Community Health Improvement Plan Implementation Strategy

BOSTON MEDICAL CENTER

About the 2025 Hospital and Community Health Needs Assessment Process

About Boston Medical Center

Boston Medical Center (BMC) is an equity-led academic medical center and the largest essential hospital in New England. Every year, BMC has more than 1.2 million patient visits, where providers deliver care to all people — including those facing significant health and social challenges that are often ignored. Equity isn't one program or initiative; it is embedded into the fabric of BMC. With more than 72 percent of patients coming from underserved populations, BMC removes barriers to care by pairing deep clinical expertise with a profound commitment to address the social and structural drivers of health, ensuring patients are not just treated but empowered to thrive.

A testament to this work is the hospital's Health Equity Accelerator, a first-of-its-kind, hospital-wide initiative designed to dismantle health inequities. Unlike traditionally siloed approaches, the Accelerator operates across research, clinical care, and community partnerships to co-create solutions with patients that close longstanding gaps. For example, the Accelerator develops targeted interventions to reduce disparities in maternal outcomes for Black and Latina women, advances cancer screenings and treatments for underserved communities, expands culturally sensitive behavioral health care, and addresses inequities in chronic conditions such as diabetes and hypertension. By transforming how treatment is designed and delivered, the Accelerator not only improves health outcomes but also sets new national models for equity-centered care.

By reimagining medicine to include access to stable housing, food security, transportation, and trauma support, BMC is modeling a future of health care in which equity fuels innovation. Health equity is at the core of our approach and means transformative thinking, challenging the status quo, and working with the community to co-create programs that serve as national models for addressing the root causes of health inequities. It is this groundbreaking approach — integrating dedicated research with community-driven solutions — that has made BMC a national leader in health equity.

About the CHNA Process

The 2025 joint Boston Community Health Needs Assessment, or CHNA, was conducted by the Boston Community Health Collaborative, a partnership of Boston health institutions, the Boston Public Health Commission, and community organizations working to improve the health and wellbeing of Boston residents. The CHNA report identifies community health needs, assets, resources, and strategies to support the health and wellbeing of all Boston residents. The CHNA serves as a foundational resource for policymakers and community leaders and informs ongoing community health improvement planning, priority setting, program and policy development, and collaboration.

The Boston Community Health Collaborative (formerly the Boston CHNA-CHIP Collaborative) was formed in 2016 to align and deepen the impact of efforts to identify pressing community health needs and to leverage this shared understanding to develop strategies for improving the health and wellbeing of local communities. The 2025 Boston CHNA is the third joint CHNA for the Boston Community Health Collaborative (the Collaborative) and builds upon previous joint CHNAs in 2019 and 2022 and ongoing work related to the key priority areas in the Collaborative's current community health improvement plan: mental and behavioral health, housing, economic mobility and inclusion, and accessing services.

The CHNA was prepared with the support of a third-party consultant, Health Resources in Action (HRIA), who led the primary data collection, analysis, and report production. Their independent facilitation ensured that the assessment reflects rigorous methodology and community input.

This work comes together in two ways. First, the Boston Community Health Collaborative works on a citywide health needs assessment. Then, the group develops and carries out a health improvement plan. The Boston Community Health Collaborative is guided by a Steering Committee, which meets regularly to provide leadership and strategic direction.

Prioritized Community Health Needs and Cohorts

Throughout the CHNA process, community residents, leaders, service providers, and public health professionals provided their insight into challenges and opportunities to support the health of Boston communities. Analysis of data from key informant interviews, focus groups, and the community survey suggest that many of the priorities highlighted in previous CHNA processes persist, and emerging challenges highlight the need for deeper collaboration and action across partners and sectors. Through a review of secondary data, community survey data, and feedback gathered from residents and stakeholders through interviews and focus groups, the following key community health concerns emerged:

- Similar to previous CHNA processes in Boston, **housing affordability** and **mental health/substance misuse** rise to the top as key concerns. Housing concerns were raised in almost all interviews and focus group discussions.
- **Economic insecurity**, and its impact specifically on mental health, emerges as a top concern. "Economic insecurity and employment" ranked as the fourth-most important concern in the most recent community survey, compared to a rank of eleventh in the 2019 CHNA community survey. The high cost of childcare remains a burden, especially for low-income families.
- **Access to affordable and healthy food** also emerges as a key concern. Rates of food insecurity are rising. Interview and focus group participants discussed numerous barriers to accessing and affording healthy foods in their communities.
- **Climate change** and the resulting **anxiety** are emerging as key concerns that will continue to impact Boston residents.
- While a majority of Boston residents are insured and have a primary care provider, challenges related to **health care access** were also raised, including structural challenges (waitlists/wait times, provider turnover, etc.) and challenges related to engagement with health care providers or staff (e.g., lack of cultural humility).

