



Boston Public Health Commission

FY2010
Federal Budget and Policy Priorities

Prepared March 2009

Boston Public Health Commission

FY2010 Federal Budget and Policy Priorities

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I. ORGANIZATIONAL OVERVIEW

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The Boston Public Health Commission

The mission of the Boston Public Health Commission is to preserve, promote, and protect the health of all Boston residents, particularly the most vulnerable. We are the health department for the City of Boston.

BPHC provides a wide range of prevention, early intervention, and treatment programs and services, including:

- Nationally-recognized EMS service
- Coordination of emergency preparedness efforts
- Infectious disease prevention, tracking, and response
- Homeless shelters and transitional housing
- Re-entry programs for individuals recently released from incarceration
- Management of federal HIV/AIDS funding for 10 county region
- Substance abuse treatment and prevention
- Violence prevention programs
- Youth development services
- School-based health services
- Maternal and child health services
- Environmental and occupational health
- Biological safety inspections
- Chronic disease prevention and control
- Public health insurance enrollment services
- LGBT and immigrant health programs

The top priority of the Commission is the promotion of health equity, and we aim to align our activities to accomplish this goal.

Residents of color in the city experience higher rates of morbidity and mortality in many health outcomes when compared with white residents. Under the leadership of Mayor Thomas M. Menino, the elimination of health disparities was identified as a major public health priority for the City of Boston in 2002. A set of detailed recommendations to eliminate racial and ethnic health disparities was released in 2003, making Boston among the first communities in the United States to establish a city-wide blueprint for addressing racial and ethnic disparities in health. Over the past 5 years we have invested over \$6 million in Boston communities to create and enhance strategies to eliminate inequities in health and health care.

Evidence clearly demonstrates that the state of public health is determined primarily by structures that impact people's lives and not poor individual decision-making, and that these structures are rooted in racism, classism, and other relationships of oppression that have benefited some individuals and communities at the expense of others. Therefore,

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we aim to focus work across programs on social determinants of health such as poverty, residential segregation, racism, discrimination, lack of access to affordable healthy foods, unequal distribution of physical activity opportunities, educational inequality, lack of employment opportunities, affordable housing, and community violence.

Barbara Ferrer, Ph.D., MPH, M.Ed., Executive Director

Boston Public Health Commission Board

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**II. FISCAL CHALLENGES
GIVEN the FY2009 CONTINUING
RESOLUTION**

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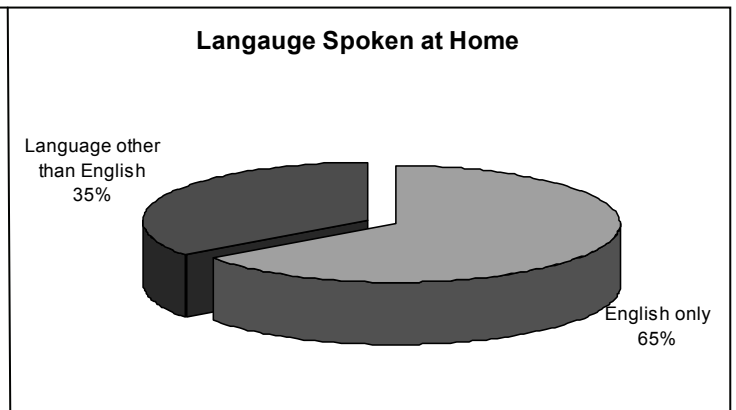
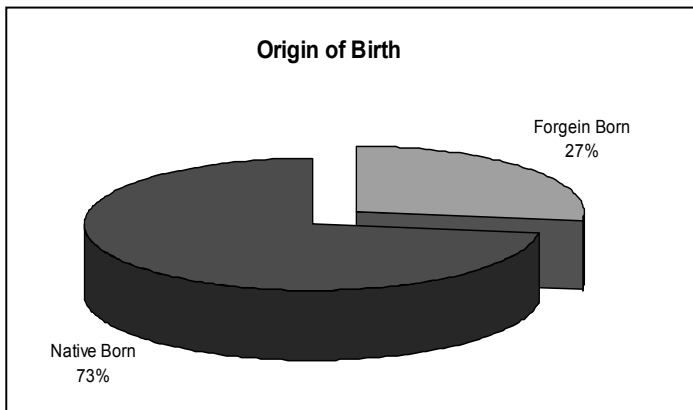
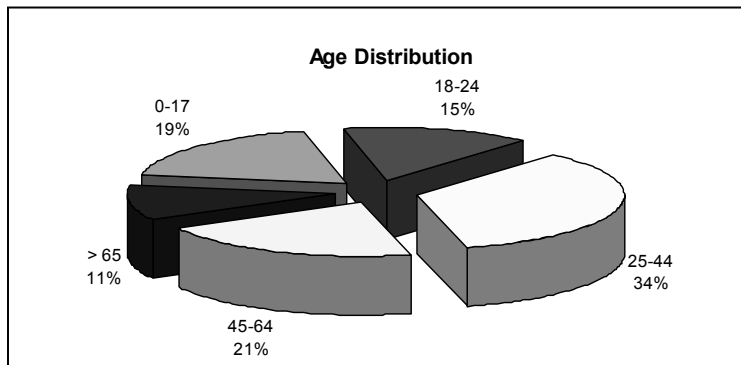
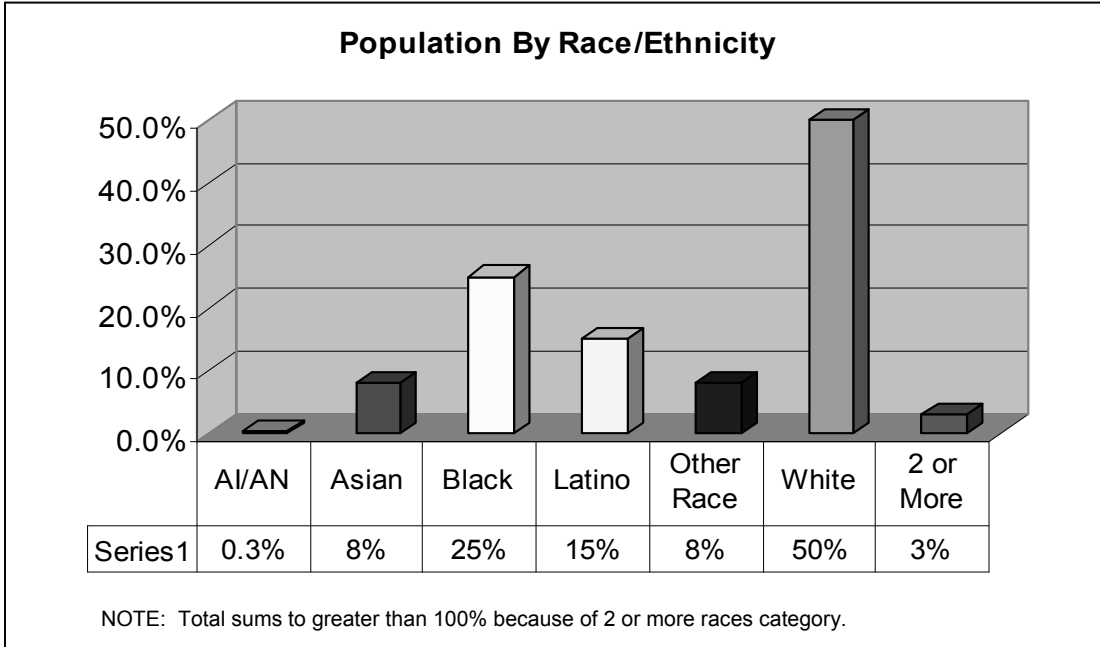
1. **Ryan White HIV/AIDS Treatment Modernization Act Funding.** The Ryan White Part A funding is driven by a mandated March 1 – Feb 28 fiscal year. Therefore, without a real federal budget, HRSA will not be able to make a full award to us on March 1, 2009. The CR could lead to a partial federal award on March 1; however, we would not know what our full award would be, causing havoc both to our internal budget and requiring us to issue short term contracts to our 50+ agencies and 100+ programs in order to avoid disruptions in service. Adjustments to agency awards and budgets and contract amendments would then be needed once there was a full award.
2. **Healthy Communities/Steps Funding.** Despite a very strong application, funding for BPHC's proposal for a 5-year grant (\$240,000 for one planning year and \$600,000 for four implementation years) is unlikely due to the CR, and in particular, the low number in the Senate mark. The FY09 House Labor-HHS subcommittee proposed funding Steps at \$30M (level funding at FY08 \$25 plus \$5M for a national partner program), whereas the Senate proposed funding at \$15.5M. BPHC's application for the recent CDC Funding Opportunity Announcement for Steps was approved but deferred. We understand that BPHC's application would be funded were Steps level funded at the FY08 level; however, the low Senate number means that funding is not available to CDC to distribute.

III. BACKGROUND DATA

III. BACKGROUND DATA

Part A. Selected Population Characteristics and Health Indicators for Boston Residents

Population Characteristics from American Community Survey sample data, 2006



III. BACKGROUND DATA

Estimated Median Household Income (Boston residents, 2006): \$47,974	
Population Living in Poverty % of Boston residents, 2006 Under Age 18 27% Ages 18-64 18% Ages 65 and Over 20% All Ages 20%	Chronic Disease Risk Factors <i>Adults</i> (% of Boston residents, 2006) Overweight or Obese 52% Inadequate Physical Activity 55% <i>Children</i> (% of public school students) Overweight/At-Risk (2005) 46% Inadequate Physical Activity (2007) 71%
Homeless Population Number of Boston residents, 2008 Individuals 3,811 Families 3,870 Total 7,681	Health Care Access % of Boston residents, 2006 Uninsured 6.9% Unable to See a Physician in Past Year Due to Cost 11.2%
Substance Abuse Treatment Admissions Number of Boston residents, 2006 17,330	HIV/AIDS Cases Number of cases among Boston residents, 2006 New Cases 194 Total Cumulative Cases 8,873
Substance Abuse Treatment Gap Number of Massachusetts residents, 2002-2003 Needing but not receiving treatment for illicit drug use in past year 168,000 Needing but not receiving treatment for alcohol use in past year 423,000 Note: Boston-specific treatment gap information does not exist, but the gap among Boston residents is estimated to comprise a large share of the statewide number.	

NOTES: Age, Race/Ethnicity, Poverty, Income, Language, Foreign-Born: Bureau of the Census, American FactFinder, American Community Survey, 2006 [Sample Data]; the sample population on which the indicators are based may vary by indicator. Income Data: In past 12 months; 2006 inflation-adjusted dollars. Homeless Counts: City of Boston Emergency Shelter Commission, 2007. HIV/AIDS Cases: Preliminary data; Massachusetts Department of Public Health HIV/AIDS Surveillance Program, 2006. Chronic Disease Risk Factors, Health Care Access: *Adults* – Behavioral Risk Factor Survey, Behavioral Risk Factor Surveillance System (BRFSS), Boston Public Health Commission, 2006; Overweight/obesity based on the Body Mass Index; Inadequate physical activity means not having moderate or vigorous physical activity for 30 minutes a day for at least 5 days a week. *Children* – Overweight: BMI Screening Project, Boston Public Schools Health Services Department, 2005; Physical Activity: Boston Youth Risk Behavior Survey, CDC, 2007; for Boston Steps Project Area. Substance Abuse Treatment Admissions: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2006. Substance Abuse Treatment Gap: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003. DATA ANALYSIS: Boston Public Health Commission Research Office.

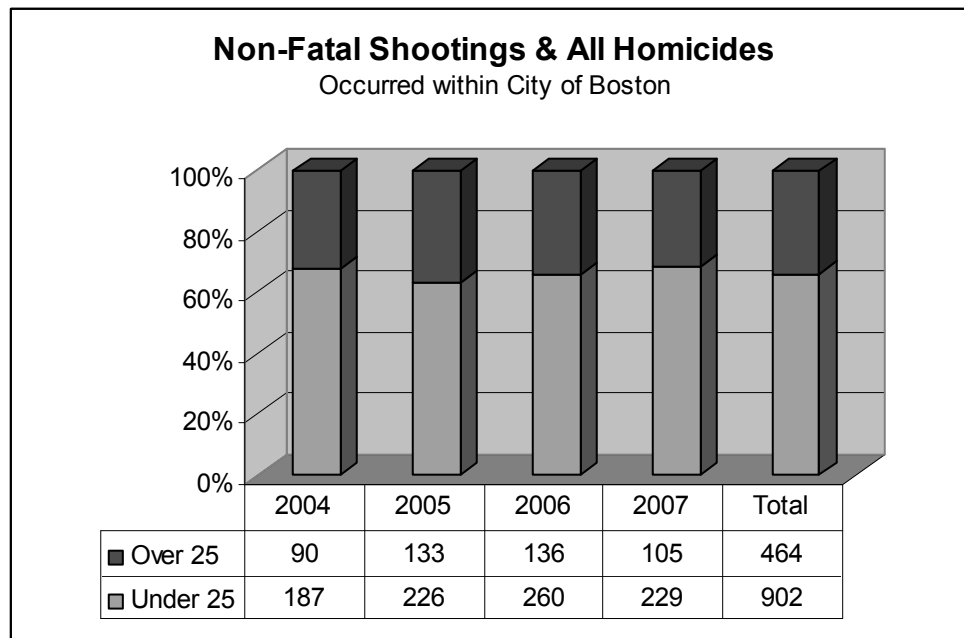
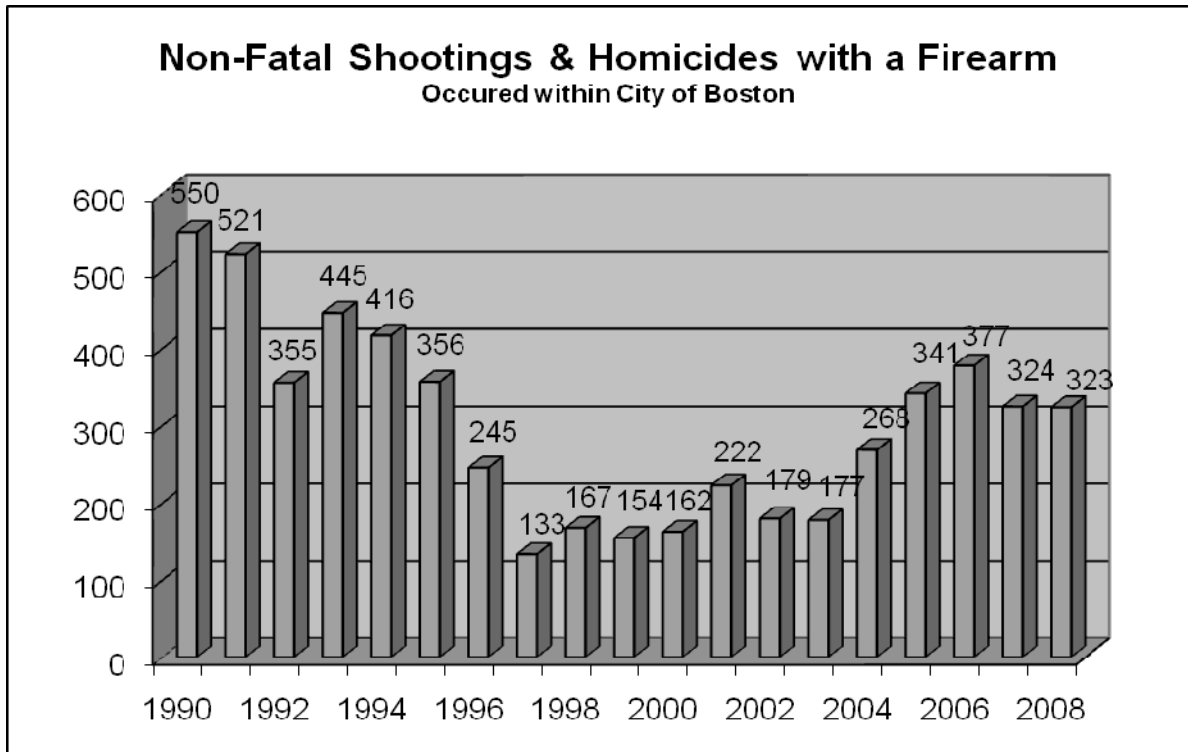
III. BACKGROUND DATA

Part B. Racial and Ethnic Health Disparities, Selected Indicators for Boston Residents

