Community Benefits Report

Fiscal Year 2020

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
Beth Israel Deaconess Medical Center (BIDMC) is a member of Beth Israel Lahey Health (BILH). BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery–academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care–in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BILH Community Benefits staff are committed to working collaboratively with BILH's communities to address leading health issues and create a healthy future for individuals, families, and communities.

The mission of BIDMC is to serve BIDMC patients compassionately and effectively, and to create a healthy future for them and their families. BIDMC's mission is supported by BIDMC's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining financial health. BIDMC is also committed to being active in the community. Service to community is at the core of BIDMC's mission. The BIDMC founders made a covenant to care for the underserved in the hospital's service area, attend to unmet need, and address disparities in access to care and health outcomes. BIDMC's commitment to this covenant and the people it serves remains steadfast today.

The following annual report provides specific details on how BIDMC is honoring its commitment and includes information on BIDMC's Community Benefits Service Area (CBSA), community health priorities, target populations, community partners, and detailed descriptions of its Community Benefits programs and their impact.

More broadly, the BIDMC Community Benefits mission is fulfilled by:

- **Involving BIDMC's staff,** including its leadership and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout BIDMC's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of BIDMC and those who are often left out of assessment, planning, and program implementation processes

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes;

- **Implementing community health programs and services** in BIDMC's CBSA that is geared toward improving the current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the healthcare system, and working to decrease the burden of leading health issues;

- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations

BIDMC's CBSA includes the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury, the City of Chelsea, and the towns of Brookline, Lexington, Needham, and Newton (Chestnut Hill). BIDMC's FY19 Community Health Needs Assessment's (CHNA) findings, on which this report is based, clearly show that low-income and racially/ethnically diverse populations living in Boston's neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury, as well as the adjacent City of Chelsea, face the greatest health disparities and are most at-risk. As a result, these Boston neighborhoods and the City of Chelsea have been identified and prioritized as the focus for community health efforts.

The FY19 CHNA also identified three smaller but high need segments of the population that are also underserved, at-risk, and face disparities, namely youth, older adults, and the Lesbian Gay Bisexual Transgender and Queer (LGBTQ) community. Collectively, these geographic, demographic, and socio-economic population segments are BIDMC priority populations. While BIDMC is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated Community Benefits

guidelines, BIDMC's IS will focus on the following most at-risk priority populations in the six Boston neighborhoods and the City of Chelsea–Low-Income, Racially/Ethnically Diverse, LGBTQ, Older Adults, Youth, and Limited English Proficient.

Basis for Selection
Community health needs assessments; public health data available from government (MDPH, Boston Public Health Commission, federal agencies) and private resources (foundations, advocacy groups); BIDMC's areas of expertise.

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in BIDMC's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- Continued to support increased capacity of primary care and OB/GYN practices at six affiliated health centers
- Continued community-based specialty care services
- Provided culturally sensitive care for patients through cancer navigation, interpreter services, and multilingual patient education
- Addressed social determinants of health, in particular violence prevention, through the Center for Violence Prevention and Recovery (CVPR) and Bowdoin Street Health Center's (BSHC) Neighborhood Trauma Team
  Increased capacity of primary care clinicians at CHCs to provide needed behavioral health services through integration of behavioral health with primary care
- Continued workforce development through summer internships for underserved youth, pipeline programs, and training programs for adults
- Promoted healthy lifestyles through the Walking Club, Farmers Markets, and Fitness in the City; pivoted programming to address food insecurity in light of COVID-19
- Conducted research that supports the understanding of health disparities
- Provided access to wellness programming including exercise classes and virtual offerings at the Wellness Center at BSHC
- Supported youth in developing leadership skills to prevent violence and create change in their community through the Youth Leadership Program at BSHC

During FY20, BIDMC dedicated significant time and resources to respond to COVID-19 needs. BIDMC worked with its licensed and affiliated community health centers and the hospitals Chelsea location to expand community testing access. Both BSHC, the hospital's licensed health center, and its Chelsea location reduced barriers to access by offering on-site interpretation, welcoming walk-ins, and not requiring a physician order. The hospital also worked with BILH to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19 to help slow the spread of the virus and delineate where residents could access services and resources in their community. BILH and BIDMC redeployed staff, supplies, and other materials to both the community and within hospitals, including Personal Protective Equipment (PPE), food, hand sanitizer, etc.

COVID-19 caused several programs highlighted in this report to be modified. In some cases, programs were expanded, and in others, programs were reduced in response to the pandemic and its impact on our community.

Plans for Next Reporting Year

In FY19, BIDMC conducted a comprehensive and inclusive CHNA that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, BIDMC will focus its FY20-22 IS on four priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in BIDMC's CBSA who face the greatest health disparities. These four priority areas are:

- Social Determinants of Health;
- Chronic/Complex Conditions and Risk Factors;
- Access to Care; and
- Behavioral Health (Mental Health and Substance Use)

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BIDMC's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine BIDMC's efforts. In completing the FY19 CHNA and FY20-22 IS, BIDMC, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BIDMC's FY20-22 IS should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care, service gaps, and other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that target low-income populations, youth, older adults, racially/ethnically diverse populations, limited English proficiency populations, and LGBTQ populations.

BIDMC partners with dozens of community-based organizations and service providers to execute its IS, including public agencies, social service providers, community health organizations, academic organizations, and businesses. BIDMC also partners with numerous

CHCs through the Community Care Alliance (CCA, BIDMC's health center network) to implement programs that address health disparities (related to race, ethnicity, sexual orientation, gender identity, and physical attributes) and implement focused public health programs and chronic disease management programs, including efforts to address health risk factors such as healthy eating and active living. BIDMC also partners with these health centers to implement, strengthen, and leverage the patient-centered medical home service delivery model to promote coordinated, cost-effective, high quality care for the community.

Example programs/strategies in the FY20-22 IS include:

- Supporting and collaborating with community-based organizations to promote access to affordable, healthy food
- Supporting the Fitness in the City Program at BSHC
- Holding healing services (circles) when appropriate for community residents affected by violence
- Responding to all incidents of homicide or violence within a catchment area that meet criteria established by the Boston Public Health Commission
- Implementing and expanding education and workforce development opportunities such as English as a Second Language, High School Equivalency, computer skills, citizenship, and financial literacy classes
- Linking patients screened positive for cancer to Cancer Patient Navigators
- Providing free or subsidized medications to eligible, low income patients
- Increasing access to care and services for Limited English Proficient individuals
- Supporting primary care and behavioral health integration at BIDMC's CCA clinic sites and BIDMC's Chelsea service site, as well as at BIDMC's Affiliated Physicians Group (APG) and Healthcare Associates (HCA) practices
- Supporting programs in CCA clinics that educate and screen patients for diabetes, hypertension, and persistent asthma
- Providing services for domestic violence, sexual assault, and community violence victims through BIDMC's CVPR program

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the BIDMC Community Benefits team completed a hospital self-assessment form (Section VII, page 94). The BIDMC Community Benefits team also shared the Community Representative Feedback Form with all CBAC members.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC):

The Community Benefits Advisory Committee (CBAC) works in collaboration with BIDMC's hospital leadership, including the hospital's governing board and senior management, to support BIDMC's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BIDMC's community. The CBAC provides input into the development and implementation of BIDMC's Community Benefits programs in furtherance of BIDMC's Community Benefits mission.

The membership of BIDMC's CBAC is representative of the constituencies and priority populations served by BIDMC's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board members and senior leadership who are held accountable for fulfilling BIDMC's Community Benefits mission. Among BIDMC's core values is the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BIDMC's structure and reflected in the myriad programs provided through different departments at the hospital and how it provides care at the hospital and in affiliated practices.

BIDMC is a member of BILH. While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

Providing direction for BIDMC's collective commitment and effort are The Community Benefits Guiding Principles that follow below. Adopted by a broad-based constituency of Board, senior leadership and staff, these principles provide the framework for the execution of the plan, spearheaded by the Director of Community Benefits. The Director is accountable to the BILH Vice President of Community Benefits and Community Relations and the Chief Strategy Officer for BILH. The Vice President of Community Benefits and Community Relations also has direct access to the BIDMC President. It is the responsibility of these four senior managers to ensure that Community Benefits is addressed by the entire organization

and the needs of the underserved populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize the extent to which efforts across the organization are fulfilling the mission and goals of Community Benefits.

Guiding Principles of BIDMC's Community Benefits Program

I. Why?

Our Community Benefits program is designed to ensure that:

- *Beth Israel Deaconess Medical Center is a good corporate citizen and, as a not-for-profit organization, fulfills its special obligation to serve the community.*
- *As a healthcare provider, our services improve the health status of the community.*
- *We remain true to the histories of Beth Israel and New England Deaconess Hospitals, each of which was particularly committed to the community service component of their multiple missions (clinical, research, teaching, community).*
- *The experiences of staff and providers at Beth Israel Deaconess Medical Center are enriched through opportunities to work with diverse patients, colleagues, and organizations.*

II. What and for Whom?

- *Community Benefits calls for a particular focus on underserved populations. Individuals may be underserved due to the many factors that influence if and how one is able to access and interact effectively with the healthcare system, including income level, insurance status, health status, ethnicity, sexual orientation, gender identity, age, etc.*
- *A major focus is to ensure that Beth Israel Deaconess Medical Center is a welcoming and culturally competent organization for all patients and employees, including racially/ethnically diverse populations and other populations traditionally underserved.*
- *Our efforts focus primarily, but not exclusively on healthcare, so that our financial resources are leveraged with our clinical, academic, and administrative strengths. The healthcare arena is where Beth Israel Deaconess Medical Center can have the greatest impact on the community.*

III. How?

- *We partner with community leaders and community-based organizations; they serve as links to the community and teachers of how we can better serve the populations they represent. In addition, we collaborate with a wide variety of organizations*

because healthcare services by themselves are not adequate to maximize improvement of health status.

- *Improving the community's health requires more than clinical services. We look to public health, prevention, and other health-related approaches not traditionally provided by many acute care hospitals.*
- *Our commitment to the Community Benefits mission is as fundamental as our commitment to our patient care and academic missions. We will constantly seek ways to fulfill all of them in as effective and efficient a manner as possible.*
- *Community Benefits programs are most successful when implemented organization-wide, just as are quality and respect. Community Benefits cannot succeed as a stand-alone activity. The importance of these principles and the efforts that result must be embraced by trustees, senior management and providers alike, as well as by the communities served.*

Community Benefits Advisory Committee Meetings

October 22, 2019
January 28, 2020
April 28, 2020
June 23, 2020
September 22, 2020

Community Partners

BIDMC recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BIDMC's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with BIDMC's staff, its health and social service partners, and the community at-large. BIDMC's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BIDMC's mission.

BIDMC serves and collaborates with all segments of the population. However, in recognition of its long-standing ties to specific Boston neighborhoods and the health disparities that exist for these communities, BIDMC focuses its Community Benefits efforts on improving the health status of the low-income, underserved populations living in Allston/Brighton, Chinatown, Bowdoin/Geneva, Fenway/Kenmore, Mission Hill, Roxbury, and the City of Chelsea.

BIDMC currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In this work, BIDMC collaborates with many of Boston's leading healthcare, public health, and social service organizations. BIDMC has particularly strong relationships with many of the community health centers that operate in its CBSA. These health centers, that are part of the Community Care Alliance (CCA), are critical components of the health care safety net in the communities in which they operate. In 2020, the CCA health centers provided primary care

medical, dental, behavioral health, and enabling services to approximately126,733 patients. The CCA health centers include:

- Bowdoin Street Health Center
- Charles River Community Health
- The Dimock Center
- Fenway Health and Sidney Borum Jr. Health Services
- South Cove Community Health Center

While Outer Cape Health Services (OCHS) voluntarily requested to leave the CCA, BIDMC continues its affiliation with and support of OCHS. These health centers are ideal Community Benefits partners because they are rooted in their communities and, as federally qualified health centers[1], are mandated to serve low-income, underserved populations.

These community partners have been a vital part of BIDMC's community health improvement strategy since 1968. Historically, BIDMC has relied heavily on its CCA partners, as well as a number of other key community health partners, to implement its Community Benefits initiatives. In this regard, BIDMC has leveraged CCA's expertise and the vital connections that these organizations have with the residents and other community-based organizations that operate in the communities they serve.

BIDMC is also an active participant in the North Suffolk Integrated Community Health Needs Assessment (iCHNA) and a founding member of the Boston CHNA- Community Health Improvement Plan (CHIP) Collaborative. Joining with such grass-roots community groups and residents, the BPHC, MDPH, and other academic medical centers, BIDMC strives to create a vision for both city-wide and neighborhood-based health improvement. Another important partnership is BIDMC's involvement with the Initiative to Eliminate Cancer Disparities (IECD) through the Dana-Farber/Harvard Cancer Center (DF/HCC), of which BIDMC is a founding member. Collectively the IECD, the DF/HCC, BIDMC and others are working to address the unequal burden of cancer within diverse communities by facilitating research in disparities and minority clinical trial education and enrollment.

BIDMC's Board of Directors along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise, education and research along with an underlying commitment to health equity are the primary tenets of its mission. BIDMC's Community Benefits Department, under the direct oversight of BIDMC's Board of Directors, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations.

See Appendix A for a comprehensive listing of the community partners with which BIDMC joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy.

[1] Bowdoin Street Health Center is part of the CCA but is not a federally qualified health center.

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment (CHNA) along with the associated FY20-22 Implementation Strategy (IS) was developed over a ten-month period from October 2018 to August 2019. These community health needs assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill BIDMC's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an IS. However, these activities are driven primarily by BIDMC's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, BIDMC's most recent CHNA was completed during FY19. FY20 Community Benefits programming was informed by the FY19 CHNA and aligns with BIDMC's FY20-FY22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods
The FY19 CHNA was conducted in three phases, which allowed BIDMC to:

- compile an extensive amount of quantitative and qualitative data;
- engage and involve key stakeholders, BIDMC clinical and administrative staff, and the community at-large;
- develop a report and detailed strategic plan, and;
- comply with all Commonwealth Attorney General and Federal IRS Community Benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, and four community forums.

BIDMC's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. BIDMC's understanding of these communities' needs is derived from discussions with and observations by healthcare and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources including The Massachusetts Department of Public Health, The Boston Public Health Commission, federal resources such as the Institute of Medicine, and Centers for Disease Control and Prevention, and review of literature relevant to a particular community's needs.