Data Collection Method

The methods employed in the 2025 CHNA process to gather insight that informed the prioritized community health needs are as follows:

1. Boston CHNA Community Survey: 1,866 responses collected and analyzed in a range of languages
2. Resident Focus Groups: 62 residents engaged through eight focus groups
3. Sector-based Focus Groups: 28 community partners engaged through five focus groups
4. Key Informant Interviews: 13 systems experts/community leaders interviewed
5. Secondary Data Review: Existing national, state, and city sources reviewed
6. Review of Summaries of Parallel Data: Additional interview, focus group, and survey summary data from parallel processes review

List of Prioritized Community Health Needs

In May 2025, the BCHC Steering Committee and BCHC partner network applied an upstream, social determinants of health lens to review the CHNA data and carry out a multistep prioritization process. The resulting priorities reflect complex, systemic challenges and community conditions that require sustained, cross-sector collaboration and a strong commitment to working in partnership with communities to advance health equity and create meaningful, long-term change. The BCHC Steering Committee finalized the following four priorities, which form the foundation for the Collaborative's 2025-28 Community Health Improvement Plan:

- Housing (affordability, quality, homelessness, etc.)
- Economic Mobility (including income inequality, employment)
- Healthy Food Access and Food Security
- Access to Care

BMC's areas of prioritization closely mirror those of the Collaborative; however, our catchment area and patient population necessitated us to include two additional areas of prioritization. The total list of priority areas is as follows:

- Housing
- Food Insecurity
- Economic Mobility
- Access to Health Care
- Violence and Trauma
- Behavioral, Mental Health, and Substance Use Disorder (SUD)

The two priority areas that are not outlined by the BCHC Steering Committee and BCHC partner network are Violence and Trauma and Behavioral, Mental Health, and Substance Use Disorder. The inclusion of Violence and Trauma stems from the geographic areas in which BMC's patient population resides, where populations are routinely exposed to violence. The inclusion of Behavioral, Mental Health and Substance Use Disorder (SUD) derives from the growing mental health epidemic that has largely affected BMC's patient populations.

In 2021, BMC Health System purchased a former nursing home in Brockton, Massachusetts, which is now operating as Brockton Behavioral Health Center. The center provides inpatient care and is designed to meet MassHealth patients' needs around co-occurring behavioral health and SUD. These health concerns are significant in the region it serves, the Metro South Region, which warranted its inclusion.

List of Priority Cohorts

The communities of focus for the 2025 Boston CHNA are:

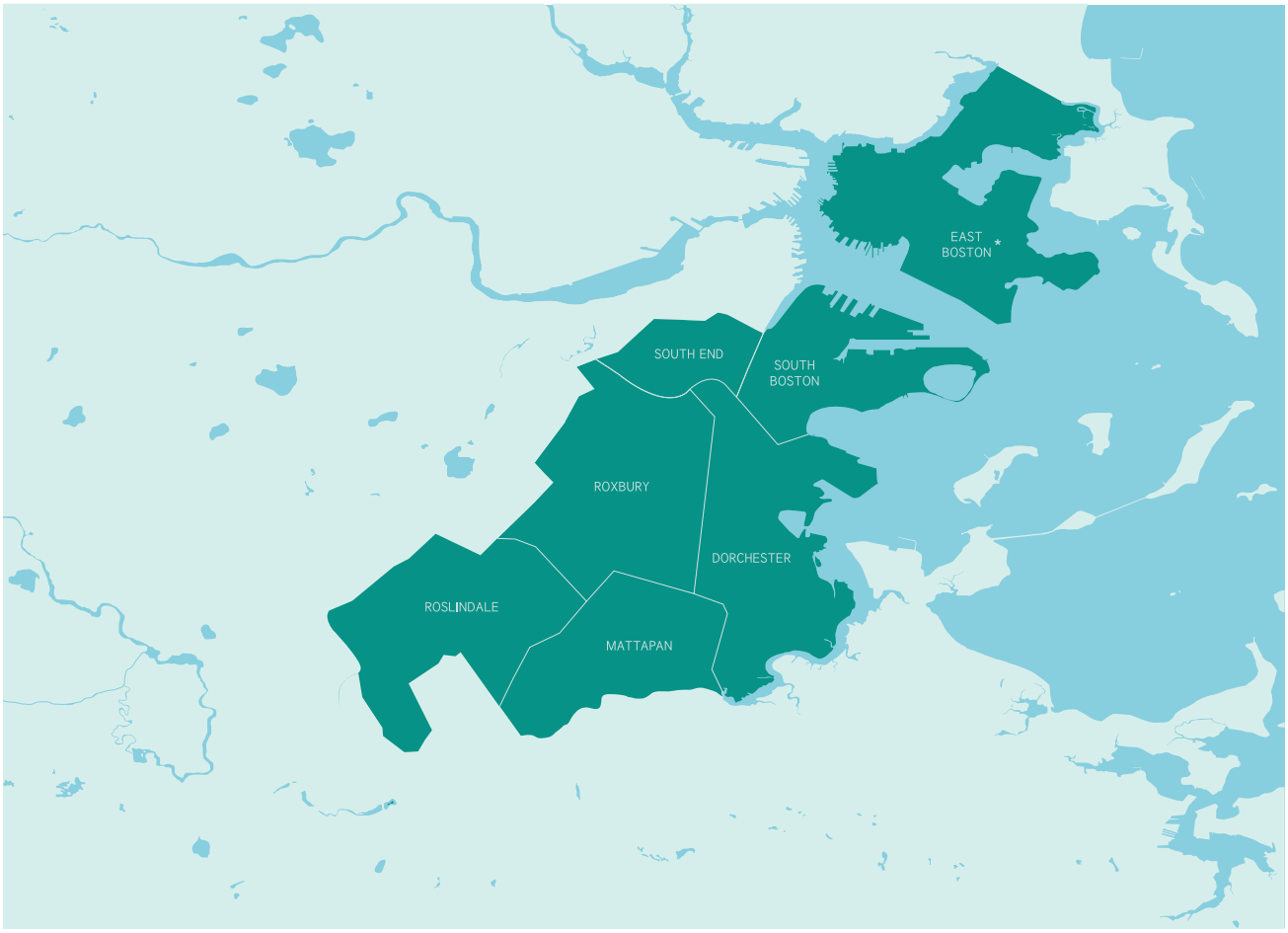
- Individuals experiencing homelessness or housing instability
- Immigrant and refugee new arrivals
- LGBTQ+ individuals
- Individuals in substance use recovery
- Caregivers of children and youth, especially those with special health needs, individuals with disabilities, and older adults
- Older adults and young adults
- Populations with a lower life expectancy