Indicator	Approx. Disparity for Blacks and Latinos compared to Whites	Black	Latino	White
Life Expectancy 2002-2004	Lowest for Blacks	73.0 yrs	81.9 yrs	77.7 yrs
Asthma Hospitalization Rate (Ages 4 and Under) 2006	5x higher for Blacks 4x higher for Latinos	14.3 / 1,000 population	9.9 / 1,000 population	2.8 / 1,000 population
HIV/AIDS Incidence Rate 2005	2.5x higher for Blacks and Latinos	77.7 new cases / 100,000 population	69.3 new cases / 100,000 population	28.1 new cases / 100,000 population
Non-Fatal Gunshots/Stabbings 2005	13x higher for Blacks 7x higher for Latinos	21.3 victims / 10,000 population	12 victims / 10,000 population	1.7 victims / 10,000 population
Overall Mortality Rate 2005	1.3x higher for Blacks	1,025.8 deaths / 100,000 population	631.7 deaths / 100,000 population	797.2 deaths / 100,000 population
Infant Mortality Rate 2006	3.7x higher for Blacks	13.2 deaths / 1,000 live births	2.9 deaths / 1,000 live births	3.6 deaths / 1,000 live births
Diabetes Mortality Rate 2005	2x higher for Blacks	35.5 deaths / 100,000 population	23.5 / 100,000 population	19.2 / 100,000 population
Stroke Mortality Rate 2005	1.6x higher for Blacks	60.0 deaths / 100,000 population	28.1 deaths / 100,000 population	37.6 deaths / 100,000 population
Homicide Rate 2005-2006	13.6x higher for Blacks 2.3x higher for Latinos	31.2 / 100,000 population	5.3 / 100,000 population	2.3 / 100,000 population
<p>DATA SOURCES: Life expectancy: Boston resident deaths and live births, MA Department of Public Health; Asthma hospitalizations: Acute Care Hospital Case Mix File, MA Division of Health Care Finance and Policy; HIV/AIDS incidence: MA Department of Public Health HIV/AIDS Surveillance Program; Gunshots/stabbings: MA Department of Public Health, Weapon-Related Injury Surveillance System; Mortality rates: Boston resident deaths, MA Department of Public Health. DATA ANALYSIS: Boston Public Health Commission Research Office.</p>				

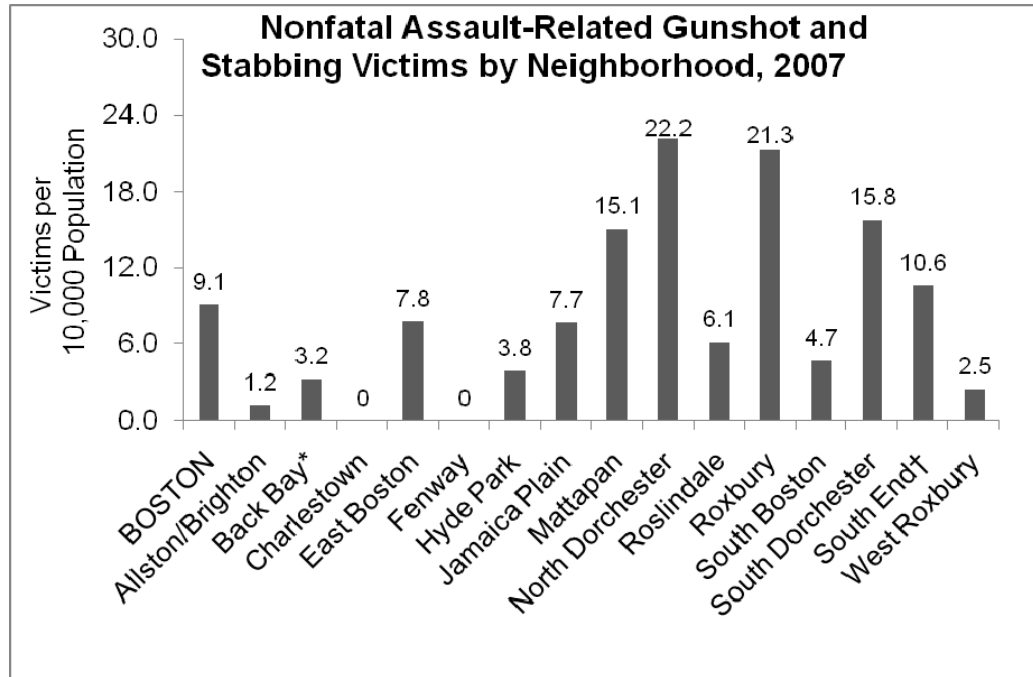
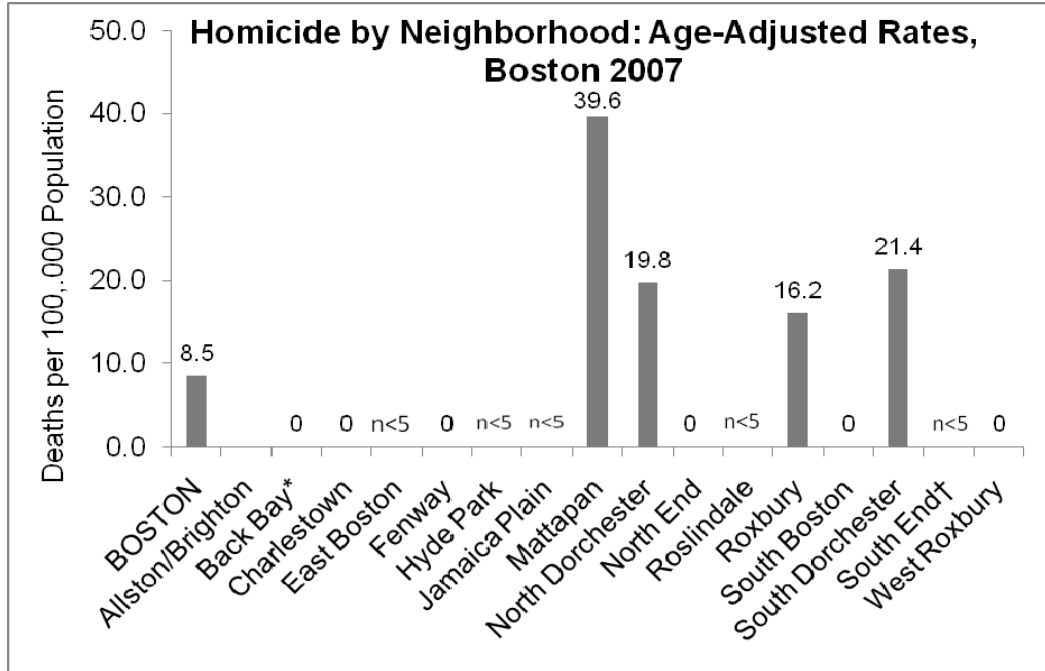
III. BACKGROUND DATA

Part C. Boston Violence Statistics



DATA: Boston Police Department. DATA ANALYSIS: Boston Public Health Commission

III. BACKGROUND DATA



* Includes Beacon Hill, Downtown, the North End, and the West End.

† Includes Chinatown

NOTE: These data do not include homeless persons or individuals whose neighborhood of residence was not reported, except in the Boston overall rate and count.

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health; Weapon-related injuries, Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System. DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office.

IV. TOP PRIORITIES

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I. Increased Federal Support for Community-Based Violence Prevention

We request increased federal funding to support local health departments' community-based violence prevention strategies. In particular, we ask that:

- A dedicated funding stream be created through the CDC's Division of Violence Prevention for community-based programs to complement CDC's existing support of research, training, and evaluation;
- DOJ violence prevention funds granted to local governmental units and police departments require partnership with and dedicated funding for local health departments, whose expertise is prevention.

Despite record decreases in violent crime in the 1990s, Boston is now facing a significant spike in violence. In 2006, the city saw a 12 year high in shootings and firearm homicides. From 1997-2006, total shooting incidents have jumped a drastic 183%. Non-fatal shootings have increased 138% from 2002-2006 and alarmingly, 53% of Boston's homicides were 24 years old or younger. Research and street intelligence officers' accounts reveal that while gang activity is a driving factor for current increases in violent crime, the violence stems from a broader range of issues, e.g., personal arguments, drugs and robberies. Officers have noticed the nature of "beefs" among youth often times escalate more rapidly, and more lethally, than in prior years and they attribute this change to the increased accessibility of, and social acceptance of gun violence.

BPHC recently opened an Office of Violence Prevention to develop a robust public health response to violence in Boston. Our public safety professionals are vital to addressing violence, but public safety focuses primarily on *response* to violence. **Public health is built upon the principles of prevention and early intervention.** The public safety and public health approaches should work hand in hand, but we currently have little infrastructure or funding for the public health side of the equation. The City of Boston currently receives no federal funding for violence prevention efforts from federal health agencies.

The CDC – the premier federal public health agency – provides minimal support for local infrastructure to prevent violence. The Division of Violence Prevention, within the CDC's National Center for Injury Prevention, was opened in 1993 and has played a critical role in research, training, evaluation, surveillance, and dissemination of best practices related to youth violence prevention. However, effective strategies to reduce violence in urban communities are resource and staff intensive. It is important for the CDC to provide funding for community-based infrastructure to address this problem, so that sustainable structures can be created in communities, and so that the availability of funding on the local level is not so constrained by trends within the private foundation sector.

Elsewhere in the federal government, DOJ programs address youth violence, gang violence, and unsafe communities, often through grants and partnerships with local governments and police departments. Examples include the Community Capacity Development (CCDP) Office, which

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administers the Weed and Seed initiative, and Project Safe Neighborhoods. These partnerships sometimes include local health departments, but this resource and source of expertise has been underutilized. We ask that local grants and partnerships require participation of and dedicated funding to local health departments to ensure that prevention methods are fully utilized, community collaboration and outreach expertise is available, and that long term community infrastructure is built.

The public health approach has been used successfully to combat other health threats, such as lead poisoning, heart disease, and HIV/AIDS. Local health departments are uniquely qualified to address violence, as they are closely linked to local mental health and substance abuse agencies, and they have been successful at combining public health technologies with grass roots community efforts to address multi-faceted health issues. The public health approach to violence prevention relies heavily on:

- **Public education** to change attitudes and behaviors;
- The building and expansion of **community coalitions** that change norms by promoting peace and denouncing violence on the street and neighborhood level;
- **Coordinated street outreach** to the most at-risk youth to link youth to employment and education and to identify conflicts before they escalate to violence;
- Expanded access to **evidence based treatment for high risk juvenile offenders**, such as multi-systemic therapy and functional family therapy;
- **Conflict resolution education** for school age children;
- **Data analysis and evaluation** to ensure interventions are directed toward the areas of greatest need and to measure progress;
- **Peer mediation, anger management, and conflict resolution programs** that provide young people with skills to prevent the escalation of conflicts into violence; and
- Mobilization to support **policy changes aimed at prevention**, including gun control policies championed by Mayor Against Illegal Guns.
- Addressing the **needs of survivors of violence, including trauma response services**, to mitigate the mental and physical impact of violence on children, youth and families.

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II. Comprehensive Health Reform Focused on Prevention

We request support for comprehensive national health reform to improve the health of individuals and communities. For health reform to be comprehensive, it must:

- Emphasize prevention in both clinical and community settings, recognizing that upstream improvements in healthy neighborhoods will be more effective and economical in improving health than costly medical treatments;
- Promote medical home and family-centered care coordination;
- Support local and regional preparedness and response to everyday medical emergencies as well as large scale public health emergencies, recognizing the vital role of EMS systems.

We support the widely-shared goal of passing national health reform this year. Comprehensive national health reform has great potential to:

- Reduce the shameful numbers of US residents without access to health insurance;
- Improve the poor health outcomes seen across populations and conditions compared to other industrialized nations;
- Reduce health inequities based on race/ethnicity and socioeconomic status; and
- Reduce the skyrocketing costs of medical care that threaten the financial health of families, employers, and local, state, and federal governments.

Access to health insurance is an important determinant of health and an important goal of health reform. However, reorganizing our system of financing and care to support prevention is the only way to truly impact population health. Of the contributions to premature death in the US, just 10% is attributable to health care, while 60% is attributed to social circumstances, behavioral patterns, and environmental exposure. Addressing these determinants that comprise the biggest piece of the pie will be more effective at improving health than simply expanding access to insurance.

We offer the following six recommendations for successful national health reform:

1. Emphasize Prevention in Clinical and Community Settings

Community-based prevention. By supporting efforts to promote healthy communities, health reform can save money spent on expensive medical treatments. We recommend:

- Requiring a greater level of community benefits funding from private insurance companies. These additional proceeds would be dedicated to state and local public health

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prevention activities, including health education, surveillance, improving access to healthy foods and physical activity, and limiting exposure to tobacco products.

- Establishing a Public Health Advisory Commission to recommend to the Congress how these core public health funds should be allocated to have maximum impact on the health of Americans. The Commission should advise on strategies to hold federal, state, and local public health agencies accountable for achieving the HHS-sponsored Healthy People National Health Objectives.¹ Membership should include representatives from local health departments with expertise in community-based prevention and intervention.

Health impact assessments. We add our voices to request of the Partnership for Prevention and Drs. Cole and Fielding from the UCLA School of Public Health in requesting increased use of Health Impact Assessments (HIA) by federal agencies, in particular, the request to establish a national, quasi-governmental National Center for Health Impact Assessment.

Health Impact Assessment (HIA) is a combination of methods to systematically examine the potential health effects of proposed policies, programs, and projects. HIA provides decision-makers and stakeholders with information on potential health benefits and harms, disparities in the distribution of impacts, and alternatives for improving the ratio of benefit to harm. As a result, HIA enables more informed policymaking and implementation, with the aim of improving population health, equity, and sustainability. It is particularly useful for highlighting the health impacts of proposed policies outside the health sector, where potential health impacts may be under-recognized or poorly understood. Health impact assessments of federal policies and programs are particularly important since the number of people affected by these policies and programs tends to be large.

When Congress, executive branch agencies, and policymakers in state and local governments make decisions affecting transportation infrastructure, taxes, energy, agriculture, housing, and other “non-health” policies, they may not realize that they are making important health decisions. These decisions shape the underlying determinants of the public’s health and well-being. While the provision and financing of health care and public health services are vital for protecting and improving the public’s health, many of the most important decisions on health are made in other sectors.²

Clinical prevention. We recommend that coverage for all clinical preventive services recommended by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices be included in federally-sponsored health insurance programs and that incentives be created for states and private insurance companies to include such coverage.

In addition, proper reimbursement should be provided to clinical staff for health services such as case management, care coordination, health education, and outreach. These services promote

¹ Modified from *Real Health Reform Starts with Prevention*. Partnership for Prevention. December 2008.

² Excerpted from *Building Health Impact Assessment Capacity: A Strategy for Congress and Government Agencies*. Brian Cole, DrPH and Jonathan Fielding, MD, MPH, MBA. A Prevention Policy Paper Commissioned by the Partnership for Prevention. December 2008.

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prevention, early intervention, and proper management to keep families healthy and avoid costly treatments.

2. Promote Medical Home and Family-Centered Care Coordination.

Principles. Reform should adhere to and create financial incentives for achieving the principles of medical home. In particular:

- Personal medical provider – Each patient should have an ongoing relationship with a personal provider trained to provide continuous and comprehensive care.
- Whole person orientation – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, community-based services, schools).
- Payment appropriately reflects the value of physician and non-physician staff care case management work that falls outside of the face-to-face visit, including care coordination and wrap around services within a practice and between consultants, ancillary providers, and community resources, schools, and social services.³

Case management. In order to promote comprehensive patient-centered care, it is important that case management services currently reimbursed by CMS be maintained, and that the seven regulations regarding case management issued by CMS be permanently revoked. These services provide important enrollment and referral services, as well as medical case management for disabled individuals, persons seeking substance abuse services, and school children.

3. Support Local and Regional Preparedness

Emergency Medical Services. We recommend the development of a National EMS Office to coordinate the fragmented EMS system (full third service, police and fire based and privatized services) and to provide the national link between public health and public safety that exists at the local level for better disaster response and preparedness. Investing in the health care and public health infrastructure at the national level will have a profound effect on the preparedness of communities. The current National Disaster Medical System (NDMS) would benefit from re-examining the institutions and agencies that provide emergency medical support to patients on a daily basis. EMS’ primary function is to respond to medical emergencies, yet the current NDMS language is essentially void of any reference to EMS.

³ Modified from *Joint Principles of the Patient-Centered Medical Home*. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. March 2007.

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EMS plays a role in every phase of the disaster preparedness and response efforts, from mitigation to recovery. In fact, through monitoring symptoms of patients seen by Boston EMS, management personnel can receive automated email warnings of specific symptoms that exceed normal thresholds providing nearly real-time detection of threats. Through having a hand in public safety, EMS can play a role, as we do in Boston, in intelligence and information sharing with medical and public health partners who may not otherwise be notified of critical issues and threats.

The health care system as a whole, including everything from EMS to hospitals, to community health centers, to specialty centers, to long term care facilities, need to be considered Critical Infrastructure. More investment must be made in the institutions that are in the business of saving lives; when disaster strikes, the most important component to the response *should be* helping the injured.

Expanding recognition of public health emergencies. Federal public health agencies should expand their support to local health departments to address public health emergencies that are endemic or emerging in local communities that threaten lives and wellbeing, including such emergencies as gun violence and infectious diseases. For these recognized emergencies, additional federal assistance should be provided to local communities.

4. Relax Requirements for Citizenship and Identification Documentation for Medicaid Eligibility.

We request a relaxation of the federal rule that requires original or certified copies of documents to prove citizenship and identity for Medicaid eligibility. This rule creates unnecessary burdens and disruptions of care for both Medicaid applicants and provider organizations. On the applicant side, original documents can be expensive and difficult or impossible to obtain to obtain. This is especially true for individuals experiencing homelessness and residents born outside the state in which they're applying. The cost of obtaining documents, delays in accessing necessary care, and inappropriate rejection of some applicants is creating an undue barrier to health care. On the provider side, the enrollment process had been lengthened, adding to the administrative burden and costs, creating delays in referrals, and decreasing Medicaid reimbursement. This is especially troublesome for community health centers, for which Medicaid is the largest source of funding.

