

*Community Health Needs Assessment  
Executive Summary  
2012-2015*



Impact • Excellence • Compassion & Respect • Discovery



# **DANA-FARBER CANCER INSTITUTE COMMUNITY HEALTH ASSESSMENT REPORT OVERALL EXECUTIVE SUMMARY**

*This Executive Summary is intended to satisfy the Community Health Needs Assessment report requirement under Internal Revenue Code Section 501(r) and in accordance with the provisions of the Patient Protection and Affordable Care Act.*

## **BACKGROUND**

Dana-Farber Cancer Institute (DFCI) is one of the world's leading cancer treatment and research centers. In addition to providing expert clinical care, DFCI is committed to educating the community and raising awareness about the importance of cancer prevention, outreach, screening, early detection, and clinical trials. To this end, DFCI's Community Benefits Office provides education and screening across Boston and beyond, offers support services and resources, and conducts a broad scope of evidence-based programs through its collaborative work in local neighborhoods as well as through its national public and professional education initiatives. The mission of DFCI's community benefits contributes to the larger goal of advancing the diagnosis, care, treatment, cure, and prevention and early detection of cancer and related diseases.

To ensure that DFCI's community outreach activities and programs are meeting the health needs in the community, the DFCI Community Benefits Office partnered with Health Resources in Action (HRiA), a non-profit public health consultancy organization in Boston, to undertake a comprehensive community health assessment. This effort incorporated a process of completing assessment activities in two phases. In Phase I, social, economic, and epidemiological data at the community level were reviewed and analyzed to provide a health portrait of DFCI's priority communities (Roxbury, Mission Hill, Dorchester, Mattapan, and Jamaica Plain). Phase II involved a comprehensive qualitative study, where DFCI staff, community leaders, and residents provided feedback in focus groups and interviews to identify community needs and assets as well as areas for further community engagement and program expansion. In addition, HRiA conducted a review of DFCI's current programming activities as well as an environmental scan of interventions external to DFCI to understand the current programming and service environment in these communities. This executive summary compiles the findings of Phase I and Phase II of the DFCI community health assessment.

## **METHODS**

A social determinants of health perspective guided the assessment and report development. Through this lens, it is critical to look beyond proximal, individual-level factors in accounting for a community's health problems. Upstream factors such as housing, education, employment status, racial/ethnic disparities, and neighborhood-level resources critically impact population health. The assessment approaches data in a manner designed to discuss who is healthiest and least healthy in the community as well as examines the larger social and economic factors associated with good and ill health.

This document provides a summary of the key findings from the Phase I secondary data analysis and Phase II qualitative research for the assessment, which included:

- Phase I: From August 2009-October 2009, HRiA staff compiled, reviewed, and analyzed existing socioeconomic and epidemiological data. Phase I findings aimed to provide a comprehensive overview of cancer outcomes and related behaviors for residents of Boston and the DFCI priority neighborhoods and to serve as a starting point for discussion among DFCI staff and community members to identify areas for further primary research efforts and community engagement.

HRiA reviewed existing data drawn from state and local sources. Data comprised of self-reported responses from surveys (e.g., Boston Behavioral Risk Factor Survey), state vital statistics, reported hospitalizations, and the U.S. Census. To ensure that HRiA could tap into local resources as well as gather perspectives on DFCI's engagement with the community, eleven brief interviews were conducted with several staff members from related organizations.

After the completion of Phase I, findings were discussed with DFCI internal staff during a day-long staff retreat and with members of the DFCI Trustees Community Programs Committee and Community Benefits External Advisory Committee (EAC) during subsequent meetings. These discussions helped shaped the focus of Phase II of the assessment.

- Phase II: From August 2010-February 2011, HRiA staff conducted seventeen in-depth interviews and four focus groups with DFCI staff and leadership; a discussion group with the Community Benefits External Advisory Committee; and four focus groups with community audiences (three focus groups with adult neighborhood residents and one focus group with community-based organization (CBO) staff). Of the three adult resident focus groups, one was conducted in Spanish.  
A total of 86 individuals participated in the Phase II qualitative research in order to gauge their perceptions of their neighborhood, their health concerns, what programming or services are most needed to address these concerns, and the role of DFCI in these efforts.

## **FOCUS AREA PRIORITIZATION PROCESS**

Identifying key areas of focus for this plan was conducted through an iterative, multi-phased process. Between phases I and II of the CHNA, 37 Dana-Farber internal staff and stakeholders participated in a day-long retreat. This event included a discussion of quantitative data from CHNA, followed by small group and large group discussions focused on identifying initial key priority areas to build upon Dana-Farber's existing portfolio of community benefits activities.

Upon completion of the CHNA, over a dozen presentations were conducted to internal and external stakeholders, including the Dana-Farber Board of Trustees, Community Benefits External Advisory Committee, and community coalitions among others. The prioritization of focus areas included a number of considerations:

- Alignment with Dana-Farber’s mission and current work;
- Potential impact and the ability to demonstrate measurable outcomes;
- Feasibility including technical and financial capacity and strength of partnerships; and
- The magnitude and severity of the issue

As a result of the process described above, Dana-Farber identified key priority areas based on our potential to demonstrate measurable outcomes in reducing cancer incidence and mortality through programmatic enhancements in these areas.

Our identified focus area priorities – **1) addressing the cancer burden; 2) reducing access barriers; and 3) addressing the community perceptions of cancer** – reflect a commitment to meeting the health needs of the medically underserved in our priority neighborhoods and leveraging our unique role in the continuum of care as a comprehensive cancer center.

