Community Benefits Report to the Attorney General

FY 2017

Beth Israel Deaconess Medical Center
330 Brookline Avenue
Boston, MA 02215

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Section I: MISSION STATEMENT

Summary

The mission of Beth Israel Deaconess Medical Center is to serve our patients compassionately and effectively, and to create a healthy future for them and their families. Our mission is supported by our commitment to personalized, excellent care for our patients; a workforce committed to individual accountability, mutual respect and collaboration; and a commitment to maintaining our financial health. The Medical Center is committed to being active in our community as well. Service to community is at the core and an important part of our mission. We have a covenant to care for the underserved and to work to change disparities in access to care. We know that to be successful we need to learn from those we serve.

This Community Benefits mission is fulfilled by:

- Implementing programs and services in Greater Boston and Cape Cod to improve the current and future health status of medically underserved communities which are challenged by barriers in accessing and interacting effectively with the healthcare system, and impacted by other social determinants of health.

- Ensuring that all patients receive equitable care that is respectful and culturally responsive and that the medical center is welcoming and inclusive.

- Encouraging collaborative relationships with other providers and government entities to support and enhance rational and effective health policies and programs.

Name of Target Population

BIDMC is committed to improving the health status and well-being of those living throughout its Community Benefits Service Area. BIDMC's FY 2016 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, Chinatown, Dorchester, Fenway/Kenmore, Roxbury, and the South End, as well as the adjacent City of Quincy and the isolated areas on the Outer Cape portion of Cape Cod are the most at-risk. As a result, BIDMC focuses its community health/community benefits efforts primarily on these geographic, demographic, and socio-economic segments of the population, which make up BIDMC's Community Benefits Service Area (CBSA). In addition, the assessment identified two smaller but high need segments of the population that are also underserved, at-risk, and face disparities, namely older adults and the LGBTQ community. Collectively, these population segments are BIDMC's priority target populations as detailed in the FY 2016 CHNA.

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 of Reporting Year

The key accomplishments highlighted in this report are based on the priorities and programs identified in BIDMC's FY 2016 Community Health Needs Assessment (CHNA) and FY 17-FY 19 Community Health Implementation Plan (CHIP).

- Supported increased capacity of primary care and OB/GYN practices at six affiliated health centers
- Continued community-based specialty care services
- Provided care for diverse patients through Cancer Navigator, Interpreter Services, and multilingual patient education
- Addressed social determinants of health, in particular closing the achievement gap, through the distribution of Boston Basics pamphlets and posters to diverse communities
- Continued case management support services for residents with complex physical and behavioral health issues who are patients at CHCs to keep them in their community
- Increased capacity of primary care clinicians at CHCs to provide needed behavioral health services
- Continued workforce development through summer internships for disadvantaged youth, partnerships with local community colleges, and training programs for adults
- Promoted healthy lifestyles through the Walking Club, Farmers Markets, and CSA
- Promoted health of elderly residents through fitness classes
- Conducted research that supports understanding of health disparities
- Provided access to wellness programming including exercise classes and healthy cooking demonstrations at the Wellness Center at Bowdoin Street Health Center
- Empowered youth to develop leadership skills, prevent violence and create change in their community through the Youth Leadership Program at Bowdoin Street Health Center

Plans for Next Reporting Year

BIDMC conducted a CHNA during FY 2016. The approach and process of BIDMC's FY16 CHNA was based on qualitative and quantitative data. In response to the FY16 CHNA, BIDMC has focused the FY 17-FY 19 CHIP around four priority areas, all of which encompass the broad range of health issues and social determinants of health facing residents living in BIDMC's Community Benefits Service Area (CBSA). These four areas are:

1) Social Determinants, Health Risk Factors and Equity;

2) Chronic Disease Management and Prevention;

3) Access to Care and;

4) Behavioral Health (mental health and substance use).

The FY 16 CHNA provided new guidance and invaluable insight on quantitative trends and community perceptions that can be used to inform and refine BIDMC's efforts. In completing the FY 2016 CHNA and FY 2017-FY 2019 CHIP, BIDMC, along with its other health, public health, social service, and community health partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. Based on the assessment's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BIDMC's FY 17-19 CHIP should target certain demographic, socio-economic and geographic cohorts that have complex needs, face barriers to care and service gaps, as well as other adverse social determinants of health that can put them at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the assessment identified the importance of supporting initiatives targeted at low income populations, older adults, racially/ethnically diverse populations, and the LGBT populations.

Through BIDMC's collaborations with individual health centers, and collectively through the Community Care Alliance (BIDMC's health center network), BIDMC will address health disparities (related to race, ethnicity,

sexual orientation/gender identity, and physical attributes) and implement targeted public health programs and chronic disease management programs. BIDMC will continue its efforts on implementing, strengthening, and leveraging the patient-centered medical home service delivery model to ensure coordinated, cost-effective, high quality care for the community. Emphasizing prevention and physical activity, BIDMC will continue to partner with the six health centers to identify and address the underlying root causes and contributing factors hindering health and well-being in BIDMC's community.

Section II: Community Benefits Process

Community Benefits Leadership/Team

The Board of Directors has charged its permanent Community Benefits Committee with authority and oversight of activities to fulfill the mission of Community Benefits. Specifically, the responsibilities of the Committee are to:
"(i) work to recognize and confront health disparities and ensure that the Corporation is welcoming and inclusive for all individuals of diverse backgrounds; (ii) make recommendations of policies and priorities with regard to programs that meet the health care needs of its communities; (iii) strengthen the integration of the Corporation's community service activities, public health programs and its overall strategic planning efforts; (iv) oversee the development and implementation of the community benefit plan to address identified needs in the community; (v) identify, share and replicate innovative and evidence-based models and best practices to address these needs; (vi) review, at least annually, the extent and nature of the commitment of resources to programs targeted at improving the current and future health status of surrounding communities; (vii) encourage collaborative relationships with other providers and government entities to support and enhance rational and effective public health policies and programs; (viii) discuss public policy issues and relevant legal and regulatory matters related to public health and community benefits and advise the Board of Directors of the implications for the Corporation; and (ix) educate directors, trustees, overseers, staff and the community about how the Corporation addresses its mission to focus on the health needs of its communities."

The membership of BIDMC's Community Benefits Committee aspires to be representative of the constituencies and target populations of 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 and senior leadership that are held accountable in fulfilling BIDMC's Community Benefits mission. Consistent with the medical center's core values is the recognition that the most successful community benefits programs are those that are implemented organization-wide and integrated into the very fabric of the medical center's culture, policies and procedures. It is not a stand-alone effort that is the responsibility of one staff or department but rather an orientation and value manifested throughout BIDMC's structure, reflected in how it provides care at the medical center and in affiliated practices in urban neighborhoods and rural areas.

