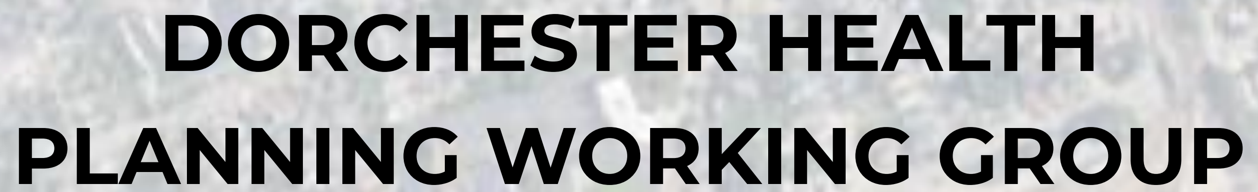

DORCHESTER HEALTH PLANNING WORKING GROUP

Report and Recommendations

April 22, 2025

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Executive Summary

This report offers a framework for addressing gaps in health care and social needs in the community formerly served by Carney Hospital. The Dorchester Health Planning Working Group engaged providers that serve the community including hospitals, community health centers, physicians, nurses, public health officials, emergency service providers, as well as community members, labor leaders, community leaders, elected and non-elected government officials.

The Working Group reviewed data related to health services gaps and social needs following the Carney Hospital closure and engaged in a process of envisioning a future where the Dorchester area has excellent, well-coordinated care and investments in the community resources that ultimately improve health outcomes.

The Working Group reviewed the findings from a robust community engagement process that included conversations with thousands of community residents conducted in partnership with Health Care For All, as well as a community listening session, written comment period, staff research, and briefings from Working Group members and other subject matter experts.

The community-driven recommendations in this report focus on the future use of the hospital site as well as the need to financially support organizations, including the area's wealth of community health centers, that have been working under challenging circumstances to address gaps in health services created or worsened by the closure of Carney Hospital.

The recommendations also focus on addressing broader systemic needs and social determinants of health, including economic mobility, housing, and transportation that drive health inequities in the surrounding communities.

The Working Group's recommendations are organized around the following five priority areas:

1. **Site Use**: Facilitate the reuse of the former Carney Hospital site for the provision of high-quality health care and social services that meet the community's health and social needs.
2. **Emergency Services**: Address the immediate impact of the hospital closure on access to emergency medical services.
3. **Primary Care and Care Coordination**: Respond to health care access gaps by adding additional capacity in community settings, including community health centers, to deliver culturally and linguistically appropriate primary and specialty care.

4. **Behavioral Health**: Increase behavioral health care and treatment capacity in community-based settings avoiding emergency department use where appropriate.
5. **Health-Related Social Needs and Social Determinants of Health**: Invest in holistic systems of care that prioritize health related social needs and social determinants of health, including through the ongoing use of the site.

In addition to facilitating the sharing of information and expertise in the development of this report, the Working Group helped to strengthen the lines of communication across the varied stakeholder groups that will be needed to advance the ongoing work of addressing the needs of the community.

A more detailed description of the recommendations, the needs they respond to, and action steps follow below. The full findings of the Working Group are detailed in subsequent sections.

Introduction

Following the closure of Carney Hospital on August 31, 2024, community members in Boston's Dorchester and Mattapan neighborhoods and the surrounding communities are facing a gap in health care and emergency room access.

As City, State, and local healthcare providers activated to address this gap in the short term, Governor Healey and Mayor Wu are working to develop a long-term plan to meet community needs as quickly as possible and ensure that health care remains accessible on the former Carney Hospital site.

The Working Group was co-chaired by Dr. Bisola Ojikutu, the Commissioner of Public Health for the City of Boston, and Michael Curry, the President and CEO of the Massachusetts League of Community Health Centers. The full membership list is included above.

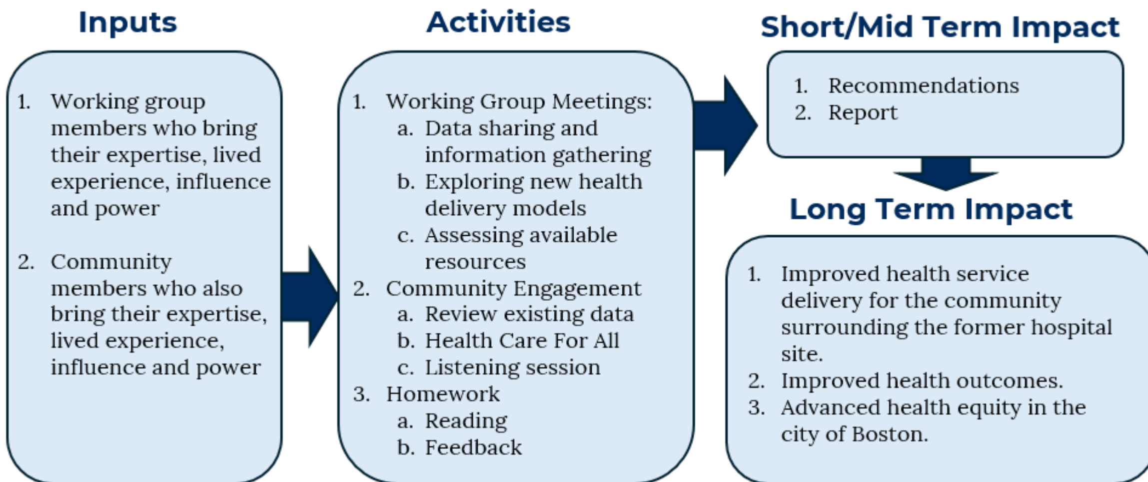
Working Group Charge:

Identify unmet health needs of the community previously served by Carney Hospital and provide recommendations to Mayor Wu and Governor Healey to address health service delivery needs and promote equity following hospital closure

The Working Group's tasks included reviewing the services Carney Hospital provided to the community prior to its closure and understanding the immediate and potential long-term impacts of the hospital's closure. The Working Group also reviewed data describing the inequities in health and social conditions that predated the closure, as well as working toward a future where health and social determinant of health needs are met through high-quality services in both existing and new settings.

The Working Group acknowledged longstanding and emerging challenges, including the current climate of funding uncertainty, well-documented health care financing issues, workforce needs, and fragmentation of care. The group worked to identify system-level strategies to make long-term progress while identifying tools needed to preserve access to health care services in the more immediate term.

The Working Group set an expectation that all proposed solutions should align with the guiding principles of equity, quality, accessibility, prevention, population health, and financial sustainability.



In developing and reviewing proposed recommendations and action steps, the Working Group was guided by the following scoping criteria:

1. Responsive to needs and concerns expressed by the impacted community
2. Informed by information gathered by the working group
3. Focused on both health and social determinants of health
4. Relate to the physical structure and beyond
5. Ambitious, but realistic

Recommending any specific new ownership structure for the site is outside the scope of this report. The recommendations also do not take a position on which entity or entities would operate the services envisioned by the Working Group. Furthermore, the recommendations do not state a position on the reuse of existing facilities versus the construction of new facilities. The Working Group sought to achieve consensus to the extent possible in developing these recommendations, however not all specific action steps should be understood to represent the perspective of all working group members.

Taken together, the recommendations create a framework for collective action to address the immediate health needs created by the hospital's closure and guide the reuse of the hospital campus in a way that helps to address the longstanding health and social determinant needs of the community.

The recommendations are presented early in the report with key findings that inform them and are followed by sections of the report that summarize the research and findings of the Working Group and the community engagement process.

Recommendations

Site Use

The Carney campus is approximately 12.7 acres and comprises two parcels. The main hospital parcel is 11.7 acres, with 728,348 sq. ft of building space and is owned by a subsidiary of Apollo Global Management, Silver Carney Dorchester LLC. An adjacent roughly one-acre parcel contains the 35,865.00 sq. ft. Seton Medical Office Building and at the time of this report is owned by a separate real estate investment trust.

Both the City and State have important roles in guiding the future use of the property and ensuring that community needs are prioritized. Mayor Wu has communicated the City's intent to use its land use authority to ensure that the site continues to be used for the provision of health services. Depending on the proposed health services, various approvals would be required from MA DPH and other agencies at the State level.

Given the size of the hospital campus, the site could accommodate multiple uses, including direct health care services and uses that address longstanding unmet health-related social needs, as well as close gaps in social determinants of health.

The working group reviewed case studies covering the reuse of other former hospital campuses and found the creation of high-quality medical uses was often supported or enhanced by adjacent socially and economically beneficial uses on the land, including but not limited to childcare, affordable housing, and senior housing. The recommendations will seek to address two needs of the community: acute health needs and the upstream conditions that influence health outcomes. More detailed information about health and social needs prioritized in the reuse of the hospital site is included in the body of this report.

The individual action steps are labeled S, M, L to indicate anticipated timeline with short term defined as less than year, medium term defined as one to five years, and long term as more than five years.

<u>Recommendation</u>: *Facilitate the reuse of the former Carney Hospital site for the provision of high-quality health care and social services that meet the community's health and social needs*. *Action steps include:*

1. Use local authority to ensure that current or future site owners include health care services on the Carney Hospital site (S)
2. Ensure that site owners invest financial resources in uses of the site recommended by the working group, including but not limited to healthcare delivery, workforce development, employment, inclusive economic development, and other social determinants of health (S)

3. The site should offer holistic, comprehensive services that support coordination of patient care including prevention and management of high-incident, high-impact illnesses affecting the community and driving disparities in life expectancy, including but not limited to behavioral health, cardiometabolic disease, cancer, and substance use disorders. Encourage the creation of a set of co-located health services to be included in any proposal seeking City and State approvals such as a high-quality urgent care center that accepts public and private insurance, co-located with a range of health care services prioritized through the community engagement process. Consider including additional high-frequency services, including lab capacity, screening, and diagnostic imaging such as MRI, CT, mammography, ultrasounds, X-rays, and colonoscopies. Additional services may include specialty care, time intensive specialties such as occupational therapy, intensive outpatient behavioral health as well as inpatient behavioral health beds. New uses may be subject to Determination of Need, licensure, and other approvals (S)
4. Restore health care services that currently operate in the Seton Medical Office Building, where health care providers currently offer culturally and linguistically appropriate health care including primary and specialty care such as cardiology, neurology, pulmonary, podiatry, orthopedics, ophthalmology, otolaryngology, and sleep medicine in the community (S)
5. Ensure that the proposed mix of health services and operators on the site has a path to long-term financial sustainability by incorporating specialty services with higher revenue margins, such as surgical services (S)
6. Explore all available State and Federal capital funding sources as well as any other mechanisms for operational funds to support the creation of new facilities serving the catchment area. Partner with MassHealth to ensure that reimbursement rates for new services account for the high level of medical need in the community and the acuity that health-related social needs impose on clinical conditions (S)
7. Continue to facilitate state regulatory approvals to new health care facilities seeking to operate on the site or serve the Carney catchment area (M)
8. Improve the physical connections between the neighborhood, site, and Dorchester Park, increasing access to opportunities for physical activity and social cohesion (L)

Emergency Services

There were approximately 30,000 emergency department visits per year at Carney Hospital prior to its closure, meeting a broad range of health needs. This was the sixth-highest volume ED in Boston at the time of closure. A review of available data shows that the many patients seen at the hospital's emergency department experienced lower severity illness and injury. The hospital did not hold a trauma center designation.

A small number of patients seen in the emergency department were admitted for inpatient treatment. In Hospital Fiscal Year 2023, for example, of the 28,136 patients served by the ED, only 2,470, or 8% were admitted to inpatient care. Over a third of the ED visits were classified as avoidable. It is important to note that the utilization patterns of the Carney emergency department do not necessarily indicate that there is not a need for emergency services in the community, and it is important to understand community perceptions of area health facilities and how they influence utilization and may influence decisions about where to seek care.

The feedback from the community engagement activities carried out through the Working Group process highlighted concerns about where the population previously served by Carney's ED would seek emergency and urgent care. Boston EMS has worked to maintain low response times while seeing a 20% increase in transport time post-closure. Emergency departments surrounding Carney Hospital have seen increased volume and crowding. Use of the urgent care sites operated by community health centers in the area has increased, straining capacity and increasing wait times. Urgent care volume increased 12% following the closure at Codman Square Health Center and 10% at DotHouse Health.

Massachusetts has a high and growing rate of residents reporting difficulty accessing care, particularly for residents of lower income communities. The closest CHC to Carney Hospital, Codman Square Health Center, reports a 4.5 month wait time for new primary care patients. Delayed access to primary care contributes to health disparities and can result in higher acuity of patients' conditions and worse outcomes in a community that already faces barriers to care.

While significant work is needed to ensure that more residents have access to the right types of care for non-emergency health needs, interventions are needed in the near term to ensure that residents of the area previously served by Carney Hospital's ED have access to emergency care when needed.

<u>Recommendation</u>: *Address the immediate impact of the hospital closure on access to emergency medical services. Action steps include:*

1. Advocate for increased state financial support and reimbursements for community health centers serving the Dorchester community to increase urgent care capacity, including through space and staffing, to meet the need created by the loss of Carney's emergency department and create alternatives to unnecessary ED visits (S, M)
2. Advocate for increased state financial support and reimbursements for existing hospitals serving the Dorchester community to meet increased demand for services (S)
3. Continue deployment of additional Boston EMS resources in the Carney hospital catchment area to improve EMS response times, as indicated by data (S)

4. Ensure the continuation or adequate replacement of an EMS ambulance garage and radio infrastructure currently in operation at the former Carney Hospital site (S)
5. Disseminate culturally and linguistically appropriate public guidance regarding how and when to access preventative, primary, and urgent care in order to reduce unnecessary use of emergency services (S)
6. Advocate for continued financial resources for emergency medical service providers and alternative models of care to ensure they are able to provide timely, high-quality prehospital care (M)
7. Continue to strengthen and expand the Boston EMS workforce through continued investment in staffing and recruiting initiatives (M)

Primary Care and Care Coordination
While the data reviewed by the working group and described in the report above show that residents in the catchment area generally have relatively high insurance coverage and report having a primary care provider, many members of the community report challenges accessing primary care.

The concept of providing the right care, at the right time, and in the right place, was raised repeatedly throughout the working group process. Ready access to primary care is foundational to achieving this goal. Community health centers in the communities previously served by the hospital have been serving a critical function since the closure of the hospital and the health centers in this community that offer urgent care services, most notably DotHouse Health and Codman Square Health Center, have seen increasing wait times for this service and worked to fill this need under challenging financial conditions.

Ensuring that residents of this area have better access to primary care providers would likely increase quality and coordination of care, while decreasing use of unnecessary urgent care and emergency medical services. Similarly, having clinical space that provides increased access to screening, imaging, and testing services would help to ensure that residents are more readily able to follow through on referrals for services that help to prevent future illness. Overall, the working group heard that the goal should be to improve access and coordination of high-quality care, and seek to provide better, more holistic care than was previously provided.