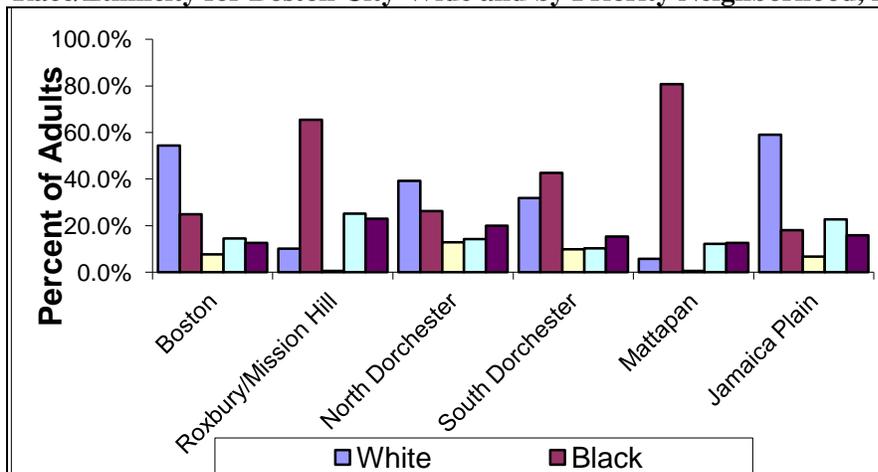
### KEY FINDINGS

The following provides a brief overview of the key findings that emerged from Phase I and Phase II of this assessment:

#### Community Social and Economic Context

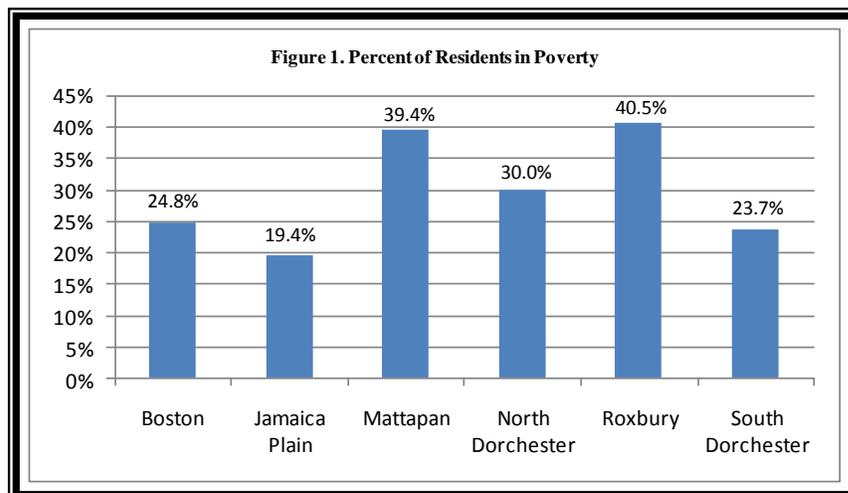
- DFCI’s priority neighborhoods of Roxbury, Mission Hill, Dorchester, Mattapan, and Jamaica Plain collectively comprise 38% of Boston’s overall population. As noted by focus group participants, these neighborhoods are ethnically and culturally diverse. For example:
  - According to the 2005-2009 American Community Survey, in Mattapan and Roxbury/Mission Hill, 87.8% and 53.1% of residents respectively identified themselves as Black, compared to 23.5% of Boston residents city-wide. Approximately one-quarter of residents in Roxbury/Mission Hill (22.5%) and Jamaican Plain (20.9%) identified themselves as Latino.

**Race/Ethnicity for Boston City-Wide and by Priority Neighborhood, 2000**



DATA SOURCE: US Department of Commerce, Bureau of the Census, 2000 Census

- Cost of living, unemployment, housing, and violence were highlighted as the four most dominant themes when focus group participants described their local community.



Source: 2005-2009 American Community Survey, U.S. Census Bureau

- Participants shared experiences of financial hardship faced by low-income residents and their struggle to “survive” amidst the rising cost of living. Census data show that in Roxbury/Mission Hill, 40.5% of individuals live in poverty, as do 39.4% of individuals in Mattapan, as seen in Figure 1.

- Furthermore, the recent economic downturn led to an increase in the monthly unemployment rate across Boston, from 5.0% in October 2008 to 7.9% in October 2009.
- Focus group participants also agreed that there was a significant lack of housing in their communities. The majority of housing units (60-70%) in DFCI’s priority neighborhoods are renter-occupied, with tenants at risk of losing their apartments during the recent wave of foreclosures.

- Crime was described by focus groups as ubiquitous throughout the neighborhoods, including murders, gun violence, gang activity, and drug dealing or use. Roxbury, Mission Hill, Mattapan, and parts of Dorchester encounter a disproportionate percentage of the violent crimes that occur in Boston, with an unequal distribution across racial/ethnic lines: The 2007 homicide rate for Black residents was almost four times the rate than for Latinos and Boston overall.

*“Trying to make ends meet. I can say right now, people are struggling, in a financial crisis.” – Men’s focus group*

*“I’ve seen too many of our Black males die, and the only time we start squealing is when someone gets killed.” – Women’s focus group*

- Despite the numerous challenges facing communities, there were several assets noted by participants.