The articulation of each specific community's needs (done in partnership between BIDMC and community partners) is used to inform BIDMC's decision-making about priorities for its Community Benefits efforts. BIDMC works in concert with community residents and leaders

to design specific actions to be undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BIDMC's Community Benefits Plan that is adopted by the Board of Directors.

Summary of FY19 CHNA Key Health-Related Findings

Access to Care

- **Limited Access to Primary Care Medical, Medical Specialty, and Oral Health Care Services for Low-Income, Medicaid Insured, Uninsured, and Other Vulnerable Populations Facing Health Care Disparities and Barriers to Care.** Despite the fact that Massachusetts has one of the highest rates of health insurance and the communities that make up BIDMC's CBSA have strong, robust safety net systems, there are still substantial numbers of low-income, Medicaid insured, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical and oral health services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care medical, medical specialty, and oral health services.

- **Barriers to Access and Disparities in Health Outcomes Continue to Challenge Three Special Populations (Infants/Mothers/Fathers, Frail Older Adults, and Lesbian, Gay, Bi-sexual, Transgender, and Queer (LGBTQ) Populations).** Based on information gathered primarily from the interviews and community forums, the assessment identified a number of specific populations that face barriers to care and disparities in access. More specifically, infants/mothers/fathers, frail older adults, and LGBTQ populations face disparities in access and outcome and are particularly at-risk. If these disparities are going to be addressed, then care needs to be taken to tailor identification/screening and preventive services as well as acute and chronic disease management services for these specific populations.

Chronic/Complex Conditions and their Risk Factors

High Rates of Chronic and Acute Physical Health Conditions (e.g., heart disease, hypertension, cancer, and asthma). The assessment's quantitative data clearly shows that many communities in BIDMC's CBSA have high rates for many of the leading physical health conditions (e.g., heart disease, hypertension, cancer, and asthma). In many communities these rates are statistically higher than Commonwealth rates, indicating a particularly significant problem. However, even for those communities where the rates are not statistically higher, these conditions are still the leading causes of premature death.

- **Limited Access to Cancer Screening for Racial/Ethnic Diversity and Other At-risk populations.** Many of the communities that are part of BIDMC's CBSA have high cancer mortality rates. This is particularly true for certain cancers in specific communities in specific Boston neighborhoods, such as Roxbury, Dorchester, and Chinatown that have

a high proportion of racial/ethnic diversity. At the root of addressing high mortality is screening, early detection and access to timely treatment.

- **High Rates of the Leading Health Risk Factors (e.g., Lack of Nutritional Food and Physical Activity, Alcohol/Illicit Drug Use, and Tobacco Use).** One of the leading findings from the assessment is that many communities and/or population segments in BIDMC's CBSA have high rates of chronic physical and behavioral health conditions. In some people, these conditions have underlying genetic roots that are hard to counter. However, for most people these conditions are widely considered preventable or manageable. Addressing the leading risk factors is at the root of a sound chronic disease prevention and management strategy.

Social Determinants of Health

- **Social Determinants of Health (e.g., economic stability, education, and community/social context) Continue to Have a Tremendous Impact on Many Segments of the Population:** The dominant theme from the assessment's key informant interviews and community forums was the continued impact that the underlying social determinants of health are having on the CBSA's low-income, underserved, diverse population cohorts. 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.

- **Disparities in Health Outcomes Exist in BIDMC's CBSA by Race/Ethnicity, Foreign Born Status, and Language:** As was established in the FY19 BIDMC Community Benefits CHNA Report, there are major health disparities for residents living in BIDMC's CBSA. This continues to be particularly true for racially/ethnically diverse, foreign-born, and non-English speaking residents living in Chelsea and the neighborhoods in Boston that are part of BIDMC's CBSA (i.e., Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury). The impact of racism, barriers to care, and disparities in health outcomes that these populations face are widely documented in the literature and are confirmed by numerous national, Commonwealth, and local data sources, including data from the Boston Public Health Commission's 2016-2017 Health of Boston Report.

  It is crucial that these disparities be addressed and, to this end, BIDMC's IS continues to include a myriad of programs, strategic interventions, and services that are carefully targeted to address these disparities. However, it is critical to note that there is a multitude of individual, community and societal factors that work together to create these inequities. The underlying issue is not only race/ethnicity, racism, income, or language but rather a broad array of interrelated social issues including economic opportunity, education, crime, transportation, and community cohesion.

- **Limited Access to Primary Care Medical and Specialty Care, Oral Health, and Behavioral Health Services for Low Income, Medicaid Insured, Uninsured, and Other Population Segments Facing Barriers to Care.** Despite the fact that Massachusetts has one of the highest rates of health insurance and the communities that make up BIDMC's CBSA have strong, robust safety net systems, there are still substantial numbers of low-income, Medicaid insured, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical and behavioral health services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care and specialty medical, oral health, and behavioral health services.

Mental Health and Substance Use

- **High Rates of Substance Use (e.g., Alcohol, Prescription Drug/Opioids, Marijuana) and Mental Health Issues (e.g., Depression, Anxiety, and Stress).** Behavioral health issues (i.e., substance use and mental health) are having a profound impact on individuals, families and communities in every geographic region and every population segment in BIDMC's CBSA. Depression/anxiety, suicide, opioid and prescription drug dependency, and alcohol and marijuana use, particularly in youth, are major health issues and are having a tremendous impact on the population and are a burden on the service system. The fact that physical and behavioral health are so intertwined compounds the impact of these issues. Of particular concern are the increasing rates of opioid abuse in the Commonwealth.

- **Limited Access to Behavioral Health Services, Particularly for Low Income, Medicaid Insured, Uninsured, and those with Complex, Multi-faceted Issues.** Despite the burden of mental health and substance use on all segments of the population, there is an extremely limited service system available to meet the needs that exist for those with all mild to moderate episodic issues or those with more serious and complex chronic conditions. Efforts need to be made to expand access, reduce barriers to care (including stigma), and improve the quality of primary care and specialized behavioral health services.

Beth Israel Lahey Health

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Access to Care - Community Based Primary and Specialty Care	
Brief Description or Objective	BIDMC believes that Community Health Centers (CHC) are in a unique position to provide accessible, culturally sensitive, linguistically appropriate primary care and specialty care services, including outreach, preventive, and enabling services, to diverse medically underserved communities in its Community Benefits Service Area (CBSA). The health centers that BIDMC supports are rooted in their communities, understand the unique social, cultural, and health-related needs of those they serve, and are better equipped than any organization to meet these needs. The CHCs also have access to teaching and growth opportunities including the Linde Family Fellowship Program (LFFP). The LFFP provides early and mid-career physician leaders with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation. BIDMC's commitment to community-based care translates into a number of BIDMC specialties (e.g., OB/GYN, Infectious Disease, etc.) and ancillary services (e.g., radiology, lab) being provided on-site at the health centers.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Chinatown, Dorchester, Fenway/Kenmore, Mission Hill, Roxbury), Waltham, Provincetown, Wellfleet, Harwich, Quincy • **Gender**: All • **Age Group:** All • **Ethnic Group:** Asian, Black, African, Hispanic/Latinx, White • **Language:** Cape Verdean Creole, Chinese, English, Portuguese, Russian, Spanish, Haitian Creole, Other • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban

	• **Additional Target Population Status**: ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐ None/Not Applicable

Health Issues Tags	Access to health care, Uninsured/underinsured, Immunization, Injury and violence, Mental health, Alcohol and substance abuse, Asthma/allergies, Cancer, Diabetes, Family planning, Hypertension, Language/literacy, Lead poisoning, Nutrition, Osteoporosis/menopause, Pregnancy, Pulmonary disease/tuberculosis, Rape, Safety, Sexually Transmitted Diseases, Sickle cell disease, Smoking/tobacco, Stroke, Vision, Overweight and obesity, Responsible sexual behavior, Substance Abuse, Tobacco Use

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, BIDMC will increase the number of patients receiving primary care, OB/GYN, and specialty care at affiliated CHCs from 123,788 patients in FY19.	Goal met: 126,733 patients received primary care, OB/GYN, and specialty care at affiliated CHCs in FY20.	1	3	Process Goal
By the end of FY20, BIDMC will increase the number of specialists practicing at CHC sites from 23 in FY19.	Goal met: 26 BIDMC specialists practiced at CHC sites in FY20.	1	3	Process Goal
By the end of FY20, BIDMC will increase the number of residents with CHC preceptors from 31 residents in FY19 and 7 in the primary care residency track in FY19.	Goal not met: 28 residents were assigned to CHCs during the 2020 Academic Year. 7 residents were in a primary care residency track in the 2020 Academic Year.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Bowdoin Street Health Center	Licensed Community Health Center	https://www.bidmc.org/locations/bowdoin-street-health-center
The Dimock Center	Affiliated Community Health Center	https://www.dimock.org
Fenway Health and Sidney Borum Jr. Health Services	Affiliated Community Health Center and Clinical Site for Fellowship project	https://fenwayhealth.org/
Charles River Health Center	Affiliated Community Health Center	https://www.charlesriverhealth.org/
Outer Cape Health Services	Affiliated Community Health Center	https://outercape.org/
South Cove Community Health Center	Affiliated Community Health Center	https://scchc.org
Cambridge Health Alliance	Clinical Site for Fellowship project	www.challiance.org

Beth Israel Lahey Health

Access to Care – Community Care Alliance

Brief Description or Objective

In 1997, BIDMC was instrumental in helping its affiliated and/or licensed health centers form a new network called the Community Care Alliance (CCA). By collaborating together on clinical and administrative issues, the CCA helps its members continue to provide high-quality, cost-effective healthcare services by collectively contracting for services and funding, as well as sharing resources and expertise for the benefit of their patients and communities. BIDMC's Community Benefits staff have been actively engaged in managing and participating in the CCA's activities.

BIDMC is committed to strengthening the capacity of its five affiliated CHCs in the CBSA: Bowdoin Street Health Center (BSHC), The Dimock Health Center, Fenway Health and Sidney Borum Jr. Health Center, Charles River Community Health (CRCH), and South Cove Community Health Center. The partnership takes many forms: recruitment, retention, financial support and credentialing of physicians and mid-level providers, BIDMC admitting privileges and access to managed care contracts, Harvard Medical School appointments and teaching opportunities, BIDMC-sponsored educational programs, and access to Up-to-Date.

In March 2019, with the formation of Beth Israel Lahey Health (BILH), the CCA health centers became part of the BILH health system. Participating in the BILH system provides the health centers with the opportunity to continue their long-standing partnerships with BIDMC and further explore new relationships with hospitals and providers in Eastern Massachusetts.

COVID-19 Activities

BIDMC also supported the CCA health centers throughout the COVID-19 pandemic by supporting testing, sharing BILH protocols, procedures, and guidelines in real-time, and providing clinical and other supports to the community. For example, BIDMC facilitated expansion of CHC ambulatory testing capacity and deployed staff to CHC testing sites. Other activities included the development and dissemination of neighborhood-specific community resource sheets and integrating CHCs into referrals for BIDMC's Advanced Respiratory Care Center, among many more efforts.

Target Population (indicate/select as many as apply for all fields)

- **Regions Served:** Middlesex County, Suffolk County, Boston (Allston, Brighton, Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Quincy, Waltham, Malden, Everett
- **Gender**: All
- **Age Group**: All
- **Ethnic Group:** Asian, Black, African, Hispanic/Latinx, White
- **Language:** Cape Verdean Creole, Chinese, English, Haitian Creole, Portuguese, Russian, Spanish, Vietnamese

	• **Environment Served**: ☐ All ☐ Rural ☒ Suburban ☒ Urban • Additional Target Population Status: ☒ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions

Beth Israel Lahey Health

EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	Access to health care, Cultural competency, Immunization, Injury and violence, Mental health, Uninsured/underinsured

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC Mystery Shopping team will shop Bowdoin Street Health Center four times each month, totaling 48 shops per year. Reports will be disseminated to Bowdoin Street Health Center staff on a monthly basis.	Goal not met: Mystery Shopping was put on hold from May-August during the COVID-19 pandemic. It began again in September 2020.	1	3	Process Goal
In FY20, BIDMC specialists will practice at all Community Care Alliance health centers.	Goal met: In FY20, 26 BIDMC specialists practiced at CCA health centers.	1	3	Process Goal
In FY20, BIDMC will identify opportunities for administrative and fiscal savings.	Goal met: BIDMC has continued monthly regulatory OIG reviews for all CHC personnel and vendors.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Bowdoin Street Health Center	Licensed Community Health Center	https://www.bidmc.org/locations/bowdoin-street-health-center
The Dimock Center	Affiliated Community Health Center	https://www.dimock.org
Fenway Health and Sidney Borum Jr. Health Services	Affiliated Community Health Center	https://fenwayhealth.org/
Charles River Health Center	Affiliated Community Health Center	https://www.charlesriverhealth.org/
South Cove Community Health Center	Affiliated Community Health Center	https://scchc.org

Beth Israel Lahey Health

Access to Care – Trauma, Emergency Management and Public Health Surveillance	
Brief Description or Objective	BIDMC's robust Emergency Management program is highly involved in local, city, state, and regional emergency preparedness systems and a leader in the hospital emergency management field. BIDMC is a regular participant in citywide committees, drills, task forces, project and plan development, and meetings including those for citywide mass casualty events. The Emergency Management program also includes BIDMC's health center partners in planning, training, and exercises. During the COVID-19 pandemic response, BIDMC Emergency Management has continuously been in contact with citywide hospitals, public health entities, education partners, and first responder agencies. This integrated response to the pandemic stems from a well-known external presence and established relationships with BIDMC's community partners. BIDMC Emergency Management participates in numerous city and state committees such as the MASCO Emergency Preparedness Committee and the State Region 4C project workgroup. BIDMC also participates in the ASPR hospital preparedness program.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served**: All Massachusetts • **Gender**: All • **Age Group**: All • **Ethnic Group**: All • **Language**: English • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☒ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	First Aid/ACLS/CPR, Injury and violence, Public safety