Primary Service Area

The 2025 Boston CHNA focused on the geographic area of the city of Boston. While Boston is a city of neighborhoods, CHNA data are presented for Boston overall and by different sub-populations where appropriate and available. This includes by neighborhood and by race/ethnicity, sex, LGBTQ identity, housing status, income, and other defining characteristics. BMC's service area covers the majority of the city with most patients coming from the following neighborhoods:

- South End
- Roxbury
- Dorchester
- South Boston
- East Boston*
- Mattapan
- Roslindale

Each neighborhood within our service area holds unique characteristics as well as ongoing challenges that include rising housing costs and displacement, economic inequities, and uneven access to resources, public safety, and investment. Taken together, these neighborhoods illustrate cultural vitality, community strength, and the broader issues of growth and equity that continue to shape the city of Boston. The neighborhoods also share many similar community health priorities and needs. While these neighborhoods make up BMC's primary service area, BMC also serves patients who are residents of other neighborhoods in Boston (e.g., Hyde Park, Jamaica Plain, West Roxbury) and the Greater Boston area (e.g., Revere, Quincy, Brockton, Chelsea).



* *East Boston is the only neighborhood that is not contiguous to the rest of BMC's service area.*

About the 2025 Hospital and Community Health Needs Assessment Process

Priority: Housing

Housing insecurity is a measure of how close a person or family is to being homeless, determined by factors such as being behind on mortgage or rent, making multiple moves, living in a shelter, and experiencing homelessness. A lack of stable housing increases the risk of poor health outcomes and other hardships. Many pediatric and adult health issues, such as asthma, lead exposure, and depression, are associated with housing insecurity. Additionally, unstable housing can lead to interrupted schooling for children, difficulty finding work, and choosing between paying for rent or paying for medication and other health expenses.

Boston Medical Center's Living Well at Home is the hospital's housing services program. Created from a 2022 merger of two established programs — Elders Living at Home, which had served the community since 1986, and the Housing Prescriptions program — Living Well at Home addresses housing insecurity through comprehensive support services. The program's clients range in age from teens to individuals over 80. Clients are referred through BMC's primary care providers or via contracts with the City of Boston and the state Executive Office of Elder Affairs for individuals 55 and over who are unhoused or at risk of losing their housing.

Operating under three core pillars — pre-tenancy support, post-tenancy stabilization, and eviction prevention — Living Well at Home provides behavioral health support, case management, and individualized service plans. Over the past year, the program housed or prevented eviction for 199 individuals and provided case management services to 734 clients, with the majority being very low income and approximately half aged 60 or older.

The following chart details BMC's additional existing and future commitments to housing as a community health priority.

Goal: Aim to foster health through stable housing.