Recommendation: *Respond to health care access gaps by adding additional capacity in community settings, including community health centers, to deliver culturally and linguistically appropriate primary and specialty care. Action steps include:*

1. Expand and financially support the use of community health workers and patient navigators at community health centers to ensure greater coordination of primary care, preventative services, and specialty care (S, M)

2. Expand the role of BPHC's Mayor's Health Line to help residents navigate health and social service systems, disseminate information during public health crises, and strengthen core health insurance navigation services (S)
3. Partner with established CHCs or hospitals to increase the deployment of mobile health units in the affected area in a systematically predictable manner to allow residents to schedule and plan for access. Mobile units may increase access to screening and intervention for chronic diseases, such as hypertension and diabetes; navigation to substance use disorder services; and access to family planning and reproductive health care services (S)
4. Continue expediting state credentialing for health care providers, prioritizing those seeking to practice in underserved areas (S)
5. Expand access to primary care through implementation of recommendations included in the Health Policy Commission's January 2025 report, such as: increasing and reforming spending and payment for primary care, reducing clinician administrative burden through support staffing and administrative simplification, and ensure sustainability of primary care in community health centers; strengthen the primary care provider pipeline, particularly for community health centers serving underserved areas and populations, and reduce barriers to practice including by funding programs to increase the number of primary care providers, reducing barriers to practice for advanced-practice providers, and better supporting and retaining clinicians from underrepresented groups (M)
6. Ensure full implementation of *An Act Enhancing the Market Review Process* in order to increase oversight of the healthcare industry (M)
7. Review the essential service closure process and update statutes and regulations to better protect patient safety, expand requirements for community information and engagement, and sustain orderly access to services over time (M)
8. Ensure pharmacy access, protect community health center pharmacies from discriminatory contracting practices, and support clinical pharmacies and pharmacist staffing, particularly in community health centers (M)
9. Advocate for workforce-related legislative solutions like graduate medical education, nurse practitioner residency, non-clinical loan repayment, and expansion of programs to strengthen youth exposure to health professions (M)
10. Assess the need for additional maternal health services in the catchment area, building on existing and ongoing assessments to gain a more detailed understanding of community resident needs and perceptions to inform future policy and programmatic responses (S)

Behavioral Health

In addition to serving a high volume of behavioral health conditions in the emergency department, Carney Hospital's most common discharge diagnoses in years before its closure included bipolar disorder, schizophrenia, and major depressive disorders. Carney Hospital also provided inpatient capacity through 50 licensed beds, which included adolescent, adult, and geriatric units and served many patients with co-occurring mental health and substance use disorder needs.

In addition to removing inpatient behavioral health beds from the local continuum of care, the use of emergency department for behavioral health needs underscores the necessity for a full range of behavioral health crisis response and long-term services that should be readily available to this community. While the data show that adults in these neighborhoods experience statistically similar rates of key indicators for depression among adults, the data also show that a higher rate of residents from Dorchester and Mattapan are seeking and receiving behavioral health care in emergency departments. Data also show higher drug overdose rates in parts of Dorchester and Mattapan than the citywide average. Stakeholders also identified the use of hospital beds by behavioral health patients awaiting appropriate placement, referred to as boarding, as a persistent challenge.

Significant changes have been made to the behavioral health system in Massachusetts that have the promise to improve care for the former Carney catchment area, such as behavioral health emergency medical services diversion and community behavioral health centers. The following recommendations focus on ensuring access to innovative models of behavioral health care, while ensuring appropriate capacity in the system more broadly.

Recommendation: *Increase behavioral health care and treatment capacity in community-based settings, avoiding emergency department use where appropriate. Action steps include:*

1. Advocate for additional financial resources to community health centers in order to increase the number of behavioral health providers, which will lead to further integration of this service into primary care teams (S)
2. Increase incentives for mental health screening in primary care settings along with brief interventions and connections to needed services (S)
3. Expand community behavioral health services serving the catchment area to provide urgent behavioral health services and ongoing care, and offer needed adolescent and pediatric urgent behavioral health services (M)
4. Expand community behavioral health center services to people irrespective of their insurance status (M)
5. Advocate for the restoration and addition of inpatient behavioral health capacity lost by the closure of Carney Hospital in or near the community and advocate for workforce initiatives that will increase staffing (M)

6. Strengthen and ensure a sustainable funding model for mobile integrated health efforts, which allows for behavioral health treatment on scene by EMS providers and diversion to non-hospital destinations (M)
7. Fund community health workers who are trained in behavioral health to provide outreach in the catchment area (M)
8. Provide additional support for efforts like BPHC's youth mental health initiative that contributes to behavioral health workforce development and service expansion (M)
9. Expand community-based substance use disorder services, including expansion of naloxone and other services, such as detox and residential treatment access at the site (M)

Health-Related Social Needs and Social Determinants of Health
The responses from across the community engagement activities demonstrate that in addition to wanting high-quality health care services, community members recognize the importance of meeting health-related social needs, impacted by social determinants of health, and the imperative to address the longstanding drivers of health inequities facing the community. Specifically, residents named access to care, affordable housing, economic mobility, homelessness and housing insecurity, food access, and community safety.

Repeated themes and analysis of community engagement data show that addressing these longstanding issues remain priorities for the community previously served by the Carney Hospital, and that actions to reuse the site should address both the provision of health care and health-related social needs. The review of case studies related to hospital closure and revitalization showed that leveraging hospital campus land to address health-related social needs identified by the community can be an effective strategy to meet health and social needs.

Recommendation: *Invest in holistic systems of care that prioritize health related social needs and social determinants of health, including through the ongoing use of the site. Action steps include:*

1. Strengthen multilingual public information, outreach, engagement, and care coordination services by creating a one-stop information portal spanning literacy levels for residents in the affected area that can provide access to information related to health services and transportation assistance, enhancing outreach to support efforts to support residents with enrollment in health and social service care coordination through the BPHC Mayor's Health Line, the Boston Age Strong Commission, as well as other community-based organizations, as well as and reform payment mechanisms to better financially support and expand the use of

navigators, community health workers, and social workers in community health center settings (M)

2. Make transportation to care more accessible by increasing utilization of transportation reimbursement through MassHealth, enhancing public-private partnerships, and increasing access to transportation options, including through voucher and reimbursement programs including Boston's Age Strong shuttle, BPHC's Cancer Health Ride program, the MBTA's income-eligible reduced fare program, the RIDE, and parking reimbursements for medical visits (S)
3. Enhance economic mobility and financial security through community-based partnerships including by leveraging the City's philanthropic partnership with Atrius Health Equity Foundation and Boston Community Health Collaborative to specifically address communities disproportionately impacted by a higher burden of cardiometabolic disease (M)
4. Expand and diversify workforce pathways for a range of needed health related professions, including lab technology, direct patient care, phlebotomy, nutritional counselors, EMTs, community health workers, certified nurse aids, and personal care workers. Leverage or update State workforce development fund as well as any other available workforce funding, including private sector funding for access to training funds with the goal of creating or expanding high schools offering health career development and higher education (M)
5. Strengthen social cohesion and civic engagement, including through the Mayor's Office of Immigrant Advancement's *City of Belonging Campaign* and place-based approaches to building social connections, such as Boston Age Strong social programming for older adults (S)
6. Ensure housing stability and expand affordable housing opportunities, especially for older adults (M)
7. Create new spaces for social connection including for older adults (L)
8. Improve access to nutritious, affordable, culturally relevant food and access to food-related benefits; increase food and nutrition education programming at BPHC, enhance the Healthy Incentives Program (HIP), and explore initiatives to increase enrollment in entitlement programs including Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women Infants and Children program (WIC) (M)

The Dorchester Region

The Working Group gathered and reviewed data primarily focused on the health needs of the residents of Dorchester and Mattapan. While the Carney Hospital served many communities across the region, discharge data and EMS data showed that the communities of Dorchester and Mattapan relied most heavily on the hospital. For this reason, the data reviewed, community stakeholders engaged, and the scope of the analysis of community health needs in this report is focused primarily on the zip codes that make up these two neighborhoods.

The report and recommendations acknowledge that the impacts of the hospital closure and needed interventions will in many cases have broader geographical scope, and many of the health needs identified in the data and community feedback require statewide policy and systems changes that would have broader benefits.

Community Demographics

The total population of Dorchester and Mattapan combined is 167,276. If this area were an independent municipality, it would be the third largest in the Commonwealth. The area is racially, ethnically, culturally and linguistically diverse as compared to the citywide average and the state. Median household incomes are lower than Boston citywide average. The table below shows additional demographic data for Dorchester and Mattapan, compared with the citywide averages.

Due to the size of the Dorchester neighborhood, BPHC presents health data in two segments, each made up of two zip codes. Like much of Boston, these larger neighborhoods are marked by residential segregation and uneven geographic distribution of the resources that promote health, both within the health care system and outside of it.

Relevant to considerations of access to care, the area has higher percentage of individuals with low English proficiency and non-US born residents. Language access has been consistently elevated by the community and providers as a barrier to access to health care and social services.

The area also has significantly higher rates of residents who are covered by public health insurance. While 42% of Boston residents overall are covered by MassHealth, the percentages in the two sections of Dorchester and Mattapan are 65%, 69%, and 74% respectively. Carney Hospital was classified as a High Public Payer hospital, with 75.3% of its Gross Patient Service Revenue (GPSR) coming from Medicare, MassHealth, and other government payers, including the Health Safety Net.[1]

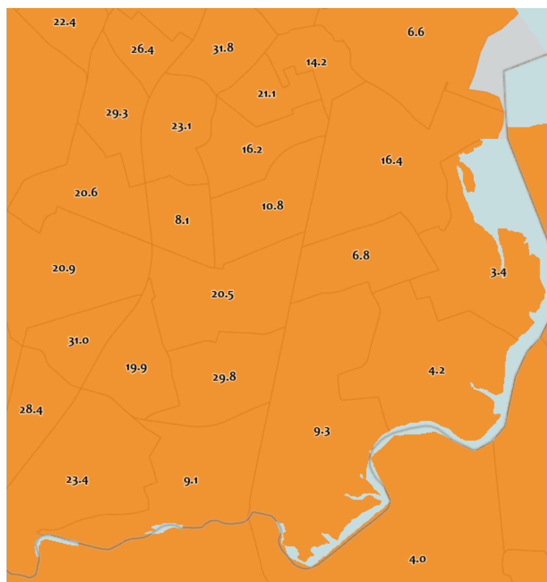
[1] https://www.chiamass.gov/assets/docs/r/hospital-profiles/2023/carney.pdf

	Boston Overall	Dorchester 02122, 02124	Dorchester 02121,02125	Mattapan
Race/Ethnicity				
White Alone	49%	25%	24%	7%
Black or African American Alone	23%	43%	42%	73%**
Asian Alone	10%	9%*	6%	1%
Hispanic or Latino	20%	18%	28%	18%
Non-US Born	28%	34%	32%	38%
Low English Proficiency	11%	21%	19%	17%
Median Household Income	$89,212	$76,607	$53,697	$66,689
Median Age of Population	32.9	34.7	33.4	36.9
Age 60+	17%	18%	18%	21%
College Degree	58%	39%	37%	31%
Employed	70%	70%	66%	72%
Insured	96%	95%	96%	96%
MassHealth	42%	65%	69%	74%

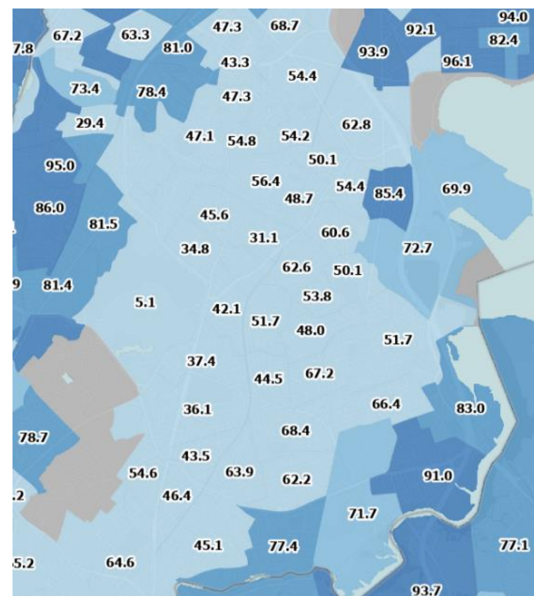
Data source: American Community Survey, 2022 5-year Estimates, Boston Behavioral Risk Factor Surveillance Survey 2017, 2019, 2021, MassHealth

There are also differences within the community between smaller areas at the census tract level, including insurance type, and indicators including poverty levels. The percent of the population living in poverty is higher in the census tracts to the west of Dorchester Avenue than the areas to the east. The percent of residents with private insurance is lower in the tracts in the western part of the community.