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
Develop and implement a Highly Infectious Disease Plan in FY20 to address the gap identified in a hazard vulnerability analysis at BIDMC. Work with citywide partners (COBTH) to share best practices, PPE brands and types, and to jointly drill as a city for a highly infectious disease.	Goal not met: With the onset of COVID-19, the goal to develop and implement this plan was only 45% complete. Q1 and Q2 planning efforts were significant with a planned exercise involving all Boston hospitals for late February. BIDMC had a significant part in the development of this exercise that was designed to test draft plans and to identify areas for improvement. This was postponed due to the COVID-19 response. However, BIDMC worked with the same citywide partners in the pandemic response, further establishing these relationships and resource sharing capabilities.	1	3	Process Goal
BIDMC will continue to collaborate with city, state and federal emergency management programs to ensure preparedness of medical center and CHCs for untoward emergencies.	Goal met: BIDMC continued to participate in trainings, simulations and planning meetings. BIDMC continued to collaborate with city, state and/or federal partners on drills/exercises. BIDMC also continued to house the Emergency Medical Services Station serving Boston's Longwood, Mission Hill, and Roxbury neighborhoods.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://bphc.org/Pages/default.aspx
MA Department of Public Health	Government agency	https://www.mass.gov/orgs/department-of-public-health
Boston Fire Department	Public safety agency	https://www.boston.gov/departments/fire-operations
Boston Emergency Medical Services	Public safety agency	https://www.boston.gov/departments/emergency-medical-services
Mayor's Office of Emergency Management	Government agency	https://www.boston.gov/departments/emergency-management
MASCO	Non-profit organization that supports Longwood Medical Area	https://www.masco.org/about/about-masco
Medical Intelligence Center	Coordinates emergency management	https://www.bphc.org/whatwedo/emergency-services-preparedness/public-health-preparedness/medical-intelligence-center/Pages/Medical-Intelligence-Center.aspx
COBTH	Coalition of teaching hospitals	http://www.cobth.org/about.html

Beth Israel Lahey Health

Access to Care – Culturally Responsive Care	
Brief Description or Objective	BIDMC was one of the first hospitals with an Interpreter Services Department and has a proven track record in helping patients overcome linguistic barriers to care, expanding interpreter services capacity and resources every year. BIDMC led the way in employing an American Sign Language (ASL) interpreter full time and installed multiple Sorenson public videophones to increase communication access for the Deaf and Hard-of-Hearing. By developing and translating patient information and educational materials, BIDMC has facilitated access to care, helped patients understand their course of treatment, and adhere to discharge instructions and other medical regimens. In the past year Interpreter Services engaged in extensive translations for a wide array of COVID-19 related activities. Some of these activities included translations for BIDMC's drive through testing sites, screening questions for patients, translations of research consent forms, a team of interpreters making screening phone calls together with clinicians to ensure continued limited English proficiency (LEP) patients access to services. This was in addition to continuing interpreter services both on-site and remotely throughout the pandemic.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All of Massachusetts: Middlesex County, Norfolk County, Suffolk County, Plymouth County, Boston, Harwich, Provincetown, Quincy, Truro, Waltham, Wellfleet • **Gender**: All • **Age Group:** Adults, Elderly • **Ethnic Group:** Asian, Black, African, Hispanic/Latinx, European, Caribbean Islander, Middle Eastern, Native Hawaiian/Pacific Islander, White • **Language:** ASL, Cambodian, Cape Verdean Creole, Chinese, English, Haitian Creole, Portuguese, Russian, Spanish, Vietnamese • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	Access to health care, Cultural competency, Language/literacy

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By Q1 of FY20, Interpreter Services will have rolled out the new dispatching software. It should demonstrate improved efficiency and improved satisfaction.	Goal met: Achieved in January 2020.	1	3	Process Goal
In FY20, BIDMC will increase Interpreter Services department interactions.	Goal not met: Number of interpreter services interactions (in-person, telephone, and video) totaled 128,350 in FY20 compared to 138,297 in FY19. The lower number of interactions is largely attributable to the state-mandated shutdown of all elective procedures and non-urgent ambulatory visits from March 15, 2020 – June 8, 2020.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
South Cove Community Health Center	Affiliated Community Health Center	https://scchc.org
Found in Translation	Community-based organization	https://found-in-translation.org
Massachusetts Commission for the Deaf and Hard of Hearing	Government agency	https://www.mass.gov/orgs/massachusetts-commission-for-the-deaf-and-hard-of-hearing

Beth Israel Lahey Health

Access to Care – Geographically Isolated Communities	
Brief Description or Objective	To address access to care challenges in the Outer Cape region, BIDMC continues to offer on-site medical specialty care services, including infectious disease services, digital radiology and mammography screening. BIDMC continues to support the Med-Flight helicopter program which transports those living in isolated areas that need emergency medical services. For those patients and families who are a long distance from home, BIDMC provides housing assistance through programs such as Hospitality Homes or specially adapted apartments for those undergoing bone marrow transplantation. BIDMC has a staff member who helps patients find lodging with Room Away from Home.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All of Massachusetts • **Gender**: All • **Age Group**: All • **Ethnic Group**: All • **Language**: English • **Environment Served**: ☐ All ☒ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group

DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable •
Health Issues Tags	Access to health care, Injury and violence

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
BIDMC will continue to address unmet medical needs for rural Cape Cod.	Goal met: BIDMC continued to offer on-site infectious disease services and collaborate with Outer Cape Health Services on digital radiology services which includes mammography screening. On-site pulmonary services were suspended due to COVID-19.	1	3	Process Goal
BIDMC will continue to provide access for remote communities to quaternary care.	Goal met: BIDMC continued ongoing support for Med-Flight.	1	3	Process Goal

Beth Israel Lahey Health

Partners

Partner Name	Description	Partner Web Address
Boston Med-Flight	Emergency medical transport company	https://www.bostonmedflight.org/
Viridian Apartments	Apartment building	http://www.theviridian.com/
Hospitality Homes	Nonprofit organization that provides short-term housing for patients	http://hosp.org

Beth Israel Lahey Health

Access to Care – Care Connection	
Brief Description or Objective	For many years, BIDMC has dedicated resources to helping patients and/or their referring physicians connect to both primary and specialty care service. BIDMC's Care Connection department offers a number of services that benefit the Community Health Centers (CHC) and their patients, including: • The Find a Doctor call center where detailed information about the Community Health Centers, their services and availability of appointments is updated monthly to facilitate timely appointments for patients. • The Doctor to Doctor call center supports the CHC providers with their specialty referral needs, especially for urgent and complex care needs. • Care Connection's Inpatient Discharge Follow Up program helps CHC patients who were admitted to BIDMC arrange post discharge follow up care. During the pandemic, the Care Connection team worked collaboratively with the inpatient physician team in creating protocols to help decrease possible spread of COVID-19.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender**: All • **Age Group:** Adults, Elderly • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☒ Veteran Status

Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	Access to health care

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC's Care Connection Department will facilitate access through referrals to and from community primary care providers.	Goal met: The Care Connection call center made 801 appointments/referrals to or from CHCs in FY20.	1	3	Process Goal
In the Doc-Doc Group, BIDMC's Care Connection Department will answer 80% of calls with an abandonment rate of 5% in FY20.	Goal met: In the Doc-Doc group, the BIDMC Care Connection Department processed 1,906 calls with a service level of 87% and an abandonment rate of 2.5%.	1	3	Process Goal
In the Find a Doc group, BIDMC's Care Connection Department will answer 80% of calls with an abandonment rate of 5% in FY20.	Goal not met: In the Find a Doc group, the BIDMC Care Connection Department processed 10,649 calls with a service level of 76% and abandonment rate of 8%.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Not applicable		

Access to Care - Seamless Continuity of Care	
Brief Description or Objective	As patients move between community-based and hospital-based care (ambulatory specialty care, Emergency Department (ED) or inpatient hospitalization), it is imperative that providers in both settings have accurate, real-time clinical information. BIDMC has harnessed technology to ensure this communication through Health Information Exchange (HIE) enhancements and BIDMC remains an important part of the Governor's launch of the state healthcare information exchange (Mass HIWay). BIDMC provides ongoing reference lab services to The Dimock Center and South Cove Community Health Center, with results being delivered directly to each site's electronic health record (EHR) via an electronic interface. In FY 2020, BIDMC expanded the availability of a "magic button" interface between the EHRs at BIDMC and Fenway Health to better support patient referrals during the COVID-19 pandemic. BIDMC also provided The Dimock Center access to an online self-attestation form and monitoring program used by staff for daily symptom reporting during the pandemic. From FY16-December 2019 BIDMC also supported two major Massachusetts Executive Office of Health and Human Services initiatives which directly benefited the community, worked on educational initiatives for the public, and led a Dimock community health center digital design effort. BIDMC also participated in the Healthcare Information Technology Council and the Digital Health Council, leading the distributed data network and provided lectures in public venues around the Commonwealth about such issues as digital health, privacy, security, and patient engagement.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender**: All • **Age Group**: All • **Ethnic Group**: All • **Language**: English • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban

	• **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable

Health Issues Tags	Access to health care

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC will continue to contribute to Mass HIWay initiative.	Goal met: BIDMC continues to share Meaningful Use data, including immunizations and public health surveillance data with the state via the Mass HIWay. BIDMC continues to work with the CHCs on their connections to the HIWay.	1	3	Process Goal
In FY20, BIDMC will continue sending inpatient and ED discharge summaries with the expanded primary care network.	Goal met: BIDMC continues to share patient's daily discharge information with an expanded primary care network including Affiliated Physicians Group and Atrius Health.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Massachusetts Health Information Highway	Health Information Exchange	https://www.masshiway.net/
Bowdoin Street Health Center	Licensed Community Health Center	https://www.bidmc.org/locations/bowdoin-street-health-center
The Dimock Center	Affiliated Community Health Center	https://www.dimock.org
Fenway Health and Sidney Borum Jr. Health Center	Affiliated Community Health Center	https://fenwayhealth.org/
Charles River Health Center	Affiliated Community Health Center	https://www.charlesriverhealth.org/
South Cove Community Health Center	Affiliated Community Health Center	https://scchc.org

Beth Israel Lahey Health

Access to Care – Care to Uninsured and Underinsured in Underserved Communities	
Brief Description or Objective	Residents without health insurance coverage may qualify for assistance from the Health Safety Net (HSN) Program, a fund to which BIDMC makes a significant annual contribution. A team of financial benefits counselors work with uninsured and underinsured patients to facilitate access to entitlement programs. BIDMC's on-site retail pharmacy and specialty pharmacy continued its patient co-payment assistance program for patients with family income at or below 300% of the federal poverty level. Additionally, the retail pharmacy is registered as an HSN pharmacy and provides courtesy fills for low-income patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, BIDMC employs patient assistance staff. During the COVID-19 pandemic the BIDMC pharmacy reached out proactively to patients and increased home delivery of medications. They also increased the capacity of the "med to bed" program – delivering prescriptions to patient's homes. BIDMC's Community Resource Specialists connect low income patients to resources such as transportation, housing, support groups, food assistance, financial assistance, insurance, Social Security Disability Insurance, unemployment benefits, etc. They determine what resources would optimally meet patients' and families' needs, including beds in continuing care facilities, transportation, Meals on Wheels, financial assistance, Medicaid, special housing, special funds, etc. BIDMC also pays the transportation costs for patients discharged from inpatient units and the Emergency Department when they do not have the means to return home. For low income patients being discharged from the medical center with a newborn child, BIDMC links them to services that may provide infant car seats to these families at no cost. BIDMC also subsidizes inpatient psychiatric services for those most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others, or who are unable to care for themselves due to mental illness. Additionally, BIDMC subsidizes primary care services provided by BIDMC's Affiliated Physicians Group throughout BIDMC's Community Benefits Service Area.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender**: All • **Age Group**: All • **Ethnic Group**: All • **Language**: All • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban

	• **Additional Target Population Status**: ☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☒ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☒ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable

Beth Israel Lahey Health

Health Issues Tags	Access to health care

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC Community Resource Specialists will continue to connect all low-income patients who need services to resources based on identified need.	Goal met: In FY20, Community Resource Specialists connected low income patients to multiple services such as transportation, housing, support groups, food assistance, financial assistance, insurance, Social Security Disability Insurance, and unemployment benefits.	1	3	Process Goal
BIDMC will continue to subsidize Health Safety Net (HSN) Trust Fund.	Goal met: Continued to make annual contribution to the HSN. During FY20, BIDMC served 1,317 uninsured patients who used the HSN.	1	3	Process Goal
In FY20 BIDMC will screen and enroll eligible patients into entitlement programs.	Goal met: Staff screened 9,892 patients for eligibility and enrolled 7,463 patients into entitlement programs. Continue to provide medication assistance and no-cost pharmaceutical prescriptions to low-income patients.	1	3	Process Goal
By the end of FY20, the Retail pharmacy will meet 100% of requests for adherence packaging and talking scripts and provide home delivery for patients with difficulty accessing the medical center for pick up.	Goal met: Met 100% of requests for adherence packaging growing 37% from 169 patients in FY19 to 268 Patients in FY20. Due to COVID-19, BIDMC worked to ensure patients could receive prescriptions delivered to their home. Home delivery grew 177% - from 22,000 prescriptions in FY19 to 61,000 prescriptions in FY20.	1	3	Process Goal
In FY20, BIDMC Pharmacy will expand services to Bowdoin Street Health Center including Medication Authorization, patient assistance, and an ambulatory clinical pharmacist.	Goal met: Expanded medication prior authorization services and enhanced patient co-pay assistance services to Bowdoin Street Health Center patients. Hired a pharmacist who started in August 2020 to support the clinical care team at Bowdoin Street Health Center with medication management and patient education with a specific focus on diabetes and hypertension.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Pine Street Inn	Homeless services provider	https://www.pinestreetinn.org
La Alianza Hispana	Social services organization	https://laalianza.org
WilmerHale Legal Services	General practice law firm	https://www.legalservicescenter.org
Fair Foods	Food access organization	https://www.fairfoods.org
A Room to Grow	Community-based organization supporting new parents	https://www.roomtogrow.org

Beth Israel Lahey Health

Access to Care- Boston Healthy Start Initiative	
Brief Description or Objective	In April of 2014, Bowdoin Street Health Center (BSHC) became an official site of th Boston Healthy Start Initiative (BHSI) with grant funding through the Boston Public Health Commission (BPHC). The BHSI funding allows BSHC to provide dedicated Community Health Worker (CHW) support to its prenatal patients and better support their needs through frequently high-risk pregnancies. The BHSI is a federally funded program designed to improve birth outcomes and eliminate birth outcome disparities among Boston women. BHSI works closely with clinical sites, consumers, and partners outside the traditional health sector to achieve these aims through five federally-defined approaches: 1) Improving the health of women, 2) Promoting quality of health services to women and families, 3) Strengthening the resilience of families, 4) Achieving collective impact through enhanced collaboration, and 5) Increasing mutual accountability across the BHSI system of care, through quality improvement, performance monitoring and evaluation. Target populations for BHSI clinical services reflect Boston's persistent patterns of birth outcome disparities. Through use of federal funding, the Boston Public Health Commission currently funds five sites within the city (including health centers, hospital clinics and one community-based health organization that serve high proportions of Black and Latina women from Mattapan, Dorchester or Roxbury). As one of the sites, BSHC serves pregnant Black women by providing: • Support and case management from a family partner with specialized skills and training around pregnancy and parenting support, including confidential support related to family social and emotional concerns; • Connections to enhanced support from a skilled public health nurse over the short-term or for up to five years post-partum if risk assessment at any point in care indicates the presence of chronic health conditions or social needs requiring more intensive care; • Engaging and supporting fathers or significant others who play or could play a positive role in pre and post-partum parenting; • Personalized support around maternal and child nutrition, including but not limited to breastfeeding support.

Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston/Brighton, Chinatown, Dorchester, Fenway/Kenmore, Mission Hill, Roxbury) • **Gender**: All • **Age Group:** Adults, Children, Infants, Teenagers • **Ethnic Group:** Black, African • **Language**: All • **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable

Beth Israel Lahey Health

Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	Access to health care, Family planning

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, Healthy Start Family Partner will serve 100 clients total including 50 pregnant and 50 other (interconception/parenting).	Goal met: Family Partner served 56 pregnant clients and 62 interconception/parenting clients.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://www.bphc.org/Pages/default.aspx

Beth Israel Lahey Health

Chronic Disease Management – Diabetes, Hypertension, and Asthma	
Brief Description or Objective	With more than 50% of disease attributable to health behaviors, BIDMC and its affiliated and/or licensed Community Health Centers (CHC) providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. The Bowdoin Street Health Center's (BSHC) Diabetes Initiative is a comprehensive care management program, caring for more than 900 adults diagnosed with diabetes. As part of the Patient Centered Medical Home model, members of a multidisciplinary team collaborate to promote improved health outcomes through disease prevention, detection, education and treatment. Individual appointments with a dietitian, nurse or physician, plus group medical visits, self-care management visits, exercise and behavioral health programs are available to patients sensitive to their language, education and learning needs. BIDMC's affiliated federally qualified health centers screen and educate patients for diabetes, hypertension and asthma, provide evidence-based care and treatment, and work with BIDMC to ensure access to needed specialty care. BIDMC also supports a diabetes management program at Charles River Community Health (CRCH) called the Live and Learn Diabetes Program. Through the Live and Learn Program, CRCH providers proactively contact diabetes patients who are overdue for care. These patients are able to attend a Diabetes Day event, during which they have multiple appointments (dental, vision, nutrition, nursing self-management support, podiatry, and lab work) in one day with only one co-pay. Additionally, CRCH typically offers provider-led group diabetes visits that were suspended in FY20 due to COVID-19. At BSHC, the Prevent T2 program did not run in FY20 due to staffing constraints caused by COVID-19.
Target Population (indicate/ select as many as apply for all fields)	• **Regions Served:** Boston (Allston/Brighton, Dorchester, Roxbury), Chelsea, Waltham • **Gender**: All • **Age Group**: Adults • **Ethnic Group**: All • **Language:** All • **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban

	• **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐ None/Not Applicable

Beth Israel Lahey Health

Health Issues Tags	Access to health care, Asthma/allergies, Diabetes, Dental health, Hypertension, Overweight and obesity, Vision

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By 9/30/20, 100% of CRCH Medical Assistants (MAs) will be trained to use EMR prompts to identify health center patients with diabetes when they come in for care for any reason.	Goal met: Continued to train MAs and providers on the use of prevention and wellness template to identify care gaps. In addition, 100% of MAs are trained to use Pre-Visit Planning (PVP) document during all visits that alert them to actions they can take during any visit.	1	3	Process Goal
By 9/30/20, CRCH MA's will proactively reach out to patients in need of care by using diabetes registry and documentation of A1C checks within the last 12 months, with a goal of 69%.	Goal met: Expanded the role of MAs as population health managers by training and "turning on" more alerts in Pre-Visit Planning document. 69.9% of A1Cs were checked within the last 12 months. Significant drop from last year (82%) due to limited in-clinic services from March – July 2020 due to COVID-19.	1	3	Process Goal
By 9/30/2020, <30% of CRCH patients ages 18-75 with a diagnosis of diabetes will have HBA1c > 9% or no test recorded.	Goal not met: From November until March CRCH was on track to meet this goal as we were consistently between 30-31%. For the year, 39.4% of CRCH patients ages 18-75 with a diagnosis of diabetes had an HBA1c>9% or no test recorded. This number was higher due to-limited in clinic services from March-July 2020 due to COVID-19.	1	3	Outcome Goal
By 9/30/2020, 75% of CRCH patients 18-85 years of age with hypertension will have hypertension controlled (<140/90).	Goal not met: From November until March CRCH was consistently between 68-69%. For the year, 58.1% of CRCH patients 18-85 years of age with hypertension will have hypertension controlled (<140/90). This number dropped significantly due to limited in- clinic services from March-July 2020 due to COVID-19.	1	3	Outcome Goal
By the end of FY20 BSHC will hire a full time dietician to reinvigorate/restart CDC Prevent T2 program.	Goal partially met: A new dietician was hired but training opportunity for T2 program is not currently available.	1	3	Process Goal

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20 BSHC will recruit a minimum of 15 participants to participate in second offering of Prevent T2 program.	Goal not met: Due to staffing constraints.	1	3	Process Goal
By the end of FY20, BSHC will become a fully recognized CDC Prevent T2 site.	Goal not met: Due to staffing constraints.	1	3	Process Goal
By the end of FY20, BSHC will increase the number of completed annual eye exams to 58% from 50.2% in patients with diabetes.	Goal not met: Due to staffing changes.	1	3	Process Goal
In FY20, the percent of CCA FQHC adults with diabetes whose condition is controlled (HbA1c $\leq$ 9) will be higher than 70%.	Goal met: 80% of adults with diabetes had HbA1C < 9 in FY20.	1	3	Outcome Goal
In FY20, the percent of CCA FQHC adults with hypertension whose blood pressure is < 140/90 will increase from 65.5%.	Goal met: 71% of patients with hypertension had blood pressure < 140/90 in FY20.	1	3	Outcome Goal
In FY20, the percent of CCA FQHC adults with persistent asthma who are appropriately ordered medication will increase.	New measure for FY20. 75% of patients with persistent asthma were appropriately ordered medication in FY20.	1	3	Process Goal
The affiliated federally qualified health centers will serve patients with diabetes, hypertension, and asthma.	Goal met: The health centers collectively served 5,639 diabetic patients (of which 17% were Hispanic/Latino and 10% were Black/African American); 9,815 patients with hypertension (of which 13% were Hispanic/Latino and 9% were Black/African American); and 2,058 patients with persistent asthma in FY20.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Joslin Clinic	Healthcare institution	https://www.joslin.org
Mount Auburn Hospital	Healthcare institution	https://www.mountauburnhospital.org

Beth Israel Lahey Health

Chronic Disease Management – Reducing Disproportionate Burden of Cancer in Diverse Communities	
Brief Description or Objective	BIDMC participates in both the Dana Farber/Harvard Cancer Center (DF/HCC) and through the DF/HCC, the Faith-Based Cancer Disparities Network, facilitating the educational and outreach programs within 10 churches and the Black Ministerial Alliance. Building on the partnership with the faith-based community, beginning in FY 2013, the DF/HCC incorporated a new strategy that provided cancer survivors within the faith community an opportunity to break through the silence through a photo exhibit called Faces of Faith. When cancer specialty care or inpatient hospitalizations are necessary, BIDMC offers the services of bilingual and bicultural Cancer Patient Navigators who bridge the gulf between community providers and the medical center. One Patient Navigator specializes in serving the Latino community and the other specializes in serving the Chinese community, though they also serve patients from other ethnic groups. This Patient Navigator also leads support groups for cancer patients such as Tea Time (for Chinese women with breast cancer). To provide support to Patient Navigators, BIDMC typically hosts a city-wide Patient Navigator Network that meets quarterly for education, support, networking, and sharing of resources.
Target Population (indicate/ select as many as apply for all fields)	• **Regions Served:** Boston (Allston/Brighton, Chinatown, Dorchester, Fenway/Kenmore, Roxbury, Hyde Park, Jamaica Plain, West Roxbury, Roslindale), Lexington, Quincy, Revere, Waltham, Winthrop, Lawrence, Fall River, Newburyport, Gloucester, Rockport, Andover, Plymouth, Milton, Brockton • **Gender**: All • **Age Group**: Adults • **Ethnic Group**: All • **Language:** All • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	Access to health care, Breast cancer, Lung cancer, All cancer

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC will increase the number of mammograms in CHCs from, 732 mammograms at Outer Cape Health Services, 545 mammograms at Fenway Health, and 4,627 mammograms at South Cove Community Health Center in FY19.	Goal partially met: Offer on-site mammography services at Fenway Health, Outer Cape Health Services, and South Cove Community Health Center. In FY20, 727 patients received mammograms at Outer Cape Health Services, 495 patients received mammograms at Fenway Health, and 4,727 patients received mammograms at South Cove Community Health Center.	1	3	Process Goal
In FY20, BIDMC will coordinate and host a city-wide Patient Navigator Network.	Goal not met: The meetings BIDMC was scheduled to host were moved to virtual meetings due to COVID-19.	1	3	Process Goal
In FY20, BIDMC patients will have access to a Cancer Patient Navigator.	Goal met: In FY20 the BIDMC Cancer Patient Navigators worked with 417 unique patients and totaled 1,640 encounters.	1	3	Process Goal
In FY20, BIDMC Social Work will provide Cancer Support Groups.	Goal met: BIDMC hosted 7 different types of cancer support groups in FY20.	1	3	Process Goal
In FY20, BIDMC will provide low-income individuals with mammograms.	Goal met: 1,613 low-income individuals received a mammogram at BIDMC in FY20.	1	3	Process Goal
In FY20, BIDMC will provide low-income individuals with colon cancer screenings.	Goal met: 928 low-income individuals received a colon cancer screening at BIDMC in FY20.	1	3	Process Goal
In FY20, the Faces of Faith photo exhibit will be displayed publicly at BIDMC.	Goal met: Through a physical distancing process, eleven cancer survivors posed for portraits to be included in the Faces of Faith photo exhibit, which now includes over 80 cancer survivors. The reveal of the new photos will be held in June 2021. The exhibit also had the opportunity to be on display at BIDMC in March 2020 and Boston City Hall in October 2020.	1	3	Process Goal
In FY20, BIDMC will participate in the Patient Navigator Network.	Goal met: In 2020, the Patient Navigator Network met virtually to discuss barriers and solutions to ensure quality and effective integration of navigation services.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Dana Farber Cancer Institute	Healthcare institution	https://www.dana-farber.org

Beth Israel Lahey Health

Chronic Disease Management – HIV/HCV Coinfection Screening, Prevention, and Treatment	
Brief Description or Objective	A BIDMC infectious disease consultant is contracted with The Dimock Center to provide screening, care, and education regarding Human Immunodeficiency Virus (HIV)/Hepatitis C Virus (HCV) co-infection on-site at The Dimock Center every week. This care and service includes a special focus on access to care, initiation, and completion of state-of-the-art HCV therapy. Making these services available at The Dimock Center reduces access barriers for patients who are particularly vulnerable and who otherwise might not receive the latest regimen or be able to access or complete treatment. This program also has a BIDMC infectious disease liaison from The Dimock Center to the BIDMC Liver Center for full engagement and advocacy for vulnerable patients to promote successful treatment outcomes.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Suffolk County, Boston (Dorchester, Roxbury) • **Gender**: All • **Age Group**: Adults • **Ethnic Group:** All • **Language:** English, Spanish • **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group

DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	Access to health care, Hepatitis, HIV/AIDS

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, The Dimock Center will screen over 80% of HIV+ patients for HCV.	Goal met: 98% of HIV+ patients were screened for HCV.	1	3	Process Goal
By the end of FY20, the number of visits to The Dimock Center attended by an infectious disease physician will be 50 visits over 6 months.	Goal met: 55 visits with 110 patients were attended by an infectious disease physician.	1	3	Process Goal
By the end of FY20, the number of HIV/HCV co-infected patients who have begun HCV treatment will be at least 4.	Goal not met: 3 HIV/HCV co-infected patients began HCV treatment.	1	3	Process Goal

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Partners

Partner Name	Description	Partner Web Address
AIDS Action Committee	HIV/AIDS service provider	https://aac.org
Boston Living Center	Resource center for HIV+ individuals	https://www.vpi.org/boston/
Community Research Initiative	Clinical research organization	https://crine.org
Community Servings	Food services organization	https://www.servings.org
New England AIDS Education and Training Center	AIDS education and training organization	https://www.neaetc.org
The Dimock Center	Affiliated Community Health Center	https://www.dimock.org
MA Department of Public Health (DPH)	Government agency	https://www.mass.gov/orgs/department-of-public-health

Beth Israel Lahey Health

Chronic Disease Management – HIV Support Groups	
Brief Description or Objective	For many years, BIDMC has offered a support group called Experienced and Positive for gay men who have advanced AIDS. These long-term survivors, many of whom were first diagnosed in the 1980s, are coping with multiple stressors including the death of partners, significant complications from medications, and reoccurring hospitalizations. Recognizing that women with HIV are an underserved population who often feel socially isolated and stigmatized due to their diagnosis, BIDMC formed the Support Group for HIV+ Women nine years ago. Both of these support groups focus on helping patients cope with their diagnosis, providing a welcoming environment that fosters mutual support and encourages patients as they continue with treatment.
Target Population	• **Regions Served:** All Massachusetts • **Gender**: All • **Age Group**: Adults • **Ethnic Group**: All • **Language**: English • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	HIV/AIDS

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, the BIDMC Social Work Department will provide 22 support group sessions for male HIV positive patients and 22 support group sessions for female HIV positive patients.	Goal partially met: In FY20, BIDMC continued offering support groups for HIV positive patients (25 sessions for men, 2 hours per session, 6 men per group and 21 sessions for women, 2 hours per session, 4 women per group).	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Not applicable		