Strategy	Patient Population/ Cohort(s)	BMC Programs and Initiatives to Address This Priority	Identified Community Partners*	Secondary Priority(ies)
Maintain current programming to house or preserve tenancy for low-income individuals	• Low-income individuals • Older adults • High-risk homeless individuals • Individuals facing housing instability	• Living Well at Home • BMC Department of Population Health	• Boston Housing Authority • Cambridge Housing Authority • City of Boston • State of Massachusetts • Caritas Communities, Preservation of Affordable Housing • Codman Square • Bay Cove Human Services • Community Development Corporation • Nuestra Communidad Development Corporation	• Behavioral/Mental Health and SUD
Expand service capacity for key populations/older adults experiencing homelessness	• Low-income individuals • Older adults • High-risk homeless individuals	• Living Well at Home • BMC Department of Population Health • StreetCred + Economic Justice Hub + Economic Advisory	• City of Boston: Community and Home-Based Care for Older Adults Experiencing Housing Instability	• Economic Mobility • Behavioral/Mental Health and SUD

Explore new permanent supportive housing partnerships	• Low-income individuals • Older adults • High-risk homeless individuals	• Living Well at Home • BMC Department of Population Health	• Sailors Snug Harbor Foundation	• Access to Health Care • Behavioral/Mental Health and SUD
Expand transitional housing opportunities as a step to permanent housing pathways for the highest-risk clients	• Low-income individuals • Older adults • High-risk homeless individuals	• Living Well at Home • BMC Department of Population Health	• YMCA Huntington Ave • YWCA Cambridge • Bay Cove Human Services	• Access to Health Care • Behavioral/Mental Health and SUD
Continue to provide mental and behavioral health clinical service capacity and scope alongside housing services	• Low-income individuals • Older adults • High-risk homeless individuals • Individuals with severe mental illness	• Living Well at Home • BMC Department of Population Health	• Boston Housing Authority (City of Boston)	• Access to Health Care • Behavioral/Mental Health and SUD

** This list represents past, current, and future community partners with whom we will engage over the next three years.*

Priority: Food Insecurity

At Boston Medical Center (BMC), we recognize that access to nutritious, affordable food is a critical factor in achieving better health outcomes. For more than 20 years, BMC has tackled food insecurity by embedding food and nutrition services throughout care models across the hospital. BMC not only wants to treat acute access issues, but the hospital also is dedicated to addressing the root causes of food insecurity and building a sustainable, accessible food system in our communities. A testament to this commitment is BMC's long-standing Nourishing Our Community services umbrella. Nourishing Our Community at Boston Medical Center unites three signature programs — the Rooftop Farms, Preventive Food Pantry, and Teaching Kitchen — into a single, comprehensive effort to advance health equity through food.

With nearly 8,000 square feet of rooftop growing space across two urban farms, BMC harvested 9,828 pounds of culturally relevant produce in 2024, valued at over $63,000, while welcoming more than 1,100 visitors for hands-on education and connection. This fresh food directly supports the nation's first hospital-based Preventive Food Pantry, founded in 2001, which has served more than 1.5 million people and distributes 1 million pounds of food annually. Physicians "prescribe" nutritious foods through the Pantry to help patients manage conditions such as cancer, heart disease, and HIV/AIDS. To further support healthy choices, the BMC Teaching Kitchen offers more than 15 monthly classes — both in-person and virtual — where nearly 150 monthly participants build culinary skills and learn to prepare medically appropriate, affordable, and culturally relevant meals. By weaving these three initiatives together, Nourishing Our Community strengthens local food systems, reduces disparities in access to nutrition, and demonstrates how hospitals can lead nationally in treating food as medicine.

The following chart details BMC's additional existing and future commitments to food and nutrition as a community health priority.

Goal: Aim to continue to leverage food as medicine to improve food access for all, invest in a sustainable local food system, and empower communities through skill-building education.

Strategy	Patient Population/ Cohort(s)	BMC Programs and Initiatives to Address This Priority	Identified Community Partners*	Secondary Priority(ies)
Provide healthy food, nutrition services, home delivery of food and meals, and navigation of benefits to patients experiencing food insecurity	• Families • Low-income individuals • Older adults • Community members	• BMC Preventive Food Pantry • BMC Rooftop Farms • BMC Teaching Kitchen • BMC General Internal Medicine Department • BMC Family Medicine Department • BMC Department of Pediatrics • BMC Department of Endocrinology and Nutrition • StreetCred	• Greater Boston Food Bank • Ocean State Job Lot • DoorDash • Rosie's Place	• Access to Health Care • Economic Mobility
Increase access to diet-appropriate foods and resources such as cooking demonstrations/ classes and recipes for chronic diseases such as diabetes, hypertension	• Patients with chronic disease • Low-income individuals	• BMC Preventive Food Pantry • BMC Rooftop Farms • BMC Teaching Kitchen • BMC General Internal Medicine Department • BMC Family Medicine Department • BMC Department of Pediatrics • BMC Department of Endocrinology and Nutrition • BMC Department of Oncology • BOS Collaborative • BMC Community Engagement • Immigrant and Refugee Health Center	• Nubian Market • Greater Boston Food Bank • MassHealth • WellSense Health Plan • Boston Public Schools • Rosie's Place • Project Bread	• Access to Health Care
Increase supply of healthy foods available to patients and communities through farm production, on-site farmers markets, supporting neighborhood businesses, and engaging local leaders	• Families • Low-income individuals • Patients with chronic disease • Older adults	• BMC Preventive Food Pantry • BMC Rooftop Farms • BMC Teaching Kitchen • BMC General Internal Medicine Department • BMC Family Medicine Department • BMC Department of Pediatrics • BMC Department of Endocrinology and Nutrition • BOS Collaborative • BMC Community Engagement	• Boston Public Schools • Greater Boston Food Bank • Nubian Market • Rosie's Place	• Access to Health Care