Percent of Population Below Poverty Level by Census Tract



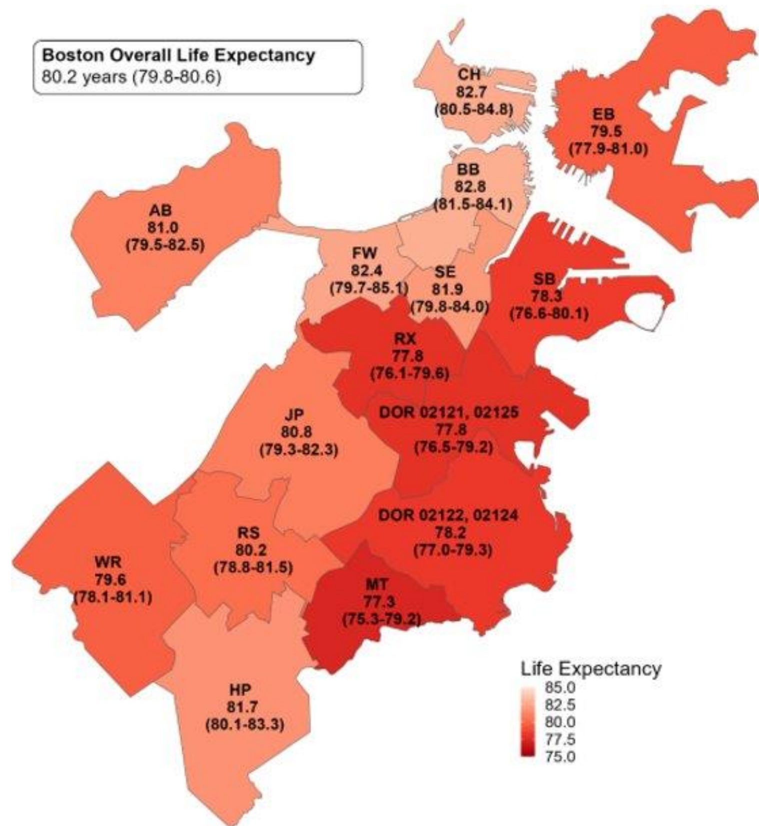
Percent of Population Insured, Private by Census Tract



Source: American Community Survey 2017-21 (poverty); 2019-23 (pop insured) Map: Massachusetts Health Data Tool, https://www.mass.gov/info-details/community-health-data

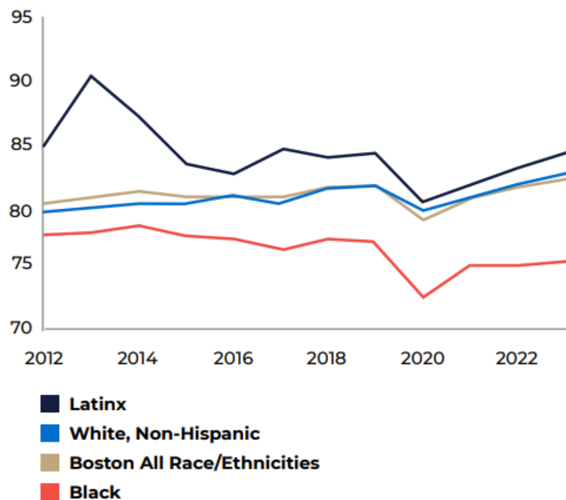
Health Outcomes and Needs

Boston is a vibrant, diverse, and thriving city. It is also a city with persistent and troubling health inequities. The most striking of these are the difference in life expectancy and premature mortality, which vary sharply by race and neighborhood in Boston. These disparities are primarily due to social, economic, environmental, and structural factors. Within Boston, the neighborhoods of Dorchester and Mattapan have among the lowest life expectancy. Mattapan has the lowest life expectancy at 77.3 years.



State and local public health agencies are working with renewed focus to deepen our understanding of specific health disparities, with a focus on understanding and addressing the conditions that drive differences in life expectancy. Efforts are underway to make multi-sector investments to address root causes of these disparities.

Through Boston's Live Long and Well agenda, BPHC and the City of Boston aim to close the life expectancy gap entirely citywide by 2035, including by addressing the three leading causes of premature mortality, unintentional drug overdose, cancer, and cardiometabolic disease.



DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health

The Commonwealth's Advancing Health Equity in Massachusetts initiative seeks to make place-based investments in areas of the state experiencing the greatest disparities. Dorchester and Mattapan are among these geographies. This initiative, led by the Executive Office of Health and Human Services, is starting with two key focuses: maternal health and social determinants of health, examining all of the living conditions and societal structures that make a person more vulnerable to heart disease, stroke, and other cardiometabolic diseases.

Premature mortality, defined as deaths before age 65, show similar patterns. For 2017-2021 combined, the neighborhoods with the highest age-adjusted premature mortality rates (per 100,000 residents) were Dorchester (02121, 02125) (293.9), Dorchester (02122, 02124) (289.5), Roxbury (282.9), and Mattapan (265.7). These rates in Dorchester were twice that of the lowest rates observed in Back Bay (140.3) and Roslindale (142.4).[2]

The Working Group reviewed data regarding these leading causes of premature mortality and associated conditions, comparing the neighborhoods of Dorchester and Mattapan with Boston overall.

Leading Causes of Premature Mortality
Count under age 65

RANK	2019	2020	2021	2022	2023
1	Cancer 222	Unintended overdose 252	Unintended overdose 265	Unintended overdose 254	Unintended overdose 281
2	Unintended overdose 191	Cancer 233	Cancer 233	Cancer 224	Cancer 223
3	Diseases of the heart 179	Diseases of the heart 190	Diseases of the heart 189	Diseases of the heart 161	Diseases of the heart 159
4	Accidents 39	COVID-19 122	COVID-19 70	COVID-19 44	Accidents 47
5	Chronic liver disease & cirrhosis 38	Diabetes mellitis, Homicide 52, 52	Diabetes mellitis 56	Diabetes mellitis 42	Diabetes mellitis 38

NOTE: Rank is based on number of deaths.
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health

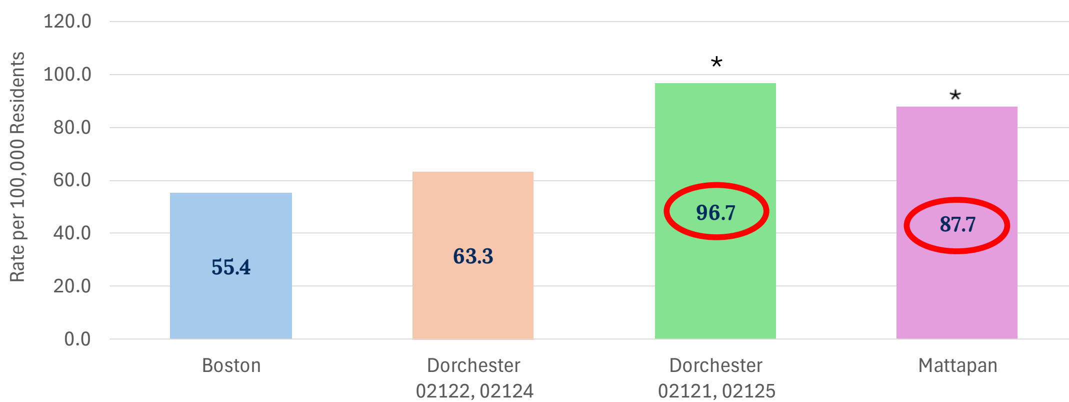
[2] https://www.boston.gov/sites/default/files/file/2024/03/HOB_Mortality_LE_2023_FINAL_Corr_032524.pdf

The following tables compare the health outcome data related to the leading causes of premature mortality in focus community to the citywide average. Across these conditions, all or part of the community previously served by Carney Hospital experience worse outcomes than Boston as a whole.

The review of health data related to behavioral health and substance use disorder showed that part of Dorchester and Mattapan experienced higher overdose death rates than the city average, and that residents of Dorchester and Mattapan are more likely to use the emergency department for behavioral health issues than residents of Boston overall. While the neighborhood data show that adults in these neighborhoods experience statistically similar rates of key indicators for depression (persistent sadness) among adults the data also show that a higher rate of residents from these neighborhoods are seeking and receiving behavioral health care in emergency departments. This is consistent with the data about what services Carney hospital provided most by volume.

The rates of the population relying on emergency departments for behavioral health including substance use are disproportionately higher among Black residents across conditions including anxiety, depression, bipolar, schizophrenia, post-traumatic stress disorders/trauma-related disorders, attention deficit hyperactivity disorder, and disruptive behavioral and impulse-control disorder, and Latinx residents for mental health-related visits overall and anxiety, depression, and disruptive behavioral and impulse-control disorders specifically.

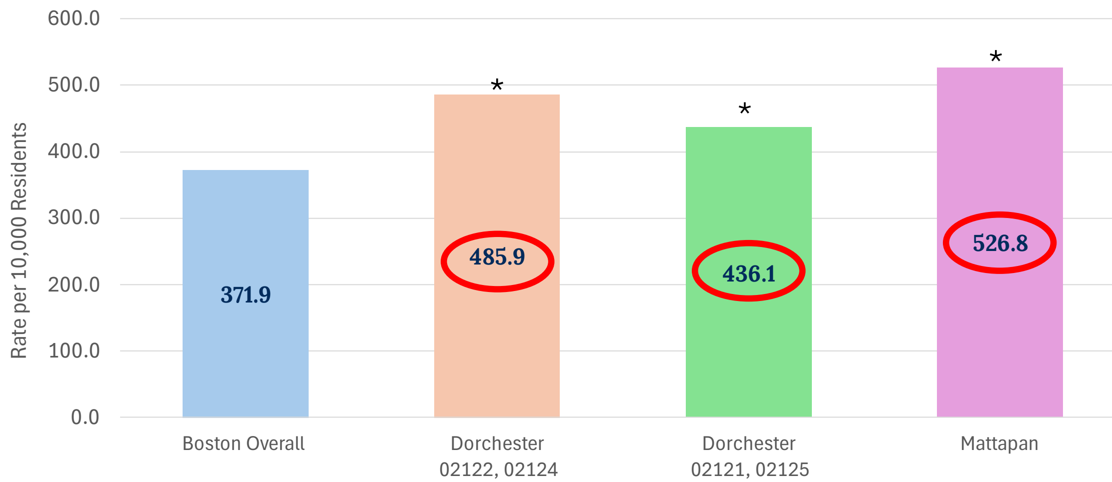
Drug Overdose Deaths† by Neighborhood
Years 2021-2023 Combined



†Age-adjusted rates per 100,000 residents
*Statistically significant difference when compared to other neighborhoods in Boston
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health

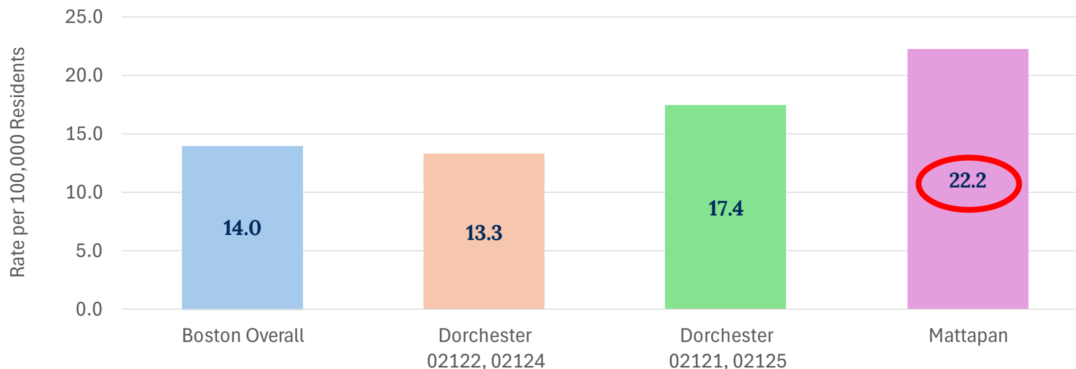
Mental Health Emergency Department Visit Rates by Neighborhood, 2021

*Excluding Substance Use Disorder



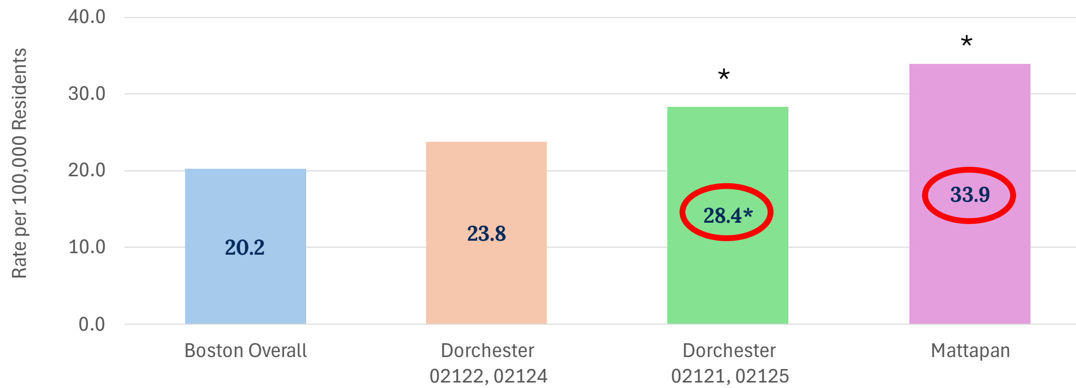
†Age-Adjusted rates per 10,000 residents
*Statistically significant when compared to other neighborhoods in Boston
DATA SOURCE: Acute Hospital Case Mix Database. Massachusetts Center for Health Information and Analysis

Breast Cancer Mortality† by Neighborhood, 2019-2023 Combined



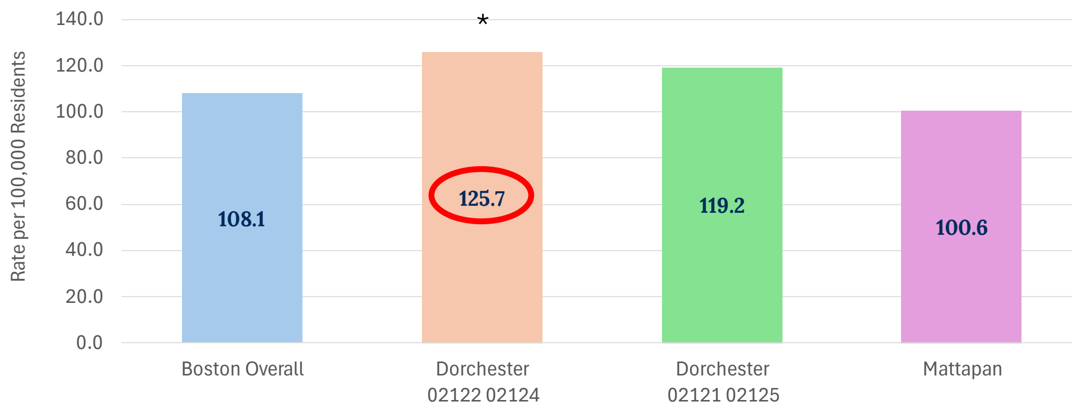
†Age-adjusted rates per 100,000 residents
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health
Please be advised that 2023 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regards to small numbers of events

Prostate Cancer Mortality† by Neighborhood, 2019-2023 Combined



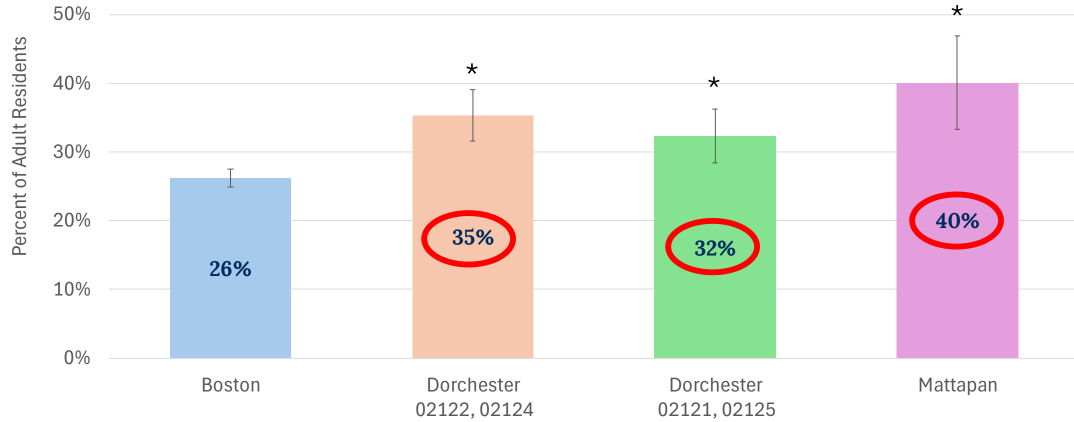
*Statistically significant difference when compared to other neighborhoods in Boston
†Age-adjusted rates per 100,000 residents
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health
Please be advised that 2023 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events.