Social Determinants of Health - Healthy Food and Healthy Eating	
Brief Description or Objective	Bowdoin Street Health Center's (BSHC) assessment of healthy, affordable food options revealed no full-service supermarkets in the neighborhood. Instead, there are small corner stores which are unequipped to store and sell fresh fruits and vegetables. BSHC's Healthy Food Equity Plan continues to increase access to healthy foods in the Bowdoin/Geneva neighborhood. BSHC's Healthy Food Equity plan articulated three strategies to provide access to healthier food choices: sustaining a weekly Farmers' Market during the summer-autumn months; sustaining a subsidized Farm to Family CSA program; and implementing a community education campaign. Bowdoin Street Health Center continues its Healthy Champions program. The Healthy Champions are a cadre of youth who plan, implement, and sustain their own plot in a local a community garden, and educate their peers and families about healthier eating habits and the importance of having fresh and affordable sources of food available in their neighborhood. The Healthy Champions program serves to teach youth about health and wellness in a variety of settings, and encourages them to become ambassadors of health and voices of change in their neighborhood. Plans to continue to expand the Healthy Champions program are currently underway. Food Insecurity and COVID-19 To address food insecurity caused by COVID-19, BIDMC partnered with Community Health Centers (CHCs) and other organizations to improve food access. BSHC provided food and other supports to over 400 residents in the community. Charles River Community Health (CRCH) provided 40 households with food boxes and distributed free dairy items to patients during a monthly mobile market. BIDMC also provided low cost access to thousands of pounds of rice and beans to About Fresh, who provided staple item boxes to Boston residents and low cost meal boxes to Chelsea residents via Sodexo. Chelsea residents were also given masks and gift cards to their local grocery store.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Dorchester, Roxbury, Mattapan, Hyde Park), Chelsea, Randolph, Waltham • **Gender**: All • **Age Group**: All • **Ethnic Group:** All • **Language:** English, Spanish • **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban

	• **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable

Health Issues Tags	Access to healthy food, Nutrition, Income and Poverty

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, the Bowdoin Geneva Farm Stand will increase its sales and customer attendance by 5% by increasing outreach to customers of the Bowdoin/Geneva community.	Goal not met: Due to COVID-19.	1	3	Process Goal
In FY20, BSHC Farmers Market will provide weekly access to fresh fruits and vegetables in Boston neighborhoods.	Goal not met: In 2020, weekly farmers markets were not held due to COVID-19.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://www.bphc.org/Pages/default.aspx
Mayor's Office of Food Initiatives	City initiative to promote access to food	https://www.boston.gov/departments/food-access
Urban Farming Institutes	Organization that promotes urban farming	https://urbanfarminginstitute.org
Ward's Berry Farm	Local farm	https://www.wardsberryfarm.com
Dorchester Neighborhood Service Center	Social services provider	https://bostonabcd.org/location/dorchester-neighborhood-service-center/
Dorchester Head Start	Social services provider	https://bostonabcd.org/location/abcd-dorchester-head-start/
Brigham and Women's Faulkner Hospital	Healthcare institution	https://www.brighamandwomensfaulkner.org
Dorchester North WIC	Federal supplemental nutrition program	https://www.wicprograms.org/ci/ma-dorchester
Mass in Motion	Government program to promote active living and healthy eating	https://www.mass.gov/orgs/mass-in-motion
Trustees of Reservations	Preservation and conservation nonprofit organization	http://www.thetrustees.org
Fresh Truck	Local food nonprofit organization	https://www.aboutfresh.org/fresh-truck/

Social Determinants of Health – Active Living and Healthy Eating Programs	
Brief Description or Objective	The Wellness Center at Bowdoin Street Health Center (BSHC) contains a demonstration kitchen, a large exercise room for dance and physical activity classes including Tai Chi classes for older adults, and a gym with work-out equipment, offers Bowdoin/Geneva residents the opportunity to learn and practice healthy habits in their own neighborhood. Fitness in the City (FITC), offered by BSHC, is a team-based approach to weight management, actively involving a provider, nutritionist, and case manager in ongoing care planning for each participant. The intervention includes referrals to physical activities, connection to nutrition resources, and referral to mental health counseling when appropriate. BMI check-ups for all children who are obese or at-risk for obesity are monitored on a regular basis, with active participants checking in with the Case Manager regularly over the course of the year. Due to COVID-19, a 6-week virtual basketball clinic was held. The FITC patients learned about shooting, dribbling and passing. They also received a basketball so they could continue to practice everything they learned in the clinic. BIDMC also supports the Walking Club, which encourages students to walk during non-school hours with a parent/guardian in an effort to combat childhood obesity and inculcate healthy lifestyle behaviors. Each child in the Walking Club is given a pedometer to track their steps. Adopted by many Boston Public Schools, the Walking Club kit includes a booklet that has information sheets to promote healthy behaviors, including: workout logs, an examination of the anatomical parts utilized while walking, and basic math and science exercises, such as calculating heart rates and steps into miles. The kits also include booklets for staff at the schools. BIDMC staff collaborated with staff from Tufts University's Child Obesity 180 program. Historically, BIDMC provided the Walking Club supplies to the schools in the fall semester. This effort was a centerpiece of BIDMC's plan to refocus and concentrate its efforts on the population that has far and away made the best use of the Walking Club materials and provided the most demand: Boston Public Schools.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Dorchester, Roxbury, Mattapan, Hyde Park), Randolph • **Gender**: All • **Age Group**: All • **Ethnic Group:** All • **Language:** Cape Verdean Creole, English, Haitian Creole, Spanish

	• **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☒ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions

Beth Israel Lahey Health

EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	Access to healthy food, Cancer, Cardiac disease, Hypertension, Mental health, Nutrition, Overweight and obesity, Physical activity

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, BSHC will host a total of six sessions of Fit Kids/Fit Families programming, targeting Fitness in the City participants.	Goal not met: Due to Covid-19 restrictions. Able to conduct a 6 week basketball clinic and provided breakfast and lunch to FITC participants.	1	3	Process Goal
By the end of FY20, the percent of children seen at affiliated federally qualified health centers that were screened for BMI and counseled on nutrition and physical activity will be greater than 69%.	Goal met: 73% of children seen at affiliated federally qualified health centers were screened for BMI and counseled on nutrition and physical activity.	1	3	Process Goal
In FY20, BSHC will provide 5-2-1 counseling recommended by the AAP during routine well-child visits at BSHC.	Goal met: Nutrition, healthy eating, and exercise information shared at routine pediatric appointments.	1	3	Process Goal
BIDMC will provide pedometers/walking packets to 28 BPS Schools and 13 after school programs in FY20.	Goal not met: BIDMC Marketing Department provided pedometers/ walking packets to 8 BPS schools.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Children's Hospital	Healthcare institution	http://www.childrenshospital.org
Sportsmen's Tennis Club	Tennis club for underserved	http://www.sportsmenstennis.org
Trustees of Reservations	Preservation and conservation nonprofit organization	https://thetrustees.org/
Tufts University, Child Obesity 180 Program	Community program to reduce childhood obesity	https://nutrition.tufts.edu/research/projects-initiatives/childobesity-180

Beth Israel Lahey Health

Social Determinants of Health – Public Safety	
Brief Description or Objective	Public safety is of concern within BIDMC's local neighborhoods, including the Bowdoin/Geneva area. BIDMC's police and public safety presence contributes to a sense of well-being. The medical center has an excellent, cooperative working relationship with the Boston Police Department (BPD) and provides support in the Longwood Medical Area and to Bowdoin Street Health Center (BSHC). BIDMC's security technology and apparatus, including cameras and a BPD shot-spotter at BSHC, have been used to identify perpetrators and assist BPD investigators. In FY 2020, there were a total of 14 officers including the Police Chief. Officers are deputized by the Suffolk County Sheriff's Department and granted special police powers by the Massachusetts State Police.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Chinatown, Fenway/Kenmore, Dorchester, Roxbury, Mission Hill) • **Gender**: All • **Age Group:** All • **Ethnic Group**: All • **Language:** English • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group

DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	Public safety, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, Public Safety will install 15 emergency call stations throughout the BIDMC campus.	Goal partially met: Installation on West Campus completed; work on East Campus is ongoing with FY 21 completion.	1	3	Process Goal
By the end of FY20, Public Safety will rebadge all 9K+ employees and provide them choice to only display first name as an enhanced security precaution.	Goal not met: Initiative paused due to Covid-19 pandemic and the need for contact precautions. Will resume in FY21 when safe to do so.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Police Department	Public safety agency	https://www.boston.gov/departments/police
MASCO	Nonprofit serving Boston's Longwood Medical Area	https://www.masco.org
Massachusetts State Police	Public safety agency	https://www.mass.gov/orgs/massachusetts-state-police

Beth Israel Lahey Health

Social Determinants of Health – Environmental Sustainability	
Brief Description or Objective	BIDMC is actively engaged in creating a vibrant, sustainable community that fosters healthy lifestyles, enhances quality of life, and improves environmental conditions—be it improved air quality, green spaces, and parks and recreational facilities. BIDMC collaborates with colleagues at both the grass-roots level and city and state government to reduce detriments to public health and address determinants that impact health status. As part of BIDMC's commitment to enhancing the physical environment, BIDMC maintains bus stops, Joslin Park, and other green spaces near its campus. Within the hospital itself, BIDMC is implementing an Environmental Strategic Plan, spearheaded by BIDMC's multi-departmental Sustainability Committee. This year highlighted one of the most important synergies between COVID-19 and the climate crisis; the centrality of the health sector at the epicenter of the response. BIMDC's operational practices will have a direct impact on its communities and BIDMC will always have the responsibility to evaluate our business practices to ensure that "we do no harm" for the future of our patients and our staff. BIDMC is committed to conserving natural resources, reducing its carbon footprint, fostering a culture of sustainability, and advancing cost-saving opportunities through: • Energy • Engagement (which is integrated throughout all focus areas) • Healthy Building • Food • Resilience • Responsible Procurement • Transportation • Waste • Water BIDMC achieves environmental commitments through employee engagement, community partnerships, and innovative solutions. BIDMC pledges to continually improve environmental performance by balancing economic viability with environmental responsibility.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Chinatown, Fenway/Kenmore, Dorchester, Roxbury, Mission Hill) • **Gender**: All • **Age Group:** All • **Ethnic Group**: All • **Language:** English

	• **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☒ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions

Beth Israel Lahey Health

EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	Access to transportation, Environmental quality

Goal Description	**Goal Status**	**Current year of program**	**Total Years of Program**	**Goal Type**
By the end of FY20, the Sustainability Department will expand waste diversion programs to improve solid waste diversion from incineration by 5% from 2020 compared to 2019.	Goal partially met: Waste diversion programs for metal and construction and demolition were added and tracked. Waste diversion increased by 3% in 2020 compared to 2019	1	3	Process Goal
By the end of FY20, BIDMC Food Services will increase total sustainable and local food & beverage spend to over 20%.	Goal not met: Due to supply chain shortages during COVID-19, adjustments to food purchases were made to meet demand and unfortunately shifts away from sustainable and local food had to be made. BIDMC purchased ~15% sustainable and local food & beverage.	1	3	Process Goal
By the end of FY20, BIDMC will decrease greenhouse gas emissions related to anesthetic gases by over 50% by transitioning away from desflurane, a potent greenhouse gas.	Goal partially met: The anesthesia department successfully transitioned away from desflurane. Due to COVID-19, reporting has not been finalized to identify the impact that this transition has had based upon case volume changes this year.	1	3	Outcome Goal
By the end of FY20, BIDMC will decrease greenhouse gas emissions related to employee commuting by 5% due to transitioning to support remote work and decrease single occupied vehicles during COVID-19.	Goal met: Due to the pandemic, many office administrative staff have shifted permanently to remote work, which has resulted and will continue to result in a reduction of ~29% greenhouse gas emissions in this population or a ~5% reduction across the entire BIDMC workforce. The magnitude of this reduction will vary based upon how the part-time workers commute to work in a post-pandemic state.	1	3	Outcome Goal

Beth Israel Lahey Health

Partners

Partner Name	Description	Partner Web Address
MIT	Education Institution	https://web.mit.edu/
City of Boston's Green Ribbon Commission	Group of business, institutional, and civic leaders in Boston	https://www.greenribboncommission.org
MASCO	Nonprofit serving Boston's Longwood Medical Area	https://www.masco.org
Healthcare without Harm	Environmental justice organization	https://noharm-uscanada.org/Boston
Practice Green Health	Sustainable healthcare organization	https://practicegreenhealth.org
MassDEP	Government agency	https://www.mass.gov/orgs/massachusetts-department-of-environmental-protection
Mass DOT	Government agency	https://www.mass.gov/orgs/massachusetts-department-of-transportation
US EPA	Government agency	https://www.epa.gov
ABC A Better City	Organization with 130 member companies; dedicated to Boston region economic development	https://www.abettercity.org
Eversource	Gas/electric company	https://www.eversource.com/content/ema-c
Boston Green Academy	Education institution	https://www.bostongreenacademy.org/

Beth Israel Lahey Health

Social Determinants of Health – Violence Intervention and Prevention Program in Bowdoin/Geneva Neighborhood	
Brief Description or Objective	Over the past ten years, Bowdoin Street Health Center (BSHC) has collaborated with community partners to lead the Violence Intervention and Prevention (VIP) program from the Boston Public Health Commission. Known as "Village in Progress" in many neighborhoods, VIP's mission is to prevent violence through building and sustaining strong communities where residents are knowledgeable and empowered. VIPs over-arching goals are to build, knowledge, capacity, community, provide tools, and improve access. The Bowdoin/Geneva VIP outreach team includes a resident Block Captain and a VIP Coordinator who engage in a door-to-door campaign and community organizing activities. Particular focus areas of VIP are to strengthen resident and community engagement; increase access to leadership opportunities for youth; coordinate community actions in the event of homicides and shootings to promote peace and non-violence and a commitment to changing the expectation of violence in the community; ensure residents in the Bowdoin/Geneva neighborhood have access to quality services, resources and support. Prior to the COVID-19 pandemic, VIP held in-person engagements, community meetings, meet and greets, engaged with community police officers, and served as a visual presence in the community for residents who needed Emergency resources. During the COVID-19 pandemic, VIP assisted with the following activities/tasks for community residents and patients: • Distribution of COVID educational materials and PPE kits (over 10,000) • Outreach phone calls and checking in on residents and patients to ensure that needs were addressed while on lock down • Contract tracing for positive BSHC test results • Community meetings to address gun violence in the Bowdoin/Geneva area • Bowdoin Bucks food voucher distribution to over 435 community residents and patients • Outdoor Story Time event • Youth summer job outreach
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Bowdoin/Geneva in Dorchester) • **Gender**: All • **Age Group:** Adults, Children, Elderly, Teenagers • **Ethnic Group:** African, Asian, Black, Caribbean Islander, Hispanic/Latinx, Middle Eastern, White • **Language:** Cape Verdean Creole, English, Haitian Creole, Portuguese, Spanish