5. Use Technology to Promote More Efficient Disease Prevention, Management, and Care

We request that electronic patient records be standardized. Doing so would present not only opportunities to reduce costs but also allow for sharing of costly infrastructures and mitigate the issues associated with data sharing. The ability to share data for proactive as well as preventive measures to address health risk to communities is a homeland security issue that is driven by state and local governments. The ability to share data is often hampered by the lack of standards as it relates to technologies being used and the databases that store information at hospitals, clinics as well as public health facilities.

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6. Move to An Opt-Out System of Organ Donation

We request the move to a national “opt out” system for organ donations, in which people would be automatically considered to be donors unless they officially declare their wishes otherwise, a system that has been used with successful results in several European countries.

Currently, there are over 92,000 people on the organ waiting list in the US, with 3,700 individuals added each month. It is estimated that 18 people die each day waiting for transplants because of the shortage of donated organs. In addition, tremendous costs are incurred by families, medical institutions, and payers when patients are waiting for organs to become available.

In order to address the ethical issues surrounding organ donation, we support the 2005 statement of the American Medical Association (AMA) Council on Ethical and Judicial Affairs that argues an opt-out system can only be ethical when (1) individuals are aware of the presumption, (2) accessible and effective mechanisms are established for documenting an individual’s decision to opt out, and (3) physicians verify that the deceased did not object to donation either in documentation or to the individual’s family.

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III. Support for Re-Entry Programs

We request support for increased funding for consistent, coordinated re-entry programs for ex-offenders and programs for currently incarcerated individuals that will effectively prepare them to re-enter their communities as healthy and productive members of society. These programs have consistently been shown to reduce recidivism, homelessness, and substance use and to increase education and job placement opportunities

In Massachusetts, about 20,000 prisoners are released each year – approximately 55 each day. This population has a well documented need for, as well as a historical disparity in receiving, services related to substance abuse treatment, sexually transmitted infections, job training/placement, medical/mental health services and housing, among others. Yet many of these individuals re-enter our communities with no place to live, no job, and no family or social supports.

Re-entry programs have had demonstrated success in reducing outcomes such as recidivism, homelessness, and substance use and increasing education and job placement. However, there continues to be too few re-entry programs to serve the large number of individuals re-entering their home communities from incarceration, as well as a lack of consistency and coordination among those programs that do exist.

A 2003 report by the Massachusetts Public Health Association, *Correctional Health: The Missing Key to Improving the Public's Health and Safety*, calls for stronger “linkages with community-based agencies to provide the necessary health, mental health, and substance abuse programming, support and services they need to function productively and pose less of a threat in society.” The report also urges the “replication and expansion of model programs that rely on partnerships between corrections and community-based agencies”. Only a few such programs currently exist in Massachusetts. For example, out of 465 state-funded substance abuse programs, only eight involve criminal justice collaborative; and these enroll barely 1% of all clients in state-funded substance abuse programs.

Lack of access to re-entry programs has a detrimental impact on public health, most notably:

- **Recidivism.** Lack of stable housing, employment and education, as well as unmet medical/mental health and substance abuse needs are also linked to high rates of recidivism among this population. 63% of offenders are rearrested for a felony crime or serious misdemeanor within three years of release. The period immediately following release from jail and prison is often singled out as a moment of highest risk for substance abuse relapse fatal and non-fatal overdoses, and other risky behaviors.
- **Racial and Ethnic Health Disparities.** Over the past 20 years, many studies have shown that people of color are far more likely to experience poorer health outcomes than whites. The effect of these disparities on our population has become the number one public health concern for the City of Boston.

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One place where these disparities are alarmingly apparent is in our prison population. Boston and Suffolk County hold the state's largest jail population. Of inmates at the two major correctional facilities in Boston, over three quarters are people of color and the vast majority are Boston residents. While there is currently no statistical measure of how many of these inmates stay in the city after release, anecdotal evidence strongly suggests that 90% of the inmates reside within a 5 mile radius of the facility upon release. These neighborhoods – Dorchester, Jamaica Plain, Roxbury and the South End hold the city's largest numbers of low-income people, people of color, and non-English speakers.

- **Unmet Substance Abuse Treatment Needs.** Massachusetts overall is heavily affected by substance use - we rank 8th among all states in overall illicit drug use – and a disproportionate share of those suffering from addiction can be found in our prison population.

The Massachusetts Department of Correction reports that over 85% of state inmates would benefit from substance abuse treatment. A research study on hepatitis C presented at the American Public Health Association conference in 2001 found that 59% of men entering the Massachusetts state prison system reported past injection or inhalation of drugs. In Boston, 25% all individuals admitted to publicly-funded substance abuse treatment last year was criminally involved, a percentage that has remained relatively stable over the last eight years. Our substance abuse system of care, however, is stressed and under-resourced – still recovering from a series of devastating budgets cuts in the early 2000s and now vulnerable to new cuts due to the current fiscal situation. Combined 2002-2004 data from the National Survey on Drug Use and Health (NSDUH) indicate that Boston has higher rates of persons needing but not receiving treatment for alcohol or illicit drug use than do other regions of Massachusetts. Of the more than 325 state planning areas tracked by the SAMHSA Office of Applied Studies, Boston ranks second in the percentage of people needing, but not receiving, treatment for illicit drug use.

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IV. Reducing Health Inequities by Greening our Communities

We request support for green innovations that ensure equal economic and health benefits to all people and that help to reduce health inequities based on race/ethnicity and income. In particular, we request that:

- Congress adequately fund the Green Jobs Act of 2007;
- Job training programs, public transit improvements, and energy conservation programs be targeted toward low income communities and communities of color;
- Strong worker protections and occupational safety programs be implemented in new or expanded industries; and
- Newly-sited facilities not continue the patterns of environmental injustice that already burden low income communities and communities of color.

The greening of the economy has received much attention and support, as well as being a central piece of President Obama's economic stimulus plan. Green innovations have great promise to improve the health of our natural environment and to provide new jobs and economic activity. In addition to these benefits, green innovations can play a key role in improving health and reducing health inequities if targeted correctly and if the benefits and burdens are distributed equally.

- **Green Jobs Act.** This bill, signed by President Bush in 2007, authorized \$125 million per year to create an Energy Efficiency and Renewable Energy Worker Training Program; however, the funds have not yet been appropriated. The Green Jobs Act is an pilot program to identify needed skills, develop training programs and train workers for jobs in a range of green industries—including energy efficient building, construction and retrofits, renewable electric power, energy efficient vehicles, biofuels, and manufacturing that produces sustainable products and uses sustainable processes and materials. It targets a broad range of populations for eligibility, but has a special focus on creating green pathways out of poverty.
- **Equal Benefit.** Green jobs and green technology are the direction of future economic growth for the nation. It is important that we make sure that all people benefit equally from job creation. This is particularly important for the communities and populations that have already been disadvantaged by the “digital divide” in computer and high technology growth – low income communities of color and recent immigrants. They will be able to see the greatest benefit if efforts are made in the form of job training programs and educational assistance to ensure that they are not left behind.

The heart of the green development movement is the conservation of resources and reduction of consumption. This conservation can have the most impact in the lives of those who spend the highest proportion of their income on basic resources like fuel

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and electricity – people with low incomes. It is important to ensure that green innovations are affordable to people of all means. For example, we will have failed if the lowest income households are still driving fuel-inefficient cars and paying high electricity costs while those who are more affluent avoid these costs (a relatively much smaller percent of their household income) thanks to hybrid cars, solar panels, and other green technology. This can best be addressed by improvements to public transportation systems and assistance programs for energy conservation home improvements.

- **Worker safety and health.** A green economy will mean many new types of jobs, many with new or unknown occupational health risks. As industries develop, it has been the pattern that the most vulnerable individuals (recent immigrants, those with less education, people of color, and low income workers) are employed in the more hazardous, difficult, and low-paying jobs. To combat this, we must have in place strong worker protection and occupational safety education programs in new or expanded industries.
- **Environmental justice.** There is a “less green” side to the green economy. Many of the products that will fuel green job growth rely on heavy manufacturing, recycling, and other industries that can have an adverse impact on surrounding populations. It is important to take steps to ensure that this growth does not contribute to another round of environmental injustices where such industries are disproportionately sited in communities that already carry a heavy environmental burden.

V. APPROPRIATIONS REQUESTS

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Part A. Violence Intervention Prevention (VIP) Project

Despite record decreases in violent crime in the 1990s, Boston is now facing a significant spike in violence. In 2006 the city saw a 12 year high in shootings and firearm homicides. From 1997-2006, total shooting incidents have jumped a drastic 183%. Non-fatal shootings have increased 138% from 2002-2006 and alarmingly, 53% of Boston's homicides were younger than 25. Research and street intelligence officers' accounts reveal that while gang activity is a driving factor for current increases in violent crime, the violence stems from a broader range of issues, e.g., personal arguments, drugs and robberies. Officers have noticed the nature of "beefs" among youth often times escalate more rapidly and more lethally than in prior years, and they attribute this change to the increased accessibility of, and social acceptance of gun violence.

Boston has a history of leading the way in violence prevention that must be revived. Between 1990 and 1997, Boston achieved an unprecedented 75% reduction in firearm homicides and non-fatal shootings, and became a national model for combating violence. This "Boston Miracle" was achieved through strong interagency collaboration, street outreach, and extensive community involvement – most notably from the clergy.

The Violence Intervention Prevention Project (VIP) is a new initiative that will combat shootings and homicides in four high-risk neighborhoods through a comprehensive public health approach that incorporates core public health components of prevention, intervention, and treatment. Boston will model all strategies on evidence-based interventions, including successful strategies employed by the Chicago CeaseFire program, among others. Chicago CeaseFire, developed by public health practitioners, reduced homicides between 25% and 67% in the first year of operation in high-violence communities.

VIP will target at risk youth aged 14 to 25 through outreach and service connection, and the community as a whole through a media campaign and community coalition building. Community groups with records of leadership in the target neighborhoods will coordinate all community activities. The Boston Public Health Commission will provide training and technical assistance and will work with the community groups to develop partnerships with key State and City agencies, including employment services, education, housing and police. The initiative will have four key components:

1. **Public education** aimed at delivering the message that shooting is not acceptable;
2. **Community coalitions** that promote peace and denounce violence;
3. **Street outreach** that provides concrete interventions that bolster the antiviolence message -- these interventions include linking the most at-risk youth to needed services, such as employment and education, and being able to identify and intervene in conflicts before they escalate to violence; and
4. **Partnerships with law enforcement** to ensure that implementation of the model is data driven and addressing the areas of highest need.

The Boston Public Health Commission is well suited to lead this collaborative effort by virtue of its public health expertise and proven ability to lead a diverse coalition of stakeholders to effectively address complex problems. CeaseFire was developed by public health practitioners to create behavior change through repetitive prevention messages and concrete services that support and give credibility to the message. This approach has been successfully used by the Health Commission to attack problems as

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diverse as sexually transmitted diseases and childhood lead poisoning. Experience in Chicago indicates that public health approaches can successfully reduce community violence.

Request Amount:

\$1,000,000 from Department of Justice.

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Part B. Boston Wellness NET

46% of students in the Boston Public Schools are either overweight/obese or at risk for becoming overweight/obese, with Black and Latino students having the highest rates. Nearly half of Boston high school students do not get adequate exercise. Obesity in children is a major risk factor for diabetes, heart disease, some types of cancer, high blood pressure, and emotional problems and has been associated with asthma.

BPHC will take its childhood obesity prevention programs to the neighborhood level through a new program, Boston's Wellness NET – Neighborhoods Engaging Together, that places Wellness Advocates/Educators in 4-6 Boston Center for Youth and Families community centers (as part of Mayor Menino's Community Learning Initiative) to offer and coordinate culturally appropriate healthy eating, physical activity, and wellness resources that are based on each neighborhood's specific needs and interests. Because childhood obesity is a complex problem that involves organizational and community change as well as individual and family behavior change, the wellness advocates will function at multiple levels in their neighborhood.

With the support of BPHC, they will offer or coordinate evidence-based nutrition education and physical activity programs for children and families. Advocates will also work within their neighborhoods to educate and organize for policies and practices that support healthier communities. Advocates will align with an existing coalition in each neighborhood that either already includes a focus on obesity prevention or can be expanded to include this focus, in order to implement a workplan that addresses neighborhood needs and interests, and engages neighborhood leadership in policy change.

Examples of organizational and community initiatives that wellness advocates might undertake include: developing a community-supported agriculture (CSA) fresh produce network for low-income families; organizing youth-serving programs to develop and implement healthy foods policies; outreach to neighborhood family day care providers to participate in a citywide program for healthier eating and physical activity; and training/organizing neighborhood residents to conduct and submit walkability / bikability audits and follow up with appropriate city agencies.

BPHC will support the advocates with training, technical assistance, program support and resources through its existing chronic disease prevention initiatives, including a nutritionist (2/3 time).

Boston's Wellness NET will participate in the citywide Boston Collaborative for Food and Fitness to bring neighborhoods together for broader policy change at the state and federal level.

Request Amount

\$400,000-\$550,000 per year for three years from HUD, Neighborhood Initiatives.

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Part C. Re-Entry Program for Adult Men

Black and Latino men in the City of Boston are incarcerated at a much higher rate than any other group, comprising more than 75% of inmates at the Suffolk County House of Corrections (SCHC). The rate of substance abuse among inmates is very high, but there are few treatment options for men when they are released from incarceration. It is estimated by corrections officials that more than 90% of released inmates return to Boston neighborhoods following their periods of incarceration. High rates of substance abuse compound the great number of barriers that stand in the way of successful reintegration.

Currently, there is no program in Boston's poorest neighborhoods specifically designed to serve this population.

This program will service Boston male residents of color ages 25 and older with a history of incarceration, an age group that comprises more than 70% of released inmates. This project will fill a critical gap in our system of care, focusing on our target population of African American and Latino men living in Boston's poorest neighborhoods. This program will provide: 1) intensive outpatient substance abuse treatment, 2) job training/placement, 3) medical/mental health services, and 4) intensive case management services to assist with housing and educational needs, among others. Substance abuse services currently offered by BPHC will also be expanded to better serve this population.

The placement of this program at BPHC will allow coordinated care with other health services that may benefit this population, such as help with child support, healthy relationships with family and partners, and enrollment into public health insurance programs, among others.

The need for this program is great:

- Data from National Household Survey on Drug Abuse indicate that of the 15 largest metropolitan areas, Boston had the highest reported rates of illegal substance use (8.5%).
- The Massachusetts Department of Correction reports that over 85% of state inmates would benefit from substance abuse treatment.
- A recent profile of inmates at SCHC reported that the average prisoner, "has a history of substance abuse [and] lacks a high school diploma or a graduate equivalency degree. Many owe substantial back child support payments, often in the tens of thousands of dollars. The prisoners' return to the community also poses challenges to those communities. About one-third of ex-prisoners from the facility will be re-arraigned for a new crime within just eight months of their release."

Request Amount

\$500,000.

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Part D. EMS Superstation/Training Center

Boston EMS plays a major role in the health of the city, both as the emergency first responder and as a key part of emergency preparedness and response efforts. However, the applicant pool for Boston EMS positions has decreased significantly in recent years, and is less qualified than in the past. In addition, people of color comprise only 18% of the Boston EMS workforce, compared to more than 50% of the City population. Mayor Menino has made it a top priority to eliminate racial and ethnic disparities in health, as well as to diversify the city government workforce. It is well-recognized that a health care workforce representative of the population being served is a key component of reducing disparities, and this goal is explicitly stated in Mayor Menino's Blueprint to Eliminate Racial and Ethnic Health Disparities.

This facility will create a vibrant connection between Boston EMS and the diversity of the young people in the City by tying everyday EMS operations with EMS and public health career training, community training, a base for a Cadet program, and a disaster simulation lab. Partners would include the Boston Public School Department, area hospitals, Boston Area Health Education Center, and community based organizations. This would also be a training resource for our Urban Area Security Initiative (UASI) partners in the Metropolitan Homeland Security Region.

This facility would create opportunities to connect the community with pre-hospital and public health programs. Moreover, it would actively engage the community in everyday aspects of EMS and expose students and adults to health and safety skills building and career learning opportunities.

This facility would capitalize on Boston EMS' pivotal relationship with area hospitals, trauma centers, community health centers, senior centers, public health programs and community organizations.

Key components of the facility:

- Located near or in conjunction with a Boston Public School facility.
- Provides classroom and lab space for:
 - An after-school or a school day learning environment for students interested in EMS and other health careers.
 - Simulation lab for hands on learning.
 - Base of operations for Cadet Program and training.
 - Community programs from CPR to EMT classes to health career learning for youth and adults.
 - Community space for meetings and health screenings.
 - Emergency dispensing site, cooling center or emergency shelter.
 - Meeting and training resource for UASI partners.
- Includes an active Ambulance station.

Request Amount

\$2,000,000 from Department of Health and Human Services, Health Resource Service Administration, construction/equipment/program development.

**VI. FEDERAL POLICY
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VI. FEDERAL POLICY PRIORITIES/RECOMMENDATIONS

Part A. Promoting Health Equity

1. We request adequate funding for programs that provide critical services to **reduce health inequities** – in particular: Racial and Ethnic Approaches to Community Health (REACH) US, Healthy Start, and Area Health Education Centers (AHEC).

