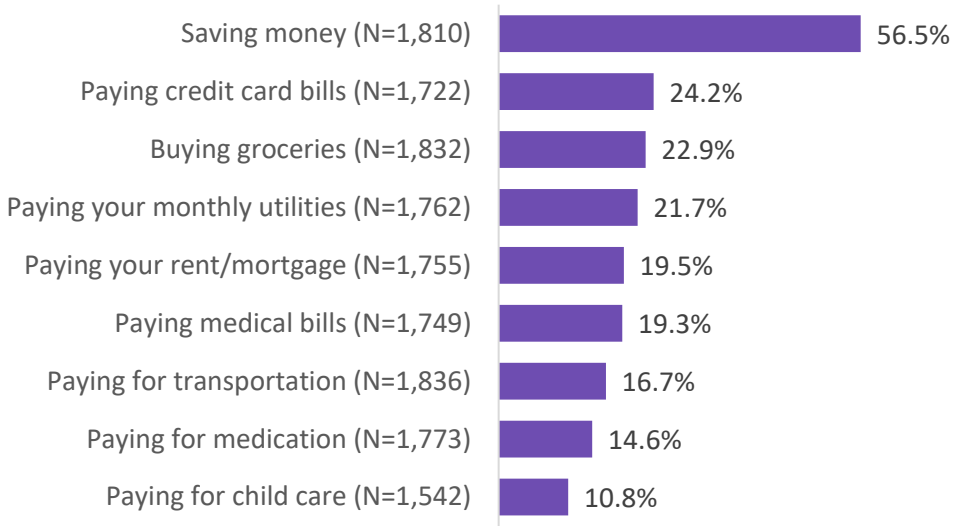
Median Value of Total Assets Reported to be Held by Households (in U.S. Dollars), by Boston Metropolitan Statistical Area, 2014



DATA SOURCE: Duke University, National Asset Scorecard for Communities of Color (NASCC), Boston NASCC survey, as analyzed and reported by Muñoz, A. P. et al, Federal Reserve Bank of Boston, The Color of Wealth in Boston (2015), 2014

NOTES: Boston Metropolitan Statistical Area includes the following Massachusetts counties: Essex County, Middlesex County, Norfolk County, and Suffolk County, and Rockingham County, New Hampshire and Strafford County, New Hampshire; Asterisk denotes where the difference in the percentage of nonwhites as compared with the percentage of white households was statistically significant at the 95% level; The "not elsewhere classified" (NEC) category includes mainly respondents that chose more than one race; This study focused on U.S. born Black, Caribbean Black, Cape Verdean, Puerto Rican, and Dominican differences and did not report data on other racial/ethnic groups, such as Asian or Native American/American Indian residents.

Percent Boston CHNA Survey Respondents Reporting Having Trouble with Finances, by Type of Finances, 2019



DATA SOURCE: Boston CHNA Community Survey, 2019

NOTES: Percentage calculations do not include respondents who selected "don't know/prefer not to answer"

Appendix D: Acronym List

AMI:	Area Median Income
AOP:	Acquisition Opportunity Program
APS:	Association for Psychological Science
BCCC:	Boston CHNA-CHIP Collaborative
BHA:	Boston Housing Authority
BPS:	Boston Public Schools
CBO's:	Community-Based Organizations
CDC's:	Community Development Corporations
CHEC:	Community Health Education Center
CHIP:	Community Health Improvement Plan
CHNA:	Community Health Needs Assessment
CHW's:	Community Health Workers
DHCD:	Department of Housing and Community Development
DND:	Department of Neighborhood Development
DPH:	MA Department of Public Health
FQHC:	Federally Qualified Health Center
FMLA:	Family Medical Leave Act
HCV:	Housing Choice Voucher
LEHD:	Longitudinal Employer Household Dynamics
LGBTQ:	Lesbian, Gay, Bisexual, Transgender, Queer
MA DOT:	MA Department of Transportation
MBTA:	MA Bay Transportation Authority
MCP:	Massachusetts Contingency Plan
NACCHO:	National Association of City and County Health Officials
NTT's:	Neighborhood Trauma Teams
OWD:	Mayor's Office of Workforce Development
PBV:	Project Based Voucher
PSH:	Permanent Supportive Housing
UPK:	Universal Pre-kindergarten