- Focus group participants generally described their communities as vibrant and active.
- There was a tremendous amount of social capital in these communities in the form of social networks and support.
- In addition, the numerous local organizations and businesses in these communities were viewed as an asset.

*“The greatest strength in my neighborhood for me are the people, the residents themselves.” – Women’s focus group*

*“Our churches are a great source of strength in the community.” – Women’s focus group*

## Community Perceptions of Cancer

- Participants stated that cancer was a low priority compared to the day-to-day concerns of living (i.e., meeting basic needs).
  - Chronic diseases and their risk factors—specifically obesity, diabetes, and asthma—were the most commonly mentioned health issues facing communities.
  - A few participants raised cancer as a concern when discussing health issues; however, for most it was not considered top of mind.
- While participants discussed different types of cancer when probed, many noted that, in their view, there was little distinction between types of cancer, because cancer leads to death.
  - Types of cancers frequently mentioned by focus group participants included cervical, breast, prostate, and skin cancer.
- Several cultural norms and beliefs surrounding cancer emerged from the focus group discussions with community residents and front-line CBO staff. Participants, including EAC Members, described cancer as a personal and private matter, rather than a public one.
- It was also readily apparent that for all participants, cancer was associated with negative outcomes, especially for communities of color.
  - The strong correlation between death and cancer for participants was reflected in the personal stories they shared, most of which ended in death rather than survival.
- In addition, focus groups discussed perceived disparities in cancer diagnosis, treatment, and mortality. Several participants mentioned the disparate rates of cancer mortality affecting women of color, often related to socioeconomic inequities.
- The skepticism and distrust around cancer research and healthcare institutions in general were also common themes. Most focus group participants were familiar with cancer from the perspective of research subjects (e.g., “Do you want to be a guinea pig and make \$1,200 for six weeks?”).

*“I really have not seen a concern over cancer in the community.” – Men’s focus group*

*“Obesity [is a major concern.]... And diet. Diet and obesity.” – Men’s focus group*

*“Asthma...because of where we live, the cars and just the things [we’re] breathing in.” – Women’s focus group*

*“The outcome [of cancer] is usually death...It’s something that, it’s not really public. It’s not really talked about. It’s like a private thing, you know?” – Front-line CBO focus group*

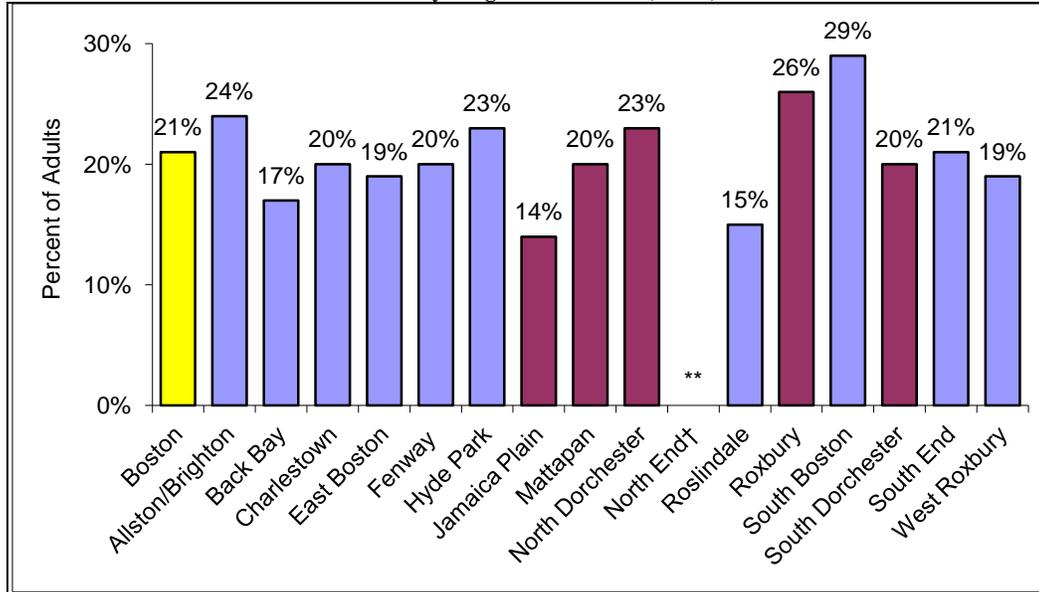
*“In our community, we don’t face cancer until cancer shows up and says, ‘Hey, I got you.’” – Men’s focus group*

## Cancer Prevention

- There appeared to be a general lack of awareness regarding the underlying causes of cancer, particularly among the participants of the men’s focus group.
  - Nevertheless, participants did frequently cite the sun and smoking as potential causes of cancer, as well as other environmental factors, such as chemicals in polluted water.