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 Senior Vice President and General Counsel with direct access to the President and CEO. 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 goals of community benefits.

Guiding Principles

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 Committee Meetings

December 6, 2016

March 7, 2017

June 6, 2017

September 5, 2017

Community Partners

The Medical Center 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 Community Health Implementation Plan (CHIP) 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, Dorchester, Fenway/Kenmore, Roxbury, and the South End. BIDMC also has historical ties to underserved communities in Quincy and to some of the most isolated, vulnerable areas of Cape Cod, specifically the Outer Cape (Harwich, Wellfleet, Truro, and Provincetown).

BIDMC currently supports numerous educational, outreach, and community-strengthening initiatives within the Commonwealth. In the course of these efforts BIDMC collaborates with many of Boston's leading healthcare, public health, and social service organizations. BIDMC has particularly strong relationships with many of the primary care clinics that operate in its Community Benefits Service Area, many of which are affiliated with BIDMC's Community Care Alliance (CCA). Serving 118,000 patients annually, the CCA health centers include:

- Bowdoin Street Health Center
- Charles River Community Health (formerly Joseph M. Smith Community Health Center)
- The Dimock Center
- Fenway Heath and Sidney Borum Jr. Health Services
- Outer Cape Health Services
- South Cove Community Health Center

The CCA health centers are ideal community benefits partners as they are rooted in their communities and, as federally qualified health centers, mandated to serve low income, underserved populations. These clinic partners have been a vital part of BIDMC's community health improvement strategy since 1968, when Beth Israel Hospital first joined forces with The Dimock Center to address maternal and child health issues. 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 residents and organizations in the communities they serve.

BIDMC is also an active participant in the Boston Alliance for Community Health (BACH). Joining with such grass-roots community groups and residents, the Boston Public Health Commission (BPHC), Massachusetts Department of Public Health, and academic partners, 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.

Other community partners with which BIDMC joins in developing and implementing community benefits health improvement efforts include:

ABCD Health Services	Dorchester Bay Economic Development Corporation	Massachusetts Senior Action Council
ABCD Parker Hill/Fenway Neighborhood Service Center	Dorchester Cares	Mattapan Community Health Center
AIDS Action Committee	Dorchester Community Food Co-op	Mayhim Hayim
Albert Schweitzer Fellowship Program	Dorchester House Community Health Center	Mayor's Office of Emergency Management
American Association of Medical Colleges	Dorchester Neighborhood Service Center	Mayor's Office of Food Initiatives
American Cancer Society	Dorchester North WIC Office	Mayor's Office of Neighborhood Services
American Diabetes Association	Ecumenical Social Action Committee	Mayor's Office of Workforce Development
American Gastroenterological Association	EPA New England	Mayor's Office, Boston
American Heart Association	Ethos	Medical Academic and Scientific Community Organization, Inc.
American Kidney Fund	Evercare	(MASCO)
American Parkinson Disease Association, MA chapter	Family Nurturing Center	Medical Intelligence Center
Arthritis Foundation	Fenway Community Development Corporation	Mission Hill Youth Collaborative
Associated Industries of Massachusetts	Fenway Health	Mount Auburn Hospital
Atrius Health/Harvard Vanguard Medical Associates	Fenway High School	Multicultural Coalition on Aging
Boston ABCD Family Planning Division	Fitness in the City	National Alliance for Mental Illness
Boston Alliance for Community Health	Found in Translation	National Pancreas Foundation
Boston Area Rape Crisis Center	Friends of Geneva Cliffs	National Parkinson Foundation
Boston Athletic Association	Friendship Works	Neighborhood Health Plan
Boston Basics	Geneva Avenue Head Start	New England Baptist Hospital
Boston Career Link	Gertrude E. Townsend Head Start	Northeastern University
Boston Center for Independent Living	GLAD	Outer Cape Health Services
Boston Center for Youth & Families- Street Workers Program	Greater Boston Interfaith Organization	Partnership for Community Health
Boston Collaborative for Food and Fitness	Greater Boston Food Bank	Pine Street Inn
Boston Elder Services	Greater Bowdoin/Geneva Neighborhood Association	Powisset Farm
Boston Emergency Medical Service	Greater Four Corners Action Coalition	Practice Green Health
Boston Fire Department	Hamilton Street Resident Group	Project Bread
Boston Green Ribbon Commission	Harvard CATALYST	Red's Best Seafood
Boston Healthcare Careers Consortium	Harvard Center for Primary Care	Roxbury Community Alliance for Health
Boston Medical Center	Harvard Medical School	SAGE-Boston (Stop Abuse Gain Empowerment)
Boston Natural Areas Network/Youth Conservation Corps	Harvard School of Public Health	Schwartz Center for Compassionate Healthcare
Boston Police Department	Harvard Street Community Health Center	Sexual Assault Nurse Examiner Program
Boston Private Industry Council	Health Care for All	Sidney Borum Jr. Health Center
Boston Public Health Commission	Health Resources in Action	Sociedad Latina, Inc.
Boston Public Schools	Healthcare Without Harm	South Cove Community Health Center
Boston Red Sox Foundation	Healthworks at Codman Square	Southern Jamaica Plain Health Promotion Center
Boston Regional Domestic Violence Providers	Healthy Kids Healthy Futures	Sportsman's Tennis and Enrichment Center
Boston Regional Mental Health Providers serving Latinos	Healthy Waltham	St. Mary's Center for Women and Children
Boston Senior Home Care	Hebrew Senior Life	St. Peter's Teen Center
Boston Visiting Nurses Association	Hope Funds for Cancer Research	Suffolk County District Attorney's Office, Victim Witness
Boston Youth Fund	Holland Community Center	Advocates
Bottom Line	Hyde Square Task Force	Suffolk County Sheriff's Department
Bowdoin Geneva Alliance	International Institute of New England	Sustainability Guild
Bowdoin Geneva Main Streets Program	Jane Doe, Inc.	Tech Boston Academy
Bowdoin Street Health Center	Jewish Family and Children's Services	The Ancient Bakers
Breast Cancer Research Foundation	Jewish Community Housing for the Elderly	The Boston Foundation
Bridges Together	Jewish Community Relations Council	The Dimock Center
Brigham and Women's Hospital	Jewish Domestic Violence Coalition	The Network, La Red
Brookline Community Mental Health Center	Jewish Vocational Services	The Partnership, Inc.
Brookline Emergency Food Pantry	Jobs for Massachusetts	The Trustees of Reservations (City Harvest and Powisset Farm)
Brookline Health Department	Joslin Diabetes Center	Unitarian Universalist Urban Ministry
Brookline Public Schools	Kit Clark Senior Services	United Way of Massachusetts
Brookline Senior Center	Leventhal Sidman Jewish Community Center	UMASS Boston
Brookside Community Health Center	Louis D. Brown Peace Institute	Upham's Corner Health Center
Bunker Hill Community College	Mary Lyon Pilot High School	Upham's Corner WIC
Butterfly Music Transgender Chorus	Massachusetts Association of Mental Health	US Substance Abuse and Mental Health Services Administration
Cambridge Health Alliance	Massachusetts Attorney General Office	Urban Farming Institute of Boston
Cambridge Office of Workforce Development	Massachusetts Commission for the Blind	US Environmental Protection Agency
Casa Myrna Medical Legal Partnership	Massachusetts Commission for the Deaf and Hard of Hearing	Veterans Affairs Healthcare System- Boston
Career Collaborative	Massachusetts Department of Children and Families	Victim Rights Law Center
Charles River Community Health	Massachusetts Department of Environmental Protection	Vietnamese American Civic Association
Child Obesity 180, Tufts University	Massachusetts Department of Public Health	Violence Intervention and Prevention Initiative
Child Witness to Violence Project	Massachusetts Department of Transitional Assistance	Ward's Berry Farm
Children's Hospital Boston	Massachusetts Department of Transportation	Whittier Street Health Center
Codman Square Health Center	Massachusetts Executive Office of Health and Human Services	YearUP
College Bound Dorchester	Massachusetts General Hospital	YMCA Black Achiever's Program
Combined Jewish Philanthropies	Massachusetts Hospital Association	YMCA of Greater Boston
Community Care Alliance	Massachusetts Immigrant and Refugee Advocacy Coalition	YMCA Training, Inc.
Community Servings	Massachusetts Office for Victim Assistance	Youth Connect
Conference of Boston Teaching Hospitals: COBTH	Massachusetts League of Community Health Centers	Youth Villages
Cooking Matters, Boston	Massachusetts Prostate Cancer Coalition	YWCA Boston
Cradles to Crayons	Massachusetts State Police	
Crohn's and Colitis Foundation of America	Massachusetts Taxpayers Foundation	
Dana Farber/Harvard Cancer Center	Massachusetts Workforce Investment Board	
Dana-Farber Cancer Institute		