Heart Disease Mortality† by Neighborhood Years 2019-2023 Combined



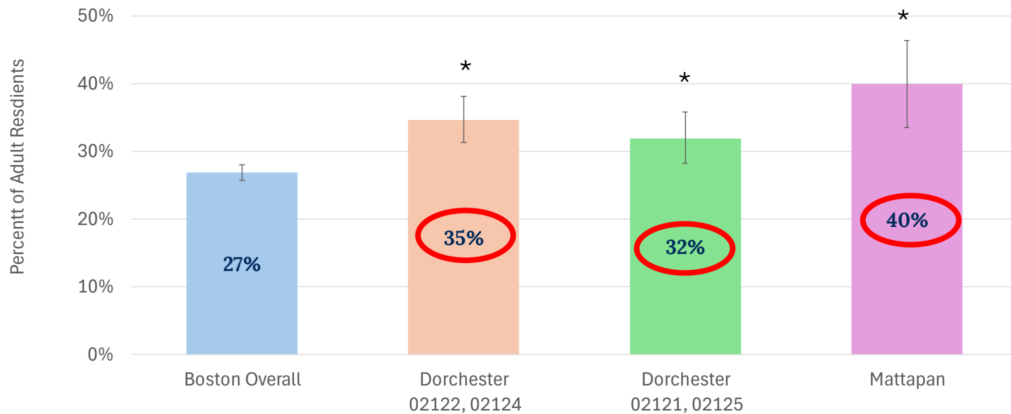
† Age-adjusted rates per 100,000 residents
*Statistically significant difference when compared to other neighborhoods in Boston
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health
Please be advised that 2023 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events

Obesity Among Adults (BMI>=30) by Neighborhood, Years 2017, 2019, 2021

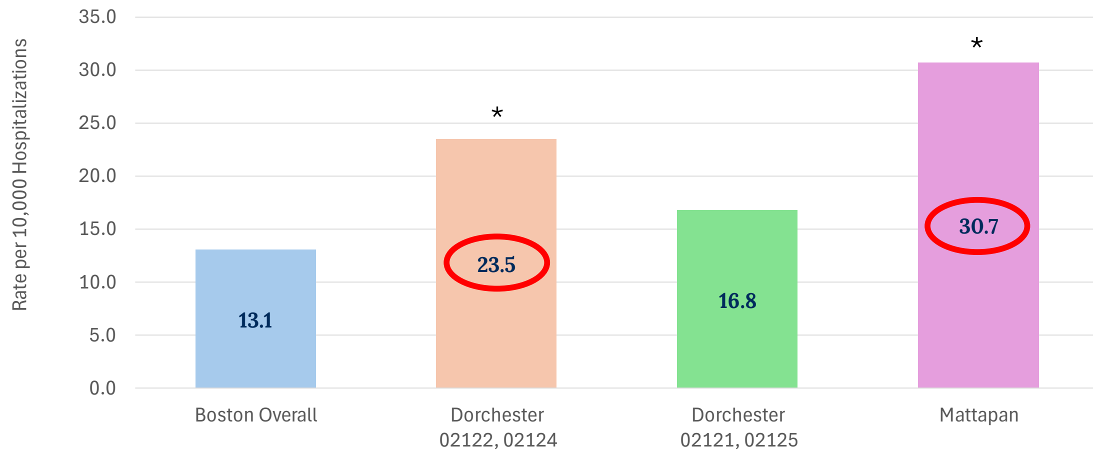


*Statistically significant difference when compared to other neighborhoods in Boston
DATA SOURCE: Boston Behavioral Risk Factor Survey (2017, 2019, 2021), Boston Public Health Commission

Self-Reported Hypertension Among Adults by Neighborhood, Years 2017, 2019, 2021 Combined



*Statistically significant difference when compared to other neighborhoods in Boston
Data Source: Boston Behavioral Risk Factor Surveillance Survey (2017, 2019, 2021), Boston Public Health Commission



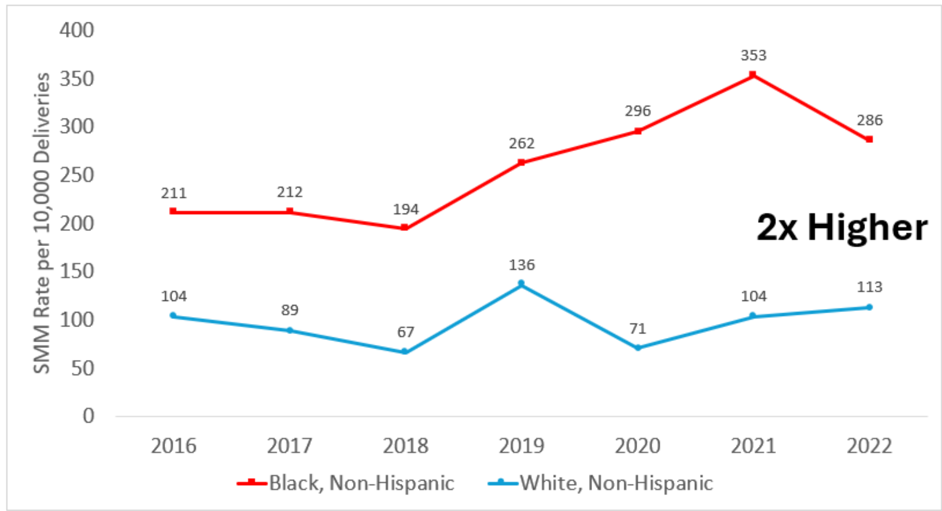
Maternal and Infant Health

While Carney Hospital was not a birthing hospital and maternal and infant health services were not identified as a new gap in care created by the hospital closure, addressing persistent maternal and infant health disparities was raised by multiple working group and community members throughout the process as an area of ongoing focus for state and local health officials.

BPHC analysis of Boston resident live birth data shows that the neighborhoods of Dorchester and Mattapan have higher rates of low birthweight births and preterm births than Boston overall (2021-2023 combined). Infant mortality in Dorchester zip codes 02122 and 02124 and Mattapan was higher than Boston overall (2014-2023 combined).

Particularly concerning racial inequities are found in the severe maternal morbidity outcomes, which are defined as unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman's health, such as bleeding, eclampsia, pulmonary embolism.

Severe Maternal Morbidity Rate per 10,000 Deliveries by Race and Ethnicity for Boston Residents, 2016-2022



Summary
The community previously served by Carney Hospital is racially, ethnically, linguistically diverse. As compared to Boston overall, the population of these neighborhoods is lower income and more likely to be publicly insured. The neighborhoods of Dorchester and Mattapan experience lower life expectancy and higher premature mortality than Boston overall. These neighborhoods also experience worse outcomes in the underlying health conditions that drive these differences, including overdose, preventable cancers, and cardiometabolic disease. The review of the data show that this community also has unmet behavioral health needs and worse maternal and infant health outcomes.

Former Carney Hospital Services

Carney Hospital provided emergency, primary, and specialty care and served a vulnerable patient population. In addition to experiencing worse health outcomes across many key indicators, patients who live in Dorchester and Mattapan experience other barriers to care and overall wellbeing. They are more likely to be covered by public health insurance, older adults, those dealing with chronic disease, and non-English speakers and immigrants.

Despite a long history of providing valued care to this community, Carney Hospital was under-resourced, and understaffed, and underutilized in the years before its closure. The facility was also limited in that it was not a designated trauma center and was therefore not able to accept the most acute patients. It also did not offer maternity or newborn services.

Community feedback emphasized that the hospital provided valued access to care for area residents and provided culturally and linguistically competent care to a patient population that experienced barriers to care and services. Both inpatient and outpatient providers at all levels had long trusting histories of working with the populations they served, and the facility itself allowed for easy parking and navigation, seen by many members of the communities as barriers to care at larger hospitals.

A full accounting of the factors that lead to the closure of Carney Hospital is beyond the scope of this report. Publicly available reports show that the hospital had been operating at a deficit in most recent years (Hospital Year 21(HY21) negative operating margin -9.6%, HY22 -23.0% HY 23 -5.1%).

Summary of Carney Hospital Services at Closure

Inpatient Medical/Surgical beds: 83

- Average daily census (ADC) in 2024: 13
- No pediatric beds

Intensive Care Unit beds:19

- ADC in 2024: 4

Licensed inpatient behavioral health beds: 50

- ADC in 2024: 34

Emergency department

- FY 2023 volume: 30,211
- Not a trauma center

Ambulatory care

- MRI, CT, X-Ray, OBGYN, and Orthopedics

- FY 2023 volume: 204,061

In addition to serving a significant number of behavioral health patients in its Emergency Department, Carney Hospital's top inpatient discharge cases by type in Hospital Year 2021 and 2022 included bipolar disorder, schizophrenia, and major depressive disorders.[3]

DPH data show that while the Carney hospital Emergency Department handled approximately 30,000 visits per year, through its closure in 2024. In Hospital Fiscal Year 2023, of the 28,136 patients served by the ED, 2,470, or 8% were admitted to inpatient care, and 397 or 1.4% were admitted to observation.

Of all visits in the same year 9,954, or 35.4% were classified as avoidable, meaning they were classified as potentially avoidable, defined as visits that could more effectively be cared for in another clinical setting, such as primary care. Among the group not classified as avoidable but who were not admitted the largest categories by volume were injuries (5,497) and mental health, alcohol, and drug related (2,697). The lack of a trauma center also likely played a role in shaping the types of illness treated at the Carney Emergency room.

The Seton Medical Office Building, situated behind Carney Hospital, has continued to offer primary and specialty care including cardiology, neurology, pulmonary, podiatry, orthopedics, ophthalmology, otolaryngology, and sleep medicine since the hospital closure. These include providers who were relocated from the Carney Hospital building at the time of its closure. Physician tenants have reported that they have received termination notices of their leases effective May 22, 2025. Mayor Wu has issued a letter to the property owners demanding that they reverse this decision.

[3] https://www.chiamass.gov/assets/docs/r/hospital-profiles/2022/carney.pdf

Former Carney Hospital Site and Facilities

Site

The Carney campus is approximately 12.7 acres and comprises two parcels currently owned by a subsidiary of Apollo Global Management, Silver Carney Dorchester LLC. The main hospital parcel is 11.7 acres, with 728,348 sq. ft of building space. An adjacent roughly 1 acre and parcel contains the 35,865.00 sq. ft. Seton Medical Office Building.

The Campus has over 750 parking spaces in a garage and lots, occupying a large portion of the campus space. The site is approximately half a mile from Ashmont station and is served by the MBTA's 21, 22, 24, 240, 15, 217, 12, 215, 26 bus lines.

The site is surrounded on much of its perimeter by Dorchester Park, a 28.5-acre City-owned park designed by Olmstead, Olmstead, and Eliot in 1895, which is a significant community asset and is currently undergoing a project to improve pathways in the park and make them and entrances ADA accessible. The campus is also within walking distance of other public open and recreational spaces including Walsh Playground, Neponset River Trail, and Cedar Grove Cemetery. The site is largely surrounded by residential uses and sits between the Lower Mills and Ashmont/Peabody Square business districts.

Hospital Campus Facilities

The main hospital building was initially built in 1953. Findings from a walkthrough of the site by BPHC, and City of Boston Operations and Property Management staff in August 2024 guided by hospital property management staff found that overall, the occupied portions of the building appeared to be in fairly good condition. Flooring, lighting, ceilings, and finishes appeared to be well maintained.

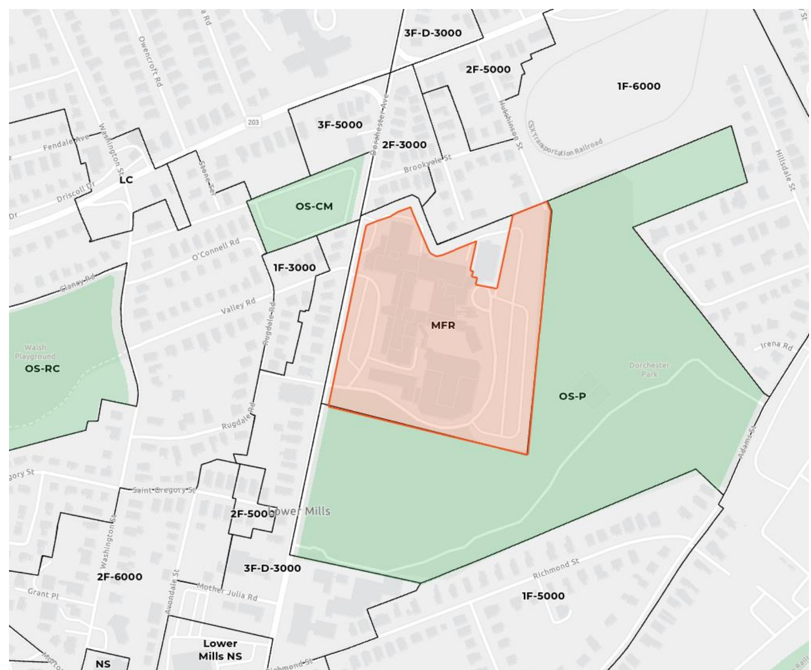
Some areas of the building were renovated in the last decade, including the Emergency Department, the Seton medical office building, wound care clinic, and operating rooms. The site visit suggested that an owner could potentially operate the building with minimal changes to the buildings in the short term.

However, the site visit showed that there are major deferred capital improvements for building systems and the envelope. Several 'state of good repair' projects would likely be needed in the next several years, including: generator replacement, boiler replacement, mechanical systems replacement, security system upgrades (cameras, card readers), elevator replacements or repairs (three out-of-service at time of visit), roof repairs, window replacements, masonry repointing, fire suppression system upgrades, remediating major structural issues in the parking garage.

These observed issues could require significant investments in the next 5-10 years and the capital investments needed to make the facility usable in the long term would require additional capital investment.

Again, these findings represent observations from a brief site visit and should be read with caution. Any potential operator would need to undertake further due diligence efforts. An owner or operator would need to perform a robust facility conditions assessment to ascertain the state of all building systems and the building envelope, to identify needed work, remaining useful life, and estimated replacement/repair costs by building element. This would likely include assessing how certain building systems (steam, chilled and hot water, etc) are linked together across buildings to ascertain which buildings could be operated separately. Additionally, because the hospital has been decommissioned and contents auctioned, it would require all new furnishings and equipment.