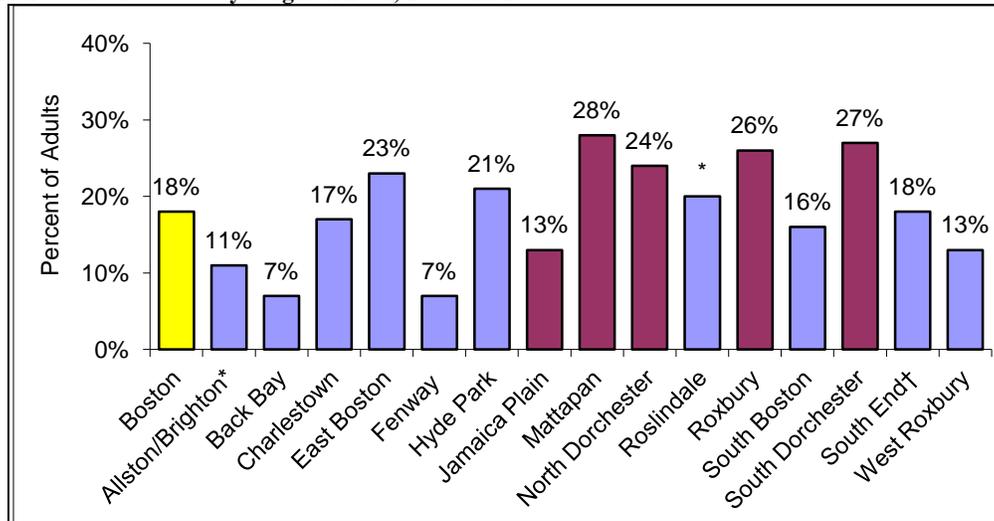
*“I can’t even tell you what causes cancer. I can’t. I can tell you that the sun can cause it. But I can’t really tell you why somebody just up and dies from cancer, and he...never smoked in his life...I don’t know.” – Men’s focus group*

**Adults who are Current Smokers by Neighborhood 1999, 2001, 2003\***



DATA SOURCE: BBRFS 1999, 2001, 2003, BPHC Health Status Report for South Dorchester.  
 DATA ANALYSIS: Boston Public Health Commission Research Office

**Adults who are Obese by Neighborhood, 2005 and 2006**



DATA SOURCE: BBRFS 2005 and 2006, BPHC Health of Boston 2009 Report  
 DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

- Epidemiological data show that smoking and obesity still affect many Boston residents, particularly Blacks and Hispanics.
  - Although rates of current smoking declined from 2005 to 2006 for the city overall, Whites, and Asians, rates increased during this same time frame for Blacks (16% to 18%) and Latinos (16% to 19%).
  - Furthermore, about 1 in 4 adult residents in Mattapan (28%), South Dorchester (27%), Roxbury (26%), and North Dorchester (24%) were considered obese in 2006, compared to Boston citywide (18%). Racial/ethnic differences in obesity rates were stark: Among female adults in Boston, 36% of Blacks were considered obese, compared to 25% of Latinas and 14% of Whites.

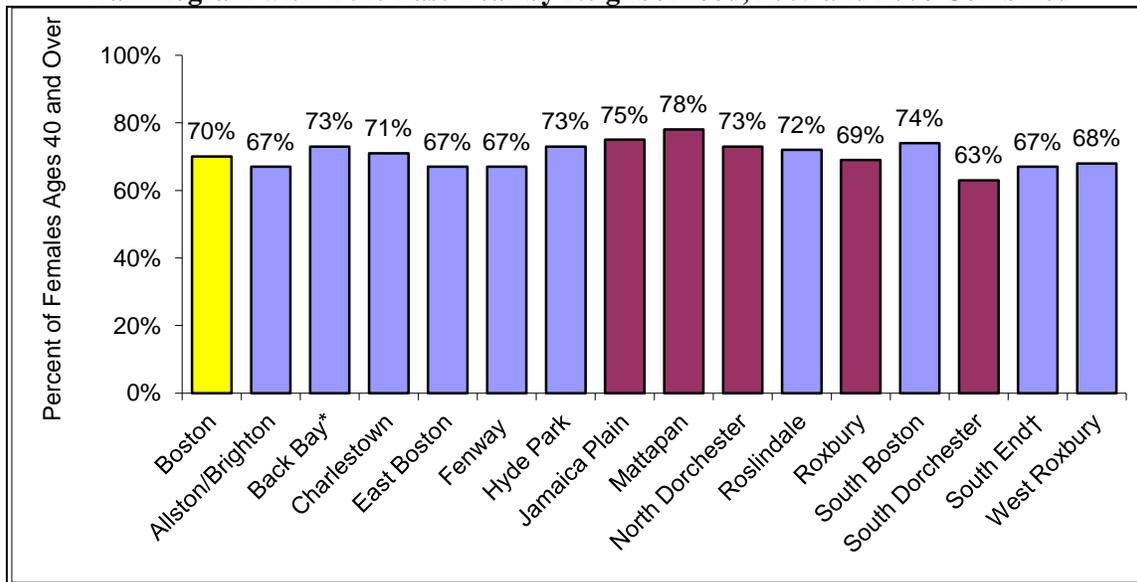
- While Jamaica Plain and Roxbury were similar to Boston (54%) in the percentage of residents who engaged in regular physical activity, rates were lower among adults in Mattapan (50%), North Dorchester (48%), and South Dorchester (44%).
- According to focus group participants, a primary method for reducing the risk of cancer was becoming an informed patient. Across all focus groups, participants frequently mentioned health education and information sharing as critical for preventing cancer, in the form of both group sessions and one-on-one education by peers.
  - Participants also expressed that seeking primary, preventive care was important for lessening one’s risk of cancer. According to residents, it is important that men and women establish preventative health care visits as a routine part of their lives, although there are many challenges to doing so.