Appendix E: Year One CHIP Action Plan Summary

Boston CHNA-CHIP Collaborative

Year One CHIP Action Plan Summary

Priority 1: Housing	
Goal 1: Ensure safe, stable, healthy, equitable, affordable housing solutions for the diverse communities of Boston through a racial equity lens.	
Year One Objectives	Year One Strategies
1.1: By 2022, increase above the current baseline, the city of Boston's supply and production of affordable, safe and healthy housing options.	**1.1.1:** Advocate to increase the incentives/subsidies for commercial and non-profit developers on density, affordability, efficient, safe and transit-oriented development. **1.1.2:** Advocate for public and private funding to support the production of affordable home ownership opportunities. **1.1.3:** Direct resources, including pooled investments, grant, soft-debt loans, below market loans and potential other financial instruments, towards Community Development Corporations and other non-profit developers in order to increase their ability to construct, preserve, and manage affordable housing in their communities.
1.2: By 2022, decrease by 25% the current proportion of low/moderate-income residents who are displaced from their homes.	**1.2.2:** Advocate for public policy (e.g., rent control, etc.) that protects individuals against unfair or unlawful evictions and that promotes strategies to maintain housing affordability, particularly for those who spend more than 30% of their income on housing. **1.2.6:** Create medical-legal partnerships within appropriate health care or other settings to preserve tenancy, access housing and build income. (cross with 1.4 and 2.1) **1.2.7:** Invest in supportive services that are co-located within affordable housing developments (e.g., education, job and skills training, health and wellness, eviction prevention, youth and family services, employment services and career development).

Priority 1: Housing	
Goal 1: Ensure safe, stable, healthy, equitable, affordable housing solutions for the diverse communities of Boston through a racial equity lens.	
Year One Objectives	Year One Strategies
1.3: By 2022, reduce chronic homelessness by 25% above the current rate by enhancing and supporting City initiatives and systems.	**1.3.3:** Advocate for additional project-based or mobile vouchers to keep people housed long-term. **1.3.4:** Invest in community and hospital-based strategies (e.g. housing navigators, behavioral health supports and case managers, integrated systems of care and community building) to support community members who are homeless or at risk of homelessness to search, apply for, and preserve housing. (see 3.1.1). **1.3.5:** Support policies that incentivize/subsidize developers and small property owners to increase the supply of affordable units using universal design to accommodate the needs of the elderly population.
1.4: By 2022, increase pathways to independence by helping 50 households per year in subsidized and affordable housing stabilize and/or move on to home ownership.	**1.4.3:** Support down payment assistance programs targeted toward low-income homebuyers, first-generation homebuyers, and those needing extra assistance to buy a home (see 1.2.6). **1.4.4:** Promote home ownership by investing in community-based organizations that provide homeownership education and counseling, and foreclosure prevention services.

Priority 2: Financial Stability and Mobility	
Goal 2: Close the historic, generational, racial and ethnic income and wealth gaps in the city of Boston across the life spectrum.	
Year One Objectives	Year One Strategies
2.1: By 2022, increase *over identified baseline*, the number of opportunities and utilization rates for generating savings (beginning with ability to meet short-term emergency and beyond) and wealth through financial equity options.	**2.1.1**: Advocate for policies that promote short-term and long-term financial health for lower-income and marginalized populations, including **strategies** such as increased minimum wage and/or living wage and improved retirement savings opportunities (see 1.2.6 and 2.2.1). **2.1.2**: Identify and collect baseline data to support the objective. **2.1.5**: Promote or provide incentives for BCCC organizations to offer opportunities for advancement within and outside current employment (cross reference with objective 2.4).
2.2: By 2022, increase by 10% the number of Boston residents who have a household income above the living wage across communities of color.	**2.2.1**: Advocate for policies that protect and promote income, educational and **economic** mobility and stability (e.g. paid FMLA) (see 2.1.1) **2.2.2**: Fully engage federal, state and local policy makers and relevant public agencies to **help** them clearly comprehend unintended consequences of regulations related to subsidized housing, food, childcare, health, etc. programs related to increased wages or employment outcomes. **2.2.3**: Support financial and economic mobility programs (e.g. CONNECT in Chelsea and Uphams Corner neighborhood).
2.3: By 2022, Increase the number of current, 2019 Boston residents within 50-80% area median income who can afford to stay in Boston to preserve neighborhood cohesion and diversity.	**2.3.1**: Support transportation advocacy groups to facilitate more progressive, equitable, and affordable transportation policies, including **effective** commuting to/from work for residents from neighborhoods that are underserved by public transit. **2.3.2**: Mentor and educate residents in designated neighborhoods interested in wealth building and preserving social cohesion.