- ✓ **We request \$50 million for the REACH program**, funding that supports work in Boston and Lawrence, MA. In Boston, the REACH 2010 Breast and Cervical Cancer Coalition was originally funded by Centers for Disease Control and Prevention (CDC) in 2000. This innovative program has provided culturally-specific health education to more than 9,000 Black women, provided comprehensive case management services to over 1,000 women, implemented an award-winning media campaign on disparities in breast cancer mortality, and developed a thriving community-based coalition.

In 2007, REACH 2010 became REACH US. In this same year, BPHC was designated one of 18 US Centers of Excellence in the Elimination of Disparities (CEED) through a highly competitive process. As part of the designation, the new CEED was awarded \$4.5 million over 5 years. The CEED will support the elimination of disparities by collaborating with local and regional partners to disseminate and support the REACH model in communities across New England and beyond.

In the REACH US 2007 funding cycle, 18 CEEDs were designated, along with 22 Action Communities. Adequate funding is needed for REACH US to continue funding the CEEDs and Action Communities.

- ✓ **We request \$120 million for the Healthy Start program**. In Boston, this funding supports the Boston Healthy Start Initiative (BHSI), a community driven initiative whose primary goal is to eliminate disparities in perinatal health among Cape Verdean, African American, Caribbean, African, and Latino women who self-identify as Black, between the ages of 15-44. The program seeks to ensure that women enter into their pregnancy in good health, and have connections to needed support services. In 2006, infant mortality among Black babies was nearly four times higher than for White babies. It is important that services such as Healthy Start be available to all Black women in Boston to eliminate this injustice.

In 2007, 1034 women were enrolled in Healthy Start; of these, about 75% have had the recommended home visits and assessments. The program also serves fathers and partners of the women. BHSI seeks to ensure that these women establish a permanent medical home for themselves and their infants. In addition, BHSI assists them in accessing financial entitlements, transportation, interpreter services, and health education materials in the appropriate language and reading level to increase their awareness of the risk factors associated with poor birth outcomes. The BHSI service model includes case management from the prenatal period up to the child's second birthday, and it incorporates home visiting, coordination of care, women's health and psychosocial assessment, perinatal and postpartum

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screening for maternal depression, and health education related to self care during and after pregnancy.

- ✓ **We request \$35 million for the AHEC program (within Title VII Health Professions funding).** In Boston, this funding supports the Boston Area Health Education Center (BAHEC), which focuses on increasing the racial, ethnic and linguistic diversity of Boston’s health-care workforce—a critical objective to help eliminate racial and ethnic disparities. BAHEC provides both a Youth to Health Careers Program (Y2HC) and Medical Interpreter Training Program. Over the past 25 years, more than 10,000 Boston students have participated in programs emphasizing careers in preventive and primary care medicine, allied health, public health, and complementary medicine. The Youth to Health Careers Program offers educational programs designed in such a way that a student can start in the 8th grade and continue through high school. Over the past 7 years, 100% of high school seniors participating in Y2HC – nearly 200 total – have been accepted to college, most with financial aid.

2. We request support for **comprehensive legislation to address racial and ethnic disparities in health.**

- ✓ We support S. 1576/H.R. 3333, The Minority Health Improvement and Health Disparity Elimination Act, sponsored by Senator Kennedy and Representative Jackson (110th Congress). Key provisions include:
 - **Codifying the CDC Racial and Ethnic Approaches to Community Health (REACH) Program** to assist communities in mobilizing and organizing resources to support effective and sustainable programs to reduce disparities in health and healthcare;
 - **Improving cultural competency among healthcare providers** through curricula for health professions schools and support for improved provider-patient communication;
 - **Increasing diversity in the healthcare workforce** through reauthorizing Health Resources Services Administration (HRSA) diversity in the health professions programs, establishing scholarships to minorities who make a mid-career change to a health profession;
 - **Enhancing healthcare quality and access** through community grants aimed at outreach and enrollment in healthcare programs, establishing grants to improve access to patient navigators and health literacy education services, and establishing Health Action Zones to support state, tribal, and local initiatives to improve minority health;
 - **Supporting research on health disparities** through reauthorizing and strengthening the National Center for Minority Health and Health Disparities at the National Institutes of Health (NIH), and requiring Agency for Healthcare Research and Quality (AHRQ) to create a strategic plan regarding health disparities; and

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- **Supporting data collection, analysis, and quality** through ensuring the collection and reporting of data on race and ethnicity, primary language, and other health disparity indicators within federal health programs.
- ✓ We support H.R. 3014, The Health Equity and Accountability Act, sponsored by Representative Solis (110th Congress). Key provisions include:
- **Reducing disparities in HIV/AIDS incidence and treatment** by expanding the Minority HIV/AIDS Initiative;
 - **Improving health care workforce diversity** activities, including Regional Minority Centers of Excellence Programs;
 - **Improving data collection** by requiring the Department of Health and Human Services to collect data on race, ethnicity, and primary language;
 - **Building federal leadership** through establishing an Office of Health Disparities at DHHS; directing each federal health agency to implement a strategic plan to eliminate disparities, and establishing of an Office of Minority Health within CDC, HRSA, Substance Abuse and Mental Health Services Administration, Administration on Aging, Center for Medicare and Medicaid Services, and Food and Drug Administration;
 - **Addressing environmental justice** through directing the President to execute, administer, and enforce provisions to improve environmental justice in minority and low-income populations; and
 - **Enhancing healthcare quality and access through** establishing Health Empowerment Zone programs in communities that disproportionately experience disparities in health status and health care, and designating centers of excellence at public hospitals and other health systems that demonstrate excellence in providing care to minority populations and reducing health disparities.

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Part B. Preventing Chronic Diseases

1. We request \$44 million for the **Healthy Communities/Steps** program.

This funding would allow CDC to continue this successful program that funds intensive community-based chronic disease prevention. **Boston Steps was funded through a four-year CDC grant that ended in September 2008. Boston Steps was “approved but deferred” for continued funding in fall 2008, due to the FY09 Continuing Resolution and the low (\$15.5M) Senate mark.** If FY08 Healthy Communities/Steps funding levels are maintained, we understand the Boston Steps will be funded. If funding is not maintained, we risk losing the tremendous infrastructure built by Steps in the past 4 years.

If Boston is not able to secure funding in, the results may include:

- ✓ Loss of more than **\$1 million of annual funding to more than 50 Boston community organizations** to do direct community programming and capacity building related to healthy eating, physical activity and chronic disease management.
- ✓ Loss of funding for **9 full time equivalent positions** at BPHC, that support BPHC’s basic chronic disease prevention and control infrastructure, as well as a key position on the Health Connections Van, and an environmental health inspector position which is responsible for school inspections for environmental triggers for asthma.
- ✓ The following successful programs may be forced to be shut down:
 - The **NeighborWalk** program that has engaged more than 1700 participants each year in neighborhood-based walking groups and health education;
 - The **Steps to Wellness** program that has engaged more than 700 participants each year in weekly physical activity programs;
 - Funding support for 14 community health centers to **improve their chronic disease prevention and management** programs;
 - Loss of the only **full time nutritionist position** at the Boston Public Health Commission, which provides direct community education, technical assistance and capacity building in the community;
 - Loss of the **Wellness Coordinator in the Boston Public Schools**, responsible for overseeing BPS’ new and exciting efforts to implement federally mandated Wellness Policies at all 144 schools;
 - Loss of the **mini-grant program to support wellness activities** at more than 25 schools; and
 - Loss of support for **health education curriculum** implementation at 25 schools

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2. We request reauthorization and adequate funding of the **Child Nutrition Reauthorization Act** in order to reduce hunger and food insecurity in America, help reduce childhood overweight and obesity, improve child nutrition and health, and enhance child development and school readiness. In addition, we request **expanded funding to keep pace with need and costs.**

The Child Nutrition Reauthorization Act expires on September 30, 2009. This act includes all the federal child nutrition programs, including the School Breakfast and the National School Lunch Programs (NSLSBP), the Summer Food Service Program (SFSP), the Child and Adult Care Food Program (CACFP), and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Congress has a unique opportunity to improve access, meal quality and nutrition for millions of children, particularly low-income children in child care

These extraordinarily successful, cost-effective child nutrition programs play a critical role in helping children, especially those in low-income families, achieve access to quality nutrition, child care, educational and enrichment activities while improving their overall health, development, and school achievement. In addition, the adult component of CACFP provides needed nutrition assistance to elderly and impaired adults.

However, federal support for these programs has not always kept pace with need, food cost inflation, the costs of delivering services, or increased scientific knowledge. A substantial investment of new funding must be included in the federal budget to achieve these goals. Without new program investments, it will be impossible for Congress to build upon the successes of the 2004 reauthorization. With enhanced federal support, priorities for the 2009 Child Nutrition reauthorization should include:

- **Improve access to nutritious foods in schools, child care centers and homes.**
 - Provide federal funding for breakfast commodities, currently only available to the school lunch program.
 - Expand free meal eligibility to children from households with incomes up to 185% of the national poverty line.
 - Amend current area eligibility guidelines for family child care homes and afterschool and summer programs to be consistent with other federal programs and serve more children.
 - Make suppers available nationwide through afterschool programs in low-income areas to provide food, supervision, and educational and enrichment activities.
- **Enhance the nutritional environment to promote healthy eating habits for women and children.**
 - Establish national nutrition standards, consistent with the Dietary Guidelines, for foods and beverages sold outside of the school meals programs; and provide assistance to state and local school food service programs to interpret the Guidelines consistently.

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- Increase meal reimbursements to help schools, sponsors and providers improve meals and snacks and increase access to fruits and vegetables (including those sourced from regional farms), whole grains and reduced-fat dairy products.
- Preserve the scientific basis for the WIC food package and ensure that the recommendations of the Institute of Medicine (IOM) are fully implemented.
- Appropriate funds to carry out the Congressionally-created USDA Team Nutrition Network.

3. We request support for a **Transportation Bill** that will address transportation inequities, especially in urban and low income communities, and encourage development practices that promote health.

The 2009 reauthorization of the Transportation Bill is an opportunity to align our federal transportation policy with the promotion of active living and equitable neighborhood investment, both of which will increase population health and address health inequities.

Transportation policy should maximize opportunities for walkable and bikeable communities. These types of communities allow for active living as part of daily life and reduce emissions that are harmful to human health and the environment. Obesity, heart disease, diabetes, and asthma exist in urban neighborhoods at much higher rates than elsewhere and could be addressed with a smarter transportation policy.

Equitable investment in public transit is also sorely needed in urban communities. Efficient and accessible public transit reduces emissions (associated with asthma) and car traffic (a major cause of injury), while expanding access to jobs and amenities. Families in Black and Latino neighborhoods – more likely to be poor than families in White communities – have particularly inadequate public transit services. For instance, Black neighborhoods in Boston have more bus services and fewer subway lines than white neighborhoods, with segregated and poorer areas served by bus routes that require longer lead times and longer total transit times. These disparities in infrastructure investments contribute to health inequities.

We support the goals of the **Transportation for America Coalition** which includes the American Public Health Association, the National Association of City and County Health Officials, Trust for America's Health, PolicyLink, the National Coalition for Promoting Physical Activity, the National Association of City Transportation Officials, the Environmental Defense Fund, among many other national and local organizations and agencies.

In particular, we support the following requests of Transportation for America:

- **Invest in a world-leading, sustainable transportation system.** As oil grows costlier, the aviation system teeters and metro areas grow ever more central to our economy, we must rapidly catch up to other developed countries with high-speed rail and world-class public transportation. We must fix bottlenecks in our freight corridors. Our cities and towns must have safe streets for walking and biking to reach transit, school and jobs.

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Public planning and implementation of rail transit, especially, can unleash billions in private investment, which can be applied to its construction and operation. Expanding highways must no longer claim the lion's share of national investment.

- **Establish national transportation objectives and hold agencies accountable.** The federal government must ensure that funding for transportation is invested wisely by holding the U.S. Department of Transportation and its grantees accountable for progress toward primary objectives, including: reducing dependence on oil, lowering carbon emissions from transportation, improving the safety and health of our citizens, and ensuring economic access and prosperity across our society.
- **Support safe walking and biking, reduced exposure to vehicle injuries and dirty air.** Provide federal funding and direction so that communities may retrofit unsafe urban roads; create complete streets safe for motorists, pedestrians and cyclists; and encourage active living in communities free of harmful levels of vehicle emissions.
- **Establish a special program to restore and maintain our existing highways, bridges and transit and maximize their efficiency.** To protect our investment, federal funds should be conditioned on demonstrated performance by grantees that existing transportation infrastructure is kept in a state of good repair.
- **Provide funding and decision- making authority to local regions.** Empower metropolitan planning organizations and other local entities to address their transportation and development issues, but require improved performance and democratic representation in decision-making bodies.
- **Give priority to investments with multiple pay-offs.** Transportation and development go hand in hand. Our nation can no longer afford to sink money into highway lanes or transit that become overwhelmed or undermined by poorly planned development. We need a more efficient system that rewards communities for developing in smarter, more sustainable ways, reducing energy use and carbon emissions while ensuring the availability of housing affordable to families of all incomes, near job centers and public transit.
- **Broaden the capital and operating funding base.** The probable financial need will be far greater than current Federal sources; therefore, encourage smarter methods of state and local government and private sector funding matches of limited Federal resources, while maintaining public control.

4. We request adequate funding and designations for programs **that improve health within the home**, in particular, a dedicated Healthy Homes office, increased funding, and a guaranteed budget.

The home is a critical place to reduce health hazards, due to the time spent within a home, especially by children; the relatively closed air circulation; and the perception of safety. Numerous childhood injuries, lead poisoning, asthma, and other health problems can be prevented or mitigated by changes in the in-home environment.

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We support the creation of a dedicated Healthy Homes office and increased funding that is dedicated to supporting Healthy Homes interventions. In addition, we support the use of lead hazard funding to support related home interventions, such as mold removal, ventilation improvements, and pest control. While federal agencies provide an important source of funding for Healthy Homes projects, they can do more to support the development of comprehensive programs by eliminating “disease silos” and short-term grant cycles in federal funding. Federal agencies should also recognize that this work must be supported by improvements in the interface with clinical care and increased availability of healthy, affordable housing.

BPHC operates a Healthy Homes Program that provides free home evaluations and in-home education, with a focus on reducing asthma triggers, lead poisoning hazards, and potential sources of childhood injury. Massachusetts has among the highest asthma rates in the United States for both children and adults. In 2003-2004, over 10% of Massachusetts children reported having current asthma, and asthma rates nearly doubled for those of the lowest income compared to the highest income.

Since its inception in 1998, the BPHC Healthy Homes Program has provided evaluations and education in nearly 1,000 homes and has consulted on new construction for affordable and Hope VI developments. The Healthy Homes model has great promise for primary prevention and early detection of numerous health issues, as well as for promoting effective management of chronic diseases. BPHC supports the expansion and support of this model with these policy and programmatic priorities:

- ✓ Including additional health issues within the Healthy Homes model (e.g., healthy eating, physical activity, and violence prevention);
- ✓ Expanding the scope of services within the Healthy Homes model to include health education, psychosocial/mental health services, environmental evaluation, mitigation, and advocacy, as needed;
- ✓ Investing in the construction and redevelopment of affordable inner-city housing;
- ✓ Better using technology to increase communication between clinical care and public health home-based services and to target services to those most in need; and
- ✓ Requiring green building guidelines to include health promoting design and construction criteria.

Federal support for Healthy Homes suffers from several limitations. First, “disease silos” and short-term grants in federal funding make it difficult to sustain comprehensive programs. The ability to include additional health issues and types of services outside the scope of a specific funding stream is limited.

Federal agencies including the Department of Housing and Urban Development (HUD), the Environmental Protection Agency (EPA), and the Center for Disease Control and Prevention (CDC) all have healthy homes programs. We request that federal agencies better coordinate resources to allow for more comprehensive programs, recognizing the unique opportunity to address wide range of health issues during a home visit. Federal agencies should recognize that maintenance and development of new and existing low-income housing is critical, and work in this area must ensure that health is a consideration.

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5. We request support for S. 3654, **comprehensive legislation to address Healthy Housing** (110th Congress).

- ✓ We support S. 3654, The Nation’s First Comprehensive Healthy Housing Bill, sponsored by Senator Jack Reed (110th Congress). Key provisions include:
- Provides funding for existing federal housing programs, such as CDBG, HOME, and LIHEAP to add healthy homes components to their programs.
 - Leverages the private market interest in healthy homes by creating a voluntary “Healthy Homes Seal of Approval” modeled after the successful Energy Star program.
 - Authorizes \$7,000,000 for each of the next five years for the National Institute of Environmental Health Science and the Centers for Disease Control and Prevention (CDC) to evaluate the health risks and human health effects of indoor exposure to chemical pollutants including carbon monoxide, chemical asthma triggers, and common household and garden pesticides.
 - Authorizes \$6,000,000 for the Department of Housing and Urban Development (HUD) to study methods for the assessment and control of housing-related health hazards.
 - Provides \$10,000,000 for HUD and CDC to study the indoor environmental quality of existing housing and to create a system for monitoring housing related hazards.