*“[Prostate cancer isn’t] stuff we talk about. But at the same time, we know it’s necessary [to get screened], it’s like getting a vaccination... You’re scared that it’s going to hurt, and it does take a lot of time.” – Men’s focus group*

### Cancer Screening

- With regard to screening practices, seven in ten Boston adult women reported receiving a mammogram in 2006, and rates were similar across neighborhoods and by racial/ethnic groups. However, breast cancer incidence rates in both the early and late stages were significantly higher for Boston women compared to women statewide.
- In 2006, 70% of all Boston women surveyed reported receiving a Pap test for cervical cancer in the past year, while 60% of Boston men over age 45 reported getting a PSA test for prostate cancer in the past year. Screening rates in DFCI neighborhoods and among Blacks and Latinos were similar to those Boston city-wide, and in some cases were higher.
- Screening rates for colon cancer vary by race/ethnicity and education level. In 2006, White adults ages 50+ reported the highest percentage of these screening tests in the past five years (65%) followed by Blacks (62%); Latinos (56%) reported the lowest percentage. Adults ages 50+ who had a college education or more were more likely to report ever having a colonoscopy or sigmoidoscopy (64.0%). Older Boston adults with a high school education or less reported the lowest percentage of ever having one of these screening tests (51.0%).
- Focus group participants shared a variety of experiences with regard to cancer screening. While there appears to be an awareness of screening, they were not always viewed positively.
  - Despite recognizing the role of preventive care (i.e., screening), men in particular did not seek primary care.

### Mammogram within the Last Year by Neighborhood, 2005 and 2006 Combined

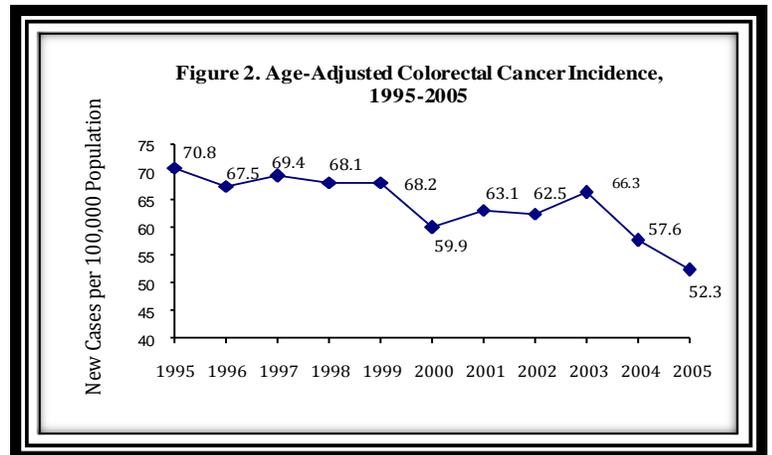


DATA SOURCE: BBRFS 2005 and 2006, BPHC Health of Boston 2009 Report  
 DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

- Participants also noted several barriers to screening, including gender specific challenges, cultural norms, healthcare access, and lack of information. Participants primarily avoided screening due to the fear of diagnosis.
  - Healthcare access also posed a significant barrier to screening, including cost of exams, navigating the system, and lack of culturally sensitive services.
- Lastly, lack of information was viewed as preventing screening. Participants described feeling uninformed about cancer risks, prevention, screening, and treatment due to inexperience (e.g., no family history) with cancer.

### Cancer Incidence

- Colorectal cancer incidence rates in Boston fell from 70.8 cases per 100,000 population in 1995 to 52.3 cases per 100,000 in 2005, as shown in Figure 2.
  - However, more new cases of colorectal cancer in Boston were diagnosed during the late stage of the condition than the early stage, demonstrating the need for earlier diagnosis.



Source: Boston Public Health Commission, Health of Boston Report, 2009

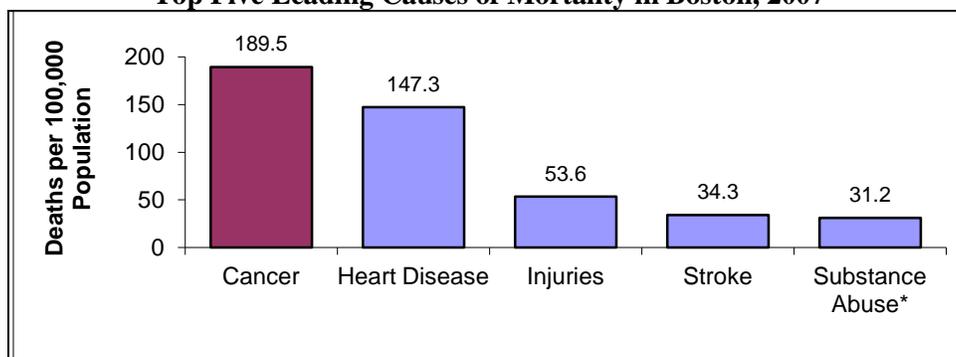
- Although rates of breast cancer fluctuated from 1995-2005, overall, the age-adjusted incidence rate of breast cancer for Boston women decreased from 137.7 cases per 100,000 population in 1995 to 121.9 cases per 100,000 population in 2005.

- During this same 10 year time period, White women consistently reported the highest age-adjusted incidence rate of breast cancer, while Asian and Latina women reported the lowest age-adjusted incidence rates of breast cancer.
- In 2005, Boston men reported an age-adjusted incidence rate of 172.9 cases per 100,000 population. Between 1995 and 2005, Black men consistently reported the highest incidence rate of prostate cancer compared to all other racial/ethnic groups.

### Cancer Mortality and Survivorship

- In 2007, cancer was the leading cause of death among all Boston residents (189.5 deaths per 100,000 population). Overall, Boston males had a greater cancer mortality rate than females (248.3 deaths per 100,000 population vs. 117.9 deaths per 100,000 population).

