Beth Israel Deaconess
Medical Center

COMMUNITY HEALTH IMPLEMENTATION PLAN

Final Report

Approved by the
Beth Israel Deaconess Medical Center
Board of Directors

September 20, 2016

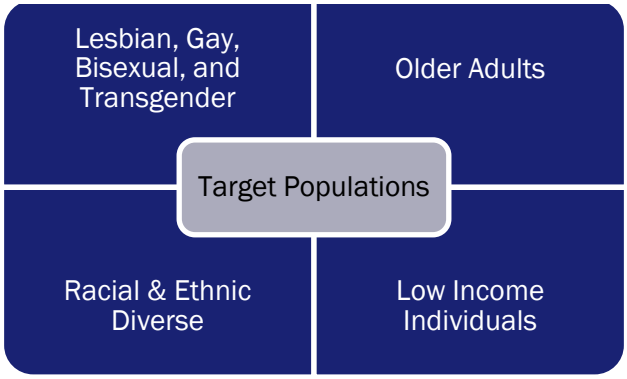
Community Health Priorities and Target Populations

Once all of the assessment's findings were compiled, hospital and community stakeholders participated in a strategic planning process that integrated data findings from Phases I and II of the project, including information gathered from the interviews and community forums. Participants engaged in a discussion of: 1) the assessment findings, 2) current community benefits program activities, and 3) emerging strategic ideas that could be applied to refine their community benefits strategic response. From this meeting, community health priorities were identified, as were target populations and core strategies to achieve health improvements.

Following is a brief summary of the target populations and community health priorities that were identified with the support of community stakeholders. Also included below is a review of the goals, objectives, and core elements of BIDMC's Community Health Implementation Plan (CHIP).