Zoning and Regulatory Context



The site is zoned Multi-Family Residential under Map 5E, Dorchester Neighborhood District (Art. 65). The parcel was home to a convent before the construction of Carney Hospital in the early 1950s and has been zoned residential since zoning was adopted in 1924.

<u>Allowable Uses under Current Zoning</u>:

- Existing nonconforming hospital use
- One, two, and multi-family (three or more units)
- Other medium scale residential
- Some Open Space Uses
- Limited Public Service, Community, and Education Uses are Conditional
- Artist Mixed Uses and Nursing Homes, also Conditional

<u>Design Basics</u>:

- Maximum building height of 3 stories or 35 feet
- Maximum floor area ratio of 1.0
- Off-Street parking governed by Art. 80 Large Project Review
- Surrounded by single family (1F) two-family (2F) three-family (3F) and open space (OS) districts/uses.

Additional reviews at the city level including Article 85 (Demolition Delay), and Parks Design Review.

An Act enhancing the market review process, signed into law by Governor Healey in January 2023, added new property ownership restrictions that prevent the Massachusetts Department of Public Health ("DPH") from granting hospital licenses to hospitals or systems where the main acute care campus is on Real Estate Investment Trust (REIT)-owned property.

While the local land use approval for a site of this significance will necessarily involve community engagement and process, any use that would require zoning relief will require significantly higher level of engagement with the community and City of Boston to ensure that the use is aligned with community priorities. Mayor Wu has communicated in writing to the site owners to make clear the City's intent to use all relevant local authority to ensure the site continues to be used for the provision of health services.

Health Care Services in the Dorchester Region

Health System Considerations

The Working Group discussions and community engagement processes identified challenges in the health care system nationally and in Massachusetts that make it harder to meet the health needs of the Dorchester and Mattapan communities. These include reimbursement structures that do not adequately compensate providers for some of the most needed services, emergency department boarding, workforce challenges – particularly for primary care providers – coordination of care, and transportation. Proposed solutions to some of these persistent challenges are included in the recommendations section.

Stakeholders across sectors shared the sense that it is a particularly precarious time for health care providers, and that there is more that the institutions serving these communities would be able to do if they were more adequately resourced. This view was expressed strongly by community health center stakeholders. Working Group discussion included observations about needing to revisit lessons learned from the COVID-19 pandemic, including collaboration, communication, and focusing on addressing health inequities, and social needs.

Acute Care Hospital Access

There are no other acute care hospitals in the neighborhoods of Dorchester or Mattapan. The closest acute care hospital is Beth Israel Deaconess Milton, a community hospital which is two-mile drive from the former hospital site.

The Boston area is home to a wealth of hospitals. There are 3,350 average daily occupied medical/surgical beds by month within a 30-minute drive of the Carney Hospital site as of December 2024. The average daily occupied medical/surgical beds by month has slightly decreased between September-December between 2023 and 2024.[4]

The community engagement data underscored that the perceived availability of health care services is impacted by several factors, including transportation, parking, familiarity, trust, language access, and cultural competency, among others.

Emergency Services

[4] https://www.mass.gov/info-details/health-care-capacity-interactive-dashboard

Carney Hospital was the receiving hospital for over 6,300 Boston EMS transports annually, or 17 per day. Most Boston EMS patients transported to Carney Hospital originated from Dorchester (62%) and Mattapan (22%). Boston EMS has been closely following operational data since the hospital closure. Boston EMS transport times have increased year-over-year for trips originating in Dorchester and Mattapan. Despite the additional transport time, Boston EMS Priority 1 response times in Dorchester have decreased 2.5%. However, priority 1 response times in Mattapan have increased 6.8%.

<u>Boston EMS Data</u>

Dorchester (Sept 1, 2024 to March 16, 2025)

- 15,905 incidents, compared to 15,924 last year, so the totals are effectively on par.
- 2.5% reduction in Priority 1 response times.
- 14.1% increase in transport time.

Mattapan (Sept 1, 2024 to March 16, 2025)

- 3,043 incidents, compared to 2,876 last year (6.8% increase)
- 6.8% increase in Priority 1 response times.
- 7.6% increase in transport time.

The hospital closure created additional challenges for Boston EMS as an Advanced Life Support (paramedic) ambulance station and radio infrastructure continue to be located at the Carney Hospital.

Boston EMS actively participated in the local incident command structure to ensure coordination with public health and area hospitals and has been continuously following data to understand impacts and make needed operational adjustments.

An additional (24-hour) ambulance has been posted in Dorchester. An agreement was negotiated with the hospital owner to allow for ongoing operation of the EMS garage and radio infrastructure for a period of time.

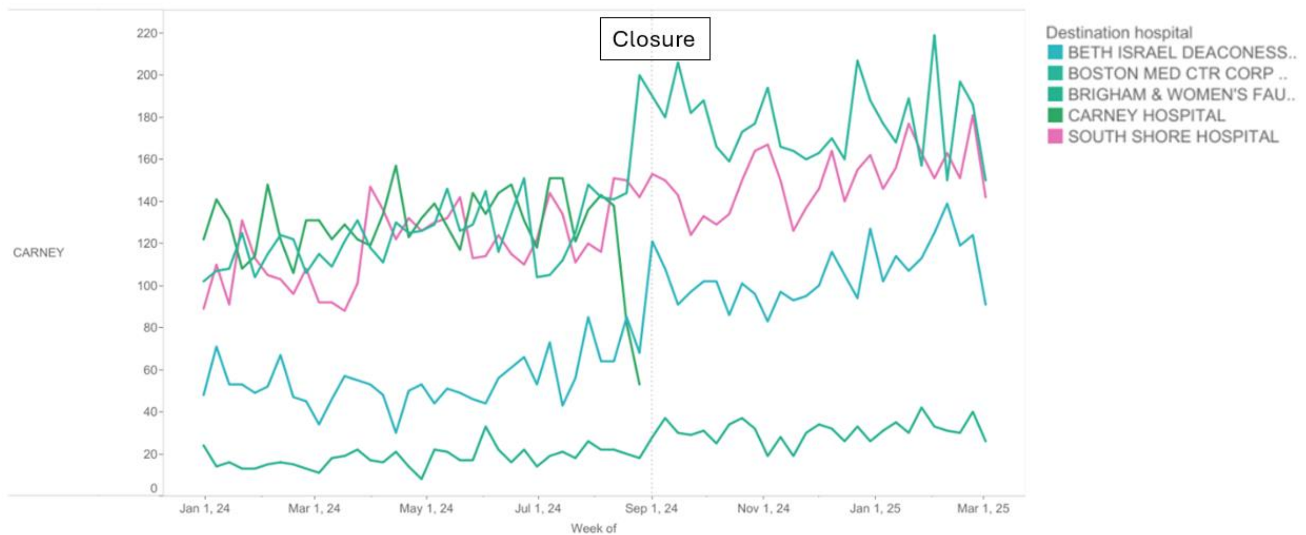
The closest hospital to the Carney Hospital site, Beth Israel Deaconess Hospital Milton had 1,073 ambulance trips end at its Emergency Department in the December 2024, up from 853 in January 2024.[5] In January 2025, 24.5% (263 trips) of these trips originated in Boston, up from 11.1% (95 trips) in January 2024. Representatives from BI Milton confirmed

[5] https://www.mass.gov/info-details/health-care-capacity-interactive-dashboard

observed increased emergency department volumes around and after the time of the Carney Hospital closure.

Data from Massachusetts Department of Public Health show that the number of EMS runs from the Carney region to area hospitals Beth Israel Deaconess Hospital-Milton, Boston Medical Center, Brigham and Women's Faulkner, and South Shore Hospitals has increased since the August 31st closure date.

Number of EMS Runs from Carney Primary Service Area by Destination Hospital



Last updated on March 11, 2025 and include data through March 8, 2025. Source: Massachusetts Department of Public Health MATRIS V3. Data includes emergency runs and interfacility transfers/medical transports where the patient was transported by EMS and where the incident locations and destinations could be reliably identified. Ambulance services are required to enter data into MATRIS per A/R 5-403 Statewide EMS Minimum Dataset. Data are required to be submitted within 7 days; however, actual submission timeframes vary by ambulance service. Transport time is defined as the time in minutes between when the ambulance left incident scene and when it arrived at the destination.
Created by the Massachusetts Department of Public Health, Regional Healthcare Incident Visualization for Resiliency (RHIVR).

Beth Israel Deaconess Hospital-Milton is continuing to see higher ED volume in 2025 than in 2024. February 2025 saw 16% higher ED patient volume. All hospitals within a 30-minute drive saw increases as well, though less striking (+7.3% in January and +3.9 % in February).[6]

The Working Group discussion put the additional need created by the closure of Carney Hospital in the context of ongoing challenges facing emergency departments. One important driver of emergency department capacity challenges and wait times is emergency department boarding, defined as when patients are held in the emergency department awaiting further treatment such as an inpatient level of care, whether medical or psychiatric.[7]

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[6] https://www.mass.gov/info-details/health-care-capacity-interactive-dashboard
[7] https://masshpc.gov/sites/default/files/2025-02/20250227_BoardPresentation.pdf

Emergency departments also serve many patients with conditions that could have been seen in primary care or urgent care, placing additional strain on emergency department resources. Statewide data show regional differences in the share of emergency department visits that are avoidable, defined as most recent emergency department visit in past 12 months was for a non-emergency condition. Metro Boston has the highest reported percentage of avoidable ED visits at 44.3%, compared to 25.6% in Metro West and 29.9% in Central MA.[8]

Urgent Care

In the neighborhoods of Dorchester and Mattapan (zip codes 02122, 02124, 02121, 02125, and 02126) there are three urgent care sites, all of which are operated by community health centers (DotHouse Health, Codman Square Health Center, and Uphams Corner Health Center).[9]

Throughout the community engagement process, residents recommended increased access to urgent care facilities in the community following the closure of the hospital. Urgent care was also identified as one of the top answers to the question about (data to follow in community engagement section below). Information about the role of urgent care facilities in the health system was presented to the Working Group, including successes and challenges. Discussion included that urgent care sites can treat relatively minor conditions and prevent more costly treatment in the emergency rooms.

Challenges include the lack of formal regulatory oversight that prevents the state from receiving complete data about their operations or imposing requirements that care be provided equitably. Many urgent cares that are operated by CHCs or health systems are able to effectively coordinate care with existing care teams. Conversely, urgent care sites that are not associated with a patient's usual care, or the use of urgent care as a stand in for a regular primary care provider may lead to more fragmented care and worse health outcomes. Because the term urgent care can cover a range of facilities, the Working Group and community feedback focused on the importance of co-location of any new urgent care facility with a range of other services.

Multiple case studies of former hospital campus reenvisioning processes included urgent care facilities that are co-located with other clinical and social services.

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[8] https://www.chiamass.gov/massachusetts-primary-care-dashboard/

[9] https://www.mass.gov/info-details/urgent-care-and-retail-clinics-in-massachusetts#interactive-map-

Primary Care

The Massachusetts Health Policy Commission's January 2025 report, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*, documents that primary care in the Commonwealth is facing many challenges, including burnout for providers and access barriers for patients. The report also found that residents of lower income communities are most likely to have no primary care use.

Access to primary care physicians improves health and helps to ensure access to appropriate care. Conversely, limited access to primary care can lead to potentially avoidable ED and inpatient hospital use and associated higher spending, as well as worse patient outcomes, especially for patients managing chronic conditions. Further, patients with distance, transportation, or language barriers to accessing primary care are also more likely to use the ED for non-emergent conditions. Community health centers – an essential source of primary care for patients who are medically underserved – are experiencing an exacerbated version of the trends and obstacles facing primary care across the Commonwealth.[10]

Massachusetts Health Insurance Survey data shows that access challenges in are greater in the Boston metro area compared to other areas of the state as the percentage of residents in metro Boston with a primary care provider (88%) was lower than the state average.

There are persistent disparities statewide in potentially avoidable ED use. As of 2023, 47.9% of Black non-Hispanic Massachusetts residents and 51.3% of Hispanic residents reported that their most recent ED visit was for a non-emergency condition, compared to 26.5% of White non-Hispanic residents.[11]

The percentage of residents who had a visit to a general doctor, nurse practitioner or midwife for preventative care in the past 12 months was lowest in Metro Boston (77.3%), compared to the state average (81.3%). There are also disparities in this measure between white residents (84.7%), Hispanic (68.4%), Black (71.1%), and Asian (79.1%) residents.[12] While access to primary care is a national issue, the Boston area is particularly challenged.