Section III: Community Health Needs Assessment

Date Last Assessment Completed and Current Status

The Community Health Needs Assessment (CHNA) along with the associated Community Health Implementation Plan (CHIP) is the culmination of ten months (October 2015 – August 2016) of work and was borne largely out of BIDMC's commitment to better understand and address the health-related needs of those living in its Community Benefits Service Area with an emphasis on those who are most disadvantaged. The project also fulfills Commonwealth Attorney General's Office and Federal Internal Revenue Service (IRS) regulations that require that BIDMC assess community health needs, engage the community, identify priority health issues, and create a community health strategy that describes how the Medical Center, in collaboration with the community and local health department, will address the needs and the priorities identified by the assessment. BIDMC conducted its most recent CHNA in FY 2016, the approach and methods of which are detailed below.

Approach and Methods

The FY 2016 CHNA was conducted in three phases, which allowed BIDMC to: 1) compile an extensive amount of quantitative and qualitative data, 2) engage and involve key stakeholders, BIDMC clinical and administrative staff, and the community at-large, 3) develop a report and detailed strategic plan, and 4) 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.

Beth Israel Deaconess Medical Center'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. These data were 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 Beth Israel Deaconess Medical Center and community partners) is used to inform BIDMC's decision-making about priorities for community benefits efforts. Following the Guiding Principles described above, for each priority area, BIDMC works in concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is thus developed and eventually woven into the annual goals and agenda for the medical center's Community Benefits Plan that is adopted by the Board of Director's Community Benefits Committee.

Summary of Key Health-Related Findings from FY 2016 CHNA

Social Determinants and Health Risk Factors

- **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. Large proportions of individuals residing within Boston and BIDMC's Community Benefits Service Area live in poverty, have limited formal education, are unemployed, and struggle to afford food and other essential household items. These populations are disproportionately from racially/ethnically diverse groups and, partly

as a result of their poverty, face disparities in health and access to care outcomes. It is critical to note that there is a multitude of individual, community and societal factors that work together to create these inequities. It is insufficient to talk solely about race/ethnicity, immigration status, or language; as the underlying and correlative issues related to health and well-being involve economic opportunity, education, crime, and community cohesion.

- **Disparities in Health Outcomes Exist in BIDMC CBSA by Race/Ethnicity, Foreign Born Status, and Language:** As was established in the FY 2013 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 the neighborhoods in Boston that are part of BIDMC's CBSA (i.e., Allston/Brighton, Dorchester, Fenway, Roxbury, and South End/Chinatown). 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 2014-15 Health of Boston Report.
- **It is crucial that these disparities be addressed and, to this end, BIDMC's FY 17-19 CHIP 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, foreign born status, or language but rather a broad array of inter-related issues including economic opportunity, education, crime, and community cohesion. Arguably, these are the leading determinants of health for all urban communities in the United States, and they are daunting challenges. Many of Boston's major academic and healthcare institutions, including BIDMC, have been at the heart of this national dialogue for decades. BIDMC is committed to doing what it can to address these factors and every priority area and goal in BIDMC's FY 16-19 CHIP is structured to address health disparities and inequities in some way.
- **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 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.
- **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 to be preventable or manageable. Addressing the leading risk factors is at the root of a sound chronic disease prevention and management strategy.

Behavioral Health

- **High rates of Substance Use (e.g., Alcohol, Prescription Drug/Opioids, Marijuana) and Mental Health Issues (e.g., Depression, Anxiety, and Stress).** If the impact of social determinants was the leading finding, a close second was the profound impact that behavioral health issues (i.e., substance use and mental health) are having 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 as well as 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.

Chronic Disease Management

- **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 South End/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 HIV/AIDS Particularly on the Outer Portion of Cape Cod and in a Number of Boston Neighborhoods that are Part of BIDMC's CBSA.** Great strides have been made in controlling and managing HIV/AIDS, and for many it is managed as a chronic condition with medications. Rates of illness, death, and HIV transmission declined overall in the past decade. However, HIV/AIDS still has a major impact on certain segments of the population, including men who have sex with men and injection drug users. In BIDMC's CBSA, rates of HIV/AIDS are particularly high in the outer portion of Cape Cod and a number of Boston's neighborhoods.

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 1) Massachusetts has one of highest rates of health insurance and 2) 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, and Transgender (LGBT) Populations.** Based on information gathered primarily from the interviews and community forums, the assessment identified a number of special populations that face barriers to care and disparities in access. More specifically, infants/mothers/fathers, frail older adults, and the lesbian, gay, bi-sexual, and transgender (LGBT) 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 special populations.