	• **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status**: ☐ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions

EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags	Bereavement, Domestic Violence, Public safety, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, VIP will continue to sustain communities and empower residents by building knowledge, building capacity, and building community.	Goal met: VIP has continued to sustain communities and empower residents.	1	3	Process Goal
By the end of FY22, VIP will develop 5 new community leaders that are dispersed throughout the area through partnerships with civic associations.	Goal in progress: In the beginning stages of collaborating with multiple civic associations to streamline information sharing.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Family Nurturing Center	Child development organization	https://www.familynurturing.org
St. Peter's Teen Center	Program for teens operated by Catholic Charities	https://www.ccab.org/TeenCenter

Beth Israel Lahey Health

Social Determinants of Health – Center for Violence Prevention and Recovery	
Brief Description or Objective	Domestic violence, sexual assault, community violence and homicide bereavement are addressed through BIDMC's Center for Violence Prevention and Recovery (CVPR). As one of the founders of the Domestic Violence Council of the Conference of Boston Teaching Hospitals (COBTH) and one of the oldest hospital-based rape crisis intervention programs in the country, BIDMC has led the way in developing a continuum of education, outreach, and treatment interventions to respond to victims of interpersonal, sexual, community violence, and homicide bereavement. It is also one of the leaders in developing programming to address secondary traumatic stress in service providers in the domestic violence and medical communities. CVPR has also recently begun providing psychological evaluations for individuals seeking asylum in the United States. In response to sexual violence, CVPR provides individual and group support and counseling – medical, legal, and personal advocacy - and developed trauma-informed policies and programs with medical providers throughout the Medical Center. In response to Domestic and Interpersonal violence, CVPR provides outpatient and inpatient counseling and advocacy. For those patients with severe and acute safety concerns following interpersonal assault, BIDMC provides a Safebed – a place for a survivor to remain in the hospital overnight -- if no safe shelter option can be identified. In addition, CVPR provides advocacy and follow up care to those who utilize Safebeds. CVPR's community violence initiatives include neighborhood-based support groups, individual counseling, outreach, training, and advocacy. Additionally, BIDMC provides clinical support and counseling through community-based partnerships. CVPR's newest program is aimed at supporting victims of labor and sex trafficking. CVPR's trafficking intervention program will provide training to medical professionals on dynamics of human trafficking and offer identification and acute intervention for patients entering the medical system. COVID-19 has challenged survivors to access services during the pandemic, as most in-person, ambulatory care has been suspended since March. CVPR quickly pivoted to providing telehealth services to outpatients, both individual and group support, and has continued to provide in-person care when safe to inpatients in the hospital. Additionally, CVPR expanded its direct support to patients facing food insecurity, additional mental and behavioral health challenges due to isolation and other pandemic-related stressors, and housing insecurity.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Chelsea, Brockton, Lawrence, Lynn, Lowell, Milton, Newton, Quincy, Somerville, Watertown • **Gender**: All • **Age Group:** Adults, Children, Elderly

	• **Ethnic Group**: All • **Language:** All • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☒ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions

Beth Israel Lahey Health

EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☒ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags	Bereavement, Domestic violence, HIV/AIDS, Sexually transmitted diseases, Violence and trauma

Goal Description	**Goal Status**	**Current Year of Program**	**Total Years of Program**	**Goal Type**
By the end of FY20, CVPR will provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence in the Greater Boston Area.	Goal met: CVPR provided support to 695 victims of domestic, sexual, and community violence in the Greater Boston area.	1	3	Process Goal
By the end of FY20, CVPR will provide services to 50 or more survivors of sexual violence in the Emergency Department.	Goal met: CVPR provided services to 56 survivors of sexual assault in FY20.	1	3	Process Goal
By the end of FY20, CVPR will provide free overnight stays for 5 domestic violence victims without safe shelter.	Goal met: CVPR provided overnight stays for 34 victims.	1	3	Process Goal
By the end of FY20, CVPR will provide education and outreach services to 50 health centers, colleges and universities, and other community groups around sexual assault, interpersonal violence, community violence, secondary traumatic stress.	Goal not met: CVPR provided training to 17 community sites in FY20. COVID-19 impacted ability to provide trainings to community partners.	1	3	Process Goal
By the end of FY20, CVPR will provide 50 peace circles to community members in the Greater Boston area.	Goal met: CVPR provided 86 peace circles in FY20.	1	3	Process Goal
By the end of FY20, CVPR will provide services to one or more community group around issues of secondary traumatic stress.	Goal met: CVPR provided 2 community groups and 3 individual trainings.	1	3	Process Goal

Beth Israel Lahey Health

Partners

Partner Name	Description	Partner Web Address
Louis D. Brown Peace Institute	Nonprofit organization dedicated to healing from violence	http://www.ldbpeaceinstitute.org
SANE	Sexual Assault Nurse Examiner program	https://www.forensicnurses.org/page/aboutSANE
BARCC	Nonprofit organization committed to ending sexual violence	https://barcc.org
Sexual Assault Unit of DPPC	Government agency	https://www.mass.gov/locations/disabled-persons-protection-commission-sexual-assault-response-unit-statewide-saru.gov
Casa Myrna	Provider of shelter and support services for domestic violence survivors	https://www.casamyrna.org
Brigham and Women's Hospital	Healthcare institution	https://www.brighamandwomens.org
Victim Rights Law Center	Legal services organization	https://victimrights.org
Ria House	Community-based organization providing services for people with experience in the commercial sex trade	https://www.riahouse.org/index.html

Beth Israel Lahey Health

Social Determinants of Health – Neighborhood Trauma Team (NTT)	
Brief Description or Objective	In collaboration with and funding from the City of Boston/Boston Public Health Commission (BPHC), Bowdoin Street Health Center (BSHC) plays the lead agency role for the Bowdoin Geneva Greater Four Corners Neighborhood Trauma Team (NTT). As the lead healthcare agency, BSHC partners with a community organizing agency, Greater Four Corners Action Coalition (GFCAC), and provides outreach to individuals, families, and neighborhoods impacted by community violence. The NTT functions as a "hub" team comprised of a licensed clinical social worker, a Family Partner/Community Health Worker, other staff members throughout the health center, and community organizers from GFCAC. The NTT team assesses community need related to trauma in order to support and deliver prevention, response, and short- and long-term recovery services. These services are intended to support existing neighborhood strategies. The Boston NTT Network offers the following services for individuals, families, and communities impacted by community violence: • Access to a support hotline 24/7 365 days a year • Immediate support services for any individual impacted by community violence • Support for individuals and families during community events including vigils, memorial, and funeral services • Referral to ongoing behavioral health services for individuals and families • Trauma education and support at community meetings • Community outreach to distribute basic health information on trauma • Community coping/healing groups Support is available to all residents who feel impacted by community violence and all services are free and private.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Dorchester, Roxbury) • **Gender**: All • **Age Group**: All • **Ethnic Group**: All • **Language**: All • **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban

	• **Additional Target Population Status**: ☐ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐ None/Not Applicable

Health Issues Tags	Bereavement, Domestic violence, Mental health, Stress management, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, NTT will respond to every incident of homicide or stabbing within BSHC's catchment area and offer outreach to victims and impacted residents.	Goal met: NTT responded to 100% (15 total) of incidents and offered outreach to victims and impacted residents within BSHC's catchment area in FY20.	1	3	Process Goal
By the end of FY20, BSHC will provide at least 500 direct therapeutic services to children, adults, and their families who have been impacted by violence.	Goal partially met: NTT Clinician provided 478 direct service/therapy visits in FY20. No NTT Clinician for two months which impacted total visits.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission Neighborhood Trauma Team	Health department	https://bphc.org/whatwedo/mental-emotional-health/trauma-response-and-recovery/Pages/Trauma-Response-and-Recovery.aspx
Greater Four Corners Action Coalition	Neighborhood coalition in Dorchester	https://grassrootsfund.org/groups/greater-four-corners-action-coalition-0
Boston Police – C11	Police unit	https://www.boston.gov/departments/police
Family Nurturing Center	Child development organization	https://www.familynurturing.org

Beth Israel Lahey Health

Social Determinants of Health- Education and Workforce Development	
Brief Description or Objective	As an academic medical center, BIDMC's mission includes a strong commitment to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. Due to the COVID-19 crisis, many of BIDMC's workforce development programs transitioned to being held virtually. In FY 2020, BIDMC offered incumbent employees six "pipeline" programs to train for professions such Central Processing Technician and Associate Degree Nurse Resident. BIDMC's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement and competitive scholarships and other classes. BIDMC sponsored two employees to participate in The Partnership, Inc.'s year-long leadership program. BIDMC is committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies. In FY20 BIDMC contracted with Jewish Vocational Services (JVS) to host 9 and hire 6 Pharmacy Technician Trainees from the community. BIDMC also hosted 4 interns from the JVS Transitions to Work program, which provides work experience for young adults with disabilities. BIDMC also participated in the Hack Diversity program that addresses the underrepresentation of Black and Latino tech talent in Boston's innovation economy, sponsoring the program and offering one paid summer internship in IT. In Fall 2019, BIDMC hosted a series of four career development workshops at Bowdoin Street Health Center (BSHC) for health center staff, patients and families, and the broader community. BIDMC provides paid summer jobs and mid-year internships to introduce high school students and out-of-school youth to careers in the medical field. BIDMC is also a presenting sponsor of the Red Sox Scholars Program that pairs BIDMC Medical Champions with academically talented, economically disadvantaged 8th graders from Boston Public Schools. BIDMC senior leaders are active in advocating on behalf of educational and job opportunities. For example, Joanne Pokaski, Senior Director of Workforce Development and Community Relations, is a member of the Boston PIC and chairs the PIC's Boston Health Care Careers Consortium, which brings together healthcare employers, the workforce system and educational institutions in the greater Boston area. This year she was named Chair of the MassHire Workforce Board. She also co-chairs the Greater Boston Chamber of Commerce's Talent Development and Retention Leadership Council.

Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Chinatown, Dorchester, Fenway/Kenmore, Roxbury, Mission Hill), Chelsea, Brookline • **Gender**: All • **Age Group:** Adults, Teenagers • **Ethnic Group**: All • **Language**: English • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status**: ☒ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☒ Employment • ☐ None/Not Applicable

Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable
Health Issues Tags	Education/Learning, Income and poverty

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC will develop a vehicle to regularly share information on program and job opportunities with community partners.	Goal met: In January 2020, sent first job and program listing to 16 community partners. Aim to send monthly.	1	3	Process Goal
In FY20, BIDMC will increase number of pipeline program participants to at least 45.	Goal partially met: Including the Pharmacy Tech program with JVS, BIDMC had 43 participants in pipeline programs. Due to COVID put a few programs on hold.	1	3	Process Goal

Partners

Partner Name (Partial List – See Appendix A)	Description	Partner Web Address
Private Industry Council	Employment organization	https://www.bostonpic.org
Louis D. Brown Peace Institute	Nonprofit organization dedicated to healing from violence	http://www.ldbpeaceinstitute.org
The Partnership, Inc.	Nonprofit organization that builds racially and ethnically diverse leadership pipelines	https://www.thepartnershipinc.org

Beth Israel Lahey Health

Behavioral Health and Substance Use– Facilitating Access	
Brief Description or Objective	BIDMC formed an Opioid Care Committee in FY 2017, whose members include clinical and nonclinical staff. This committee is working to prevent Opioid Use Disorder and to improve the care of patients with Opioid Use Disorder. The goals of the committee include implementing a comprehensive team approach to addiction treatment; achieving best practices for opioid use in assessment, treatment, and continuity of care for acute and chronic pain management; improving management and control systems for opioid use and misuse; and complying with Federal and State regulatory requirements regarding opioid management. Bowdoin Street Health Center (BSHC) continues to integrate behavioral health services into their primary care clinic. The Integrated Behavioral Health Clinician (IBHC) provides co-located, collaborative care within the primary care clinic. The clinician serves as a consultant to primary care staff and provides clinical interventions for patients that are based on brief, functional assessments rather than traditional specialty mental health assessments and interventions. The clinician is available to see patients during primary care visits when needed, to provide follow-up brief intervention, and to help facilitate referrals and "warm hand-offs" to Behavioral Health for ongoing intervention. Primary Care Providers refer patients to the IBHC either during a primary care visit or for a scheduled follow-up visit. The IBHC can spend time during the visit providing psychoeducation, brief assessment and intervention, and recommendations for follow-up care. The IBHC serves to complement care for patients from the patient-centered medical home perspective.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Dorchester, Roxbury) • **Gender**: All • **Age Group**: Adult • **Ethnic Group:** All • **Language:** All • **Environment Served**: ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status**: ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☒ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	Access to health care, Alcohol use, Bereavement, Depression, Domestic violence, Mental health, Opioid use, Stress management, Substance use, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, BSHC Behavioral Health Team will provide at least 150 Integrated Behavioral Health Consultations in Primary Care Clinic.	Goal met: BH Team provided 184 Integrated Behavioral Health Consultations in Primary Care Clinic.	1	3	Process Goal
By the end of FY20, the BSHC Primary Integrated Behavioral Health Clinician will provide at least 600 individual therapy sessions.	Goal met: Primary Integrated Behavioral Health Clinician provided 608 individual therapy sessions.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://bphc.org/Pages/default.aspx