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[10] https://masshpc.gov/sites/default/files/HPC%20Chartpack_A%20Dire%20Diagnosis%20-%20The%20Declining%20Health%20of%20Primary%20Care%20in%20MA_0.pdf
[11] https://masshpc.gov/sites/default/files/HPC%20Chartpack_A%20Dire%20Diagnosis%20-%20The%20Declining%20Health%20of%20Primary%20Care%20in%20MA_0.pdf
[12] https://www.chiamass.gov/massachusetts-primary-care-dashboard/

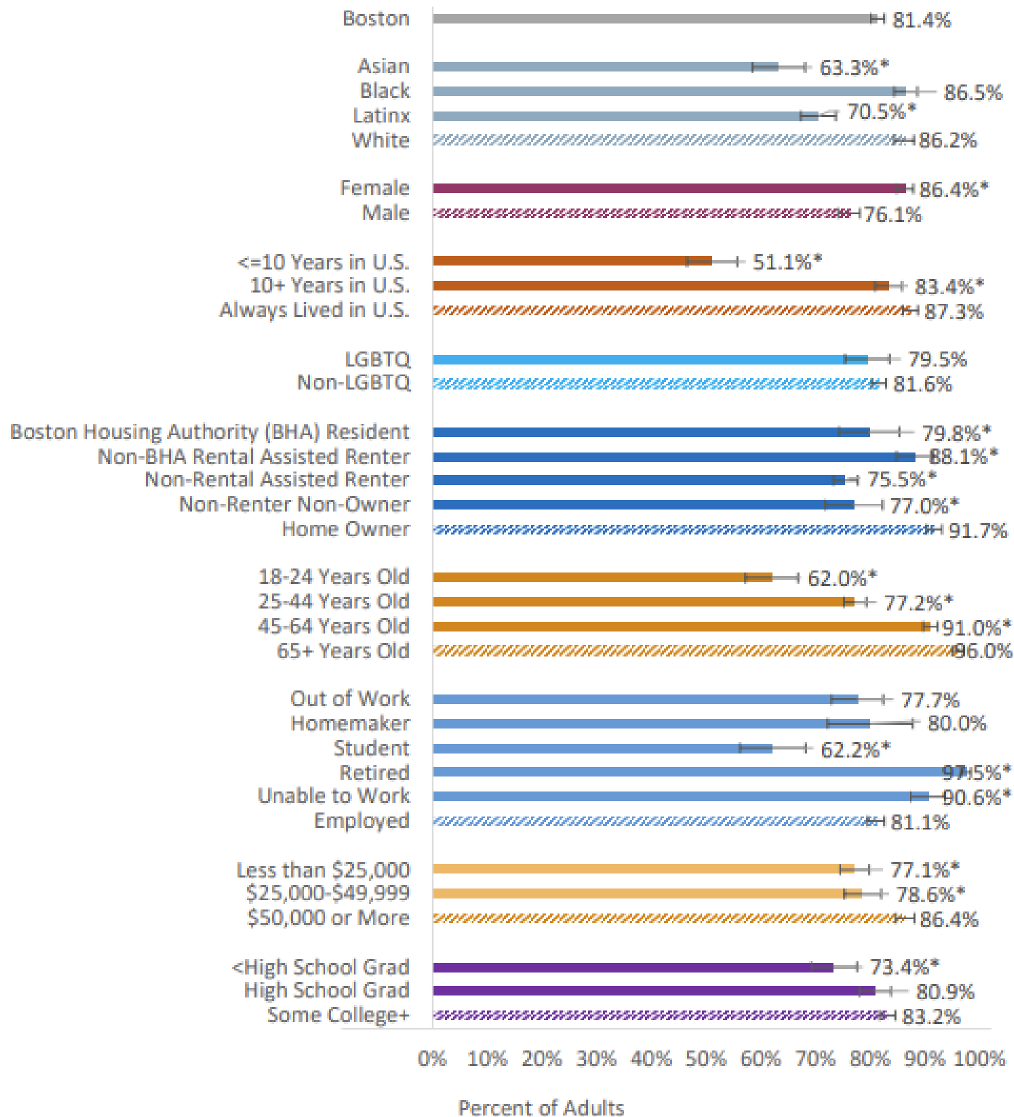
A study of 15 US metro areas found that Boston had the second longest wait times for a new patient appointment for a physical in 2022.

BPHC's 2024 Health of Boston Access to Care report showed that Dorchester zip codes 02122 and 02124, population 75,357 had two primary care practices, Dorchester 02121 and 02125, population 63,692 had no primary care practices and Mattapan, population 22,734 had two.[13] More analysis is needed to determine exactly how the catchment area neighborhoods compare to other parts of the city and state, increased access to primary care is essential to improving population health in these communities.

Data regarding whether residents currently have a doctor or healthcare provider show differences between populations and suggest that certain populations experience more challenges in accessing regular care than others. These groups include Asian and Latinx residents, males, immigrants, residents of subsidized housing and rental housing, lower income, and residents with lower educational attainment.

[13] https://www.boston.gov/sites/default/files/file/2024/06/HOB_Access%20to%20Care_2024_Final.pdf

Adults who Have a Doctor or Healthcare Provider by Selected Indicators 2017, 2019, and 2021 Combined



*Statistically significant difference when compared to reference group
NOTE: Bars with hatch marks indicate the reference group within each selected indicator
DATA SOURCE: Boston Behavioral Risk Factor Surveillance System (2017, 2019, 2021), Boston Public Health Commission

The closure of Carney Hospital and potential closure of the Seton Medical Office Building are likely to further reduce geographical and linguistic access to primary care, particularly for the residents of Dorchester and Mattapan who disproportionately experience barriers to care.

While additional analysis may be helpful to inform comparisons between the catchment area and other areas in the city and state, review of existing data and community feedback show that the geographical distribution of locations where primary care, paired with transportation and language access challenges limit access to primary care.

There was broad agreement among the Community Health Center representatives on the Working Group that health centers are well suited to serve Carney's patients and meet the needs stated by the community. Community Health Centers provide a broad range of services to address health related social needs and the social determinants of health. Health centers are also well positioned to continue to advance initiatives aimed at promoting health and reducing the need for residents seeking care in urgent care or emergency department settings.

While Mattapan Community Health Center does not operate an urgent care facility, it reports triaging an increasing number of walk-in patients, adding additional complexity to their work.

Whittier Street Health Center, Harbor Health Services, Harvard Street Neighborhood Health Center, South Boston Community Health Center, Manet Community Health Center, South Cove Community Health Center, NeighborHealth, Fenway Health, Dimock Community Health Center, Bowdoin Street Health Center, and Upham's Corner Health Center also report impacts from Carney's closure, as reported to the Mass League of Community Health Centers.

In addition to providing specialty care, CHCs play an important role in coordinating care with specialty care offered at hospitals and other sites. Community Health Centers Codman Square Health Center, Harvard Street Neighborhood Health Center, Mattapan Community Health Center, and DotHouse Health shared data for their previous referrals to specialty care at Carney Hospital. The leading referral categories included imaging, mammography, physical therapy, and colonoscopy.

The increased transportation times, transportation costs, parking cost, and unfamiliarity with new facilities were identified by the Working Group as challenges to ongoing coordination of care following the loss of Carney Hospital.

Behavioral Health

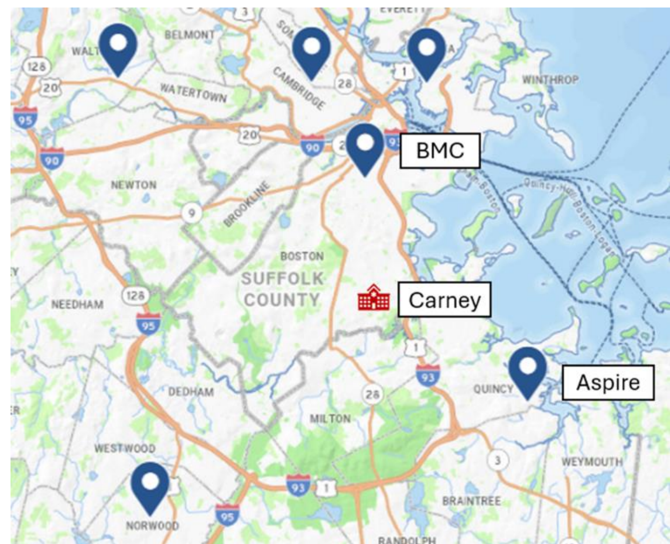
The closure of Carney Hospital resulted in the closure of 50 behavioral health beds. Additionally, as noted above the emergency department and inpatient facility regularly served individuals experiencing behavioral health issues including substance use disorders. Receiving behavioral health care at sites other than EDs helps contain healthcare spending, as well as incarceration. The Working Group explored initiatives and models of care to better serve well-documented behavioral health needs, including substance use disorder.

The Working Group received a presentation from the Department of Mental Health statewide capacity. As of December 3, 2024, the total licensed capacity across the state was 3,087 beds. This total includes 2,207 adult psychiatric, 415 geriatric psychiatric, 202 adolescent psychiatric, 63 child psychiatric, and 200 child/adolescent psychiatric beds.

The presentation also highlighted details about the Expedited Psychiatric Inpatient Admissions Protocol (EPIA), which is a state interagency response to behavioral health boarding that facilitates securing appropriate placement for individuals boarding in emergency departments who require inpatient psychiatric hospital level of care.

The group also discussed the potential role of Community Behavioral Health Centers in meeting the need for urgent behavioral health care.

Community Behavioral Health Centers (CBHCs) are described as one-stop shops for a wide range of mental health and substance use services and treatment. They offer crisis services for residents in need of immediate mental health or substance use help, outpatient clinics offering a full range of comprehensive and coordinated mental health and substance use services, community crisis stabilization, a less restrictive alternative to inpatient hospitalization for people in need of short-term, overnight crisis care.



The two closest CBHCs to the Dorchester community are located at Boston Medical Center (5.9 miles from the former Carney Hospital) and Aspire in Quincy (7.8 miles away). Working

Group discussion identified the geographic gap between these two sites as a barrier for residents in Dorchester and Mattapan in accessing these comprehensive services.

Substance Use Disorder Services
Within Boston, there are 176 substance use treatment beds, including 22 Level 4 - 24-hour diversionary withdrawal management beds, 106 Level 3.7 - 24 hour diversionary withdrawal management beds, and 48 Level 3.5 - clinical stabilization services beds. There are also 685 residential treatment beds in Boston, including 34 family residential, 140 co-occurring enhanced, and 637 adult residential.

There were 6,782 Boston residents admitted to community based and wrap around BSAS services in FY24 (July 2023 - June 2024). This was a 3% increase since FY23 (July 2022 - June 2023). There were almost 2,000 people who received OTP services, 48,000 buprenorphine prescriptions filled, over 35,000 naloxone kits received, and over 45,000 fentanyl test strips received for Boston residents.[14]

Boston Public Health Commission's Recovery Services Bureau offers a full continuum of harm reduction, access to care, day spaces, community prevention, and residential treatment programs through 11 programs and divisions and 151 staff. All of this work is done in partnership with community residents and organizations.

While there is encouraging data showing that overdose deaths may be declining in Boston, providers in Boston have emphasized the need to fill existing gaps in the continuum of care, to ensure that people in treatment are able to move through the appropriate levels of care, and that fewer people fall out of treatment between steps in their care due to lack of available beds and, and lack of coordination across the system. Particularly for those who may have co-occurring disorders and are battling behavioral health issues alongside addiction, ensuring that the individual is supported fully throughout recovery and that barriers to engaging treatment are addressed.

[14] https://www.mass.gov/info-details/bureau-of-substance-addiction-services-bsas-dashboard

Community Engagement

The Working Group process included a significant effort to engage residents to share information about the closure of Carney Hospital, how to address care needs, and gather community residents' feedback about the challenges created by the hospital closure and their solutions.

Immediate Response Communication and Engagement

To support healthcare preparedness and efforts in the period leading up to and following the hospital closure, both the Commonwealth and Boston Public Health Commission activated incident command structures to ensure situational awareness and identify and resolve emerging needs related to the closure of Carney Hospital.

The Boston Incident Management Team (IMT) convened by Boston Public Health Commission's Office of Public Health Preparedness in partnership with the Conference of Boston Teaching Hospitals, included representatives from Boston EMS, BPHC's Executive Office and Communications Office, Massachusetts Department of Public Health, Massachusetts Department of Mental Health, Massachusetts Health and Hospital Association, Massachusetts League of Community Health Centers, Boston Medical Center, Massachusetts General Brigham, and Steward Carney Hospital.

Coordination efforts included IMT meetings twice per week and organizational partner briefing meeting twice per week for Boston region healthcare emergency managers, and regular written situation briefings. The IMT structure helped to gather information about specific risks and challenges associated with the closure faced by residents and inform public communications and outreach strategies. Messaging circulated broadly in the community highlighted the availability of the Mayor's Health Line, BPHC's free, confidential and multilingual resource and referral line to help residents access health information.

At the same time BPHC staff and Health Care For All canvassers distributed fact sheets that included language responsive to community needs related to finding care, seeking ongoing care at remining practices in the Seton Medical Building, and assistance signing up for health insurance. Flyers were made available in English, Spanish, Vietnamese, Haitian Creole, and Cape Verdean Creole.

Community Listening Session

The Working Group held a community listening session open to members of the public on December 12th, 2024 in Dorchester. Comments and hemes at the meeting included:

- The ripple effects of the closure continue to reverberate across communities, neighborhoods and families that have been historically underserved.
- Behavioral health beds should be restored at the site.
- The loss of hospital also represents loss of pivotal economic engine that provided good paying jobs and supported the local economy; partnerships and funding to support workforce training are needed.
- Consider establishing hospital, urgent care, and doctor's offices; consider the case of other hospitals that have closed and reopened.
- If a fully functioning hospital cannot be reopened, then a free-standing emergency department with the capacity for lab diagnostics and imaging as well as surgical beds to stabilize patients before transfer should be considered.
- Create a model of excellence that includes multilingual primary care services, a wellness center focused on the prevention of high incident illnesses affecting the community including, high blood pressure, diabetes, sickle cell disease, obesity, substance use and mental health disorders.

Written Comment

The Working Group also made an opportunity to provide written comment available at the time of the listening session. Quotes and themes from those responses included:

- "The only reasonable solution to this issue is to return Carney as a health care facility. Re-opening the emergency room would be the best, but even establishing an urgent care center, with pediatric capabilities, imaging, IVs, EKGs, and minor procedures, would significantly assist the neighborhood."
- "Our community providers need to be assured that reimbursements are adequate and support the costs of delivering care and services, which will aid in insuring their long-term presence in our community. This would lead to patients establishing trusted relationships with care teams."
- Reimburse work to address social determinants of health. Provide upfront funding for urgent care staffing and supports.
- Develop primary care dashboards to help pinpoint access to care issues and support the direction of resources and technical assistance.
- Explore alternative cost saving solutions which might include seeking additional funding sources, implementing cost-saving measures, collaborating with other healthcare providers, exploring innovative models of care.

Health Care For All Community Engagement

A robust community education and engagement campaign was undertaken collaboration between Health Care For All (HCFA), Massachusetts Department of Public Health (DPH),

Boston Public Health Commission, and community- and faith-based organizations (CBOs/FBOs) aimed at helping individuals and families navigate the unique health care access challenges that were exasperated due to the closures and transitions. The project ran from Oct 2024 – Jan 2025. With support from DPH, several local foundations, corporate entities, and a health care union, HCFA led a campaign to support communities impacted by the Steward Health Care crisis.

The project's goals were to educate patients about accessing health care services, identify the communities' health care needs after Steward ceased operations, amplify the voices of those most impacted by the closures, and ensure culturally and linguistically appropriate care given the diverse patient population.

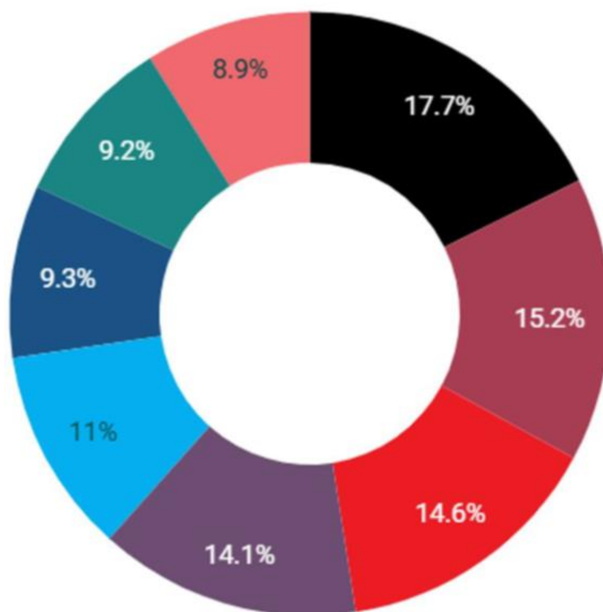
Community Canvassing Outreach

A canvassing campaign had broad reach, with 40,837 doors knocked, and 10,223 conversations had by canvassers, with a contact rate of 25.%. The Carney area canvassing team consisted of 10 local team members, with prior canvassing experience and dedication to helping communities in the aftermath of the Steward closure.