Address the root causes of food insecurity	• Families • Low-income individuals • Older adults • Community members	• BMC Food Service • BMC Food Pantry • BMC Teaching Kitchen • BMC Rooftop Farms • StreetCred	• Chang Shing Tofu • Nubian Markets • Eastie Farms	• Economic Mobility

* *This list represents past, current, and future community partners with whom we will engage over the next three years.*

Priority: Economic Mobility

Economic mobility is a social determinant of health. Boston Medical Center (BMC) serves communities that have been disinvested when it comes to housing, workforce development, education, and sustainability. Because of this, BMC has made intentional investments to increase local economic mobility to improve health outcomes not only for individuals, but also for neighborhoods and communities as a whole. To reimagine Boston's jobs ecosystem, BMC partners with the Boston Opportunity System (BOS) Collaborative, a community-driven initiative, to develop employment opportunities in historically disinvested Boston neighborhoods. BMC also engages local community members in job training to expand and diversify the workforce. Currently, 31 percent of BMC employees identify as people of color.

A key program that illuminates these intentional investments is BMC's Economic Justice Hub. The Economic Justice Hub, launched in 2023, builds on the hospital's approach to addressing economic inequity under three pillars: expanding BMC's nationally recognized tax and financial services program StreetCred, creating pathways to well-paying jobs, and funding an analysis on the "cliff effect," the correlation between increased income and loss of public benefits. The goal of the Economic Justice Hub is to create systemic change so all families can thrive. Housed in BMC's Pediatrics Department, the Hub creates job opportunities with flexible schedules for underemployed parents from low-income, historically disinvested communities — including training participants as financial navigators, peer educators, and financial coaches for other families in Pediatrics under StreetCred. Once trained, participants gain skills to seek other jobs within BMC or beyond.

Today, there are 20 health care organizations and community partners offering the BMC-developed StreetCred model in 10 states and in Washington, D.C., and BMC pediatricians have presented at White House health forums to shape pro-family economic policies.

For more examples of BMC programs and initiatives that drive economic mobility for patients and community members, see the table below.

Goal: Open pathways to employment and professional advancement for our community members.

Strategy	Patient Population/ Cohort(s)	BMC Programs and Initiatives to Address This Priority	Identified Community Partners*	Secondary Priority(ies)
Provide and promote workforce development opportunities for employment and skills training for high-need jobs at BMC	• BMC patients (referred and self-identified) + patient families	• BMC Health Care Fellows Program • BMC Human Resources Department • THRIVE • Economic Justice Hub	• YMCA Training, Inc. • African Bridge Network • YearUp • Jewish Vocational Services • Career Collaborative • Immigrant Family Service Institute • Asian Women for Health • MA Bridge to Prosperity Pilot	• Housing, Food Insecurity, Mental Health, Chronic Stress
Increase awareness of and access to economic tools and resources for families	• Families with young children • Prenatal population	• StreetCred • BOS Collaborative • Economic Justice Hub	• StreetCred • Boston Tax Help Collaborative • Health by Wealth Collective • Dudley Street Neighborhood Initiative • Full Frame Initiative • Health Resources in Action • Jewish Vocational Services • New England Community Project • BOS Collaborative • City of Boston's City Academy • City of Boston Department of Workforce Development • City of Boston Office of Economic Opportunity and Inclusion • City of Boston Planning Department • City of Boston Public Health Commission	• Housing, Food Insecurity • Behavioral/Mental Health and SUD
Maintain and expand sustainability programming available to patients through navigation and community relationship building	• BMC patients (including those enrolled through the WellSense Complex Care Management program)	• Clean Power Prescription Program	• Eversource • Action for Boston Community Development (ABCD) • Takeda • TD Bank	• Climate Change