Priority 2: Financial Stability and Mobility	
Goal 2: Close the historic, generational, racial and ethnic income and wealth gaps in the city of Boston across the life spectrum.	
Year One Objectives	Year One Strategies
2.4: By 2022, increase over identified baseline, the number of small and large Boston-based employers who adopt, implement, and model policies and practices to ensure the rights and dignity of people and provide opportunities for advancement.	**2.4.5**: Gather baseline data to support this objective (see 2.1.5).

Priority 3: Behavioral Health	
Goal 3: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.	
Year One Objectives	Year One Strategies
3.1: By 2022, increase the number of diverse, culturally/linguistically competent (a) licensed clinical behavioral health workers and (b) the number of community-based behavioral health caregivers.	**3.1.1:** Advocate to expand funding for organizations, including community agencies and **community**-based care providers, to hire community health workers (CHWs) and Recovery Coaches to provide mental health and support services to residents most in need. **3.1.2:** Increase awareness of pathways, incentives, and supports (e.g. educational grants **and** loan forgiveness), for individuals from communities of color to join the behavioral health workforce. **3.1.3:** Partner with health and social service organizations, educational institutions, including **Boston** Public Schools, professional organizations (like the Association for Psychological Science (APS), etc.), and the Mayor's Office of Workforce Development (OWD) to design and pilot an employment pathway program (workforce development pipeline) to recruit, incentivize, train and place community members of different backgrounds (culture, language, life and lived experience, age, race) in behavioral health careers. **3.1.4:** Increase the pool of CHW's and Recovery Coaches with specialized mental health/substance use training who: represent low-**income**, immigrant, LGBTQ, seniors, and/or communities of color through coordinated, funded recruitment and training programs, including expanded support for the Community Health Education Center (CHEC), the citywide CHW training resource.

Priority 3: Behavioral Health	
Goal 3: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care.	
Year One Objectives	Year One Strategies
3.2: By 2022, increase the number of non-traditional places/settings by 5 sites per year for people to access behavioral services and resources.	**3.2.1:** Explore funding to place Behavioral health specialists in every BHA and BPS site **including** after-school programs; and expand use of Family Partners in pediatric care to support families whose children have mental health and substance use needs. **3.2.2:** Increase support for city's neighborhood trauma teams (NTTs) to ensure adequate citywide **funding** and coverage for behavioral health services available in response to community violence. **3.2.3:** Explore community-based resources and settings (**including** social media or app-based technologies) where residents can access information and/or be assessed and referred to most appropriate level of care (see 4.1.2, 4.1.3). **3.2.4:** Pilot peer-led and other 'safe spaces' within Boston public schools, places of worship and **other** community-based settings that offer options to students and families for sharing behavioral health and trauma concerns. **3.2.5:** Explore harm reduction programs including open, supervised substance use sites that include integrated behavioral health.
3.3: By 2022, increase over identified baseline, the number of residents who perceive they can influence decisions made by City/State/Federal government that contribute to a more resilient community.	**3.3.1:** Gather baseline and improvement data via **community** surveys.

Priority 4: Accessing Services	
Goal 4: Ensure all people in Boston have access to coordinated and equitable health and family support services and resources to support overall health.	
Year One Objectives	Year One Strategies
4.1: By 2022, build connections and leverage existing systems and platforms to establish one network that coordinates a navigation system for existing CBO's, social service agencies, residents, and healthcare systems, to connect and access information on resources and services. DEV	**4.1.1:** Establish baseline data. **4.1.2:** Develop an outline for an online, centralized, multi-lingual data-base (patient portal) that can be accessed by clients/patients/families on the services available by various nonprofits and hospitals (see 3.2.3). **4.1.3:** Explore systems with e-referrals to allow for better connection and coordination between health care providers and community-based providers (part of landscape analysis (see 3.2.3).
4.2: By 2022, increase above baseline the number of flexible, affordable, high quality child- care options for children birth to 8-years old.	**4.2.1:** Advocate to improve employer efforts and policies to provide childcare resources to their employees and workplace communities, including **employer** investment in such resources. **4.2.2:** Advocate to expand subsidies for childcare for low income families, including a voucher system and other strategies. **4.2.3:** Advocate to pass legislation to fund early childhood education including **childcare**.
4.3: By 2022, increase above the established baseline, the number of trained health, educational, and family support service staff that provide culturally and linguistically relevant care across Boston. DEV	**4.3.3:** Identify funding and incentives (e.g. loan repayment programs, grants) to increase provider capacity and retention (e.g. training and support with licensure, hiring and retaining culturally/linguistically competent workers, interpreter services and tools for language access).