The canvassers asked two questions: Where will you seek care? And What are your top concerns now that the hospital has closed?

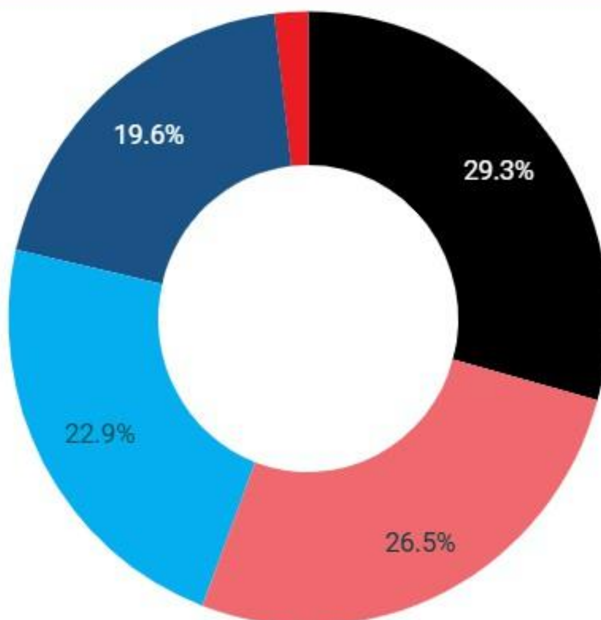
Canvassing Responses

Top Concerns



- Economic impacts caused by the closure of one of the region's largest employers
- Loss of Inpatient facilities for more serious/acute medical conditions
- Loss of access to my Primary Care Provider
- No longer an emergency room nearby
- Loss of access to medical specialties
- The strain that the closure will have on other health care providers such as urgent care and community health centers
- Lack of transportation to medical facilities
- The closure makes it even harder for veterans to access necessary care

Where Will You Seek Care Now?



- A community health center
- With my current Primary Care Provider (PCP) who's moved to a new organization/ facility
- At an urgent care center
- At an emergency room at a hospital even further away
- I don't know

Canvassing Feedback Key Themes

Occasionally, community members would share their initial reactions to the closure and their personal health care stories with canvassers. The following contains some of the stories that canvassers heard. The stories are grouped into the following key themes: access to emergency services, access to specialty services, economic and community impacts and lack of communication about the hospital closure.

Access to emergency services:

- One community member was shot and taken to Carney to be stabilized. They were then sent to BMC. They believe stopping first at Carney saved their life because they were losing so much blood and wouldn't have made it to BMC if they couldn't first stop at Carney.
- One community member's uncle fainted at Ashmont MBTA station this summer and was rushed to Carney, which is less than 5 minutes away. The next closest facility is miles away.
- One community member was nervous about ambulance fees. They have no other way to get to hospitals outside of Dorchester.
- One community member had a seizure in Dorchester and had to choose between BMC and MGH during rush hour because Carney is closed.

Access to Specialty Services:

- One community member stated that Carney had some of the best mental health facilities. Another community member was unsure how to follow up about their mental health support.
- One community member had her heart treatments and primary care visits at Carney. She wasn't sure how to proceed to ensure continuity of care.
- One community member with diabetes felt unsafe losing the closest hospital in the neighborhood. Another community member with MS was concerned about having to travel far in the cold to get to another hospital.

Economic and Community Impacts:

- One community member owns property, all his renters worked for Carney and lost their jobs. They could no longer pay their rent.
- One community member's wife worked at Carney for 15 years. At the time of canvassing, she remained unemployed. Another community member was an employee at Carney and at the time of canvassing, hadn't been paid their final wages.

- One community member explained the additional layer of work she would have to do to ensure the next hospital would be able to support her mother's language needs.
- Many community members expressed hope that the facility would remain a hospital, even if ownership had to change.

Lack of Communication About the Hospital Closure:

- Several community members stated that they were unaware that the hospital had closed.
- Multiple community members were unsure of next steps to ensure continuation of care. They were grateful for information provided by canvassers in relation to follow ups and medical records.
- Many community members were happy that canvassers were getting the word out about the Carney Hospital closure and took additional flyers to hand out themselves.

Digital Media Campaign

To enhance the campaign's outreach, HCFA engaged the services of Digital Turf, a creative agency that works with mission-driven organizations. HCFA and Digital Turf created advertisements to reinforce key messages and reach community members who may not be contacted directly.
Each of the advertisements provided links to a HCFA-created webpage where there was additional information on how to request copies of medical records, get help assess their insurance networks, and guidance on emergency care planning.

Ads ran for four weeks between Thanksgiving and the end of December and were geotargeted by zip code. Local residents could view ads on phones, tablets and computers. The campaign generated 661,338 impressions.

Community and Faith Based Organization Engagement

To increase the outreach happening on the ground within the impacted communities, HCFA subcontracted with local CBOs/FBOs including VietAID, Asian Women for Health, Codman Square Neighborhood Development Corporation, Immigrant Family Services Institute, TAC, and the Boston Public Health Commission. CBOs/FBOs participated in 47 events to disseminate information about the closure of Carney hospital with over 2,000 flyers distributed. HCFA and CBOs/FBOs co-hosted six visioning sessions.

The CBO/FBO's knowledge of the local area was critical in disseminating important information about continuation of care and facilitating an additional layer of direct contact within the communities. Additionally, the groups' longstanding history in the Carney area created an environment of trust and cultural competency, which was important for collecting insights into the true impacts of the hospital closure. The CBOs/FBOs were also able make direct contact in the languages and locations most utilized by community members.

Community groups handed out flyers with important information and resources for continuation of care. Translated flyers were provided on the HCFA website and could be accessed by scanning the QR code. The flyers were translated into the most common languages in the Carney catchment area: English, Spanish, Portuguese, Haitian Creole, Cape Verdean Creole, Vietnamese, and Chinese (simplified).

Community Visioning Sessions

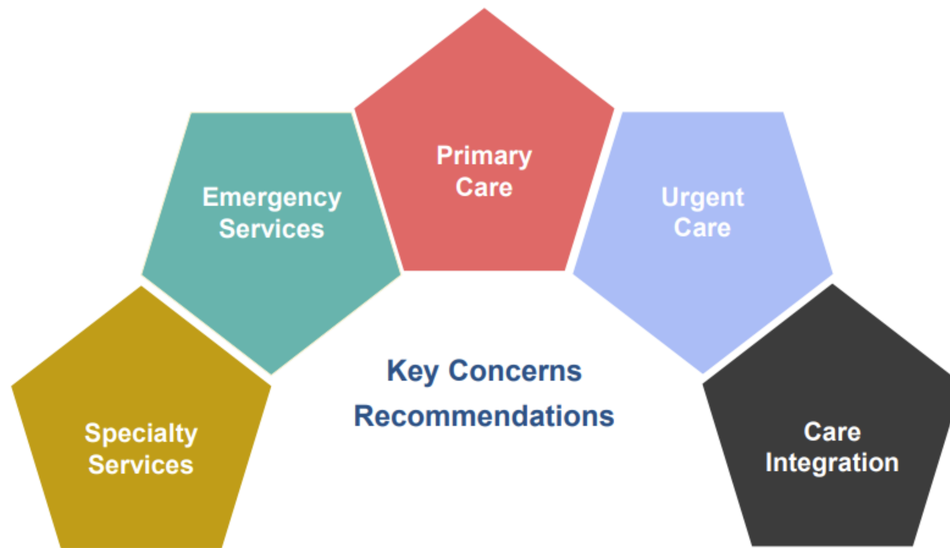
HCFA partnered with CBOs and FBOs to run visioning sessions and assess the current health care needs of the residents in the Carney catchment area. HCFA worked with CBOs/FBOs to develop and translate visioning session questions to assess community priorities and understand how to address the unique needs of the populations.

CBOs/FBOs aimed to recruit 10-12 participants for two to three sessions from the Dorchester area that were patients or employees at Carney Hospital. The team ended up running six sessions in this area, most of which had more than 12 participants. HCFA and CBOs/FBOs co-facilitated the vision sessions together. Participants were provided with $50 gift cards to compensate them for their time.

Visioning session questions included:

- What are your family's top health care concerns, especially with the recent hospital closure?
- Where do/will you seek care now?

- Have you recently delayed or missed care because of the closure of Carney Hospital?
- How many hours have you spent recently trying to get care?
- In the short term (6-8 months) what services or support do you need?
- Long term, what services do you need access to? What do you think you and your family can't go without?



Visioning Session Key Themes:

1. Transportation to other hospitals: Carney patients are now seeking care at other hospitals (MGH, BMC, BIMDC, Milton Hospital and Tufts Medical Center). Codman Square Health Center and DotHouse Health are closer options, but residents feel the health centers have fewer services compared to Carney.

   "For elderly patients, navigating subways and buses or paying for parking is impossible."

2. Loss of trust and relationships: Loss of familiarity with staff. The closure of Carney Hospital has left many feeling abandoned by the health care system, as they miss the relationships and personalized care they once trusted.

   "I feel lost at new hospitals; they don't know my history, and I don't trust them yet."

3. Challenges navigating health systems/fragmentation of care: Patients are overwhelmed by the complexity of navigating multiple locations for lab work,

prescriptions and specialty care without the support services they relied on at Carney.

> *"Social workers helped us with paperwork and finding affordable care. Now, we don't have that support."*

4. Difficulty accessing urgent and emergency care: Delays in access and long wait times are discouraging people from seeking care and causing people to leave the emergency room without being seen.

> *"We relied on Carney's ER. Now, it's chaos everywhere else, and no one seems to care."*

5. Gap in meeting diverse medical needs of families: Families are struggling without a local, trusted facility to address their wide range of needs, from pediatrics to elder care.

> *"We need a place that understands the needs of families - everything from vaccinations to elderly care."*

6. Widening of mental health care gap and barriers to accessing to mental health care: The closure of Carney has made accessing mental health care even harder, compounding stress and trauma for patients.

> *"Mental health care is nearly impossible to access - appointments take months, and by then, it's often too late."*

7. Economic and systemic impact: Closure represents loss of one of the community's largest employers. Communities feeling hurt and neglected, as many struggle with financial hardships after losing jobs and deal with lack of health care access.

> *"Many families lost their income when Carney closed, and it's affecting the community."*

8. Community and familiarity: Carney was part of the community, provided a sense of belonging, and its closure has left patients feeling disconnected and overlooked.

> *"Carney was more than a hospital - it was part of our community. Now it feels like something's missing."*

Community Visioning Session Recommendations

Centralized Care: Establish a centralized health care facility in Dorchester offering diagnostics, mental health care, urgent care and specialty services. Invest in health care infrastructure for underserved, minority communities to address systemic inequities.

- **Urgent and Emergency Care**: Allocate more resources to neighboring ERs to reduce overcrowding. Ensure 24/7 access to urgent and emergency care in Dorchester. Create temporary urgent care centers to handle overflow from Carney's closure. Expand local health centers' capacity, such as Codman Square and DotHouse, to address immediate needs.
- **Preventative and Specialty Care:** Strengthen preventative and specialty care. Develop community-driven programs for mental health, chronic disease management and health education.
- **Transportation and Accessibility**: Provide free or subsidized shuttles to nearby hospitals. Involve social service agencies to facilitate access to available transportation benefits. Ensure reliability of services like The Ride for seniors and low-income patients.
- **Navigation and Language Access**: Establish care coordination teams or community health worker hubs to assist patients with referrals and navigation. Increase interpreter and language support services.
- **Mental Health Services**: Expand mental health capacity at local clinics and integrate mental health into primary care settings.
- **Policy Advocacy**: Work with policymakers to secure funding for health care access in low-income neighborhoods. Ensure hospital closures are planned with input from affected communities.

2025 Community Health Needs Assessment: Preliminary Area Findings

The Carney Hospital-specific engagement builds upon ongoing efforts to understand and address community health needs. BPHC serves as the coordinating entity for the Boston Community Health Collaborative, which is a group of organizations that come together to conduct a citywide health needs assessment and carry out a community health improvement plan every three years. The improvement plan targets and coordinates resources among communities. The plan also provides partners with action items to help improve community health.

The 2022 Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) prioritize collaborative efforts to address upstream social

determinants of health in shaping people's health, well-being, and quality of life, including the following priority areas: Mental and Behavioral Health, Housing, Economic Mobility and Inclusion, and Accessing Services.

At the time of the hospital closure and Working Group process, BPHC was fielding a citywide survey and focus groups to inform the development of the 2025-2028 Community Health Needs Assessment. The 2025 CHNA Survey asks residents about their community health priorities, availability of resources to support health and wellbeing, and access to care. It was open to residents of Boston age 14 and up, and available in English, Arabic, Cabo Verdean Creole, Haitian Creole, Somali, Spanish, Simplified Chinese, Vietnamese, Portuguese.

The survey was in the field in the period following the Carney closure, from September 25th-January 6th. It yielded 480+ survey responses gathered from Dorchester and Mattapan residents.

Preliminary analysis of the CHNA survey and qualitative focus group data shows community priorities for Dorchester and Mattapan are broadly aligned with the feedback heard from the community through the other Working Group community engagement opportunities, emphasizing the importance of access to care factors including co-located care, availability of appointments and social determinants including economic opportunity, food access, and affordable housing.

Dorchester and Mattapan Preliminary 2025 CHNA Selected Survey Data

What Would Help You and Your Family Get the Health Care You Need?: Dorchester and Mattapan Boston CHNA Survey Responses	
Being Able to Get Many Services at the Same Location or Practice	49%
Evening or Weekend Appointments	38%
Health Care Providers Who Make Me Feel Safe and Respected.	38%
Lower Out of Pocket Costs for Services	37%
More Appointments Available	36%

Boston Community Health Needs Assessment, Boston Public Health Commission and Boston Community Health Collaborative, Preliminary Analysis, 2025

Top Factors to Improve Quality of Life and Health in the Community: Dorchester and Mattapan Boston CHNA Survey Responses	
Access to Good Jobs and Economic Opportunity	48%
Access to Low-Cost Healthy Foods	45%
More Affordable Housing	44%
Lower Crime and Violence	38%
Access to Health Care	34%

Boston Community Health Needs Assessment, Boston Public Health Commission and Boston Community Health Collaborative, Preliminary Analysis, 2025

Boston 2025 CHNA Focus Group Themes

- **Access to Care**: Affordability and accessibility of healthcare services; mobile health services, home visits for seniors, and mental health support; difficulties in finding proper care due to long wait times or closures of local health facilities.
- **Mental Health**: Mental health issues, including better access to mental health care, stress management, and resources for coping with anxiety and depression.
- **Affordable Housing**: Affordable housing, improved housing quality, particularly in communities with rising living costs and housing shortages.
- **Economic Mobility:** Economic hardships, such as living paycheck to paycheck despite having higher education or multiple jobs, pressure of balancing work, childcare, and other life responsibilities, alongside the difficulty of accessing quality food and other necessities.
- **Community Supports**: Need for community-driven solutions, community services, including more shelters individuals experiencing homelessness, better public transportation, and programs for youth.
- **Community Safety**: Importance of community cooperation and safety measures, such as more police presence, but also highlighted issues like crime and the lack of action on requests for improvements in public spaces and infrastructure.