Target Populations

Figure 1. Target Populations

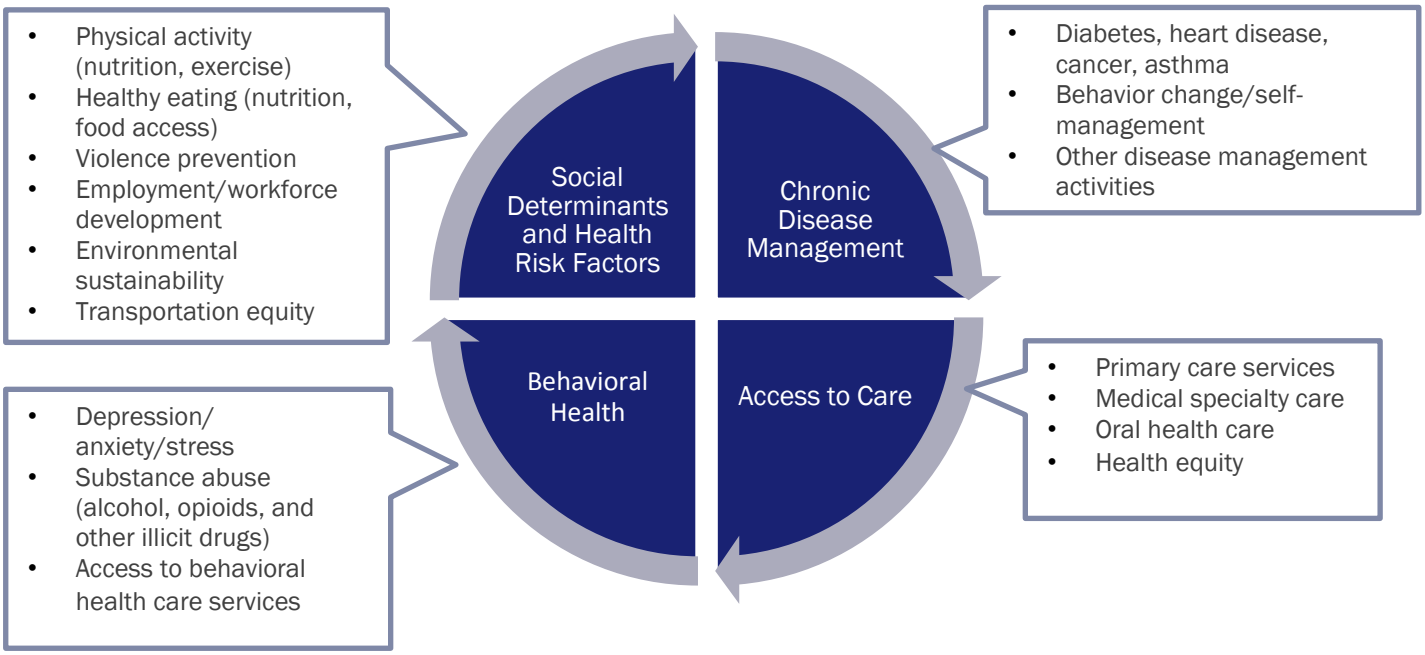


BIDMC, along with its other health, public health, social service, and community health partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. BIDMC's CHIP, summarized in the next section, includes many activities that will support residents throughout the BIDMC CBSA. However, based on the assessment's quantitative and qualitative findings, including discussions with a broad range of community participants, there was broad agreement that BIDMC's CHIP should target certain demographic, socio-economic and geographic cohorts that have complex needs, face barriers to care and service gaps, as well as other adverse social determinants of health that can put them at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the assessment identified low income populations, older adults, racially/ethnically diverse populations, and the LGBT populations.

Community Health Priorities

BIDMC's CHNA's approach and process provided ample opportunity to vet the quantitative and qualitative data compiled during the assessment. BIDMC has framed the community health needs in four priority areas, which together encompass the broad range of health issues and social determinants of health facing residents living in BIDMC's CBSA. These four areas are: 1) Social Determinants, Health Risk Factors and Equity, 2) Chronic Disease Management and Prevention, 3) Access to Care, and 4) Behavioral Health (mental health and substance abuse). BIDMC already has a robust community health implementation plan that has been working to address all of the identified issues. However, this CHNA has provided new guidance and invaluable insight on quantitative trends and community perceptions that can be used to inform and refine BIDMC's efforts. The following are the core elements of BIDMC's updated Community Health Implementation Plan (CHIP).

Figure 2. Community Health Priorities



BIDMC's Community Health Implementation Plan

Given the complex health issues in the community, BIDMC has been strategic in identifying its priority areas in order to maximize the impact of its community benefits program and work to improve the overall health and wellness of residents in its CBSA. Based on the data, BIDMC has identified the following as the highest priority needs of the CBSA:

1. Social Determinants and Health Risk Factors
2. Chronic Disease Management
3. Access to Care
4. Behavioral Health

These health priorities have directed BIDMC's community health implementation planning process. The priorities outlined below are designed to promote community-based wellness and disease prevention, and ensure ongoing self-management of chronic diseases and behavioral health disorders. The goals and activities drawn from these priorities will make extensive use of existing partnerships, resources and programs in order to facilitate the largest possible health impact.

The following goals address the existing access, care coordination issues, barriers, and targeted service gaps identified through the CHNA process.

Priority Area 1: Social Determinants and Health Risk Factors

Improvements in health status begin with knowledge of the population's characteristics as well as the underlying social, economic, and environmental factors that impact health and health equity. More specifically, determinants such as poverty, employment opportunities, violence, transportation, racial segregation, literacy, provider linguistic/cultural competency, social support, and community integration limit many people's ability to care for their own and/or their families' health. Lack of physical activity, poor nutrition, alcohol abuse, and tobacco are the leading risk factors for chronic disease and poor emotional health. Addressing these issues and developing healthy habits in these areas are among the most important things people of all ages can do to improve their health. Physical activity helps prevent many diseases (e.g. heart disease, diabetes and some cancers), strengthens bones and muscles, reduces stress and depression and makes it easier for people to maintain a healthy body weight. Eating a healthy diet can help lower people's risk for heart disease, high blood pressure, diabetes, osteoporosis and certain cancers, and also helps people maintain a healthy body weight. Healthy and safe eating is important throughout the lifespan. Limiting alcohol consumption and not using tobacco can dramatically reduce one chances of contracting heart disease, diabetes, or respiratory disease.

The following goals and objectives address the existing access care coordination issues, barriers, and targeted service gaps identified through the process.