Section IV: Community Benefits Programs

Access to Care - Community Based Primary and Specialty Care

Brief Description or Objective

Greater Boston has one of the strongest and most comprehensive healthcare systems in the world. This system is expansive and spans the full healthcare continuum, including outreach and screening services, primary care medical and medical specialty care services. There are no absolute gaps in services across the continuum, even for low income and racially/ethnically diverse populations that often struggle with access to health care services. Despite the overall success of the Commonwealth's heath reform efforts and the Affordable Care Act, data shows that segments of the population, particularly low income and racially/ethnically diverse populations, face significant barriers to care and struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and shortages of providers willing to serve Medicaid insured or low income, uninsured patients.

BIDMC believes that community health centers (CHCs) are in a unique position to provide accessible primary care, preventive care, and specialty services to medically underserved, diverse, inner-city, and rural communities. Health centers understand the needs and are attuned to the cultural sensitivities of their communities and tailor programs to meet these needs.

BIDMC is committed to strengthening the capacity of its six affiliated Community Health Centers. BIDMC makes available many administrative services to its affiliated health centers including marketing, media services, interpreter services, risk management, compliance, etc. BIDMC's partnership and support of these health centers takes many other forms, as well. These include staff training, CHC recruitment, financial support, credentialing of physicians and mid-level providers, admitting privileges, membership in BIDMC's accountable care organization (BIDCO), Harvard Medical School appointments and teaching opportunities, etc. Such teaching and growth opportunities include the Linde Family Fellowship Program (LFFP). The LFFP provides physicians with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation.

Access to Care - Community Based Primary and Specialty Care (continued)

BIDMC's commitment to community-based care translates into a number of BIDMC specialists (e.g., OB/GYN, Infectious Disease, etc.) and ancillary services (i.e., radiology, lab) being provided on-site at the health centers. Recognizing the need for increased access to mental health services, in FY 17 BIDMC psychiatrists continue to build the capacity of CHC primary care physicians so that these PCPs can provide appropriate and responsive mental and behavioral health care to patients in their medical homes.

Goal Description	Goal Status
Increase number of patients receiving primary care, OB/GYN and specialty care at affiliated CHCs	106,463 patients were served by BIDMC-affiliated FQHC health centers in FY 2017.
Increase number of specialists practicing at CHC sites	28 BIDMC specialists practiced at CHC sites in FY 2017.
Increase number of residents with CHC preceptors	34 residents were assigned to CHCs during Academic Year 2017. There were 8 residents in the Fenway HIV/LGBT residency in Academic Year 2017. Two interns and twelve junior and senior residents started in Academic Year 2017 along a primary care residency track.

Access to Care - Community Care Alliance

Brief Description or Objective

In 1997, BIDMC was instrumental in helping its affiliated health centers form a new network called Community Care Alliance (CCA). By collaborating together on clinical and administrative issues, 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 are actively engaged in managing and participating in the CCA's network activities.

Some of the CCA health centers will partner with the Beth Israel Deaconess Care Organization (BIDCO) in the MassHealth Accountable Care Organization (ACO) model.

Goal Description	Goal Status
Identify opportunities for administrative and fiscal savings	Continue monthly regulatory OIG review for all CHC personnel and vendors; maintain CCA Facebook page.
Conduct "Mystery Shopping" to address QI issues around access and patient experience	Mystery shopped six clinics monthly with reports back to CHC managers, Medical Directors and Operations Managers. Completed a total of 72 surveys.
Administer ASK development evaluation program (Advocating Success for Kids)	Continued to provide monthly developmental assessments at two health centers for school-aged children with learning and behavioral issues.

Access to Care - Trauma, Emergency Management and Public Health Surveillance

Brief Description or Objective

BIDMC has a robust trauma and emergency management program that is integrated into the City of Boston and the Commonwealth's emergency preparedness system. BIDMC's Emergency Management department routinely plans for a range of crises, from natural disasters and terrorist scenarios to outbreaks of widespread illness. Previously BIDMC Emergency Management developed templates for magnetic disaster simulation boards in order to drill multiple care areas simultaneously. In FY 2017, these boards were shared and developed for smaller hospitals in Region 4B.

BIDMC is a regular participant in citywide drills, taskforces, and projects, and plan development meetings including those for citywide planned mass casualty events which also includes BIDMC's health center partners in simulations. The Trauma team provides numerous in-service trainings throughout the year, including the semi-annual Advanced Trauma Support classes for New England-wide hospital personnel. Annually, the emergency management team supports two planned major events in Boston, the July 4th celebration, and the Boston Marathon. BIDMC collaborated with city, state and/or federal partners on 19 drills/exercises and responded to 51 events in FY 2017.

BIDMC Emergency Management participates in the following city and state committees:

- MASCO Emergency Preparedness Committee
- Boston Healthcare Preparedness Committee
- COBTH Emergency Management Committee
- BPHC Training and Exercise workgroup
- State Region 4C project workgroup
- State Region 4 Workplace Violence workgroup
- Boston LEPC Committee
- BPHC Patient Tracking workgroup
- Milton LEPC Committee
- Needham LEPC Committee
- Plymouth LEPC Committee
- Region 4B MDPH Hospital Group
- Region 5 MDPH Hospital Group
- Region 5 Healthcare Coalition

BIDMC also participates in the ASPR hospital preparedness program.

Goal Description	**Goal Status**
Collaborate with city, state and federal emergency management programs to ensure preparedness of medical center and CHCs for untoward emergencies	Participated in trainings, simulations and planning meetings. BIDMC collaborated with city, state and/or federal partners on 19 drills/exercises and 51 events. Housed the Emergency Medical Services Station serving Boston's Longwood, Mission Hill, and Roxbury neighborhoods.

Access to Care – Culturally Responsive Care

Brief Description or Objective

A growing body of literature emphasizes the importance of cultural factors in providing appropriate care to patients. Cultural influences determine cognitive constructs including how patients' define health, illness, and well-being, even dictating when and if an individual seeks medical care. Certainly understanding one's cultural background provides guidance for developing health promotion strategies as well as influencing the design of treatment interventions and patients' adherence to medical protocols. With an intentional focus on these issues for nearly 25 years, BIDMC has developed a set of tools and approaches to ensure delivery of culturally-responsive care. From intake assessment forms to multilingual patient satisfaction questionnaires, BIDMC tries to apply "culture eyeglasses" to facilitate communication with, and understanding of, the patients' experience. Among the most underserved are those for whom English is not their first language. As one of the first hospitals with an Interpreter Services Department, BIDMC has a proven track record in helping patients overcome linguistic barriers to care, expanding interpreter services capacity and resources every year, and reflecting the growing non-English speaking patient population in its diverse workforce. BIDMC was the first hospital to employ an American Sign Language interpreter and installed a Sorenson videophone to increase communication access by the Deaf and Hard-of-Hearing. By developing and translating patient information and educational materials, BIDMC has also facilitated access to care as well as helped patients understand their course of treatment and adhere to discharge instructions and other medical regimens.