The full findings from the Boston Community Health Needs Assessment process will be made available during Summer 2025.

Overarching Themes Across Community Engagement Efforts

- Access to care, including primary care, urgent care, emergency care, and specialty care, is a top priority for the community
- Community members continue to prioritize the importance of addressing health related social needs/social determinants.

- Addressing these longstanding upstream issues remain priorities for the community previously served by the Carney Hospital, and actions to reuse the site should address both the provision of health care as well as these upstream needs.
- Much of what was heard from the community aligns with what has been gathered in previous community engagement. For example, Steward Carney Hospital's 2021 CHNA prioritized mental health, substance use disorder, chronic conditions, obesity, COVID-19, homelessness, and access and involvement.
- While the closure of the hospital has exacerbated many of the issues raised by the community in the context are longstanding.

Case Studies and Frameworks

The closure of community hospitals is increasingly common in America, driven by financial pressures and a range of other challenges. The Working Group researched and received briefings about how other hospital campuses have been reused following closure, as well as models to address gaps in care.

Community Care Hub

Presenter: Dr. Guy Fish

Dr. Fish grounded the presentation with sharing the fact that 80% of health is driven by factors other than doctors seeing patients. The previous Carney Hospital staff spent a lot of time supporting patients with health-related social needs, so the closure of the hospital also represents a significant loss of this critical service.

Payors will refuse to pay for upstream interventions because the return on investment is difficult to quantify, they do not believe there are efficient ways of delivering those services, or fear that they do not realize benefit because the patient moves on and their future improved health benefits other entities.

There is a need to develop sustainable partnerships between providers, public health system, and Community Based Organizations. Medical care, social services, and public health need to be addressed more holistically.

The Community Care Hubs concept centers around finding people to screen for health-related social needs and get them met before the person needs to see a doctor. Best practices include having a single point of contracting and leveraging transition to value-based care. The Accountable Communities for Health model operates on similar principles.

The recommendation to the group was to look at communities that have done this well, starting with the needs and services that we have identified through the multiple streams of community engagement through the working group. It was noted that community health centers are well positioned to help redefine service delivery, and that services provided on the hospital site should complement and work synergistically with existing CHCs. Health care and services added in the community should focus on what is needed close to home and what families in the community need.

Discussion highlighted the need to focus on the workforce development needs for each medical and preventative service type, including wellness staff, counselors, nutritionists, and the concept of the hospital site being a hub for a health care workforce that could be deployed into the community.

Case: Healthy Villages

Location: Smithers and Montgomery, West Virginia; Woodbury New Jersey, others.

Presenters: Scott Keller, CEO, President, Dynamis Advisors; Randall Imai, Partner, Imai Keller Moore Architects

Hospital closures are increasing nationwide. The premise of the Healthy Villages model is that the best way to reduce health spending is integrating community planning and community health. Land values on closed hospital campuses are often depressed by demolition and environmental remediation cost. These factors often support a case for reuse of existing buildings where feasible.

The Smithers and Montgomery Intergenerational Gateway Community in West Virginia was the result of a community engagement process to identify economic development strategies for a vacant college campus and revitalize an aging community hospital. To address the needs of an aging population and create employment opportunities, the community leveraged low-income housing tax credit financing to develop senior housing. A key success factor was fostering a comprehensive approach to enhancing quality of life, promoting social cohesion and supporting sustainable growth.

A hospital campus redevelopment project in Woodbury, New Jersey featured the creation of a multi-phased, multi-year campus revitalization plan for a decommissioned 14.6-acre hospital campus owned by Inspira Health. The project included remodeling a medical office building and family medicine center as well as the construction of a new $71m building to house a satellite emergency department and inpatient behavioral health. An EMS station will be located adjacent. Longer term plans for the remainder of the site include senior living, housing, hotel, and community space.

In this type of redevelopment project, it is important to consider site factors including whether buildings are severable, the structure and condition of HVAC systems, and environmental liabilities. Strong leadership is key for project success, and the need to consider benefits beyond just optimizing return of income on the land value through rents, particularly the value of improved community health.

Case: NeighborHealth Satellite Emergency Facility

Location: East Boston

Presenters: Greg Wilmot, Ernani DeAraujo

Commissioner Goldstein gave an overview of clinical care and regulation of Satellite Emergency Facilities (SEF) at the state level. By its state regulatory definition, a SEF is:

> "a health care facility off the premises of a hospital that is listed on the license of the hospital, at which the hospital is authorized pursuant [under state regulation] to accept patients transported to the SEF by ambulance, and which operates on a seven day per week 24 hour per day basis. SEFs must comply with all requirements of the federal Emergency Medical Treatment and Active Labor Act in that all patients should be provided an appropriate medical screening examination to determine whether or not the patient needs emergency care."

SEF's require physician staffing experience/credentialing, and 24/7 radiology and lab services. Transfers to hospital facilities are still required for certain diagnostic equipment, inpatient capacity, and surgery. The extensive requirements make it a relatively more expensive resource, which has been a significant factor in closures. Not all SEFs accept ambulances, urgent care cannot accept ambulances.

NeighborHealth's East Boston SEF operates under Boston Medical Center's hospital license. It has the fourth highest ED volume in city (45,000 visits per year and trending upward), has low wait times, reduces hospitalizations, particularly pediatric hospitalizations, and keeps patients in coordinated care in the community.

The current facility was created through a phased full rebuild of the existing emergency department starting in 2022. It features 12 bays, with the ability to use triage rooms and other spaces to flex up to see a high volume of patients in a relatively small footprint. The site also offers same-day pediatric urgent care, allowing for greater volume and efficiency.

It has imaging capacity including CT scan, ultrasound, and X-ray. The imaging capabilities have allowed NeighborHealth to reduce the number of patients that need to be transferred to other facilities. The number of patients who leave without being seen has decreased, which is associated with managing emergency department volume.

The presentation and discussion also focused on challenges facing SEFs. While successful in meeting the needs of the East Boston community, and increasingly gaining market share nationwide, standalone SEFs are uncommon in Massachusetts, and many have ceased to operate.

Currently there are only two SEFs operating in Massachusetts, NeighborHealth's East Boston site and UMass Harrington at Webster. Five others have ceased operations, including Cambridge Health Alliance Somerville Hospital (converted to urgent care), Quincy Hospital (closed), North Adams Campus of Berkshire Medical Center (converted to critical access hospital), Lawrence Memorial Hospital SEF (closed), and Baystate Mary Lane (closed).

A key risk associated with operating a SEF is that without a high enough volume of patients, the operator must pay for health care resources that are not reimbursed. Additionally, the lack of certain diagnostic equipment, inpatient, and surgery means that certain patients will need to be transferred to other facilities.

There are also potential weaknesses associated with SEFs at the system level. SEFs that are fully freestanding may increase health care spending.[15] SEFs that are not as integrated into the care coordination network of a community health center may present similar challenges with coordination of care that seeking routine care in emergency departments present generally.

Case: Sankofa Wellness Center

Location: West Garfield Park, Chicago, IL

Presenters: Bart Mitchell, President and CEO, The Community Builders

In the West Garfield Park community in Chicago, partnerships and philanthropy enabled the creation of a facility that serves a range of health, wellness, and social service needs with an explicit goal of improving health outcomes for neighborhood residents and closing a 13-year life expectancy gap between members of the community and another neighborhood in the city, the Loop.

The wellness center component sits on roughly 2/3 of an acre of land in a new 60,000 square foot building. Approximately14,000 square feet are occupied by Erie Health Center. Services include care coordination and navigation. Not much space on the site is used for parking.

The roughly $44m development budget for the site, included $8m in New Markets Tax Credit equity, partner upfront capital from Rush, Erie, and YMCA, $8m from the Chicago Prize philanthropic initiative, $12.5m from government, among other sources. Institutions are paying $35/sq ft in rent which allows for early retirement of loan in 15 years. The institutional tenants provide sustainability while allowing institutions to pay less than downtown. This gives the institutions some debt in their capital stack and is cheaper than usual development on patient served per square foot basis. Consistent with the goals of the partner organizations, there is significant participation from minority businesses in the development.

The collaboration of the partners was motivated by interest in meeting preventative care needs. The role of a capable master developer helped to increase confidence in key

[15] https://pmc.ncbi.nlm.nih.gov/articles/PMC5798671/

partners and investors that the project would happen. Nonprofit ownership of land was seen as key to the project's success.

Observed and anticipated impact includes improved health outcomes, decreased community violence, reduction in emergency urgent care, financial wealth for legacy and new residents, increased employment rates, residents earning family-sustaining wages, decrease in adverse childhood experiences, decreased incarceration and recidivism, increased community ownership, increased graduation rates, network of trusted community resources, and that the site will serve as a scalable model.

Case: Lynn Medical Village

Location: Lynn, MA

Presenter: Dr. Elsie Taveras

Massachusetts General Brigham owned 20 acres of land in Lynn that was the site of the former Union Hospital campus that was redeveloped after the hospital's closure following a process led by Lynn Health Task Force. The community engagement process revealed similar themes to the Dorchester community; the biggest losses identified were emergency and outpatient clinical services.

Following the demolition of the Union Hospital building, five acres of the site were developed as Lynn Medical Village. The new medical village site offers 9am-9pm urgent care with 14,000 annual visits, two on-site providers, and six exam rooms. The site also includes a community farm, and a Program of All-inclusive Care for the Elderly (PACE) program operated by Element Care.

The remaining 15 acres were sold to 2Life Communities, which assembled a financing package to develop 150 elder housing units that are 100% affordable to households with incomes up to 60% Area Median Income aside from two units for on-call live-in staff.

The Medical Village financing included a $32m investment from MGB. The health facility operates at a $2.5m annual net loss. $1.6m of the net loss is financed by Salem Hospital.

The operating loss of the facility highlights the challenge of financial sustainability of desired services. Success factors included dedicated a developer, responsiveness to community needs, and large institutional investment.

Case: Commonwealth Care Alliance, One Care

Location: Brighton, previously at Carney Hospital as well.

Presentation: Bob Master

A goal of the model was to address emergency department boarding. Care Alliance found that 70% of backup in ED psych boarding was patients waiting for inpatient psych that could be treated at another level. One Care created a level of care that was longer term than clinical stabilization services (CSS) but that did not require a locked psychiatry unit.

The model was able to manage behavioral health issues and create more continuity of care by minimizing patients churning within the system. The economics worked because the level of service could be operated more cost effectively and is still operating effectively in Brighton. With more longer-term clinical stabilization service level beds, needs could be met more cost effectively.

The Working Group discussion included new models of care that have emerged or may be needed to address behavioral health, including Community Behavioral Health Centers, diversion programs, partial hospital programs, and adult respite. The need for appropriate placements for individuals who may not meet civil commitment criteria, but need a placement, particularly in the context of avoiding boarding and homelessness.

Matter Health

Presenter: Dr. Hans Van Lancker

The presentation to the Working Group highlighted that community hospitals are in crisis but have no incentive to change and named drivers including, inflated administrative and operational costs, payment models that incentivize providing services rather than outcomes, lack of incentive to discharge patients, and absence of impetus to improve through technology.

Proposed solutions included bringing technology-driven transformation from elsewhere in the health system to the hospital settings, attracting startups to the problem, expanding home-based care, and embracing value-based care. Addressing these issues will increase revenue by saving time and money while ensuring the highest quality care is available to the whole community.

Additional components of the model presented include an acute care hospital within the existing buildings, more fully using operating rooms beyond operating hours, staffing through a four-day work week to reduce overtime and burnout, and keeping care in the community that can be safely and sustainably provided there.

The concept also includes an on-site hotel where patients can be discharged after lower acuity treatments, a café restaurant, partnerships with educational and childcare institutions, on-site wellness, physical therapy, bracing gym, and lifestyle medicine. Licensure as an acute care hospital is important to this model for reimbursement and

financing reasons. The model assumes a continued demand for operating room space and that surgery will support other service lines.

Findings

Many hospital facilities are prohibitively expensive to reuse. In many cases, a history of underinvestment leaves critical building systems past the end of their useful life, or otherwise in need of significant investment. The square footage required for new health care uses is typically significantly smaller than the previous hospital.

Additionally, the building layouts of large acute care hospital campuses often require significant configuration to meet current needs, including a range of uses that support both providing health care as well as health-related social needs. Interior building layouts of older acute care hospitals are often inconsistent with current needs or regulatory requirements. Examples of reuse of existing hospital buildings are more common in scenarios where a hospital system has retained ownership of the campus of a closed hospital and the hospital has an incentive to avoid costly demolition.

The costs associated with the reuse of existing facilities, and the relative value of the land on which they sit often lead to the demolition and construction of new health and health related uses both on the site and elsewhere, often through more efficient use of the land to accomplish multiple purposes.

An entity seeking financing for a proposed reuse and occupancy of a large campus of buildings would generally need assurances that the buildings at the start of that occupancy and their critical systems would last at least as long as the term of any debt taken on to finance the redevelopment costs.

Generally, the finding that the reuse of former hospital campuses and buildings can be reimagined to support both the health care and social determinants of health in resonated with Working Group. Members also responded to discussion about the importance of collaboration to reach sustainable multi-party arrangements that support synergistic uses that meet community needs.

Conclusion

This report and its recommendations identify unmet health needs of the community previously served by Carney Hospital and provide recommendations for addressing health service delivery needs and promote equity following the closure of Carney Hospital.

These recommendations provide a framework for future decision-making about the former Carney Hospital site, as well as policy and programmatic interventions to respond to the needs that the community and data have identified with respect to access to high-quality health care, emergency services, primary care and care coordination, behavioral health, and the health related social needs and social determinants of health that could help to address longstanding health inequities.

While the communities formerly served by Carney Hospital are the focus of this report and its recommendations, many of the findings reassert longstanding state and nationwide issues that will require the types of broader policy interventions identified in the report.