**Top Five Leading Causes of Mortality in Boston, 2007**



DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health, BPHC Health of Boston 2009 Report  
 DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

- Furthermore, cancer mortality rates were not equal across racial/ethnic groups. While Blacks had similar cancer screening rates to Whites in Boston, their overall cancer mortality rate in 2007 was higher. Among Blacks, there were 276.3 deaths due to cancer per 100,000 population compared to 183.4 for Whites, as shown in Table 1.

**Table 1. Age-Adjusted Cancer Mortality in Boston by Leading Types of Cancer, by Race/Ethnicity, 2007**

White		Black		Latino		Asian	
<i>Cancer</i>	<i>Rate</i>	<i>Cancer</i>	<i>Rate</i>	<i>Cancer</i>	<i>Rate</i>	<i>Cancer</i>	<i>Rate</i>
Lung	50.5	Prostate	80.5	Lung	31.3	Lung	35.1
Prostate	27.0	Lung	57.5	Colorectal	15.6	Liver	24.5
Colorectal	17.4	Breast	33.9	*		*	
<b>All Cancer</b>	<b>183.4</b>	<b>All Cancer</b>	<b>276.3</b>	<b>All Cancer</b>	<b>137.9</b>	<b>All Cancer</b>	<b>146.6</b>

\*Insufficient data to estimate mortality rate

Source: Boston Public Health Commission, Health of Boston Report, 2009

- The Black-White disparity in mortality rates was especially dramatic for breast cancer and uterine cancer. From 2005-2007 aggregated mortality data, the breast cancer mortality rate among Black women in Boston was 32.0 deaths per 100,000 population vs. 21.8 deaths per 100,000 for White women, while the rate for uterine cancer was 7.1 deaths per 100,000 population for Black women compared to 3.8 deaths per 100,000 for White women.

- National figures indicate that the five-year survival rate can be quite high for many cancers (e.g., 89.1% for breast cancer, 82.9% for ovarian cancer, nearly 100% for prostate cancer). Yet, across all cancers, the survival rate is consistently lower among Blacks than Whites.
- When asked about resources for cancer survivors, some focus group participants who had a personal experience with cancer shared that information was readily available for cancer survivors through resource centers, counselors, books, and the Internet.
  - However, participants whose families had not been affected by cancer were not at all familiar with services available for cancer survivors.
  - All focus group participants considered social support as critical for survivors to help reduce social isolation. In addition to social support, participants noted the importance of financial support for follow-up care.
  - Participants reported knowing people who have died of cancer but were not as familiar with the concept of survivorship and typically knew few people who had survived cancer.

Healthcare Access and Utilization/Perceptions of the Healthcare System

- While in 2009, three years after MA health care reform was passed, 91% of MA residents indicated that they had a usual place they went for health care, many still faced barriers to accessing care. As Table 2 indicates, 22% of MA residents had trouble obtaining the care they needed in the past twelve months. This was starkest among 19-64 year old adults, where 27% reported not getting needed care due to cost and 16% indicated having problems paying their medical bills.

**Table 2. Barriers to Accessing Health Care among Massachusetts Residents, by Age Group, 2009**

	Total MA Population	Children (0-18 years old)	Adults (19-64 years old)	Elderly Adults (65+ years old)
% residents with difficulty obtaining care in past 12 months	22%	14%	27%	15%
% residents not getting needed care due to cost in past 12 months	21%	9%	27%	15%
% residents in families with problems paying medical bills in past 12 months	15%	17%	16%	7%

Source: Long, S. K. & Phadera, L. Access to Health Care in Massachusetts: Results from the 2008 and 2009 Massachusetts Health Insurance Survey, The Urban Institute, Washington, DC, November 2009.

- Even though the focus group discussions did not set out to examine in-depth participants’ perceptions of the healthcare system, issues around healthcare access and utilization were discussed in all focus groups.
- The high cost of healthcare and lack of health insurance coverage was a concern for many focus group participants, particularly with regard to specialty care services (e.g., radiology).
  - Most often, when participants spoke of the lack of health insurance coverage, they were referring to the extent that their insurance covered every aspect of care rather than having zero coverage.

*“When you go for medical services ...even before they ask you your name, they ask you what kind of insurance you have. And that allows them to classify you immediately for the level of care that you will receive.” – Women’s focus group*

*“I get lost so much trying to find appointments, trying to get to appointments on time. And then they want you to follow up with something...it’s being spread out all over the place, and you can’t get an appointment for anything.”- Spanish-speaking focus group*

- Perceptions around poor quality of care were also discussed at length as a deterrent to utilizing healthcare services. Components of quality care included a strong physician-patient relationship, cultural sensitivity, and respect regardless of class or race.
- The difficulties of navigating the healthcare system were heavily discussed in all focus groups as well. Several participants expressed feeling overwhelmed by the system. They described frustration with scheduling appointments and completing follow-up care (e.g., referrals, long wait times).

## CONCLUSIONS

### CHNA Key Findings & Prioritized Areas of Focus

The CHNA findings have validated the current community outreach work that Dana-Farber has undertaken as well as helped guide the focus of future initiatives. The following list highlights Dana-Farber's prioritized areas of focus in addressing the identified community health needs.