Maintain pathways for career advancement and education for employees at BMC	• BMC employees	• BMC Pathways Program • BMC Human Resources Department • Economic Justice Hub	• College and University Partnerships; BU's Center for English Language & Orientation Programs; Regis College • Jewish Vocational Service	• Housing, Food Insecurity
Promote thriving and resilient neighborhoods and enhance opportunities for community input	• Individuals experiencing homelessness or housing instability • Immigrant and refugee new arrivals • Caregivers of children and youth, especially those with special health needs • Older adults and young adults • Populations with a lower life expectancy	• BOS Collaborative • BMC Community Engagement Department	• City of Boston's City Academy • City of Boston Department of Workforce Development • City of Boston Office of Economic Opportunity and Inclusion • City of Boston Planning Department • City of Boston Public Health Commission • Dudley Street Neighborhood Initiative • Health Resources in Action • Jewish Vocational Services • New England Community Project	• Access to Health Care

* *This list represents past, current, and future community partners with whom we will engage over the next three years.*

Priority: Access to Health Care

Boston Medical Center has a rich history of creating and expanding access to medical care, dating back to 1864 as Boston City Hospital. BMC has continued to honor that legacy by developing programs and partnerships that increase access to care. Key to that goal is the hospital's value-based care team.

Unlike traditional models that emphasize volume, value-based care (VBC) focuses on delivering the right care at the right time by prioritizing prevention, coordination, and patient satisfaction. This approach improves health outcomes while making health care more sustainable and affordable. By identifying gaps in preventive care and chronic disease management early, BMC's value-based care team helps patients avoid costly emergency visits and hospital stays, and ensures higher-quality, longer-term outcomes across populations.

A cornerstone of this work is the patient navigator. Patient navigators play a critical role in ensuring patients access vital preventive screenings, primary care visits, and chronic condition management. Through personalized outreach, they build trusted relationships with patients, provide education on screenings like mammograms, A1c checks, and colon cancer tests, and break down barriers such as transportation, insurance, and language access. They serve as a consistent point of contact, offering culturally responsive guidance that helps patients feel supported throughout their care journey. By combining direct engagement with data-driven tracking and navigation, patient navigators are helping transform care delivery at BMC — reducing disparities, improving equity, and fulfilling the hospital's mission to make high-quality care accessible to all.

For more details on how BMC is committed to making care accessible, consult the table below.

Goal: BMC seeks to provide equitable and accessible wraparound care and services that meet low-resourced patients and communities where they are.

Strategy	Patient Population/ Cohort(s)	BMC Programs and Initiatives to Address This Priority	Identified Community Partners*	Secondary Priority(ies)
Increase screening rates for chronic diseases in leading areas of mortality (e.g., cancer) through evidence-based, data-driven interventions	• BMC primary care patients	• Health Equity Accelerator • Equity in Cancer • Value-Based Care	• Heart of a Giant • Boston Public Health Commission • Faith-Based Leaders • YMCA • American Diabetes Association • Ellie Fund	• Behavioral/Mental Health and SUD
Continue to support and strengthen community advisory structures that provide community and patient perspective in areas of data interpretation and intervention development	• Community advisory boards	• Health Equity Accelerator • BMC Community Engagement Department	• Equity Partnership Network • BU Clinical Translational Science Institute	• Economic Mobility
Strengthen chronic condition care coordination pathways	• BMC primary care patients	• Health Equity Accelerator • Equity in Cancer • Equity in Diabetes • Value-Based Care • HEART of Communities	• Boston Health Care for the Homeless Program • Codman Square Health Center • Daniel Driscoll — Neponset Health Center • The Dimock Center • DotHouse Health • Gieger-Gibson Community Health Center • Greater Roslindale Medical and Dental Center • Harvard Street Neighborhood Health Center • Manet Community Health Center • Mattapan Community Health Center • Mass General Brigham • NeighborHealth • South Boston Community Health Center • Upham's Corner Health Center • Whittier Street Health Center	• Housing • Behavioral/Mental Health and SUD

Sustain wraparound supports such as transportation, navigation, and connection to community resources to help patients access services and resources to improve health outcomes	• BMC patients, historically redlined populations • Families • Older adults	• Patient Navigators • Community Health Workers • Community Wellness Advocates • THRIVE • BMC Department of Population Health • Birth Sisters Program	• ThriveLink	• Economic Mobility
Increase services to patients in the communities in which they live and work	• Maternal/child population • Historically redlined populations • Patients with chronic disease	• Curbside Care • BMC Department of Pediatrics • BMC Department of OB/GYN • HEART of Communities • Equity in Diabetes • Health Equity Accelerator	• Boston Celtics Shamrock Foundation • Mass General Hospital • Mattapan Community Health Center • Mattapan Food and Fitness Coalition • YMCA • Urban League of Massachusetts	• Behavioral/Mental Health and SUD

* *This list represents past, current, and future community partners with whom we will engage over the next three years.*

Priority: Violence and Trauma

A 2021 BMC-led study revealed that areas of Boston where redlining occurred in the 1930s currently have higher rates of firearm violence compared to those that were not redlined. BMC's patient population includes those that live in geographical areas that were affected by redlining and thus routinely exposed to violence.