Priority Area 1: Social Risk Factors and Health Equity

Goal 1: Increase Physical Activity

Goal 2: Promote Healthy Eating (Nutrition and Food Access)

Goal 3: Promote Violence Prevention (Safe Neighborhoods and Community Cohesion)

Goal 4: Support Workforce Development and Creation of Employment Opportunities

Goal 5: Promote Environmental Sustainability

Goal 6: Promote Transportation Equity

Priority Area 2: Chronic Disease Management

There are a broad range of chronic and infectious diseases prevalent in BIDMC's CBSA, including heart disease, diabetes, asthma, hypertension, cancer, HIV/AIDS, and HIV/HPC. Although treating these illnesses requires a range of clinical interventions, there is a great deal of overlap with respect to the potential community interventions. Population-level responses to chronic and infectious illnesses all require community based education, screening, timely access to treatment and seamless coordination of follow-up services.

BIDMC, in collaboration with public health officials, community based organizations and other clinical providers is already fully engaged on these issues and BIDMC has a broad range of existing programs that work to address prevention, service coordination, improve follow-up care, and ensure that those with chronic and infectious conditions are engaged in the services they need. However, these efforts need to be enhanced and refined based on data from this assessment. Moving forward,

it is critical that these issues be addressed and perfected so that BIDMC, other clinical providers, and the broad range of key community based organizations can work collaboratively to address community need.

The following goals and objectives address the existing access care coordination issues, barriers, and targeted service gaps identified through the process.

Priority Area 2: Chronic Disease Management

Goal 1: Improve Chronic Disease Management

Goal 2: Improve Care Transitions for Those with Chronic Health Conditions

Goal 3: Increase Cancer Screening

Goal 4: Support Cancer Patients and Caregivers

Goal 5: Support Older Adults to Age in Place

Priority Area 3: Access to Care

Greater Boston has one of the strongest and most comprehensive healthcare systems in the world. This system is expansive and spans the full healthcare continuum, including outreach and screening services, primary care medical and medical specialty care services. There are no absolute gaps in services across the continuum, even for low income and racially/ethnically diverse populations that often struggle with access to health care services. This does not mean, however, that everyone in Greater Boston receives the highest quality services when they want it and where they want it. In fact, despite the overall success of the Commonwealth's heath reform efforts, data captured for this assessment shows that segments of the population, particularly low income and racially/ethnically diverse populations, face significant barriers to care and struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and shortages of providers willing to serve Medicaid insured or low income, uninsured patients.

Among some of Boston's most prominent safety net primary care clinics, the uninsured rates range from 17% to 48%. These clinics struggle to ensure access to care for their patients, particularly for medical specialty care services. Massachusetts BRFSS data also indicates that approximately one in five (21%) residents living in North Dorchester and Allston/Brighton do not have a personal health care provider or primary care provider compared to one in six (17%) for Boston residents overall.

The following goals and objectives address the existing access care coordination issues, barriers, and targeted service gaps identified through the process.

Priority Area 3: Access to Care

Goal 1: Increase Access to Quality Medical Services (Inc. PC, OB/GYN, & Medical Specialty Care)

Goal 2: Increase Access to Quality Oral Health Services

Goal 3: Increase Quality and Efficiency of Clinical Services at CCA Clinics

Goal 4: Promote Equitable Care and Support for those with Limited English proficiency

Priority Area 4: Behavioral Health

The burden of mental illness and substance abuse is substantial. These issues impact all segments and age groups in the population. Hospitalization rates for substance abuse and mental health are higher in many of the towns when compared to the Commonwealth. Large portions of the population also struggle with alcohol abuse and binge drinking. Despite increased community awareness and sensitivity about mental illness and addiction, there is still a great deal of stigma related to these conditions and there is a general lack of appreciation for the fact that these issues are often rooted in genetics and physiology similar to other chronic diseases.

The following goals and objectives address the existing access care coordination issues, barriers, and targeted service gaps identified through the process.

Priority Area 4: Behavioral Health
Goal 1: Promote behavioral health (BH)/ primary care integration
Goal 2: Reduce burden of opioid use
Goal 3: Increase Access to Quality Behavioral Health Care Services
Goal 4: Identify those at risk for BH condition and provide enhanced care management