- 1) **Cancer Burden:** There is a disproportionately greater cancer incidence and mortality in our priority neighborhoods, specifically among diverse racial and ethnic populations. Specifically, the CHNA findings reflect a significant disparity in cancer mortality between Blacks and Whites in the City of Boston. Among Blacks, there were 276.3 deaths due to cancer per 100,000 in 2007 compared to 183.4 for Whites during the same year, which reflects a 50% higher mortality among Blacks.
- 2) **Access Barriers:** Residents of Dana-Farber's priority communities deal with significant challenges beyond coverage when encountering health care systems. Examples include cost barriers (i.e. co-pays) and perceived poor quality of care such as experiences of discrimination and weak physician-patient relationships. When considered through a health equity lens, the access barriers are associated with a higher risk in cancer incidence and mortality among communities of color.
- 3) **Community Perceptions of Cancer:** Cancer was not considered a priority health issue among residents compared to the daily concerns of meeting basic needs, but community members expressed a tremendous amount of fear surrounding the risk of cancer diagnosis. The CHNA findings reflect that community residents share common experiences of hardship including poverty, unemployment, and violence and often perceive a strong correlation between cancer and death rather than survivorship.
- 4) **Primary Prevention:** Primary prevention behaviors such as healthy eating and physical activity are a significant challenge in many of Dana-Farber's neighborhoods, particularly among Blacks and Latinos. 72% of Boston residents consume less than adequate amounts of fruits and vegetables per day and more than 55% of residents do not participate in adequate physical activity, which is largely correlated to the high cost of nutritious foods, lack of supermarkets in some neighborhoods, and limited access to safe outdoor environments for physical exercise.
- 5) **Community Strengths:** While residents living in Dana-Farber's priority neighborhoods face significant socioeconomic challenges, these communities possess numerous assets and strengths including youth leadership, strong neighborhood cohesion and social networks, and numerous community-based organizations.
- 6) **Social and Environmental Determinants of Health:** Dana-Farber's priority neighborhoods are dealing disproportionately with challenging situations related to the upstream social and economic factors that impact health such as unemployment, lack of affordable housing, and community violence.

## ADDENDUM

### Addressing Community Needs: Existing Community Benefits Programs and Partnerships

<b>Dana-Farber Programs</b>	<b>Description</b>
<b>Dana-Farber Mammography Van</b>	In its eleventh year, the Dana-Farber Mammography Van provides digital screening mammograms and breast health education to women 40 years of age and older in partnership with local neighborhood health centers. 3,500 women were served last year.
<b>Blum Family Resource Van</b>	Providing cancer education and screening throughout the region, the Blum van programs include sun safety education and screening, prostate cancer education and screening, HPV and cervical cancer education and tobacco control activities.
<b>Dana-Farber Community Cancer Care at Whittier Street Health Center (WSHC)</b>	Dana-Farber oncologists host a clinical outreach facility at WSHC, providing on-site cancer evaluation services to aid in the diagnosis and work-up of suspected oncologic issues. A nurse navigator triages and tracks all patients to streamline diagnosis and treatment.
<b>Open Doors to Health: A Peer Led Cancer Prevention and Early Detection Program (ODH)</b>	Peer leaders, who reside in Boston housing developments, educate other residents on prevention and early detection of breast, cervical and colon cancer and provide them with resources to local screening programs.
<b>Evidence-Based Training Programs for Community-based Organizations</b>	Evidence-based trainings are provided to community-based organizations on how to choose, customize, and localize health education programming that will meet community and organizational needs.
<b>United Way/Jimmy Fund Collaborative</b>	In its seventeenth year, the Collaborative has provided funding to community-based organizations that promote youth engagement and cancer prevention. Youth tobacco control efforts that reduce access to tobacco among residents in low-income communities is the current funding priority and is intended to help address the burden of lung cancer in our surrounding communities.
<b>Faith-Based Colon Cancer Prevention Education Outreach Program</b>	Increasing cancer prevention, education, and awareness through partnerships with six Black and Latino churches in Boston to promote colon cancer education and increase knowledge about the importance of screening among church members. Physical activity and weight management programs are also provided.
<b>Prostate Cancer Education and Screening Program</b>	In partnership with the Prostate Health and Education Network (PHEN), prostate cancer information, education, screening and patient navigation is

	provided to men of color whom are at high risk for prostate cancer. This past year approximately 1,000 men were served.
<b>Sun Safety Education and Screening Program</b>	Participants whom are at highest risk for skin cancer are provided with sun safety education and skin cancer screening by a dermatologist at health fairs, health centers, and local beaches. In FY12, a total of 26 events were held, reaching almost 2,000 participants.
<b>Tobacco Cessation Pilot Program</b>	Provides smoking cessation counseling using an evidence-based approach to support individuals who smoke through the process of quitting in order to reduce the burden of lung cancer.
<b>HPV and Cervical Cancer Pilot Education Program</b>	Educates parents and guardians on cervical cancer prevention to help them make informed decisions about their children's health with regards to HPV and cervical cancer vaccinations and screening.
<b>Dana-Farber/Brigham and Women's Cancer Center Patient Navigator Program (2005)</b>	Three (3) patient navigators address the needs of people at risk for or diagnosed with breast, cervical or colon cancer and facilitate access to the health care system for women and men from diverse backgrounds with low socioeconomic status, limited English proficiency, disability status, or payment status (uninsured/underinsured). In FY 12, the program served 660 new patients.
<b>Community Events and Health Fairs</b>	Participating in community events serves as vehicles for educating communities about cancer prevention, screening, early detection, clinical trials participation and treatment information.