Access to Care – Culturally Responsive Care (continued)

Goal Description	Goal Status
Increase understanding of cultural impacts on health care delivery, health status and health outcomes	Continue to incorporate information on cultural competence in New Employee Orientation, departmental in-services and Grand Rounds presentations, annual Comprehensive Employee Education programs, etc. Continue to increase capacity of Interpreter Services through"just in time" service delivery model for large staff language groups, as well as added capacity on Saturdays for Spanish and Russian-speaking patients in April, 2017.
Make available tools and resources to facilitate cross-cultural communication	In FY 2017, additional dual handset phones were introduced on key floors and the rollout of iPad/video services is being prepared to pilot for FY 2018.
Increase capacity of Interpreter Services department	Number of interpreter services interactions (face-to-face and phone encounters) totaled 237,255 in 73 languages.
Translate patient education and informational materials	29 new documents were translated in FY 2017, including Alcohol Use Instructions, Financial Assistance Application, Rheumatology Initial Visit Questions, Bone Density Testing, MRI Outpatient Questionnaire, Boston Basics Pamphlets, Patient Bill of Rights, Consent for Cuddling, Radiation Oncology Short Phrases, Bone Density, Waiting Room Sign, and Urgent Care Letter. These documents were translated into 8 languages: Spanish, Russian, Vietnamese, Cape Verdean, Arabic, Thai, Chinese, French, Haitian Creole and Portuguese.

Access to Care- Geographically Isolated Communities

Brief Description or Objective

Although many assume that Cape Cod is a well-resourced, wealthy community, in fact, it is one of the Commonwealth's most medically underserved areas, challenged by geography and economics. The nearest hospital is 50 miles away on a two-lane highway, frequently referred to as "suicide alley." BIDMC continues to offer on-site infectious disease (including high resolution anoscopies) and pulmonary services, and collaborates with Outer Cape Health Services on its digital radiology service which includes mammography screening.

BIDMC continues its significant support of the Med-Flight helicopter program that transports geographically distant patients for quaternary care at the medical center. For those patients and families long distances from home, BIDMC provides housing assistance through programs like Hospitality Homes, Room Away from Home, or specially adapted apartments for those undergoing bone marrow transplantation.

Goal Description	Goal Status
Address unmet medical needs for rural Cape Cod	Offer on-site infectious disease and pulmonary services, and collaborate with Outer Cape Health Services on digital radiology service which includes mammography screening.
Provide access for remote communities to quaternary care	Ongoing support for Med-Flight.

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 services. BIDMC's Care Connection department offers a number of services that benefit the Community Health Centers (CHC) and their patients. Care Connection's Inpatient Discharge Follow Up program helps CHC patients, who were admitted to BIDMC, to arrange specialty follow up care. Staff identify all members of the patient's care team and work to preserve established relationships, ensuring timely, clinically appropriate follow up care is established prior to discharge. BIDMC also assists CHC providers in meeting the specialty care needs of their patients. A BIDMC Care Connection nurse works with health center providers to arrange specialty care appointments, doctor-to-doctor consults, etc. The Care Connection staff also facilitates access to primary care with efforts targeted to BIDMC patients without a primary care provider who present in the Emergency Department (ED), a BIDMC specialty department, or urgent care. Care Connection staff maintains detailed timely information about BIDMC's affiliated health centers, the services offered, and the availability of appointments to facilitate timely access for patients.

Goal Description	**Goal Status**
Facilitate access through referrals to and from community primary care providers	Call center made 986 appointments/referrals to/from CHCs in FY 2017.

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 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).

In FY 17, BIDMC continued its participation in the statewide Mass HIWay initiative, providing the technical interfaces for the Community Health Centers to share information with quality measure databases and other data sharing initiatives. BIDMC continues to work with the CHCs to provide bidirectional viewing of clinical information and care management, and provide support to Bowdoin Street Health Center for data exchange to immunization registries and meaningful use projects. In FY 2017, BIDMC continued to work with the CHCs on their connections to the HIWay.

Goal Description	Goal Status
Enhance health information exchange between BIDMC and community practices	CCA health centers have "magic buttons" with full viewing of BIDMC data. In FY 17, BIDMC added Charles River Community Health and Fenway Health to Discharge Instruction to Consolidated Clinical Document Architecture (CCDA).
Contribute to Mass HIWay initiative	BIDMC shares Meaningful Use data, including immunizations and public health surveillance data with the state via the Mass HIWay. Made multiple updates to lab and immunization feeds to MDPH in FY 17.
Implement lab integration	BIDMC continues its work to exchange laboratory results for Fenway Health patients seen at BIDMC through a pilot with a small group of providers at Fenway.
Standardize sending of inpatient and ED discharge summaries	BIDMC is able to share patient's daily discharge information with an expanded primary care network including Affiliated Physicians Group and Atrius Health.
Provide for at-home health-outcome tracking by individual patients	BIDMC continues to collaborate with Apple to integrate subjective health data into the BIDMC@Home app that will allow patients to record health outcomes and interact with providers on their iPhone/iPad.

Access to Care - Uninsured and Underinsured

Brief Description or Objective

Despite health care reform, roughly one in six (16%) patients seen at a Massachusetts federally qualified health center is uninsured according to the CY 2016 Uniform Data System (UDS) data. For many who continue to be without coverage, they may qualify for assistance from the Health Safety Net 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, while Medication Assistance Counselors aid patients with obtaining no-cost pharmaceutical prescriptions. BIDMC also maintains a free-care pharmacy to help needy patients.

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. The medical center covers the cost of handling remains of indigent patients. 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.

Goal Description	Goal Status
Subsidize Health Safety Net (HSN) Trust Fund	Continue to make annual contribution to HSN. During FY 2017, BIDMC served 2,603 HSN patients.
Provide financial benefits and medication assistance counseling	Staff screened 9,776 patients for eligibility and enrolled 8,716 patients into entitlement programs. 99% of those enrolled patients were enrolled into MassHealth. Continue to provide medication assistance and no-cost pharmaceutical prescriptions to needy patients.
Provide free-care pharmacy medications	Provided 8,053 medication prescriptions to indigent patients.