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Behavioral Health and Substance Use – Screening, Brief Intervention, and Referral to Treatment (SBIRT)	
Brief Description or Objective	Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing substance use disorders. The SBIRT screening quickly assesses severity of substance use and helps providers to identify appropriate treatments. SBIRT is recommended by the Institute of Medicine. BIDMC's Emergency Department (ED) implemented a SBIRT program. All patients are asked about alcohol use, and those with an identified issue are provided discharge instructions including contacts for alcohol use counseling. Additionally, two large primary care practices are notified by secure messaging if their patient is seen in the ED for substance use. It has been demonstrated that trauma centers can use the teachable moment generated by an injury to implement an effective injury prevention strategy; alcohol and/or drug use counseling for patients presenting to the hospital because of substance use. BIDMC's Level I Trauma Center works collaboratively with Social Work, Nursing, Physicians, and all members of the care team to ensure screening, intervention, education, and referral to treatment is provided to every patient.
Target Population	• **Regions Served:** All Massachusetts • **Gender**: All • **Age Group:** Adults, Elderly, Teenagers • **Ethnic Group**: All • **Language**: All • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☒ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags	Alcohol use, Opioid use, Substance abuse

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY20, increase collaboration with 3 community providers to improve access to addiction services	Goal partially met: Active collaboration with community providers has been impacted by COVID-19.	1	3	Process Goal
Focus on prevention in collaboration with trauma coordinator, will provide education and outreach to two community service agencies on a quarterly basis	Goal met: Trauma prevention coordinator provides educational workshops regularly.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
The Dimock Center	Affiliated Community Health Center	https://dimock.org
Adcare	Addiction treatment center	https://adcare.com/locations/boston/
PAATHS	Program of Boston Public Health Commission	https://www.bphc.org/whatwedo/Recovery-Services/paaths-connect-to-services/Pages/paaths.aspx

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Equitable Care- Center for Diversity, Equity, and Inclusion	
Brief Description or Objective	BIDMC recognizes the importance of provider/patient cultural concordance in providing quality care. BIDMC's on-going commitment to diversity and inclusion has evolved over the past decade. Inaugurated in FY 2010, The Office of Multicultural Affairs worked to recruit, retain, and advance diverse residents and fellows, junior faculty, and in-house staff and faculty. In January 2015, a new Office for Diversity and Inclusion (ODI), headed by a senior faculty member was created and charged with working with Department Chairs to increase recruitment and retention of under-represented minority and women faculty, and to oversee data collection on health care disparities at BIDMC. Office for Diversity, Inclusion and Career Advancement (ODICA) actively participates in unconscious bias training. ODICA works with the Center for Education, including the directors of Undergraduate Medical Education and Graduate Medical Education, to improve recruitment and retention of medical professionals from underrepresented groups. Finally, ODICA participates in several informal activities and events aimed at increasing awareness of the relevance of professional diversity for the expert and compassionate treatment for BIDMC's diverse family of patients. As of FY 2020, ODICA is known as the Center for Diversity, Equity and Inclusion. Dr. Daniele Ölveczky was recently named the Interim Physician Director for the Center for Diversity Equity and Inclusion. Beth Israel Lahey Health (BILH), has also created a multi-year plan to guide its efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for its patients, employees, and communities. The BILH Diversity, Equity, and Inclusion Council is co-chaired by Dr. DeWayne Pursley, the Chief of the Department of Neonatology at BIDMC and includes 7 other BIDMC representatives.
Target Population (indicate/ select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Fenway/Kenmore) • **Gender**: All • **Age Group**: Adults • **Ethnic Group**: All • **Language**: English • **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban

	• **Additional Target Population Status**: ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☒ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒ None/Not Applicable

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Health Issues Tags	Cultural competency, Racism and discrimination

Goal Description	**Goal Status**	**Current Year of Program**	**Total Years of Program**	**Goal Type**
By the end of FY20, one underrepresented in medicine (UriM) faculty member will complete ¾ of this tenure as research award recipient.	Goal met: Awarded one two-year research career development grant to run 2018-2020.	1	3	Process Goal
By the end of FY20, develop and pilot upstander training for all Emergency faculty and residents.	Goal met: Developed and delivered upstander training for all anesthesia, OB-GYN and emergency medicine faculty with pre- and post-workshop evaluations in conjunction with the Center for Education.	1	3	Process Goal
By the end of FY20, form a DEI Faculty Leadership Committee which represents all departments to create a strategic approach to UriM recruitment.	Goal met: DEI Council created and strategic recruitment plan implemented.	1	3	Process Goal
By the end of FY20, a UriM recruitment video will be made with trainees from all departments.	Goal met: Professional recruitment video completed.	1	3	Process Goal
By the end of FY20, a strategic institution-wide DEI assessment plan will be created.	Goal met: Strategic plan created and surveys administered to each department.	1	3	Process Goal

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Partners

Partner Name	Description	Partner Web Address
The Student National Medical Association, National and NE Chapter	Student-governed organization that supports underrepresented medical students	https://snma.org
The Latino Medical Student Association	Non-profit organization founded to represent, support, educate, and unify US Latino(a) medical students	https://lmsa.hms.harvard.edu/
CHADD Mentoring Course, Harvard Medical School	Collaborative initiative co-sponsored by Harvard Catalyst	https://dicp.hms.harvard.edu/mentoring/chaddmentoring
Harvard Medical School	Education institution	https://dicp.hms.harvard.edu/leadership-and-faculty-development
Diversity Affiliates	Program of Harvard Medical School	https://dicp.hms.harvard.edu

Equitable Care - Evidence-Based Strategies and Research	
Brief Description or Objective	The Institute of Medicine's report, *Unequal Treatment*, focused the nation's attention on disparate care and health outcomes among the U.S. populace. BIDMC's clinical and research community embraced the challenges of advancing knowledge about the root-causes of racial and ethnic health disparities, and developing evidence-based strategies to improve health status of affected groups. For example, Erica Dommasch, M.D. is studying the side effects of Female-to-Male patients (transgender men) receiving masculinizing hormone therapy. Matcheri Keshavan, M.D. is comparing the effectiveness of Cognitive Enhancement Therapy and Social Skills Training for schizophrenia-spectrum disorder in the community. Lewis Lipsitz, M.D. is studying the effects of a novel video-communication program in improving outcomes of discharges from hospitals to skilled nursing facilities. This research enterprise frequently extends beyond BIDMC's campus, involving collaboration with other Harvard Medical School (HMS) affiliates. The Dana Farber/Harvard Cancer Center (DF/HCC)'s Initiative to Eliminate Cancer Disparities is one example where seven institutions are working together on community education and outreach campaigns as well as efforts to make state-of-the-art cancer care accessible to communities of color through clinical trial enrollment and enhanced culturally competent care in hospitals. The Harvard Catalyst is the latest collaboration, bringing together the expertise of Harvard University's 10 schools and 18 academic healthcare centers and other partners to aid the translation of scientific advances into clinical practice and public health policy. BIDMC also participates in the Boston Breast Cancer Equity Coalition (BBCEC), which is made up of Boston hospitals, MA Department of Public Health, Boston Public Health Commission and various other organizations that serve racially/ethnically diverse populations in Boston. The vision of the BBCEC is to eliminate the differences in breast cancer care and outcomes by promoting equity and excellence in care among all women of different racial/ethnic groups in the City of Boston.
Target Population (indicate/ select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Charlestown, Chinatown, Dorchester, Fenway/Kenmore, Hyde Park, Jamaica Plain, Mattapan, Roxbury, West Roxbury), Revere, Brookline, Chelsea, Harwich, Provincetown, Quincy, Truro, Wellfleet • **Gender**: All • **Age Group**: Adults, Elderly • **Ethnic Group**: All • **Language**: English

	• **Environment Served**: ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☒ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions

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EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐ None/Not Applicable
Health Issues Tags	Breast cancer, Cardiac disease, Cancer, Diabetes, HIV/AIDS, Hypertension, Senior health challenges/Care coordination, Substance use

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY20, BIDMC will advance knowledge about causes and remedies of health disparities.	Goal met: Researchers/clinicians engaged in health disparities research efforts through 30 unique research studies.	1	3	Process Goal
In FY20, BIDMC will participate in multi-institutional collaborations to reap synergies and share knowledge.	Goal met: BIDMC faculty and staff participated in DF/HCC, Harvard Catalyst, Harvard School of Public Health, BBCEC, and other multi-institutional collaborations.	1	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Dana Farber Cancer Institute	Healthcare institution	https://www.dana-farber.org
Boston Medical Center	Healthcare institution	https://www.bmc.org
Massachusetts General Hospital	Healthcare institution	https://www.massgeneral.org
Tufts Medical Center	Healthcare institution	https://www.tuftsmedicalcenter.org
Brigham and Women's Hospital	Healthcare institution	https://www.brighamandwomens.org

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$5,804,875	N/A
Community-Clinical Linkages	$2,848,648	$98,407
Total Population or Community Wide Interventions	$3,939,830	$592,141
Access/Coverage Supports	$18,381,472	$4,393,250
Infrastructure to Support CB Collaborations	$221,750	$103,000
Total Community Benefits Program Expenditures	$31,196,575	$5,186,798
CB Expenditures by Health Need		
Chronic Disease	$15,865,565	
Mental Health/Mental Illness	$5,376,519	
Substance Use Disorders	$3,096,520	
Housing Stability/Homelessness	$765,560	
Additional Health Needs Identified by the Community	$6,092,411	
Total Community Benefits Program Expenditures	$31,196,575	
Leveraged Resources		
Other Leveraged Resources	$6,420,700	
Net Charity Care Expenditures		
HSN Assessment	$20,986,822	
Free/Discounted Care	N/A	
HSN Denied Claims	($5,049,127)	
Total Net Charity Care	$15,937,695	
Total CB Expenditures	$53,554,970	

Additional Information	
Net Patient Services Revenue	$1,351,503,000
CB Expenditure as % of Net Patient Services Revenue	3.96%
Approved CB Budget for FY21 (*Excluding expenditures that cannot be projected at the time of the report)	$31,196,575
Bad Debt	$10,644,891
Bad Debt Certification	
Optional Supplement	
Comments	Total Charity Care is $63,772,628 and includes BIDMC's payment of $15,937,695 to the Health Safety Net; $16,508,965 in unreimbursed Medicare Services; $20,681,077 in unreimbursed MassHealth Services; $10,644,891 in bad debt. In addition, BIDMC made contributions of $183,241 to the City of Boston's Neighborhood Jobs Trust which funds jobs, job training, and related services throughout the City of Boston and $3,418,226 representing BIDMC's voluntary PILOT payment to the City of Boston, which contributes to the health and well-being of individuals residing in its Community Benefits Service Area. Additionally, BIDMC paid $749,753 to the Center for Health Information and Analysis (CHIA) and $250,100 to the Health Policy Commission (HPC).

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SECTION VI: CONTACT INFORMATION

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Beth Israel Lahey Health

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No

  - If so, please list updates:

In January 2020, the Community Benefits Advisory Committee (CBAC) adopted a new charter which expanded its function to include a broader range of community benefits activities including reviewing the Community Health Needs Assessment, Implementation Strategy, Community Benefits mission statement, and regulatory reports. BIDMC also added three members to the CBAC: Walter Armstrong, Sandy Novack, and Angie Liou.

BIDMC Community Benefits Advisory Committee Members: Walter Armstrong, Senior Vice President, Capital Facilities and Engineering, BIDMC; Elizabeth Brown, Chief Executive Officer (CEO), Charles River Community Health; Clementina (Tina) Chéry, Founder, President and CEO, Louis D. Brown Peace Institute; Lauren Gabovitch, Case Manager, BIDMC; Richard Giordano, Director of Policy and Community Planning, Fenway Community Development Corporation; Nancy Kasen, Vice President, Community Benefits and Community Relations, Beth Israel Lahey Health (BILH); Barry Keppard, Public Health Director, Metropolitan Area Planning Council; Phillomin (Philly) Laptiste, Executive Director, Bowdoin Street Health Center; Angie Liou, Executive Director, Asian Community Development Corporation; James Morton, President and CEO, YMCA of Greater Boston; Sandy Novack, Social Worker, Universal Access Council; Holly Oh, MD, Chief Medical Director, The Dimock Center; Alex Oliver-Davila, Executive Director, Sociedad Latina; Triniese Polk, Director of Community Engagement and Partner Relations, Boston Public Health Commission; Joanne Pokaski, Senior Director of Workforce Development and Community Relations, BIDMC; Jane Powers, Chief of Staff, Fenway Health; Luis Prado, Director of Health and Human Services, City of Chelsea; Richard Rouse, Advisory Board Member and former Executive Director, Mission Hill Main Streets; Jerry Rubin, President and CEO, Jewish Vocational Services; Robert Torres, Director of Community Benefits, BIDMC; LaShonda Walker-Robinson, Community Resource Specialist, BIDMC; Fred Wang, Executive Director, The Wang Foundation

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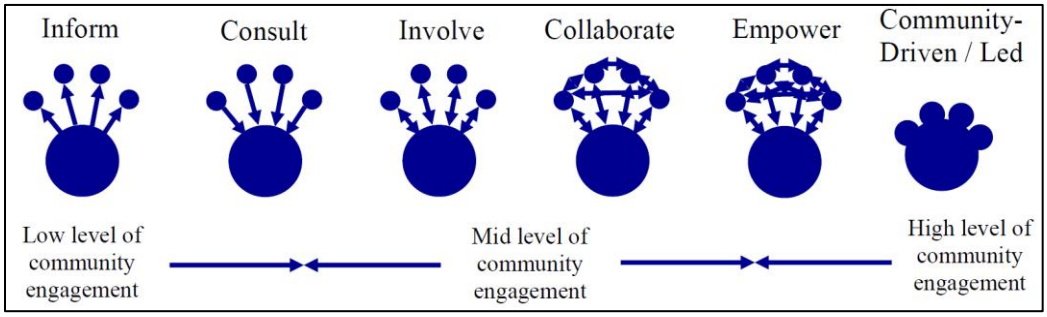
II. Community Engagement:

- If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Community Care Alliance	Holly Oh, MD, Chief Medical Officer, The Dimock Center; Phillomin, Laptiste, Executive Director, Bowdoin Street Health Center; Elizabeth Browne, Executive Director, Charles River Community Health; Jane Powers, Chief of Staff, Executive VP of Strategic Initiatives, Fenway Health; Eugene Welch, Executive Director, South Cove Community Health Center	Community Health Centers	The Community Care Alliance (CCA) is a partnership among the community health centers licensed and/or affiliated with BIDMC. BIDMC supports the CCA and its health centers through technical assistance, resource sharing, and direct financial support. CCA community health centers assisted in expanding BIDMC's community engagement efforts in high need and historically underserved communities during the CHNA and IS process. CCA community health center leadership hold positions on the committee overseeing the CHNA process.
YMCA of Greater Boston	Sarah Coughlin, Nutrition Programs Coordinator	Social Service Organizations	Food donations to address food insecurity related to the COVID-19 pandemic.
Boston Public Health Commission (BPHC)	Margaret Reid, Interim Chief of Staff; Triniese Polk, Interim Director of Office of Health Equity	Local Health Department	BIDMC engages with BPHC on a number of programs, including the Cancer Ride Program, Safe Routes to Schools, emergency preparedness efforts, and the Boston Healthy Start Initiative. Additionally, BIDMC collaborated with the BPHC to assess the health needs of the community by leveraging existing data, and capturing further data to inform the CHNA and IS.