Dana-Farber's 2013 Community Benefits External Advisory Committee Members

<p><b>Erin K. Lee</b>                  Development Director                  Health Care, Life Sciences &amp; Higher Education                  United Way of Massachusetts Bay and the                  Merrimack Valley                  51 Sleeper Street   Boston, MA 02210                  P: 617 624 8000   F: 617 624 9114                  elee@supportunitedway.org</p>	<p><b>Janet McGrail Spillane</b>                  Vice President for Health Initiatives                  American Cancer Society                  18 Tremont Street, Suite 700                  Boston, Ma 02108                  617-878-4120                  Fax 617-263-6825                  Janet.McGrail@cancer.org</p>
<p><b>Gerry Thomas</b>                  Associate Director, Community Initiatives Bureau                  Boston Public Health Commission                  1010 Mass Ave, 2nd Flr                  Boston, MA 02118                  (617) 534-2390 (direct)                  (617) 534-2372 (fax)                  GThomas@bphc.org</p>	<p><b>Cheryl R. Clark MD, ScD</b>                  Director, Health Equity Research &amp; Intervention                  Center for Community Health and Health Equity                  Hospitalist, Brigham and Women's/Faulkner                  Hospitals                  Division of General Medicine &amp; Primary Care                  Ph: 617-732-5759                  Email: crclark@partners.org                  Assistant: Amanda Mitchell</p>
<p><b>Jane Mayer</b>  <a href="mailto:janebmayer@gmail.com">janebmayer@gmail.com</a>                  Volunteer at DFCl</p>	<p><b>Mayra Negron</b>                  Chief Operating Officer                  Inquilinos Boricuas en Acción (IBA)                  405 Shawmut Avenue, Boston, MA 02118                  (617) 927-1708 Fax (617) 536-5816                  mnegron@iba-etc.org</p>
<p><b>Heather Adams</b>                  Fenway High School                  174 Ipswich Street                  Boston, MA 02215                  617-635-9911 ext. 208  <a href="mailto:hadams@fenwayhs.org">hadams@fenwayhs.org</a></p>	<p><b>Maria Idalis Torres</b>                  UMass Boston                  Gaston Institute – Director                  Healey Library, 10,0011K                  100 Morrissey Blvd.                  Boston, MA 02125-3393                  Phone: 617-287-5790  <a href="mailto:Idali.Torres@umb.edu">Idali.Torres@umb.edu</a>,</p>
<p><b>Ms. Thelma Burns</b>                  BPHC Pink &amp; Black Ambassador  <a href="mailto:Thelma_Burns@DFCI.HARVARD.EDU">Thelma_Burns@DFCI.HARVARD.EDU</a>                  &amp; tdbdst@comcast.net</p>	<p><b>Roxanne Hacker</b>                  Roxbury Tenants of Harvard, Board Member  <a href="mailto:rhaecker@roxburytenants.org">rhaecker@roxburytenants.org</a></p>
<p><b>Larry Seamans</b>                  Senior VP &amp; COO                  YWCA Boston                  140 Clarendon Street                  Boston, MA 02116                  617-585-5414  <a href="mailto:lseamans@ywcaboston.org">lseamans@ywcaboston.org</a></p>	<p><b>Jeanette Beltran</b>                  Director of Community Initiatives                  Susan G. Komen for The Cure- MA Affiliate                  89 South Street, Suite LL01                  Boston, MA 02111                  (617) 737-5111 ext. 11  <a href="mailto:jbeltran@komenmass.org">jbeltran@komenmass.org</a></p>

<p><b>Chien-Chi Huang</b> Asian Women for Health Executive Director</p> <p>83 Wallace St Somerville, MA 02144 <a href="mailto:Abch2h@gmail.com">Abch2h@gmail.com</a> 617-870-4056</p>	<p><b>Alexandra Oliver Davila</b> Executive Director <a href="mailto:alex@sociedadlatina.org">alex@sociedadlatina.org</a></p> <p>Sociedad Latina, Inc. 1530 Tremont St., Roxbury, MA 02120. Phone: 617-442-4299 x117 Fax: 617-442-4087</p>
<p><b>Robbie Robinson</b> Prostate Health and Education Network Cell: 617-595-8841; H: 617-698-2967 robbierobinson@verizon.net</p>	<p><b>Regina Harvey, MHA, RN</b> Nursing Director Southern Jamaica Plain Health Center 640 Centre St. Jamaica Plain, MA 02130 Phone: 617-983-4241 Fax: 617-524-5170</p>
<p><b>Paula McNichols</b> <i>Executive Director</i> Brookside Community Health Center 3297 Washington St Boston, MA 02130 <a href="mailto:pmcnichols@partners.org">pmcnichols@partners.org</a></p>	<p><b>Elsa Bengel</b> VP/Executive Director YMCA Training, Inc. &amp; YMCA International Learning Center 18 Tremont Street, Suite 400, Boston, MA 02108 W: 617.542.1800 x131 M: 617.620.2310 EBengel@ymcaboston.org</p>
<p><b>Chris Lathan, MD</b> Dana-Farber Cancer Institute</p> <p>Audrey Kalisz Administrative Assistant DFCI Cancer Care Equity Program 450 Brookline Avenue Dana 1122 Boston, MA 02215 Phone: 617-632-6041 Fax: 617-632-4088 Email: <a href="mailto:Audrey_Kalisz@dfci.harvard.edu">Audrey_Kalisz@dfci.harvard.edu</a></p>	