6. We request that Congress address the mismatch between expenditure of federal resources on prevention and management of chronic diseases and the proportional impact on health. **Federal funding should move beyond treating chronic diseases to impacting the primary risk factors**, which are deeply rooted in people’s everyday behaviors. Education can lead to behavior change, but the true solutions must change the many institutions and community structures that *influence and constrain* individual behavior.

Preventable chronic diseases are the leading cause of death and disability in Boston and in the nation, accounting for about 70% of all deaths. In Boston, similar to the nation, the leading causes of death are cardiovascular disease and cancer. For Black Bostonians, diabetes has now become the fifth leading cause of death, as this epidemic continues to increase. The Centers for Disease Control reports that studies have identified an association between childhood overweight and asthma. A third of all Americans live with a chronic illness and about 10% experience resulting disability that affects their daily quality of life. As our population ages, these troubling trends will accelerate.

From a public health perspective, it is useful to look at what are the underlying *actual* causes of death from chronic disease. Tobacco use, poor diet and physical inactivity are three leading underlying actual causes of death overall, and the major driver of deaths and disability from chronic diseases. Primary prevention – not smoking, healthy eating, and regular physical activity

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– is ideal, but adopting healthier behaviors at any point contributes to healthier outcomes, even for people already diagnosed with a chronic disease.

Continued and expanded funding for a Healthy Communities model will be the most effective way to impact the primary risk factors of chronic disease. Changing the institutions and community structures that affect individual behavior will help to *make healthy choices easy choices*.

The costs of not addressing chronic disease prevention and control are staggering. Chronic conditions resulting from or exacerbated by lack of physical activity account for almost \$77 billion in direct medical costs in 2000. The American Diabetes Association estimates that the 2007 cost of diabetes nationally was \$116 billion in excess medical expenditures, plus another \$58 billion in lost productivity. This is a 32% increase in just 5 years, as more Americans are diagnosed.

The Boston Public Health Commission received federal funding to address a coordinated approach to the prevention and control of multiple chronic conditions for the first time in 2003, with its Boston Steps award from Centers for Disease Control and Prevention (CDC). This five-year funding is now ending, with no clear prospect of continuation.

Working with schools, worksites, health care providers, community organizations, and other government agencies at the municipal level, the Boston Public Health Commission has begun to craft coordinated community responses that can change organizational policies, realign resources, and advocate for change at a broader state and federal level.

Federal funding should address the whole spectrum of interventions to stem the rising tide of chronic disease, including:

- Addressing the role that **transportation policy and the built environment** plays in these epidemics – especially the need to decrease automobile dependence, improve outdoor air quality and to promote safe, walkable and bikable neighborhoods and accessible parks and other greenspaces that allow for exercise to be incorporated into daily living;
- Policy change and resource development at the local organizational and community level to make healthier **food and physical activity** opportunities routinely available in schools, youth programs, and community settings;
- Increasing access to **affordable and culturally-appropriate foods**, including fresh fruits and vegetables;
- Policy change to limit availability of **low-nutrient (“junk”) foods** and sugar-sweetened beverages to children and youth;
- Simplifying and streamlining applications for **federal nutrition programs** including school lunch, food stamps and WIC;
- Promoting workforce development for **community health workers** to reach vulnerable populations;
- Strengthening **chronic disease management** through strong primary health care and patient education that is culturally- and linguistically-appropriate;
- Increasing capacity for **screening and early detection** in primary health care settings;

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- Support for health system change that incentivizes providers and patients to **emphasize prevention**;
- Increasing access to appropriate and affordable **medication**;
- Supporting community-based primary prevention through **health education** and the promotion of healthy eating and exercise, with a particular focus on children and families; and
- Integrating **healthy behavior education and skill-building** into school curricula.

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Part C. Ensuring Appropriate Communicable Disease Control, Emergency Preparedness, and Emergency Medical Services

Funding from Health and Human Services (HHS) and the Department of Homeland Security (DHS) are vital sources of support for numerous programs at the Boston Public Health Commission, including the Public Health Preparedness Office; the Infectious Disease Bureau (including the AIDS Division and the Communicable Disease Control Division); Emergency Medical Services (EMS), including the DelValle Institute for Emergency Preparedness; and the Communications Office.

HEALTH AND HUMAN SERVICES FUNDING AND POLICY CONCERNS

1. We request that funding of the **Public Health Emergency Preparedness (PHEP) Agreement be maintained or replaced.**

The Public Health Emergency Preparedness (PHEP) Agreement currently provides support for local public health surveillance, case investigation, planning, and response for disease outbreaks and emergencies. Federal funding for this program is threatened due to uncertainty among policymakers about the program's effectiveness at preventing bioterrorism specifically. However, these funds support crucial infrastructure that protects the public's health against a wide range of threats such as pandemic influenza in addition to possible bioterrorism. Currently, no other HHS funding supports this local public health infrastructure, which is the core of infectious disease containment and control. Any reduction of funding from PHEP should be replaced elsewhere within HHS, so that this carefully built infrastructure is not dismantled.

Infrastructure at the Boston Public Health Commission fully or partially supported by PHEP includes:

- ✓ **Syndromic Surveillance System.** This system electronically receives daily information on visits from all ten Boston emergency departments, several Urgent Care Clinics, and a large program that provides health care to homeless persons. Local data collected within the City of Boston are analyzed seven days a week for unusual illnesses or clusters of disease that have public health significance (including but not limited to terrorist threats). BPHC epidemiologists and public health nurses use syndromic surveillance and other data to inform the Boston health care community using email alerts. Nursing, epidemiology, and information technology staff in BPHC Infectious Disease Bureau are needed for this system to function effectively, and all are supported by PHEP funds.
- ✓ **DelValle Institute for Emergency Preparedness.** DelValle, part of Boston EMS, is the public health preparedness training arm of the Boston Public Health Commission/Boston EMS. DelValle provides all-hazards training for the Boston community, including public health, health care and public safety personnel, with a focus on chemical, biological,

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radiological, nuclear and explosive incident preparedness, response and recovery. Courses include Incident Command System Training, Managing Mass Dispensing Clinics, Behavioral Health Disaster Response, Weapons of Mass Destruction Protection & Decontamination, and Hazardous Materials Response Operations, among others. The DelValle Institute has provided over 11,000 training opportunities to Boston area responders in public health, health care and related fields, since it was created in 2003.

- ✓ **Office of Public Health Preparedness.** PHEP funds support BPHC's Office of Public Health Preparedness (OPHP), which is the planning and operational coordination agency for Boston's health and medical emergency response system. OPHP collaborates closely with multiple health and medical entities such as area hospitals, community health centers, Emergency Medical Services, state and local public health departments, and public safety partners to plan and coordinate health and medical responses to a variety of emergencies, ranging from an attack with weapons of mass destruction to a natural disaster. OPHP is also responsible for development and implementation of the HHS-mandated Cities Readiness Initiative (CRI) which tasks major urban areas with developing the capability to dispense emergency medications to the entire population within 48 hours of the decision to do so.
- ✓ **Boston Medical Reserve Corps (MRC).** The Boston Medical Reserve Corps is a group of volunteers, with and without medical backgrounds, who keep Boston safe by responding to public health emergencies. Currently, over 2000 volunteers have been recruited to the MRC, including 900 Leadership Level Volunteers who receive advanced training. Recruitment, training, and coordination of the MRC is supported with PHEP funds. The PHP Office can activate the MRC in the case of an emergency to provide medical and logistical support to the city's response efforts.
- ✓ **Communications Planning.** It will be a prodigious challenge to communicate effectively with the public in the case of a major emergency, and PHEP funding supports staff time for intra-agency planning and simulation drills in the Communications Office.

2. We request that Congress **extend the current Ryan White HIV/AIDS Treatment Modernization Act (RMTA) for 3 years.**

Under the Ryan White HIV/AIDS Treatment Modernization Act (RWTMA) of 2006, BPHC serves as the grantee of the Ryan White Part A Boston Eligible Metropolitan Area (EMA). As such, BPHC is administering a Ryan White Part A award of **\$13,184,240** in FY2008 that is distributed to 54 agencies and funds 94 programs throughout a 10 county region. These programs provide a range of HIV Health Services and HIV Support Services. Additionally the BPHC also administers a Ryan White Part A Minority AIDS Initiative (MAI) award of **\$843,100**, which is distributed to 8 minority-based agencies. BPHC has been administering Ryan White funds since 1991.

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The RWTA expires on September 30, 2009. We request extension legislation that maintains the current authorization language for the next three years, with several technical amendments, including:

- **Modify AIDS Drug Assistance Programs (ADAP) rebates.** Change rules requiring all grantees count ADAP rebates as program income that must be spent first. Direct consultation between HRSA and grantees would ensure rebate funds are used for drugs rather than part of any state general fund while allowing programs to use funds more efficiently. The requirement to count Rebate funds as program income was intended to ensure that funds were not redirected to non-HIV uses. Mandating the mechanism to prevent misuse limits the flexibility of states to maximize all resources.
- **Remove all penalties for unobligated funds.** The proposed fix would strike penalties for unexpended formula funds. All grantees must be expected to expend all grant funds; however, the penalties for under-expending more than 2% of formula funds are extreme and can only lead to unnecessary disruption to service systems. Under this policy, an eligible area can lose access to all supplemental funds just for having greater than 2% of formula funds unspent at the end of a fiscal year.
- **Client level data implementation.** Ensure that resources are available to assist grantees and sub-grantees implement Client Level Data systems, while ensuring the confidentiality of identifiable information. Funding is necessary to ensure that all providers have the capacity to comply with requirements without diverting resources from services.

3. We request that the **Health Resources Services Administration (HRSA) revise its current policies regarding the application for a core medical services waiver.**

The current core medical services waiver process as published in the Federal Register on November 27, 2007 requires extensive documentation, all of which is duplicative of data presented in the annual grant application.

We ask that HRSA continue with previous guidance issued on the waiver process. Under the regulations, **a jurisdiction should be granted a core medical services waiver if its application provides reasonable evidence that all core services are available to people living with HIV/AIDS eligible for RWTMA services and is accompanied by a certification from the CEO of the EMA that all core medical services are available, and that the HIV Services Planning Council documents that a public process was conducted to evaluate the availability of funds for core medical services.**

4. **We request funding for RWTMA Part A at \$766.1 million.**

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This level of funding is needed in order to meet the needs of a growing population of people living with HIV and keep up with the increase in the cost and complexity of their medical and health related service needs.

5. We request that the **Department of Homeland Security (DHS) and CDC overturn the HIV travel ban.**

In July 2008 President Bush signed into law a re-authorization of the President's Emergency Plan for AIDS Relief (PEPFAR), which included a reversal of the Congressionally-mandated ban on allowing HIV-positive individuals entry into the U.S. The bill returned authority to HHS to determine which communicable diseases should be grounds for refusing entry into the US. Despite CDC's claim that they intend to remove HIV from this list, they have not yet done so. In addition, DHS has issued "streamlined" rules that continue differential and burdensome treatment for individuals with HIV.

6. We request that direct **federal funds be more readily available to local health departments for tuberculosis (TB) control.**

Despite its position as a gateway city with new arrivals from all over the globe, Boston does not receive any direct federal funding for tuberculosis-related activities. In 2007, the TB case rate in Boston (8.3 per 100,000) was significantly higher than the overall rate (4.4 per 100,000) in the US. Treatment for TB cases (contagious "active" TB) requires months of directly observed treatment (DOT), currently being provided by BPHC nurses and outreach staff. DOT requires that BPHC staff visit the patient five days a week to observe TB medication being ingested but it is essential to limit the risk that multi-drug resistant TB strains will arise. Direct funding to local health departments to allow these important services to continue is needed. Federal TB funding is provided to states, but the funding is insufficient to enable the State to provide any significant resources to support BPHC staff performing TB control activities.

We propose that federal funding requirements for direct support of local health departments be changed to include any municipality where there is a TB rate significantly higher than the national rate.

7. We request that **federal immunization funds ("317 Funds") provided to states be protected and that direct funding be provided to local health departments.**

As new vaccines are developed, the cost to fully immunize both children and adults rises. Immunization is one of the most cost effective measures to reduce illness and related costs. This

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year, for the first time, influenza vaccination is being recommended for all children ages 6 months to 18 years. Federal funding to purchase all immunizations recommended by the Advisory Committee for Immunization Practices (ACIP) should be provided. In addition, direct funding should be made available to local health departments to carry out immunization related activities. Since 1999, the cost of the full immunization series has risen approximately 235%, while vaccine purchase appropriations have risen roughly 60% during the same time period.

8. We request that the Centers for Disease Control and Prevention (CDC) **BioSense program be restructured to ensure that data received on the federal level is interpretable and actionable**, and to protect individual privacy from unnecessary intrusion.

It is important that local health data be available to federal agencies to understand national health trends and design appropriate prevention and intervention efforts. The federal BioSense project – which moved forward over the objections of many local health departments around the country – has several serious limitations.

First, local health departments are better positioned to identify and respond to outbreaks because they can interpret data within a local context. Currently BioSense data are sent directly from local healthcare providers to CDC, and as a result, are often uninterpretable. **Data that are uninterpretable are unactionable.** For example, in 2007, BPHC surveillance systems identified an outbreak of norovirus very quickly, while BioSense did not detect this outbreak at all. The local data sources included syndromic surveillance system, case reports, and linkages with the Boston EMS (the local first responder agency) which allowed BPHC staff to identify the problem and act promptly.

Second, the type of data collected by BioSense is far more extensive than that collected by local health departments, raising concerns about privacy and resultant loss of trust in public health authorities. Some of the sensitive data collected includes use of reproductive health services, HIV testing, and drug testing. Much of this data is unnecessary for routine public health surveillance purposes.

We ask that CDC restructure BioSense, providing funds for data collection systems on a local level that can collect *necessary and appropriate* data, and feed it promptly into federal data systems after appropriate analysis.

9. We request that the **Hospital Preparedness Program be protected.**

We request that no additional dollars be diverted from the Hospital Preparedness Program (within CDC) in FY10. This funding supports planning for pandemic flu, isolation and quarantine, the City Readiness Initiative, Biowatch, and the Biohazard Detection System,

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including community planning and education with particularly vulnerable populations. By coordinating these efforts centrally within the local health department, we avoid unnecessary duplication of administrative costs and competing priorities of hospitals with staffing shortages. Recently, funds have been removed from this program to fund the Healthcare Facilities Partnership Program, a competitive grant to hospital partnerships, which bypasses local health authorities.

DEPARTMENT OF HOMELAND SECURITY FUNDING AND POLICY CONCERNS

1. We request that the **Urban Areas Security Initiative (UASI) funding** be protected. More specifically, we request that **Metro Boston be moved from a tier II to tier I city** and receive increased funding to support the necessary initiatives, training, and programs.

Metro Boston has seen a decline in funding, compromising critical emergency preparedness capabilities. While EMS has never been a line item under UASI funds, Boston EMS has indirectly and directly received grant funding and has an excellent track record for prudent, efficient, and innovative use of UASI funds, interfacing the region's public health and public safety partners. These funds have provided significant support to Boston EMS training and preparedness, including programs provided through the DelValle Institute for Emergency Preparedness for UASI partners. UASI funds support the following initiatives:

- ✓ Boston EMS' DelValle Institute for Emergency Preparedness inter-agency, cross-jurisdictional trainings and drills – including private and municipal EMS partners, Fire, Police, Public Health, Emergency Management, hospitals, community health centers and business partners (over 12,500 trained to date);
- ✓ The build out of a new Medical Intelligence Center;
- ✓ An Emergency Sheltering System that is easily transported, to be used for sheltering, patient care, and incident management in the field;
- ✓ Interoperable Communications between emergency medical technicians (EMTs) and other regional partners;
- ✓ Community education, coordination and awareness, stockpiling, regional interagency and inter-jurisdictional drills, exercises, conferences and tabletops regarding pandemic influenza; and
- ✓ The purchase of personal protective equipment for use by emergency medical first responders during HAZMAT and terrorist response.

2. We request that statutory language **mandate that 10% of DHS funding be granted to local EMS agencies.**

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Despite UASI being defined as supporting *multi-disciplinary* planning, operations, equipment, training, and exercise needs of high-threat, high-density urban areas, UASI funding in FY2008 mandates that a significant portion (at least 25 percent) of funds allocated be allocated to law enforcement agencies.

Although local EMS agencies and other health care organizations are essential components of the planning and response for any emergency, EMS agencies receive only 4% of DHS funding. In recognition of the level of staffing and planning needed for EMS agencies to function adequately, we believe statutory language should mandate a higher level of support from DHS.

3. We request that **funding for the Metropolitan Medical Response System (MMRS)** be continued to maintain and support innovative emergency preparedness efforts, at the local level.

Funding for this program has been continually threatened since its inception in 1996. MMRS is the only federal program that supports first responders, medical personnel, emergency management workers, businesses, and others to develop effective, integrated capability to minimize casualties in the event of a major crisis, such as a terrorist attack using a weapon of mass destruction, a pandemic flu outbreak, or a natural disaster such as a hurricane.

MMRS program managers have been satisfied with the federal management structure of this program and we support its current placement in DHS.