Bowdoin Street Health Center	Mary Kate Little, Social Worker, Bowdoin Street Health Center	Community Health Centers	The Bowdoin Food for Health program at the Bowdoin Street Health Center (BSHC) includes a partnership with Fresh Truck to deliver fresh produce to 100 families every two weeks for six months. Participating families are also screened for social determinants of health.
Louis D. Brown Peace Institute	Clementina (Tina) Chéry, Founder, President and CEO, Louis D. Brown Peace Institute	Social service organizations	The Louis D. Brown Peace Institute is an organization dedicated to helping individuals and families who are healing from violence. BIDMC is a sponsor for the annual Mother's Day Walk for Peace and has a team participate each year. Additionally, the Executive Director of the Louis D. Brown Peace Institute has participated in the CHNA process by serving on BIDMC's CBAC.

1. Please use the spectrum below from the Massachusetts Department of Public Health[2] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



[2] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, *available at*: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	BIDMC involved community members by hosting public CBAC meetings, with time allocated for public comment, posting all meeting materials online, and by sending out community newsletters.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Involve	BIDMC works closely with its' CBAC by seeking input during meetings to decide how community benefits resources should best be allocated. BIDMC also holds a public comment period during all CBAC meetings to ensure community members can share their communities' priorities.	Collaborate
Implementing Community Benefits programs	Consult	BIDMC worked with their CBAC and the Boston CHNA-CHIP Collaborative to craft the Implementation Strategy and continues their involvement through the CHNA-CHIP workgroups and CBAC meetings. BIDMC provides updates and solicits input from the CBAC to guide the implementation of Community Benefits programs (that align with the Implementation Strategy (IS)).	Involve
Evaluating progress in executing Implementation Strategy	Consult	The BILH Community Benefits department is working to refine data and metrics to better evaluate programming for the FY2020 – 2022 IS. In FY 2021, BIDMC will provide quarterly updates to the CBAC about program progress.	Consult
Updating Implementation Strategy annually	Consult	In FY20, BIDMC consulted the CBAC about recent and future updates to the IS. In the future, BIDMC will continue to consult the CBAC and community partners to review the IS and update it as needed.	Consult

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:

BIDMC remains committed to community engagement. During FY19, BIDMC undertook its triennial community health needs assessment and prioritization process. Guided by BIDMC's Community Benefits Committee, now known as the Community Benefits Advisory Committee (CBAC), and conducted in collaboration with community partners, this initiative employed a comprehensive community engagement process. In FY20, all BIDMC CBAC meetings were open to the public and meeting materials (agenda, slides, minutes, etc.) were posted on BIDMCs website.

In FY21, BIDMC will continue working with the CBAC and community partners to engage the community. BIDMC will also continue working collaboratively with other hospitals, community-based organizations, public health agencies, and area coalitions as these partnerships enhance the level and quality of BIDMC's community engagement efforts. Lastly, in order to strengthen BIDMCs Community Benefits program, BILH has hired a Director of Evaluation who will help BIDMC evaluate progress on the IS and track more outcome measures when appropriate.

- Optional FY20 Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits progams.

The health of the communities served by BIDMC was heavily impacted by the COVID-19 pandemic and BIDMC needed to quickly reassess and pivot to meet the new and previously unexpected community needs. As such, in response to the COVID-19 crisis BIDMC's Community Benefits staff along with the hospital's Community Benefits Advisory Committee (CBAC) and in response to COVID, expanded goals related to access to care and social determinants of health targeted primarily at low income populations and communities of color who have been disproportionately impacted by COVID-19.

BIDMC dedicated significant time and resources to respond to needs related to COVID-19. BIDMC worked with its licensed and affiliated community health centers and the hospital's Chelsea location to expand community testing access. Both Bowdoin Street Health Center (BSHC), the hospital's licensed health center, and its Chelsea location reduced barriers to testing access by offering on-site interpretation, welcoming walk-ins, and not requiring a physician order. The hospital also worked with BILH to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19 to help slow the spread of the virus and delineate where residents could access services and resources in their community. BILH and BIDMC redeployed staff, supplies, and other materials to both the community and within hospitals, including Personal Protective Equipment (PPE), food, hand sanitizer, etc.

COVID-19 caused several Community Benefits programs to be modified. In some cases, they were expanded, and in others, they were reduced in response to the pandemic and its impact on our community. Community engagement also transitioned from in-person meetings and events to being held virtually.

2. Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

In FY20, BIDMC held CBAC meetings that are open to the public. These meetings were held in-person at BIDMC on October 22, 2019 and January 28, 2020, and via Zoom on April 28, 2020; June 23, 2020; and September 22, 2020. BIDMC is committed to having transparent and open CBAC meetings. In an effort to engage the community during these meetings, each CBAC meeting had a dedicated time for public comments. BIDMC also accepted written public comments up to five business days prior to a meeting. Meeting agendas were posted online seven business days prior to each meeting and all meeting materials (slides, minutes, etc.) were posted on the website within five business days after a meeting. Additionally, two newsletters were sent out to inform the community about what BIDMC learned during the 2019 community meetings. One of the newsletters informed the community about BIDMC's Request for Proposals for the Community-based Health Initiative.

Additionally, BIDMC shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the triennial CHNA.

III. Updates on Regional Collaboration:

1. If the hospital reported on a collaboration in its **Year 1 Hospital Self-Assessment**, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

Nancy Kasen, Vice President, Community Benefits and Community Relations, BILH, continues to serve as Co-Chair for the 19-member Steering Committee that was formed to oversee the Boston CHNA-CHIP Collaborative and provides strategic direction on the Boston Community Health Improvement Plan. The Boston CHNA-CHIP Collaborative continues to meet virtually through its workgroups and through a virtual Annual Meeting that was held on December 2, 2020. The Boston CHNA-CHIP Collaborative's Annual Meeting was attended by about 125 people and interpretation was provided in 5 languages. BIDMC Community Benefits staff sit on the CHIP workgroups to help carry out the goals outlined in the IS.

Kelly Orlando, Executive Director of Ambulatory Operations at BIDHC-Chelsea, sits on the Steering Committee of the North Suffolk Integrated Community Health Needs Assessment (iCHNA). The Steering Committee completed and released the Implementation Plan in FY20. The Steering Committee and workgroups continue to meet to oversee the Implementation Plan. BIDMC also participates in a collaborative effort with Metro North communities including Chelsea. This regional group was convened by MAPC and provides a forum for coordinating hospital and municipal efforts related to COVID-19.

Additionally, BIDMC is part of the BILH system community health improvement planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all ten BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of high need, underserved, uninsured, and government payer patient populations in the communities. Guided by the CBC, the hospitals' Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

As a system, BILH came together to meet the needs of patients hospitalized with COVID-19. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form.**

   Not Applicable.

Beth Israel Lahey Health

APPENDIX A: PARTNERS

FY20 Partner	Level of Community Engagement	FY20 Partner	Level of Community Engagement
A Better City	Consult	HMS Diversity Affiliates	Collaborate
A Room to Grow	Involve	Hospitality Homes	Consult
ABCD	Community driven/led	International Institute of New England	Community Driven/Led
About Fresh	Collaborate	Jane Doe Inc.	Collaborate
Adcare	Collaborate	Jewish Community Center (JCC) of Greater Boston	Collaborate
African Bridge Network	Community Driven/Led	Jewish Family and Children's Services	Consult
AIDS Action Committee	Consult	Jewish Vocational Services	Involve
AIDS Support Group of Cape Cod	Consult	Joe Andruzzi Cancer Fund	Involve
Alzheimer's Association of MA (Waltham)	Consult	Joslin Diabetes Center	Collaborate
American Chinese Christian Education & Social Services, Inc.	Inform	Justice Resource Institute (JRI) in Boston	Involve
Asian American Civic Association	Inform	La Alianza Hispana (Boston)	Consult
Atrius Health	Collaborate	Leukemia & Lymphoma Society	Inform and Collaborate
Baldwin Early Learning Pilot Academy	Involve	Louis D. Brown Peace Institute	Community Driven/Led
Beth Israel Deaconess Healthcare	Community Driven/Led	Mainspring	Inform
Beth Israel Deaconess Healthcare Chelsea	Community Driven/Led	Mary Lyon Pilot High School	Collaborate
Boston Area Rape Crisis Center (BARCC)	Collaborate	Mass College of Art and Design	Collaborate
Boston Children's Hospital	Collaborate	Mass Hire Career Center-Goodwill	Collaborate
Boston DCF/Wonderfund	Empower	Mass Hire Downtown Boston Career Center	Collaborate
Boston Elder Services	Involve	Massachusetts Commission for the Blind	Community Driven/Led
Boston Emergency Medical Services	Empower	Massachusetts Commission for the Deaf and Hard of Hearing	Involve
Boston Fire Department - Special Operations	Collaborate	Massachusetts Department of Children and Families	Involve
Boston Green Academy	Empower	Massachusetts Department of Environmental Protection (MassDEP)	Delegate
Boston Health Care for the Homeless	Consult	Massachusetts Department of Public Health	Collaborate
Boston Hospital Collaboration for Community Violence	Involve	Massachusetts Department of Public Health COVID-19 Pandemic Response	Collaborate
Boston Living Center	Involve	Massachusetts Department of Transitional Assistance	Inform
Boston Med-Flight	Involve	Massachusetts Department of Transportation (MassDOT)	Inform
Boston Medical Center	Collaborate	Massachusetts General Hospital	Collaborate
Boston Police Department	Collaborate	Massachusetts Health Information Highway	Involve
Boston Private Industry Council (PIC)	Collaborate	Massachusetts HIV Drug Assistance Program	Involve
Boston Public Health Commission	Collaborate	Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA)	Inform
Boston Public Schools	Collaborate	Massachusetts in Motion	Inform
Boston Red Sox	Collaborate	Massachusetts Institute of Technology	Empower
Boston University School of Public Health	Collaborate	Massachusetts Insurance Commission	Consult
Bowdoin Street Health Center	Empower	Massachusetts Rehabilitation Commission	Collaborate
Boys and Girls Club of Greater Boston	Community Driven/Led	Massachusetts State Police	Collaborate
Brigham and Women's Faulkner Hospital	Collaborate	Mayor's Office of Emergency Management	Collaborate
Brigham and Women's Hospital	Collaborate	Mayor's Office of Food Initiatives	Inform
Brockton Area Multi Service Inc. (BAMSI)	Consult	Medical Academic and Scientific Community Organization (MASCO)	Collaborate
Brookline Steps to Success Program	Community Driven/Led	Medical Intelligence Center	Collaborate
Buckle Up Boston	Collaborate	Michael J Perkins School	Involve
Cambridge Health Alliance	Collaborate	Mount Auburn Hospital	Collaborate
Cancer Care	Inform	Nathan Hale School	Involve
Career Collaborative	Community Driven/Led	Nazzaro Community Center	Involve

Casa Myrna	Delegate		New England AIDS Education and Training Center	Collaborate
CHADD Mentoring Course, HMS	Inform		Outer Cape Health Services	Collaborate
Charles River Community Health	Collaborate		Parkway in Motion	Involve
Circle of Hope	Collaborate		Peer Health Exchange	Empower
City of Boston's Green Ribbon Commission	Inform		Pine Street Inn	Community Driven/Led
City of Newton Youth Services	Community driven/led		Practice GreenHealth	Inform
Community Health Education Center	Consult		Provider Network Breakfast	Collaborate
Community Research Initiatives	Consult		Ria House	Consult
Community Servings	Involve		Roxbury Tenants of Harvard	Community Driven/Led
Conference of Boston Teaching Hospitals	Collaborate		Ryan White Dental Program	Involve
Cradles to Crayons	Involve		Sexual Assault Nurse Examiner Program	Collaborate
Dana Farber Cancer Institute	Collaborate		Sexual Assault Unit of Disabled Persons Protection Commission	Consult
Dorchester Head Start	Collaborate		Sociedad Latina	Community Driven/Led
Dorchester Neighborhood Service Center	Collaborate		Somerville Community Development Corporation (First Choice)	Community Driven/Led
Dorchester North WIC	Collaborate		South Cove Community Health Center	Collaborate
Edison K8 School	Involve		Sportsmen Tennis and Enrichment Center	Collaborate
Ellie Fund	Inform		St. Mary's Center for Women and Children	Community Driven/Led
Eversource	Consult		St. Peter's Teen Center	Collaborate
Fair Food (Boston)	Inform		The Dimock Center	Collaborate
Family Nurturing Center	Collaborate		The Forum of Coordinators of Interpreter Services (FOCIS)	Inform
Father Bill's	Inform		The Latino Medical Student Association	Collaborate
Fenway Community Development Corporation	Community Driven/Led		The Partnership, Inc.	Empower
Fenway Health	Collaborate		The Student National Medical Association, National and NE Chapter	Collaborate
Fenway High School	Community Driven/Led		Trustees of Reservations	Collaborate
Found in Translation	Consult		Tufts Childhood Obesity 180	Collaborate
Fresh Truck	Involve		Tufts Medical Center	Collaborate
GLAAD	Inform		U.S. Environmental Protection Agency (EPA)	Collaborate
Greater Boston Employment Collaborative/Riverside Community Care	Community Driven/Led		Unitarian Universalist Urban Ministry	Community Driven/Led
Greater Boston Food Bank	Inform		United Cerebral Palsy (Watertown)	Involve
Greater Four Corners Action Coalition	Empower		Urban Farming Institute	Collaborate
Hack Diversity	Collaborate		Victims Rights Law Center	Collaborate
Harvard Kent	Involve		Victory Programs	Involve
Haynes EEC	Involve		Ward's Berry Farm	Collaborate
Health Care for All	Collaborate		WilmerHale Legal Services (also known has the Legal Service Center)	Collaborate
Healthcare Without Harm	Inform		YMCA of Greater Boston	Community Driven/Led