Access to Care- Centering Pregnancy

Brief Description or Objective

Maternal and child issues are of critical importance to the overall health and well-being of a community and at the core of what it means to have a healthy, vibrant community. Health disparities with respect to the leading maternal and child health indicators (e.g., infant mortality, prenatal care, teen pregnancies, and low birth weight) for racially/ethnically diverse populations in the nation's urban areas are well known. Boston is not immune to these issues and while the disparities have lessened over the years, there are still significant disparities in outcomes, particularly for African Americans/Blacks and Hispanics/Latinos. The infant mortality rate for Hispanics/Latinos in Boston overall is twice the rate of non-Hispanic whites, and for African Americans/Blacks the rate is three times the rate of non-Hispanic whites.

Bowdoin Street Health Center, located in Boston's racially and ethnically diverse Bowdoin/Geneva North Dorchester neighborhood, is improving maternal and child health by providing group visits for expectant mothers in the Centering Pregnancy program. Based on the Centering Healthcare curriculum, these group visits include three key components: health assessment, education, and support. Clinicians and other healthcare staff lead the group visits that empower participants to learn together and from each other. Participants are actively involved in assessing their weight and blood pressure during the health assessments. They also receive health education on a variety of topics including nutrition, exercise, gestational diabetes, stress management, family violence, and family planning. Group members are able to connect and support each other in ways not possible through traditional care. In FY 17, the Centering Pregnancy program was able to improve work flow by offering prenatal patients with Centering group visit appointments at same time as their prenatal intake visits.

Money Matters – Incorporating Financial Literacy into Centering Pregnancy Prenatal Care, a program established by Ebonie Woolcock, MD, an obstetrician at Bowdoin Street Health Center was continued in FY 2017. Dr. Woolcock's program integrates financial literacy into group prenatal care visits by providing expectant mothers with financial planning education to help them proactively plan for financial challenges. Additionally, in FY 2017, Bowdoin Street Health Center continued to provide comprehensive family planning counseling, education, and medical care for women and men.

Goal Description	**Goal Status**
Provide health assessments, health education, and support for pregnant women in a group visit setting	15 pregnant women (ages 17 to 36) participated in a series of 10 group visits.

Chronic Disease Management – Diabetes, Hypertension, and Asthma

Brief Description or Objective

Cardiovascular disease (heart disease), cancer, and cerebrovascular disease (stroke) are the three leading causes of death in the United States, Massachusetts, and Boston. In addition, diabetes is ranked in the top 10 leading causes of death across all three of these geographic areas, and asthma and other respiratory diseases have a huge impact on large portions of adults and children. Data from the Boston Public Health Commission's 2015 Health of Boston Report underscores the fact that these rates are even higher in Boston neighborhoods of Roxbury, Dorchester, and the South End/Chinatown. Boston adults have higher rates of diabetes hospitalizations, emergency department visits, and deaths compared to the Commonwealth of Massachusetts, with the highest rates in Boston being in Roxbury, North Dorchester, and South Dorchester. In 2013, 24% of Boston residents reported having been told by their doctor that they had hypertension. Boston had higher rates of hospital utilization (per 100,000 pop.) for hypertension and higher mortality rates for heart disease compared to the Commonwealth with the highest rates being in Dorchester and Roxbury.

BIDMC and its community health center providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. For example, Bowdoin Street Health Center's (BSHC) Diabetes Initiative is a comprehensive care management program, serving 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, early detection, education and treatment. The program includes individual appointments with a dietitian, nurse or physician; as well as group medical visits, self-care management visits, exercise programs, and behavioral health programs. All of these services are sensitive to patients' language, education, and learning needs. At Bowdoin Street Wellness Center patients with diabetes have access to a range of exercise and nutrition counseling classes conveniently located in their neighborhood. Bowdoin Street's Diabetes education program is recognized by the American Diabetes Association.

BIDMC also supports the diabetes management programs at its other affiliated community health centers such as the Charles River Community Health (CRCH) 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 offered provider-led group diabetes visits, including a Spanish-speaking and Portuguese-speaking group. Both CRCH and BSHC continue to collaborate with Joslin Diabetes Center on diabetes management programs. In FY 2017, Outer Cape Health Services continued to offer on-site retinopathy screening.

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. These health centers served 5,724 diabetic patients (14.5% are Hispanic/Latino; 10% are Black/African American); 16,329 with hypertension (9.4% are Hispanic/Latino; 7.7% are Black/African American); and 1,749 with persistent asthma in FY 17.

Chronic Disease Management- Diabetes, Hypertension and Asthma (continued)

Goal Description	Goal Status
Target is 83% of BSHC patients with diabetes, age 18-75, will have one HbA1c test per year	87.5% of BSHC patients had one HbA1c test during FY 2017.
Target is 85% of BSHC patients with diabetes, age 18-75, will have one LDL cholesterol screening per year	56% of BSHC patients had LDL cholesterol screening during FY 2017.
Target is 72% of BSHC diabetes patients will have one eye exam per year	38.9% of BSHC patients had an eye exam during FY 2017.
Increase number of FQHC adults with diabetes whose condition is controlled (HbA1c $\leq$ 9)	4,520 (79%) adults with diabetes had HbA1C < 9 in FY 2017; 4,034 (70.5) patients with diabetes had HbA1C < 8 in FY 2017.
Increase number of FQHC adults with hypertension whose blood pressure is < 140/90	10,186 patients with hypertension (62.4%) had blood pressure < 140/90 in FY 2017, consistent with FY 2016.
Increase number of FQHC adults with persistent asthma whose condition is under control (meaningful use defined)	1,498 (86%) of patients with persistent asthma had their asthma under control in FY 2017, remaining steady with FY 2016 (81%).
Collaboration with the Joslin Center sustained at BSHC and CRCH.	Joslin Center continues involvement with Bowdoin Street Health Center and Charles River Community Health.

Chronic Disease Management - Reducing Disproportionate Burden of Cancer in Diverse Communities

Brief Description or Objective

Cancer is the second leading cause of death in the United States and the first leading cause of death in the Commonwealth. Quantitative and qualitative data from the assessment corroborate these findings with data showing great disparities on the Outer Cape and in Boston neighborhoods that are part of BIDMC's CBSA. As with other health conditions, there are major disparities in outcomes and death rates across all forms of cancer, which are directly associated with race, ethnicity, income, and whether one has comprehensive medical health insurance coverage.

As a Cancer Center of Excellence recognized by the American College of Surgeon's Commission on Cancer, BIDMC is a leader in translating research into clinical care and community practice—"bench to trench." BIDMC participates in both the Dana Farber/Harvard Cancer Center (DF/HCC) and 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 self-portraits and testimonies, 19 survivors told their stories of hope and resilience which promoted awareness about cancer in their communities and showed that life with and beyond cancer can be glorious and fulfilling. In FY 2014, an additional 14 portraits and stories of patients from diverse backgrounds were added to the installation. BIDMC hosted the installation in FY 2017 and will do so again in FY 2018.