4. We request an expansion of support for local EMS agencies through the Federal Emergency Management Agency (FEMA) – either through the **expansion of the Assistance to Firefighter Grant (AFG) or the creation of a parallel grant designed specifically to support local EMS agencies grant.**

Boston EMS (a non-fire based, municipal EMS department) received the AFG grant for the first time in 2007, to be used for the purchase of personal protective equipment. Although local EMS agencies are essential in emergency management, there is very little support provided through FEMA. Less than 1% of the Fire grant is designated for EMS, an inadequate amount to ensure the necessary development of EMS-specific initiatives and infrastructure. To meet this need, we strongly support the drafting of an EMS Act, similar to the Fire Act, but specifically to address the medical aspects of emergency response to disasters.

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ADDITIONAL FUNDING AND POLICY CONCERNS

1. We request the creation of a **National Office for EMS.**

EMS agencies across the country are in need of a federal EMS office that reports to a Cabinet Secretary. EMS is currently under the Department of Transportation, which is indicative of the current understanding of the EMS function. A hundred years ago the service may have been nothing more than a transport service for the ill and injured; today it is an emergency room on wheels, with first rate equipment and highly skilled paramedics and EMTs. At the local level, EMS is in a unique position to leverage coordination and collaboration across public safety, health care, and public health partners to accomplish comprehensive preparedness goals. As well, EMS supports special events, coordinates with hospitals, public health, community health centers, police, fire, Mayor's Office, as well as city, state and federal representatives, on a daily basis to protect the wellbeing of residents and visitors. Although in some regions they are embedded within other public safety agencies, the medical response function is categorically different from fire suppression or law enforcement.

The structure of EMS agencies vary widely – some are volunteer programs while others, such as ourselves, are robust third service agencies with a workforce of nearly 400 uniformed personnel. In addition, funding sources vary widely within and between regions. In Boston, Boston EMS and the Boston Public Health Commission have leveraged their partnerships with other agencies and programs to maximize the effectiveness and efficiency when spending federal dollars, as well as leverage the combination of funding streams to invest in large scale initiatives that might not otherwise be possible. The Medical Intelligence Center, for example was paid for by both DHS (Urban Area Security Initiative – UASI) and HHS (ASPR) funding. Similarly, the Metro Boston Patient Tracking System, which is managed by Boston EMS, was funded by UASI and Metropolitan Medical Response (MMRS) funding, both under DHS. And, the DelValle Institute for Emergency Preparedness, a training program within Boston EMS, which provides free accredited courses to regional partners, is jointly funded with HHS (CDC) and UASI grants.

These variations across agencies only serve to enhance the need for national standards and representation. Because EMS agencies provide such a vital public service, a federal office providing oversight, national representation, and support is essential. Without a federal office, EMS has been misrepresented, frequently viewed as nothing more than a transport service, underfunded, and under supported. This has been reflected at the local level where EMS is frequently overlooked when large scale investments are made, such as enhancing radio frequency usage. A national investment in EMS, would ensure that at all levels, EMS is not overlooked during such important decisions. A federal office would similarly benefit preparedness, particularly for programs such as the National Disaster Medical System, the Metropolitan Medical Response System, and the Urban Area Security Initiative.

If a federal oversight EMS office is created, it is essential that it remain appropriately funded each year. Much of the disaster preparedness investments, from PPE and stockpiling

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pharmaceuticals to training and exercises, require consistent and ongoing funding to be maintained. Even large capital investments, such as new ambulances, have to be replaced after a few years.

2. We request that **NIH grants that require work at BSL-3 or BSL-4 labs be required to provide funding as part of the grant to the local health agency** for local regulation, oversight, and response.

Infectious Disease Research laboratories are critical to allow breakthrough, lifesaving scientific work to proceed. However, oversight of these laboratories has not been an area of focus until recently. Prior experience in Boston indicates that when an incident occurs at a high level biological laboratory, local responders (including public health) must provide all necessary services to protect the public's health. However, there is no funding for local health departments to carry out these important activities currently available (although funding is available for the research itself).

3. We request dedicated funding for local health departments' work to **improve communicable disease control under BioWatch.**

Currently all work associated with BioWatch and improving communicable disease control preparedness at international ports of entry is handled by locals, with no designated funding. Like the response to an incident at an infectious disease lab, the response to a BioWatch incident or suspect case of an infectious disease at a port of entry relies on the planning, coordination and ready-response of local public health agencies. With such profound amounts of money being allocated to programs like BioWatch and port protection, it is essential to also invest in the local entities that must be prepared to respond.

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Part D. Preventing & Treating Substance Abuse

1. We request the following **support for the Substance Abuse and Mental Health Services Administration (SAMHSA):**

- \$420 million in funding for the **Center for Substance Abuse Treatment (CSAT)**
- \$1.86 billion in funding for the **Substance Abuse Prevention and Treatment Block (SAPT) Grant.**

According to the National Survey on Drug Use and Health and the Behavioral Risk Factor Surveillance Survey, there were more than 570,000 individuals in Massachusetts in need of substance abuse treatment in 2002 (the most recent year for which data is available), including more than 117,000 who were seeking but could not access treatment and another 371,000 who had not sought treatment. Although this data is not available on the city level, it is estimated that Boston percentages are equal to or more severe than the state average. Our state treatment system has just been rebuilt to service levels that existed four years ago, after dramatic state budget cuts decimated the system beginning in state fiscal year 2001. Federal funding is vital to maintain service levels, and any reduction in SAMHSA funds could create instability in the treatment system.

CSAT is the primary federal funding source for substance abuse treatment for BPHC and is the only federal funding source that pays for residential treatment in the state. It is important to note that increasing funding to discretionary health funding initiatives like CSAT provides long-term savings by keeping costs down on mandatory programs such as Medicaid and Medicare.

BPHC has received over \$17 million in CSAT funding in the past 12 years, and currently receives \$1 million annually – or 80% of the budget of the BPHC Substance Abuse Services Bureau's Women and Families Programs. Current grants include:

- ✓ **Pregnant and Postpartum Women's Project** – providing 8 beds for pregnant and postpartum women and their infants at the Entre Familia residential program serving Latina mothers and their children; and
- ✓ **Moving onto Recovery and Empowerment** – providing intensive outpatient services for approximately 70 African American and Latina women – in a brand new facility to open in February 2008.

2. We request that **SAMHSA reauthorizing legislation maintains a focus on serving high-risk populations.** We ask that lesbian, gay, bisexual, and transgender (LGBT) individuals and formerly-incarcerated individuals be added to the high risk groups already targeted. In addition, we ask that SAMHSA expand its focus on youth prevention and treatment.

CSAT Targeted Capacity Expansion (TCE) funds have focused on high risk populations, including people of color, pregnant and postpartum women, women with children, individuals

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with HIV/AIDS, and individuals at risk for HIV/AIDS. We request that this focus be maintained.

In addition, we ask that LGBT individuals and formerly-incarcerated individuals be included in the SAMHSA reauthorization legislation in recognition of the high risk faced by these groups.

LGBT individuals

LGBT individuals face numerous social stressors including stigma, discrimination, and violence that contribute to high rates of mental health and substance abuse issues. This population also has a disproportionate rate of HIV/AIDS and drug use and faces disparities in access to culturally competent mental health and substance abuse prevention and treatment services. In recognition of this, we request that SAMHSA:

- Target suicide prevention as a priority issue for LGBT youth;
- Include sexual orientation and gender identity demographic questions in all population-based surveys to accurately assess current needs; and
- Continue to develop and disseminate LGBT cultural competency curricula.

Formerly-incarcerated individuals

We request that SAMHSA increase resources dedicated to treatment for individuals being released from incarceration. A very high percentage of individuals in county correctional facilities in Boston have substance abuse problems, but there are currently few services tailored to meet the needs of these individuals after they are released. (While city-specific data do not exist, the MA Department of Corrections estimates that over 85% of inmates statewide would benefit from substance abuse treatment.) Post-release treatment services provide a bridge between incarceration and the community for those who also have an addiction, and will increase the likelihood of sustained recovery. These services are critical in order to help offenders build successful lives upon their return to the community and thereby prevent recidivism.

Youth Prevention and Treatment of Substance Abuse

Massachusetts currently has very little support for prevention and treatment of substance abuse among youth. Such programs are particularly lacking in Boston. We request that SAMHSA provide increased support to programs such as:

- School-based substance abuse education and prevention interventions; and
- Residential substance abuse treatment services for youth.

3. We request that **all members of the MA House Delegation join the Congressional Caucus on Addiction, Treatment, and Recovery.**

Substance abuse services and advocacy organizations around the country have set a goal of enlisting one-third of the members of the US House of Representatives in the Congressional Caucus on Addiction, Treatment and Recovery. The Caucus was launched by Representative

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Ramstad and Representative Kennedy to bring members of the House together to focus attention on their shared interest and build support for policies that will support addiction recovery.

Of the ten MA Representatives, six have joined the Caucus to date: Representatives Capuano, Delahunt, Lynch, McGovern, Olver, and Tierney. We ask that Representatives Neal, Frank, Markey, and Tsongas join their colleagues to move forward policies to prevent and adequately treat substance abuse in Massachusetts and around the country.

4. We request that Congress **repeal the provision of the Higher Education Act that excludes or suspends students with drug convictions from receiving federal financial aid.**

Section 484, subsection r, known as the “Aid Elimination Penalty,” was added to the Higher Education Act (HEA) by Congress in 1998. The provision mandates that federal financial aid be suspended or revoked for students convicted of a drug offense. We support repealing this provision through legislation (such as H.R. 5157, sponsored by Representative Barney Frank, 110th Congress) or in the HEA reauthorization process currently underway.

The denial of financial aid is the wrong vehicle for reducing substance abuse, and it is counterproductive for both the individual and society as a whole. Access to education is essential for young people if they are to enter the mainstream of society and the economy. By cutting off necessary financial assistance, this provision decreases the number of people completing college, diminishing their employment prospects and potential contributions to our economy.

In addition, the penalty expands the achievement gap due to its discriminatory impact on people of color and low- and middle-income students. Low- and middle-income students are the ones receiving financial aid, and higher income students with drug convictions face no similar barrier to attaining a degree. And since the penalty only applies to individuals with a drug conviction, the gross racial imbalances in the judicial system are perpetuated within higher education. For instance, Blacks comprise 12.3% of all drug users (proportional to their share of the US population), but they account for 37% of those arrested, 53% of those convicted, and 67% of those sent to jail for drug offenses.

Repealing this act will reduce racial and ethnic disparities in health and pave the way for equal opportunity to higher education.

Part E. Supporting Individuals Experiencing Homelessness

1. We request that the **Department of Housing and Urban Development (HUD) retain a funding stream for supportive services for homeless individuals.**

The original funding streams authorized in HUD by the McKinney-Vento Act (beginning in 1986) supported an array of services including outreach, shelter, transitional housing, support services, and permanent housing to people experiencing homelessness. BPHC's Homeless Services Bureau has primarily utilized the Supportive Housing Program (SHP) funding streams to fund support services for guests in BPHC shelters. A number of major programs were started using these funding streams, including:

- ✓ **Project SOAR** – a transitional housing program that provides case management, substance abuse counseling, legal advocacy, and referrals to job training and education;
- ✓ **Safe Harbor** – a transitional residential program for individuals who are struggling with substance abuse and are HIV positive, providing counseling, support, and placement in housing; and
- ✓ **Serving Ourselves** – a job training and employment program that provides hands-on training in seven marketable trades, as well as case management, education services, and job search skills.

These programs have been successful in helping our guests transition to permanent housing and stable employment. For example, Serving Ourselves has placed over 700 individuals into jobs since it opened in 1993, and Project SOAR has placed 613 individuals in permanent housing since it opened in 1996.

Beginning in 2002, HUD began to shift service dollars to fund additional permanent housing construction, resulting in reduced funding for supportive services. BPHC programs have taken a funding cut of more than \$200,000 annually since 2003. This has resulted in the loss of six FTEs: four case managers, one substance abuse counselor, and one classroom teacher. In the past two years, BPHC has received level funding from HUD, which results in cost shifting or service cuts, as the costs to provide the same services rise each year. In 2008, BPHC lost an additional \$225,000 per year from McKinney funding for the Safe Harbor Transitional Housing Program.

An increase in permanent housing will ultimately benefit the guests we serve, but we are concerned about the reduced services available to those who remain in shelters in the present. We believe it is important that HUD retain a funding stream dedicated to support services.

2. We request that **other federal agencies provide more support to ensure that homeless individuals can get the assistance they need** to be healthy and secure permanent housing and employment.

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While the shift within HUD funding is of particular concern, it also brings into focus the lack of funding available from other federal agencies to assist homeless individuals, even though there is a clear connection between the missions of various federal agencies and the homeless population. A few of the most obvious agencies include:

- Department of Veteran's Affairs,
- Department of Labor,
- Substance Abuse and Mental Health Services Administration, and
- Administration on Aging within HHS.

Funding for job training and transitional housing that has been diverted by HUD has not been replaced by these agencies. We believe that these agencies – and others – should play a greater role in ensuring that homeless individuals have the necessary supports to become self-sufficient.

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Part F. Improving Lesbian, Gay, Bisexual, and Transgender (LGBT) Health

1. We request support for H.R. 2015, **the Employment Non-Discrimination Act** (110th Congress).

We support passage of an Employment Non-Discrimination Act (ENDA) that fully protects lesbian, gay, bisexual, and transgendered individuals from workplace discrimination and harassment on the basis of their sexual orientation, gender identity, or gender expression. This is commonsense and long-overdue legislation that protects basic civil rights.

Employment non-discrimination bills that only include sexual orientation would leave out any employee, including gay men, lesbians, bisexuals, and straight employees, whose gender identity or gender expression does not conform to stereotypes about what their gender ought to be. It would leave a gaping, unacceptable hole in employment protections for all persons.

2. We request that the Administration **overturn the ill-conceived and harmful final rule issued by HHS in December 2008 regarding “provider conscience” opt-out** that could significantly limit access to basic health services for women and LGBT individuals.

The Bush Administration claimed that these regulations were needed to educate the public and the health care industry about the scope of certain existing federal refusal clauses. However, contrary to Congress' intent, this rule permits health care providers to refuse to perform any service they deem morally objectionable.

If implemented, these regulations may preempt state laws that protect women's access to health care and undermine the nation's fragile network of safety net providers that serve low income women. The rule seeks to limit access by deliberately confusing contraception with abortion. Under this broad definition, a range of hormonal contraceptives as well as some non-hormonal devices approved by the FDA to prevent pregnancy fall within the scope of the rule because they may work by interfering with implantation. This problematic definition of pregnancy runs counter to the government's own longstanding policy, as well as the definition accepted by the American College of Obstetricians and Gynecologists (ACOG).

The rule is so broadly and vaguely written that it also poses a significant threat to civil rights protections and quality healthcare for lesbian, gay, bisexual and transgender (LGBT) people as well as people living with HIV and AIDS. The federal employment non-discrimination law already forbids discrimination based on an employee's religion; this rule invites confusion and conflict about health care institutions' legal duty not to discriminate against LGBT patients, and

VI. FEDERAL POLICY PRIORITIES/RECOMMENDATIONS

what religious employees may take as a broad, new permission to pick and choose which care they will provide, when, and to whom.

In fact, by replacing science with personal bias as a guide to medical practice, the rule threatens principles that form the basis for assuring quality of care and averting discrimination in our health care system generally.

3. **We request \$116.5 million in funding for the National Centers for Health Statistics at CDC,** including dedicated funds to update federal survey instruments to include data on LGBT health. There is currently no national survey data on the LGBT population.

LGBT individuals face numerous social stressors including stigma, discrimination, and violence that contribute to high rates of mental health and substance abuse issues. This population also has a disproportionate rate of HIV/AIDS and drug use and faces disparities in access to culturally competent mental health and substance abuse prevention and treatment services.

However, there is currently no national survey data on the LGBT population. This data is vital to assess health outcomes and design effective interventions to improve LGBT health. We request the following dedicated funds within the National Centers for Health Statistics funding:

- ✓ \$200,000 to strengthen the National Survey on Family Growth, and
- ✓ \$1.5 million for the Substance Abuse and Mental Health Services Administration to improve data collection.

4. We request support for passage of **the Matthew Shepard Hate Crimes Act**

This bill would add sexual orientation as well as gender identity and expression to federal hate crime codes, making FBI investigations into hate crimes LGBT-inclusive.

5. We request support for passage of **the Uniting American Families Act**

This bill would enable extend to same-sex couples and families the same benefits and privileges all other Americans enjoy related to immigration and visa status.

VII. NATIONAL PARTNERS

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CityMATCH is the national organization for maternal and child health leaders in city health departments. CityMATCH has mounted several learning collaboratives in which BPHC has taken an active role. Dr. Ferrer is an active member of CityMATCH.

CommonHealth Action provides leadership, guidance and technical assistance to BPHC's Center for Health Equity and Social Justice.

The Communities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national membership organization which advocates for federal appropriations, legislation, policy and regulations to meet the care, treatment, support service and prevention needs of people living with HIV/AIDS and the organizations that serve them, including Ryan White Program Part A, Part B, and Part C consumers, grantees, and providers. BPHC actively participates in CAEAR policy development and relies on CAEAR for timely policy updates.