In response to this community's need, BMC has built several programs dedicated to violence and trauma. For example, since 2006, BMC's Violence Intervention Advocacy Program (VIAP) has responded to all gunshot and stab wound patients in the hospital's Emergency Department. The team works to guide victims of community violence through physical and emotional recovery using a trauma-informed approach to care, including through crisis intervention, mental health services, ongoing case management, family support services, and more. The long-term goal is to empower patients with skills, services, and opportunities so that they may reduce violent reinjury and future violence enactment — contributing to building safer and healthier communities.

VIAP is one of eight founding members of the national hospital-based Health Alliance for Violence Intervention (HAVI) and received the 2023 Peace MVP Award from the Massachusetts Coalition to Prevent Gun Violence, which honors those who have been instrumental in promoting peace and preventing gun violence throughout Massachusetts. In the last three years, VIAP has served more than 1,100 clients and family members; since 2006 the program has responded to 7,700+ new injuries.

For more BMC programs and initiatives that address violence in trauma in its communities, see the table below.

Goal: Provide culturally sensitive programming for individuals impacted by violence at home or in their communities.

Strategy	Patient Population/ Cohort(s)	BMC Programs and Initiatives to Address This Priority	Identified Community Partners*	Secondary Priority(ies)
Support victims of violence by providing case management and family advocacy services from Community Health Workers with lived experience	• Patients and family members affected by gunshot wounds and stab wounds (caused by knives only)	• VIAP • Child Witness to Violence Program (CWVP) • Community Violence Response Team (CVRT) • BMC Child Life Department • BMC Pediatrics Department • BMC Emergency Department • BMC Psychiatry Department • BMC Patient Advocacy Department	• The Health Alliance for Violence Intervention	• Behavioral/Mental Health and SUD
Provide therapeutic services for patients, family, and community members exposed to all forms of violence. Culturally sensitive, trauma-informed, evidenced-based counseling services include short-term and long-term ongoing therapy as well as inpatient bedside intervention	• All ages* *CWVP serves children from birth to 8 years old *CVRT serves all ages, primarily 8 years old and up	• VIAP • Child Witness to Violence Program (CWVP) • Community Violence Response Team (CVRT) • BMC Child Life Department • BMC Pediatrics Department • BMC Emergency Department • BMC Psychiatry Department • BMC Patient Advocacy Department	• Boston Police Department • Boston Public Health Commission — Beth Israel's Homicide Support Services Program • Cambridge Center for Homicide Bereavement • Community Healing Response Network • Eva Center • Jane Doe Inc. • La Casa Esperanza • Louis D. Brown Peace Institute • Massachusetts Office for Victims Assistance • My Life My Choice • REACH • Safe Link • Serving Survivors of Homicide Victims Providers • Suffolk County DA's Office • The Children's Advocacy Center • The Health Alliance for Violence Intervention • Youth Connect	• Behavioral/Mental Health and SUD

Provide direct advocacy services to those who have been harmed by an intimate partner, or in the context of intimate partner violence. Services include crisis counseling, risk assessment, safety planning, accompaniment to appointments, and referral to more specialized legal and mental health services as needed	• Teens • Adults • Older adults	• Domestic Violence Program	• Conference of Boston Teaching Hospitals • Jane Doe Inc. • Boston Area Rape Crisis Center	• Access to Health Care

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Priority: Behavioral, Mental Health, and Substance Use Disorder (SUD)

While opioid-related overdose deaths in Massachusetts and Boston saw significant declines in the last few years, persistent racial disparities in overdose deaths and the continued prevalence of fentanyl in the drug supply remain concerns for Boston Medical Center's patient population. Increased treatment access and investments in harm reduction approaches — like those developed and delivered by BMC — are working to decrease overall overdose deaths and remain a steadfast commitment by BMC experts and leaders. Simultaneously, BMC providers and teams are working to address co-occurring mental health concerns through culturally sensitive, trauma-informed care.

BMC's Grayken Center for Addiction, a national leader in addiction medicine, research, policy, and advocacy, provides cutting-edge substance use disorder treatment. The Grayken Center uses best practices, most of which are developed at BMC, to treat approximately 2,500 patients a month of all ages through various hospital- and community-based programs. The hospital's Office-Based Addiction Treatment (OBAT) Program, established in 2003, currently serves more than 800 patients, making it the largest hospital-based addiction treatment program in New England. Patients receive specialized treatment for their substance use disorder integrated within a primary care setting, allowing all their medical needs to be addressed by a team of providers. The OBAT Program has been recognized nationally and replicated within many outpatient settings.