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 in serving the Chinese community, though both also serve patients from other ethnic groups. These Patient Navigators also lead support groups for cancer patients such as Tea Time (for Chinese women with breast cancer) and the Latinas with Cancer group. To provide support for its Patient Navigators, BIDMC hosts a city-wide Patient Navigator Network that meets quarterly for education, support, networking, and sharing of resources.

Cancer patients and their caregivers also have access to BIDMC's Patient-to-Patient, Heart-to-Heart Program, which offers emotional support and practical assistance from volunteers who have experienced and successfully managed the stresses of cancer.

Chronic Disease Management - Reducing Disproportionate Burden of Cancer in Diverse Communities

Goal Description	Goal Status
Increase number of mammograms in CHCs and mobile van	Offer on-site mammography services at Fenway Health and Outer Cape Health Services. In FY 2017, 714 patients received mammograms at Outer Cape Health Services and 505 patients received mammograms at Fenway Health.
Coordinate and host city-wide Patient Navigator Network	21 patient navigators representing 10 healthcare institutions participated in four network luncheons in FY 2017.
Offer Cancer Patient Navigators	The Chinese Patient Navigator saw 469 active patients of which 157 were new patients, providing a total of 2,279 encounters during FY 2017. The Latina Patient Navigator saw 231 patients for a total of 395 requests in FY 2017.
Provide Cancer Support Groups	Continued Tea Time group for Chinese women with breast cancer (21 sessions with an average of 3 participants per session) and Look Good, Feel Better groups for women undergoing cancer treatments hosted by the Latina Patient Navigator (6 groups with 29 participants).
Increase number of low-income individuals who received a mammogram	1,990 low-income individuals received a mammogram at BIDMC in FY 2017.
Increase number of low-income individuals receiving colon cancers screening	1,492 low-income individuals received a colon cancer screening at BIDMC in FY 2017.

Chronic Disease Management - Patient-Centered Medical Home

Brief Description or Objective

The Patient-Centered Medical Home (PCMH) model is touted as key to ensuring quality, effective and cost-efficient care, organized around patients' needs, learning styles, and preferences. As we strive to provide "the right care in the right place at the right time by the right provider," both the community health center partners and BIDMC's ambulatory primary care (Health Care Associates) sites are actively engaged in comprehensive and intense practice transformation activities.

All fourteen sites of BIDMC's licensed and affiliated health centers are recognized PCMHs. In FY2017, Bowdoin Street Health Center submitted its application to renew its Level 3 health center recognition and applied for the Commonwealth's PCMH Prime recognition for its behavioral health program. Fenway Health expanded its PCMH Prime recognition to two of its sites. Charles River Community Health applied for Level 3 PCMH recognition in FY2017.

Goal Description	**Goal Status**
Spread implementation of PCMH	All CCA health centers have achieved patient center medical home recognition. All the CCA health centers continue to integrate behavioral health and primary care.

Chronic Disease Management – HIV/HCV Coinfection Screening, Prevention, and Treatment

Brief Description or Objective

Hepatitis C (HCV) disproportionately affects non-Hispanic black persons, with a rate almost three times that of non-Hispanic white persons. According to the 2002 National Health and Nutrition Examination Survey, the nationwide prevalence of Hepatitis C (HCV) Viral RNA among all participants was 1.3% (CI, 1.0% to 1.5%), equating to 3.2 million (CI, 2.7 million to 3.9 million) HCV RNA–positive persons. The majority of these persons were likely infected during the 1970s and 1980s, when rates were highest.

A BIDMC infectious disease consultant collaborates with The Dimock Center to provide screening, care, and education regarding HIV/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 Dimock 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 adds a BIDMC infectious disease liaison from the Dimock Center to the Liver Center for proper engagement and advocacy for vulnerable patients to promote successful treatment outcomes.

Goal Description	Goal Status
Screen HIV positive patients for HCV	99% of HIV positive patients (144 of 146) screened for HCV. Of these, 33% were co-infected with HCV.
Ensure access to treatment	Infectious disease physician saw 91 patients across 220 visits in FY 2017.

Chronic Disease Management - HIV Support Groups

Brief Description or Objective

Great strides have been made with respect to HIV/AIDS, and for most it is considered to be more of a chronic condition that can be managed with medications than a terminal condition. Rates of illness, death, and HIV transmission have declined dramatically over the past decade. However, HIV/AIDS still has a major impact on the lesbian, gay, bisexual and transgender (LGBT) community, certain Boston neighborhoods (Fenway/Kenmore, Roxbury, North Dorchester), and the communities on the Outer Cape (Wellfleet, Truro, and Provincetown). In Massachusetts, black (non-Hispanic) and Hispanic/Latina females are affected by HIV/AIDS at levels 26 and 15 times that of white (non-Hispanic) females showing that HIV/AIDS disproportionately affects women of color.

For 18 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 seven 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.

Goal Description	**Goal Status**
Provide support groups for HIV positive patients	Continued Experienced and Positive group for gay men who have advanced AIDS (22 sessions; 2 hours per session; 9 participants) and Support Group for HIV+ Women (22 sessions; 2 hours per session; 8 participants). There has been steady membership in both groups over time, with little turnover of participants.

Social Determinants and Health Risk Factors - The Walking Club

Brief Description or Objective

Not only does BIDMC's Cardiovascular Institute have expertise in heart disease, but they are also in the vanguard with prevention programs to promote heart healthy behaviors. The Walking Club provides free kits that include workout logs and information sheets to participants. The Walking Kits have been adapted for corporate entities, patients with special needs, and Boston Public School students. While the kit is used by science/health and gym teachers, one of the primary goals of the program is to encourage 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.

The Walking Club continued to expand in FY 2017 with a redesigned walking kit adapted for elementary and middle school students. Adopted by 44 Boston public schools, the 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 again collaborated with staff from Tufts University's Child Obesity 180 program. The organization provided access to grade 3-5 teachers who offered feedback on ways to rewrite and redesign the Walking Club information packet for a younger target audience.

Historically, BIDMC provided the Walking Club supplies to the schools in the spring semester. In addition to sending these supplies in Spring 2017, BIDMC also distributed kits in Fall 2017 so that the students would be able to use them throughout the entire school year. 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.

Goal Description	Goal Status
Expand Walking Club to additional middle schools	The Walking Club curriculum was used by a total of 44 public schools with 7,175 children and 1,000 school staff participating in FY 2017, increased from 35 public schools and 835 children in FY 2016.
Provide educational materials, pedometers, and smartphone app to Walking Club members	Distributed 9,295 pedometers to Walking Club members. Provided kits including workout logs and printed educational materials.