BPHC works collaboratively with the **Department of Homeland Security** to conduct training for EMS, police, and hospitals to prepare agencies to respond to disasters. Collaborations also include equipment purchasing, investment in resources such as the patient tracking system and the Medical Intelligence Center, stockpiling medical surge supplies and backfill and overtime coverage. BPHC also participates in regional and statewide Medical Reserve Corps efforts through DHS.

BPHC/Boston EMS partners with the **Disaster Medical Assistance Team (DMAT), U.S. Department of Health and Human Services**, a federal asset for in national and international disaster response. Some Boston EMS uniformed members are also members of DMAT.

Environmental Protection Agency/Centers for Disease Control collaborative. BPHC is collaborating with these two agencies as pilot site for federal integrated support of occupational health work. BPHC is leading efforts to provide occupational health training and services to Boston autobody shops, with coordinated technical assistance from EPA and CDC related to pollutant/toxin monitoring, GIS mapping, and other resources to be identified.

BPHC/Boston EMS collaborates with the **Federal Bureau of Investigation (FBI)** through the Boston Regional Intelligence Center (BRIC), including coordination during special security events, such as the 2004 Democratic National Convention, information sharing through participation in interdisciplinary conferences, planning for disaster training, the Metropolitan Medical Response System (MMRS) Steering Committee, and medical intelligence briefings.

The Maternal and Child Health Bureau, Health Resources and Services Administration, is a partner with BPHC and other national leaders in the development of pediatric medical home and teen health initiatives.

VII. NATIONAL PARTNERS

BPHC is a member of the **National Alliance to End Homelessness**, which analyzes policy and develops pragmatic, cost-effective policy solutions. BPHC benefits from the Alliance's policy analysis and dissemination of best practices, and we participate in their advocacy efforts.

BPHC participates in the **National Alliance of State and Territorial AIDS Directors' (NASTAD)** initiative "African American Women and HIV: Confronting the Crisis & Planning for Action."

The National Area Health Education Center (AHEC) Association helps guide the work of the Boston AHEC and informs programmatic work and policy advocacy on behalf of health professions training.

BPHC is an active member of the **National Association of City and County Health Officials (NACCHO)** is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems. BPHC staff participate in NACCHO in several ways:

- Dr. Ferrer is a member of the Health Equity and Social Justice Strategic Direction Team.
- Senior staff have participated in several specialized best practice and policy development initiatives with NACCHO leadership.
- Senior staff have participated on the abstract selection committee for the NACCHO Annual Meeting.
- Staff abstracts are consistently accepted at high rates for the NACCHO Annual Meeting.
- Staff and programs have won several NACCHO model practice awards.
- Staff are active in the Chronic Disease workgroup.

BPHC is a member of the **National Coalition for the Homeless**, an organization committed to creating the systemic and attitudinal changes necessary to prevent and end homelessness, while at the same time, working to meet the immediate needs of people who are currently experiencing homelessness or who are at risk of doing so. We benefit from the Coalition's policy analysis and dissemination of best practices, and we participate in their advocacy efforts.

BPHC is an active member of the **National Healthy Start Association (NHSA)**. We benefit from NHSA's support and technical assistance related to community-based and community-driven models of care, current evidenced-based approaches to improving health outcomes, and models of cultural competence among service providers. In addition, NHSA's annual meeting helps us stay in touch with new models and innovation in the field.

VII. NATIONAL PARTNERS

BPHC provides leadership for the **National REACH Coalition (NRC)**. The NRC was established in 2004 to represent a network of REACH grantees and coalitions across the country in order to identify effective strategies and community-based interventions to improve health outcomes. NRC provides coordination and leadership for the advancement and translation of community-based participatory research into evidence-based practices, policies, and community empowerment at the local, state, and national level. As one of 18 U.S. REACH Centers of Excellence in the Elimination of Disparities, the BPHC REACH has been a member of the NRC Steering Committee since 2005.

BPHC is an active member of the **National Steps Coalition**, a network of Steps grantees and national organizations (National YWCA, NACCHO, Society of Public Health Education) that work together to advocate for appropriate Healthy Communities/Steps funding and policy.

We participate with the **Office of Women's Health, Department of Health and Human Services**, along with other community-based organizations in planning National Women and Girls HIV/AIDS Awareness Day.

Operation Ceasefire is a Chicago organization that has articulated a model of violence prevention that importantly informs our work in the field. Operation Ceasefire has provided consulting and advisory services to Dr. Ferrer and BPHC staff on program direction.

BPHC participates in **PLACE MATTERS**, a project of the *Joint Center for Political and Economic Studies, Health Policy Institute*. Place Matters is a national learning community of designed to improve the health of participating communities by addressing social conditions that lead to poor health. Through the initiative, we receive technical assistance from the *Center for Applied Research and Technical Assistance (CARTA)*, which provides evaluation of the health equity initiatives of all the participating cities and counties from across the United States. Dr. Gail Christopher, of the *W.K. Kellogg Foundation, Division of Health Programs* also provides resources, technical assistance and guidance to cities and counties through the initiative.

BPHC's Center for Health Equity and Social Justice actively collaborates with the **Society for Public Health Education (SOPHE)**, whose mission is to provide leadership to the profession of public health education and to contribute to the health of all people and the elimination of disparities through advances in health education theory and research, excellence in professional preparation and practice, and advocacy for public policies conducive to health.

BPHC/Boston EMS coordinates Military-Civil Support Teams with the **U.S. Army** during emergencies, all special events, interagency training, medical intelligence briefings, Medical Response System (MMRS) Steering Committee, planning, and preparedness work.

VIII. INNOVATIVE INITIATIVES

VIII. INNOVATIVE INITIATIVES

A. Center for Health Equity and Social Justice

The mission of the Center for Health Equity and Social Justice is to build the capacity across Boston and New England to develop strategies that address the social determinants of health and achieve health equity through community, system, and policy level change.

BPHC has invested over \$6 million in health care institutions, community-based organizations and academic institutions to develop comprehensive strategies to address inequities in health and health care. We have become the first city in the country with regulations and data systems that will allow us to better map and intervene in the problems of disparate health care access and utilization. Hundreds of health professionals have participated in cultural competency and anti-racism trainings, assuring more welcoming and responsive care for all. Through innovative partnerships with higher education and the Boston Public Schools, we are constructing a better path to diversity in the health professions. Community members have become educated about critical health disparity concerns and many have brought that knowledge into their organizations and into the political process. And we have learned new strategies for bringing people successfully into care and helping them to advocate for the services they need. Some of our prominent initiatives include:

- **Data collection regulation.** The Data Collection Regulation passed by the BPHC Board in June 2006 requires acute care hospitals in Boston to collect four fields of self-reported demographic information on all inpatient, outpatient observation, and emergency department visits during the registration process. The data will enable hospitals and the city to learn more about the patient populations they serve, to identify the health disparities that exist among these populations, and to implement quality improvement activities to reduce these health disparities.
- **Anti-racism work.** BPHC has made the elimination of racial and ethnic disparities in health a top priority. We know through our work in this area that racism and discrimination are root causes of disparities in health. We are committed to looking at our own internal policies, structures, and procedures as we work towards health equity. We have convened an internal advisory committee of 22 BPHC staff to help review, assess, and develop internal recommendations in a thoughtful and inclusive process that engages all Commission staff.
- **Health equity training center.** The mission of the center is to develop strategies that address the social determinants of health and achieve health equity through community, system and policy level change. The goals of this work are for BPHC and our partner agencies to become catalysts for change; create institutional and community changes in policies, programs and practices; create and build sustainable equity work; and have equity work rooted in community.

B. Community-Based Violence Prevention

BPHC coordinates citywide violence prevention efforts. Within the last year, we have spearheaded intensive interventions in four Violence Intervention and Prevention (VIP) sub-neighborhoods with high rates of violent crime. After year one, there is some

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fluctuation across the four VIP sites, but overall we are seeing decreases in crime within VIP areas, with decreases in shootings in two of the four neighborhoods. Some of our efforts led by the BPHC Division of Violence Prevention include:

- **Community Mobilization:** The Division funded 4 community based organizations as lead coordinators of coalitions in each VIP neighborhood and 2 organizations to coordinate youth activities. Over the last year, 34 meetings across the four coalitions were held to develop strategies to reduce violence.
- **Social Marketing:** The Division received \$200,000 from SEIU 1199 to support a city-wide social marketing campaign in spring 2009 to promote peace and challenge social norms of violence. Through a partnership with a local hip-hop group, 15 to 30 youth attended pilot skills-based workshops on Hip Hop, break dancing, and fashion design. Youth created messages, performances and rap that promoted peace with their peers. Over 60 youth attended the final performance that featured the work of the young people. After conducting focus groups and working with an advisory council of youth, the Division will launch the campaign message and issue 10 to 15 mini grants to youth organization to create visual art, YOUTube videos, and fashion promoting the message. The designs and message will be disseminated on the web through social networking websites, the MBTA, in schools/centers, and through gorilla marketing and events planned and implemented by youth.
- **Expansion of Violence Intervention Advocates (VIA) Program:** The Division secured \$1 million in funding from Robert Wood Johnson and the Boston Foundation to expand the Violence Intervention Advocate Program to include a community based component. VIA currently offers comprehensive assessment and case management services for individuals injured by violent crimes seen in the Boston Medical Center Emergency Department. In 2009, a program manager will be hired to provide clinical oversight and care coordination to the advocates and an additional advocate will be hired to provide case management to victims 6-9 months after hospital discharge.
- **RWJ Start Strong Initiative:** The Division, collaborating with the BPHC Adolescent Health Division, secured \$1 million in funding from the Robert Wood Johnson Foundation to promote the healthy development of teen dating relationships. Focused in VIP areas, the initiative includes school based curriculum, hiring new 25 peer leaders, a marketing campaign and community engagement.
- **Trauma Response Services:** To mitigate the mental and physical health implications of violence and prevent future violence, the Division formed a Trauma Response Service program. The program will provide direct services and referrals to victims of violence, their families and the community, build and strengthen community and agency capacity to cope with trauma and increase awareness of the effects of trauma and resources to address it. In 2009, the Division, with funding from Boston EMS, will fund 4 community health centers to develop a trauma response model for their neighborhood and will support training for school based health center staff.

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C. The Youth Development Network (YDN)

YDN was an initiative of Mayor Menino launched in 2007 to reach and serve high-risk youth in Boston neighborhoods. The initiative builds on and expands existing services for Boston youth and coordinates public and private programs to better serve young people. YDN utilizes Youth Development Specialists, a new category of public health workers with case management experience.

YDN is a program of The Boston Public Health Commission that provides services for Boston youth with a priority focus on residents from Violence Intervention Prevention (VIP) neighborhoods. YDN provides case management, youth development trainings, trauma recovery, and health and psycho-social groups. Youth Development Specialists facilitate collaboration and coordination among youth serving agencies, and develop public and private resources for continuous improvement and sustainability for Boston youth ages 14-21.

Youth Development Specialists work in collaboration with other BPHC youth programs, the Violence Prevention Program, Boston Center for Youth and Families; street workers, youth workers and community centers, Boston Public Schools, school based and out-of-school programs, youth and family support serving agencies, to ensure that identified youth receive timely assessment, case-management and appropriate referrals for essential services needed.

D. BPHC Re-Entry Programs

A recent profile of inmates at the Suffolk County House of Corrections (SCHC) reported that the average prisoner, “has a history of substance abuse [and] lacks a high school diploma or a graduate equivalency degree. Many owe substantial back child support payments, often in the tens of thousands of dollars. The prisoners’ return to the community also poses challenges for those home communities. About one-third of ex-prisoners from the facility will be re-arraigned for a new crime within just eight months of their release.”

The Boston Public Health Commission helps to fill this critical gap through our re-entry programs for men and women with a history of incarceration and addiction who are re-entering Boston’s neighborhoods. These programs are offered through our Addictions Prevention, Treatment and Recovery Support Services Bureau and our Homeless Services Bureau. Some highlights include:

- **Specialized Outpatient Counseling Services.** As part of our addictions treatment and recovery support services, we have specialized men’s and women’s addictions programs that provide intensive treatment and outpatient counseling including assessment, and groups and individual counseling, as well as comprehensive case management that includes linkages to education, employment, housing, and family reunification. These programs work closely with the Suffolk County House of

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Corrections' social workers, case managers and educational services program to outreach to men and women while they are still in jail to help them successfully re-integrate back into the community as well as maintain their recovery.

- **Community Prevention Services.** The Bureau was recently awarded nearly \$2 million over the next 3 years to fund 8 prevention grants in our Boston neighborhoods coalitions. Four of these grantees were given Fatal and Non-fatal Opioid Overdose Prevention Grants that required them to conduct intensive community assessments and create and submit comprehensive 3-year strategic plans to reduce fatal and non-fatal opioid overdoses in their community. These neighborhoods are now in the process of implementation following the approval of their plans by the funder. Many of these groups identified *loss of tolerance* after long periods of abstinence due to incarceration as a major contributing factor to fatal and non-fatal overdoses in their community. One coalition in particular, which represents Jamaica Plain/Roxbury, has included in their plan an initiative to work with Suffolk House of Corrections to provide better education to people who are re-entering their community about the risk factors related to abstinence and loss of tolerance.
- **The Wyman Reentry Center.** Housed in our Homeless Services Bureau, the Center is a 25- bed stabilization and transitional program for men involved in the court system who are seeking a safe and sober environment upon release from court or incarceration and who are actively working on seeking permanent placement in job training, employment, transitional or permanent housing.

Clients may be referred from state or county correctional facilities, drug courts, shelter, parole offices or agencies providing services to homeless ex-offenders. The Wyman Reentry Center provides services twenty-four hours a day, seven days per week. The program provides short term transitional residential services for men. Clients may stay 30-90 days while awaiting placement in a vocational rehabilitation program, long term transitional housing, halfway house or other safe permanent residence. The program provides case management, health, mental health and substance abuse services as well as referrals to job training, long term employment, housing and a wide range of other services and referrals. Between opening in March 2006 and January 2009, the Wyman Reentry Center has served over 300 individuals. Approximately 70% of those completed the program successfully by going on to further treatment or returning to the community.

E. Real Time Surveillance

Real time electronic information can lead to the timely identification of disease outbreaks and efficient response efforts particularly at the local level. Boston Public Health Commission experience with multiple data streams provides situation awareness for daily assessment of Boston's health and during special events. BPHC uses multiple data streams, such as syndromic information from emergency department visits, 911 calls,

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reported communicable diseases and weather patterns to monitor events of public health significance. This comprehensive approach has been used to:

- Identify a large outbreak related to two new norovirus strains and enact citywide control measures.
- Monitor yearly influenza activity.
- Identify carbon monoxide exposures with subsequent referral to the environmental health program for building assessments.
- Monitor the health of residents and visitors during special events including the 2004 Democratic National Convention, parades following national championships, and the city events such as the Boston Marathon and July 4th festivities.

BPHC's surveillance system has been successful because it was developed, refined, implemented in a local context. In addition, the Infectious Disease Bureau's experienced analysts are able to employ cost effective response strategies. Local health department surveillance systems and analysts inform and improve local response activities. Empowering local public health improves the nation's health and safety because all response is local.

F. The DeValle Institute for Emergency Preparedness

A program of the Boston Public Health Commission/Boston EMS, The DeValle Institute for Emergency Preparedness provides high quality all-hazards training for the Boston community, including public health, health care and public safety personnel, with a focus on chemical, biological, radiological, nuclear and explosive incident preparedness, response and recovery. The Institute is the pre-eminent resource for emergency preparedness training in the City of Boston. By providing a common forum for learning, it supports collaborative planning and interoperability in response to large-scale health challenges. The Institute draws on the best in the field to create and deliver programs that educate, inspire and prepare, creating a healthier and safer community for all of Boston's service providers, visitors and residents.

The DeValle Institute bases its work on the following principles:

- **Local direction.** The DeValle Institute is operated by the City of Boston, in cooperation with State and Federal funding partners, to meet locally identified needs. Trainings are available to Boston providers and residents, except when specific grants allow Urban Area partners to be included in order to enhance response to Boston-area threats.
- **Partnership.** Trainings are designed and conducted in partnership with local, regional, statewide and federal public health, health care, public safety, academic and community institutions, drawing on the insight and expertise of the best in the field.

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- **All-hazards approach.** Curricula prepare students in universal principles of public health, public safety, medical and community response, thereby raising awareness of a range of intentional and natural health threats and building performance-focused competencies to respond when needed.
- **Learner focus.** Teaching emphasizes hands-on exercises that build sustainable skills, and classroom presentations that respond to the needs of diverse adult learners.
- **Interoperability.** Trainings support standardization of equipment and skills for response across disciplines and agencies, in order to increase the flexibility and efficiency of a response.
- **Inclusion.** Curricula employ culturally competent and community-specific approaches, in order to engage diverse components of the Boston professional and lay communities.

The DelValle Institute was started with seed money from the Boston Metropolitan Medical Response System (MMRS). Funding now includes support from the Massachusetts Department of Public Health, Office of Emergency Preparedness under the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness Cooperative Agreement (PHEP) and the Assistant Secretary for Planning and Preparedness and Response (ASPR) Hospital Preparedness Program (HPP). The Institute also receives significant support from the Metro Boston Homeland Security Region with funding from the Massachusetts Executive Office of Public Safety and US Department of Homeland Security (DHS) Urban Area Security Initiative (UASI).