For more on how BMC prioritizes behavioral health, mental health, and substance use disorder care, see the table below.

Goal: Provide culturally sensitive, multi-component programming for individuals with behavioral, mental health, and/or substance use disorders.

Strategy	Patient Population/ Cohort(s)	BMC Programs and Initiatives to Address This Priority	Identified Community Partners*	Secondary Priority(ies)
Offer "multi-component" interventions in the form of tailored clinics that advance health promotion and disease prevention. The clinics combine education about the disease and its treatment, cognitive behavioral therapy aimed at reducing anxiety and depression, operant conditioning focusing on changing lifestyle habits such as diet and exercise, relaxation training to reduce stress and anger, and social support from family and friends to help maintain these new behaviors	• Individuals in substance use recovery • Children, adolescents, young adults • Pregnant people with SUD • Inpatients at BMC: patients on medical/ surgical floors, dialysis patients, transplant patients, and outpatient, medical/surgical cases • Patients from birth to 17 years old who have experienced traumatic events • Immigrant and refugee new arrivals • Individuals in substance use recovery • MassHealth patients: youth and adults	• The Child and Adolescent Behavioral Health Clinic • Boston STAR — Boston Services for Trauma and Resources for families (STAR) • Boston Emergency Services Team (BEST), which provides criminal justice diversion programs designed to provide evaluation and treatment services with the goals of diverting arrests, minimizing incarceration, and fostering recovery. These programs include: Police Co-responder Program, Mental Health Court Program and Outpatient Assisted Treatment Program • Boston Center for Refugee Health and Human Rights (BCRHHR) • Reproductive Mental Health Program • The Psychiatric Reverse Integration for Medical Expertise (PRIME) • Faster Paths • Project ASSERT • Project Trust • SOFAR • Grayken Women's Health Program: Inpatient Addiction Consult service • Emergency Department Addiction Consult service • Brockton Behavioral Health SUD rehab program (CSS) • BMC Bridge Clinic and Community-Based Health Center (CBHC) • OBAT clinic • START clinic • Project RESPECT • CATALYST • The Wellness and Recovery After Psychosis (WRAP) • WRAP Without Walls • Addiction Psychiatry Treatment Program • Psychiatry Outpatient Department • Integrated Behavioral Health (IBH) BMC Psychiatry • The Consult-Liaison Psychiatry Services (CL Services) • The BMC Emergency Department has a stand-alone Psychiatric Emergency Services (PES) • The Recovery Learning Community	• City of Boston • Boston Police Department • The Boston Municipal Courts • The Trial Court of Massachusetts — Department of Mental Health • LBPHC Providing Access to Addictions Treatment, Hope, and Support Program • Eliot Community Human Services • Gavin House • Bay Cove Human Services • Health Care Resource Centers opioid treatment programs • Behavioral Health Network • NeighborHealth • Bureau of Substance Addiction Services	• Access to Health Care

Increase access to services for patients experiencing dual diagnosis/ co-occurring SUD and mental health diagnosis with the goal of lowering readmission rates	• Individuals in substance use recovery • Incarcerated individuals	• BMC Department of Psychiatry • BMC Discharge Clinic • Community Crisis Stabilization is offering virtual intakes with Community Behavioral Health Centers and Overstory Health • Rapid ACCESS: recovery coaching • Joint program with MGB and partnering with the Department of Public Health to train/use community health workers to support re-engagement in care • Brockton Behavioral Health Center • WRAP • WRAP Without Walls • Multi Visit Patient Program • Expansion of trainees within APTP (PhD students, addiction psych fellow with longitudinal clinic, adult residents) • Project Evolve	• BPHC PAATHS Program • Eliot Community Human Services • Boston Health Care for the Homeless Program • BSAS • CBHC and Overstory Health • Suffolk County Jail	• Access to Health Care
Increase access to MH and BH services by maintaining current programming and exploring areas for expansion	• Individuals in substance use recovery	• BMC Department of Psychiatry • Brockton Behavioral Health Center • WRAP • WRAP Without Walls		• Access to Health Care
Continue assessing mental and behavioral health needs in communities served, including conducting a full CHNA assessment in the Metro South region in 2026	• Individuals in substance use recovery • Individuals experiencing homelessness or housing instability	• BMC Department of Psychiatry • Recover Boston • Brockton Behavioral Health Center	• Boys and Girls Clubs • Boston Public Health Commission • Boston Public Schools	• Access to Health Care
Maintain and expand current mental health services for youth	• Adolescent and pediatric patients	• Child and Adolescent Psychiatry • Psychiatric Emergency Services • Community Behavioral Health Centers/Bridge for Youth • CATALYST • Grayken parent outreach program	• Boys and Girls Clubs • Boston Public Health Commission • Boston Public Schools	• Access to Health Care

** This list represents past, current, and future community partners with whom we will engage over the next three years.*

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