Since its inception in 2003, the DelValle Institute has:

- Trained over 13,000 Boston area first responders, healthcare workers, Medical Reserve Corps volunteers, community organizations and others in interdisciplinary, multi-jurisdictional sessions.
- Engaged the Conference of Boston Teaching Hospitals, Massachusetts League of Community Health Centers and other key partners to develop common training standards.
- Developed DHS approved courses in WMD and hazardous materials response and protection for healthcare workers, EMS providers and law enforcement.
- Hosted annual conference series featuring internationally recognized experts in health and medical emergency response.
- Developed emergency preparedness specialization courses for working Medical Interpreters and Community Health Workers.
- Developed pre-NIMS incident command system models for Community Health Centers and Public Health.
- Trained regional collaboration partners from area hospitals, community health centers, long term care facilities, local public health and EMS in interoperable communications protocols, through ASPR-funded Partnership for Effective Emergency Response.

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- Delivered comprehensive training in Emergency Dispensing Site management and operations to Medical Reserve Corps volunteers through Cities Readiness Initiative (CRI).

G. The Metro Boston Patient Tracking System

Boston EMS manages the Metro Boston Patient Tracking System, which is a secure web-based tool designed to capture critical patient information during mass casualty incidents and public health emergencies. The system is utilized by the region's hospitals, EMS systems, health centers, public health and emergency management agencies to gain situational awareness of where and how patients are and also have individual patient information. For any response agency, understanding how many people are injured and what their status is helps determine how to respond and what resources to allocate. As well, the ability to capture identifiable information on patients allows health care providers to have accountability of their patients and assist with family reunification. On a daily basis health care providers, whether they be EMS, hospitals, public health or health centers, can manage their patients independently; during a disaster the inherent need to coordinate necessitates a system such as this that captures the information in a centralized location, so that they can ensure proper care is given to all involved.

The Patient Tracking System was purchased in 2006 and has been used for numerous large scale events; including the Boston Marathon and the Boston Fourth of July outdoor concert event, each of which result in several hundred to over one thousand real patients, as well as a flu clinic, and numerous drills and exercises. These trials ensure all partners are prepared to enter and manage real patients within the system should a large scale disaster occur in Boston.

The use of the system for an influenza vaccination clinic occurred as a pilot in November of 2008, in partnership with the Boston Public Health Commission Communicable Disease Control Division. The system successfully allowed for electronic input of information that was previously managed using paper-based forms. The real time aggregation and assessment of data could significantly improve pan flu preparedness, outreach and response capabilities.

H. The Boston EMS *Stephen M. Lawlor Medical Intelligence Center (MIC)*.

The MIC is a state-of-the-art regional communications and command center for managing the medical aspects of public health and mass casualty emergencies. The MIC allows EMS, hospitals, public health departments, community health centers, long term care facilities, as well as other first response (police and fire), public and private partners to collaboratively support the medical logistics and response during large scale disasters. The MIC will support the City's Emergency Operations Center (EOC) whenever the two are activated. The Center will provide regional health care and public health agencies an opportunity to be sufficiently represented at a single location, as well as being a forum for information and intelligence sharing.

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There are 26 health centers and 10 primary receiving hospitals within the City of Boston alone. During disasters, the City's EOC is not large enough to accommodate each health care institution or agency that plays a role in the response. Boston EMS has consistently had to exceed its allotted seating at the EOC, through its multiple medical coordination, logistics and command roles. Conversely, other agencies are either not included or are required to share a single liaison. The Conference of Boston Teaching Hospitals liaison at the EOC, for example, has had to communicate with twenty or more different public health and health care agencies during a single emergency. Plans are for the MIC to augment the one or two health care liaisons normally assigned to the EOC. This will both serve to free up space at the EOC and also ensure sufficient representation for health care and public health agencies. In addition to its use during disasters, the facility is used for meetings, trainings, lectures, exercises and weekly medical intelligence briefings for area partners, including military, FBI, police, fire, Massachusetts Port Authority, the Medical Examiners Office, and private businesses, in addition to health care partners.

I. Boston Metropolitan Medical Response System (MMRS)

As one of the original MMRS programs, Boston MMRS has been a leader in assessing shortcomings within medical response preparedness capabilities and developing comprehensive solutions to address them. Boston MMRS was used to pilot the DeValle Institute for Emergency Preparedness training center at Boston EMS. The program oversees the Metro Boston Patient Tracking System and coordinates extensively with area partners. The MMRS Steering Committee is comprised of over sixty members from the FBI and military personnel to private industries such as Target and local hotels. Last year the Boston MMRS developed an initiative to enhance emergency preparedness and continuity of operations for domestic violence shelters. The two program managers met with all local shelters, trained them on what to expect and how to prepare, and offered them document scanners and USB drives to back up client records. This initiative has been modeled in the other two MMRS regions of Massachusetts and was recognized during a national MMRS conference.

J. Medical Reserve Corps

The Boston Medical Reserve Corps (MRC) is a committed group of volunteers, over 2,000 strong, that helps keep Boston safe by responding to public health emergencies. The Boston MRC volunteers live or work within the city of Boston and receive training in areas of emergency response and preparedness. Over half of the Boston MRC volunteers are medical professionals donating their time and training.

The most recent activation of the Boston MRC was in response to the winter ice storms in December 2008. MRC volunteers were requested by the western and central parts of the state to assist in shelter operations and provide medical monitoring. Over 250 volunteers submitted availability for this incident and several volunteers from Boston traveled to shelters to support local resources overwhelmed by the storm.

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Beyond mutual aid responses, the Boston MRC supports local health initiatives. This past fall, MRC volunteers coordinated efforts with the Office of Public Health Preparedness, Boston MRRS, and the Communicable Disease Control Division of the Boston Public Health Commission to administer flu vaccine to hundreds of city residents. Participation in events such as flu clinics, the Boston Marathon, and Boston's Fourth of July celebration allow the Boston MRC to test their activation protocols and readiness in an emergency.

K. Cities Readiness Initiative

The Cities Readiness Initiative (CRI) is a federally funded effort to prepare major US cities and metropolitan areas to effectively respond to a large scale bioterrorist event by dispensing antibiotics to their entire identified population within 48 hours of the decision to do so. As we continue our Cities Readiness Initiative planning, Boston continues to score high marks in our federal evaluations.

This year we tested our CRI operational capabilities by operating six influenza clinics in Boston. We used these clinics to assess a variety of capabilities: to work collaboratively with CRI planning partners from the Boston Public Schools and the Communicable Disease Control Division of the Boston Public Health Commission; to implement the Incident Command System; to quickly transform municipal buildings into functioning dispensing sites; to move a variety of client groups (school age children, seniors, non-English speakers) through a dispensing site efficiently and accurately; to activate, mobilize, and train volunteers to assist in all aspects of dispensing site operations; and to constantly assess dispensing site operations for quality improvement for current and future clinics.

Current and future efforts include developing resource deployment plans that will enable a more mobile, flexible, and scalable response based on the requirements of any public health related incident. All efforts will continue to center on enhancing collaborative planning with internal and external partner agencies in order to most efficiently and effectively serve the residents of Boston, with a special focus on best meeting the needs of disadvantaged populations residing within the community.

L. Healthy Baby Healthy Child (HBHC) Oral Health Project

It has been documented that a mother's oral health status is directly related to the oral health of her children, especially during the perinatal period. Early childhood caries (ECC), an infectious, chronic disease is a prime example of the maternal child link. ECC disproportionately affects children of color. For this reason, BPHC's HBHC program and Boston University School of Dental Medicine have collaborated over the past 4 years to implement a number of pilot projects funded by CDC, Aetna Foundation, and NIH. The purpose of this partnership is twofold: to examine the feasibility of a home visiting program to perform basic oral screenings, and to build the capacity of the HBHC home visiting staff (nurses) to perform basic oral screens.

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In the first study, 65 children were examined. 31% had ECC and 92% had ECC risk factors. 110 mothers were screened, of which 70% had untreated decay. Women and their families are subsequently connected to local dental services.

The goal for our current project is to enroll 160 families. There are 54 enrolled families and 6 pending enrollment.

M. Healthy Baby Healthy Child (HBHC) Women's Circles

BPHC's HBHC program has hosted fall and spring community-based health, social and educational sessions to women since 2004 in partnership with the Boston Housing Authority. These sessions are designed to widen the pool of services for women of reproductive age. Participants receive health and other related information and workshops on topics that they chose, but that ultimately are related to improving the health of women regardless of their reproductive status. This is in alignment with our attempts to widen the scope of our services to a life cycle model.

Some of the workshops have included stress reduction, racism, parenting, budgeting, diabetes information and awareness, exercise and nutrition, and family planning. These groups have been very successful in decreasing social isolation, promoting community awareness, health and mobilization in an informal and safe environment. Their success can be attributed to the fact that the groups are held where the women live, there are strong partnerships with the co-hosting agencies, child care and dinner are provided, and most importantly, the participants bring enthusiasm and appreciation for the way the sessions meet their needs. It is also an avenue for networking, collaboration and sharing resources. Approximately 800 women have participated since its inception.

N. Biological Safety

Biological research laboratories are an important and increasingly-needed resource to prepare against many of the emerging diseases that we are dealing with today -- such as Avian Influenza and West Nile Virus. These laboratories pose some level of risk to those who work in the laboratories, and is a potential risk to members of the surrounding community.

The Boston Public Health Commission leads the nation in local regulation of biological research. Though governed/guided by federal and state oversight, BPHC has promulgated and is enforcing a regulation to increase visibility and transparency – and ultimately to increase health and safety. Among other elements, the regulation includes provisions that address:

- Mandatory disclosure of high risk research;
- Greater public involvement in regulatory oversight process;
- Regular on-site inspections;

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- Emergency planning and response procedures; and
- Establishment of optimal standards for staff training, safe operations and effective security.

The work of the BPHC in regulating BSL-3 and BSL-4 research laboratories has gained national attention and is considered a model for the public health management of biological research laboratories.

O. Occupational Health

Boston's 500+ automotive shops, located primarily in low-income communities of color, are a source of both well-paying jobs and potential hazardous exposures for employees and residents. The Safe Shops Project works to reduce occupational and environmental health hazards without having to close these businesses. Combining inspections, in-shop trainings, outreach, and technical/financial assistance, Safe Shops brings shops into compliance with laws and promotes use of safer practices and alternative products. After 18 months, 254 workers at 61 of 124 participating shops received trainings. Surveys showed improved worker knowledge (increased knowledge of Material Safety Data Sheets from 24.2% to 75%); work practices (safety goggle use increased from 48% to 70%); and shops investing in capital improvements such as replacing PCE-based brake cleaners with aqueous cleaners.

This successful model has been subsequently adapted for work in nail salons, and we expect that the model would work well for dry cleaning establishments as well.

P. Tobacco Regulations

The Tobacco Prevention and Control Program at BPHC is responsible for implementing regulations passed by the BPHC Board and ordinances passed by the Boston City Council pertaining to the exposure to environmental tobacco smoke and youth access to tobacco products. A new regulation and amendments to an existing regulation have been approved recently that add significant strength in both restricting youth access and protecting workers from exposure to environmental tobacco smoke. Elements of the regulations have gained national attention, including:

- Prohibition on the sale of tobacco in health care institutions;
- Prohibition on the sale of tobacco on educational institution property;
- Prohibition on the sale of blunt wraps;
- Restriction on smoking in all rooms of hotels, motels, and inns; and
- Moratorium on the issuance of smoking bar permits.

In addition to regulatory activities, the Tobacco Prevention and Control Program offers support services such as community education and cessation counseling. Boston is viewed as a national leader in the development and enforcement of tobacco policies to protect residents of and visitors to the city.

VIII. INNOVATIVE INITIATIVES

Q. BPHC Workplace Wellness Program

The mission of the Boston Public Health Commission Employee Wellness Program is to establish and maintain a workplace that encourages and supports healthier lifestyles for all employees. The program provides opportunities for employees to increase their awareness and understanding of wellness by participating in a variety of programs and workshops designed to meet their needs. The program also draws on the expertise and interests of BPHC staff and other area professionals. This will enhance the quality of education, motivation, and support that staff receives as we move toward healthier choices in our personal and professional lives.

Goal for the program include:

- Encouraging and supporting all employees as they strive to incorporate more daily physical activity into their lives;
- Encouraging and supporting all employees as they work to maintain or adopt healthier food choices;
- Fostering a work environment that promotes a sense of well-being, empowering employees to achieve organizational as well as personal goals.

In spring 2008, a workplace wellness survey was distributed to all employees. Results indicated a high level of interest in workshop related to stress reduction, healthy eating, and alternative medicine. Numerous workshops have been offered, and are advertised through a new monthly calendar disseminated to all employees.

Some of workshops conducted have included: Discussion on Stress; Commuting by Bike; Acupuncture Demonstration & Discussion; Stretch, Meditation & Relaxation; Resistance Training in the Comfort of your Home; Into to Hatha Yoga; Intramural Summer Basketball at South End Fitness Center; Self-Defense for Field Staff; Smoking Cessation; Household/Family Emergency Preparedness; and a Chronic Disease Self-Management Program, “My Life, My Health.”

R. BPHC Green Committee

BPHC’s Green Committee was started in the winter of 2007-2008 by a handful of employees to make BPHC a more sustainable operation and model. Now, with over 25 members, 3 subcommittees, and numerous ongoing projects, the Green Committee has quickly grown into a large and successful working group making real impacts across the Commission. The committee’s growth and success within BPHC stems from two main factors: BPHC-wide participation and support from executive leadership from within BPHC as well as the directives from Mayor Thomas Menino.

The Green Committee has piloted the following projects: the introduction of green cleaning products, “single-stream” recycling, converting to 30% post-consumer recycled

VIII. INNOVATIVE INITIATIVES

copy paper, purchasing only printers that “duplex,” replacing bottled water coolers with water filtration coolers, launching an employee education campaign to conserve electricity, implementing a paper conservation program in the Executive Office, and, most recently, providing periodic newsletters to BPHC staff that contain the latest on the Green Committee’s efforts, as well as tips employees can use to be more sustainable at the workplace and at home.

IX. FEDERAL GRANTS

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These are pending and upcoming federal grant applications that would provide direct funding to BPHC. BPHC receives several funding streams that are passed through intermediaries (e.g., City of Boston, Commonwealth of Massachusetts, Massachusetts Area Health Education Centers), but pending applications for these sources are not included here.

1. **Boston Healthy Start Initiative**

Health Resources and Services Administration
\$2,125,000 request submitted December 2008

The Boston Healthy Start Initiative (BHSI) is one of fifteen original Healthy Start programs funded in 1991. BHSI brings together public and private agencies to address needs of childbearing women in Boston's most vulnerable communities. BHSI enrolls high risk, low-income pregnant women of African descent, with a goal of reducing infant mortality in the city. BHSI's commitment to Black women is a response to a Black infant death rate in Boston that is four times the rate among whites. It reflects a central Boston Public Health Commission (BPHC) focus on reducing health disparities.

In prior years, BHSI focused on assuring access to care, with case management as the core service in a system aimed at supporting early and continuous access to prenatal care and providing a full array of prenatal services, including medical, psychosocial, case management, health education, mental health screening and social support through pregnancy and the first two years of infant life. It assured access to culturally competent services for Black women in the city's African American, Haitian, Jamaican, Cape Verdean, Somali, and Latino communities, including women at elevated risk due to substance use, homelessness, HIV, and domestic violence.

Outcomes suggest that this focus has been necessary but not sufficient. We have seen declines in Boston's overall infant and in Black infant mortality. But Black women in Boston still face birth outcomes far worse than white.

In this year's application we build on the infrastructure and expertise established in the past while building creative approaches to BHSI content and operations. Central to our new strategy is a life course approach, addressing the long-term impact of social factors on women's lives: the effects of poverty and its correlates – poor housing, limited options for food and health care, limited education and work opportunities – and the effects of stress caused by the daily experience of poverty and discrimination. In reshaping BHSI, we will do what we've done in the past – case management, creation of community systems of care, collaborative work with state and local partners -- with renewed rigor. But the content will reflect this new approach. We will:

IX. FEDERAL GRANTS

- Develop an enhanced needs assessment tool, aimed at better identifying social risk factors (housing, food or income insecurity, lack of education) in women's lives;
- Enhance training of BHSI case managers to address these needs;
- Link BHSI site case managers to BHSI central management and through them, to city policy leaders to address needs that defy solution at the site level;
- Involve communities in understanding and responding to birth outcome disparities through public education efforts; and
- Increase our use of advisory groups (a broad Consortium, a consumer group, and a panel of national life course experts) to help us operationalize a life course approach.

2. Ryan White HIV/AIDS Treatment Modernization Act

Health Resources and Services Administration

To be submitted September 2009

We will be submitting our annual Part A competitive application as well as our Minority AIDS Initiative (MAI) non-competitive application. While the MAI award in non-competitive, the amount is dependent on appropriations and formula.

3. Fire Grant

Department of Homeland Security

\$500,000 request submitted

This grant would fund the purchase of a Medical Emergency Response Vehicle (MERV) for multi patient use by Boston EMS.