Social Determinants and Health Risk Factors - Healthy Food Equity Project

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. The health center continued to sustain a weekly farmer's market in the summer and autumn months. The Healthy Food Equity Project continued its successful education of community members on healthy eating through the efforts of 15 youth called the Healthy Champions. The Healthy Champions program engaged a new group of teens (ages 12-16) in healthy cooking classes and nutrition education workshops led by BSHC Nutrition. In an effort to incorporate additional food access-based education into Healthy Champions programming, participants learned about BSHC's on-site Farmers Market, and were also able to shop at the on-site Fresh Truck (a converted school bus providing access to fresh fruits and vegetables), using healthy food vouchers from the BSHC "Food Rx" program. BSHC Healthy Champions also took field trips to the local Geneva Cliffs Urban Wilds, to learn about the importance of maintaining green spaces in their community.

The Food Prescription (Food Rx) Program served as an integral component of nutrition education and food access programming at Bowdoin Street Health Center in FY2017, providing patients with opportunities to purchase fresh and affordable produce in locations convenient to their needs. To enroll in the program, patients met with the BSHC Dietitian for an initial nutrition consult, and to receive an overview of the benefits of each of the participating healthy food resources. Upon completion of this visit, patients received Food Rx vouchers which could be redeemed at various locations convenient to the health center. In addition to these successes, staff from BIDMC continued to support BSHC's Farm to Family Program, a Community Supported Agriculture (CSA) project. Over 60% of BIDMC employees who purchased CSA shares volunteered to subsidize a weekly carton of fresh fruits and vegetables for a low income family.

BIDMC also collaborated with the Mayor's Office to support the Boston CanShare Program in FY 2017. The CanShare Program supports the city's Healthy Incentives Program, making healthy, local food options more accessible and affordable for low-income residents.

Goal Description	Goal Status
Provide access to fresh fruits and vegetables in Boston neighborhoods	Bowdoin Geneva Farmers' Market held weekly from July through October 2017. Vendors at the Farmers' Market accept SNAP, WIC, and Senior Farmers' Market Nutrition Program benefits. CSA project provided 30 families with subsidized cartons of fruits and vegetables.
Expand Healthy Champions Program	15 Healthy Champions program youth participated in healthy cooking classes and nutrition education workshops.

Social Determinants and Health Risk Factors – Active Living and Healthy Eating Programs

Brief Description or Objective

Regular physical activity combined with healthy eating are important for people of all ages. Physical activity helps prevent many diseases (e.g. heart disease, diabetes and some cancers), strengthens bones and muscles, reduces stress and depression, and makes it easier for people to maintain a healthy body weight.

Results from the CHNA indicate that in 2014, more than half (58%) of Massachusetts adults (18+) and nearly one-quarter (23%) of children and youth (0-18) were either obese or overweight. The percentage of Boston's residents who were overweight or obese was similar to the Commonwealth with more than half of all Boston adults being either overweight or obese. There is considerable variation by race/ethnicity and by neighborhood. Thirty-three percent of black/African American adults and 27% of Hispanic/Latino adults were obese compared to only 16% of white, non-Hispanics/Latinos, and 15% of Asians. In Roxbury, 30% of adults were obese and in North and South Dorchester approximately 27% of adults were obese, compared to 22% for the South End/Chinatown and 12% for Allston/Brighton and Fenway/Kenmore. Lack of access to healthy food, nutrition education, and physical activity within these neighborhoods hinder people's abilities to be and stay healthy. This is especially true for individuals with chronic conditions.

BIDMC's Active Living and Healthy Eating grant program continued to partner with Charles River Community Health to implement creative, evidence-based practices to increase the number of older adults who are physically active and consume a healthy, balanced diet rich in fruits, vegetables, and whole grains and lighter on red meat, refined grains, potatoes, sugary drinks, and salt.

Charles River Community Health continues its partnership with the Charlesview Apartments, an affordable housing community, to provide Zumba exercise classes for adults and older adults. Zumba class participants also have the opportunity to join a cooking class, entitled Cook Healthy on a Budget held in the Charlesview Apartments Community Center's kitchen. The participants in this program, many of whom have been involved for three years, have developed a sense of community, celebrating holidays, birthdays and other life events together.

The Wellness Center at Bowdoin Street Health Center contains a demonstration kitchen, a large exercise room for dance and physical activity classes, and a gym with work-out equipment, offering Bowdoin/Geneva residents the opportunity to learn and practice healthy habits in their own neighborhood. Youth enrolled in the Fitness in the City program at BSHC are able to engage in physical activities and nutrition-based services on-site at the Wellness Center, instead of having to solely rely on community partners for these activities. BSHC has also created a Wellness Center membership process which will allow Fitness in the City participants to bring family or friends (who are non-patients) to participate in wellness activities with them.

Social Determinants and Health Risk Factors- Active Living and Healthy Eating Programs (Continued)

Goal Description	Goal Status
Engage children in exercise programs	In FY 2017, 57 children/youth enrolled in Fitness in the City.
Increase number of children seen at affiliated health centers that were screened for BMI and provided with counseling	7,650 children (75%) who are receiving care from affiliated federally qualified health centers were screened for BMI and given counseling.
Increase patient access to physical activity and healthy food in Active Living/Healthy Eating program.	CRCH held 42 Zumba classes with an average of 8-10 people attending the class for older adults and 20 people attending the adult class each time. CRCH held 2 sessions of cooking classes for 6 classes each for a total of 12 classes. 20 individuals completed a full session.
Provide 5-2-1 counseling recommended by the AAP during routine well-child visits at BSHC	Nutrition, healthy eating, and exercise information shared at routine pediatric appointments. In FY 2017, pediatric providers encouraged patients and families to attend "Healthy Weight" clinical check-ins, which include direct referral to Wellness Center programming.
Develop programmatic plan for Wellness Center	The BSHC Wellness Center includes an exercise studio, weight room, and demonstration kitchen for healthy cooking education. BSHC Wellness Center programs promote healthy lifestyles through healthy cooking and physical activity initiatives accessible to residents of the Bowdoin/Geneva neighborhood.

Social Determinants and Health Risk Factors - Environmental Sustainability and Stability

Brief Description or Objective

Like any good neighbor, BIDMC is actively engaged in creating a vibrant, sustainable community that fosters healthy lifestyles, enhanced quality of life, and improved environmental conditions—be it improved air quality, green spaces, and parks and recreational facilities. BIDMC joins 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 its Environmental Strategic Plan, spearheaded by BIDMC's multi-departmental Sustainability Committee. BIDMC is committed to conserving natural resources, reducing our carbon footprint, fostering a culture of sustainability, and advancing cost-saving opportunities through:

Energy & Water Conservation
Waste Reduction
Safer Chemicals
Environmentally Preferable Purchasing
Local & Sustainable Food
Green Commuting

BIDMC achieves our environmental commitments through employee engagement, community partnerships, and innovative solutions. We pledge to continually improve our environmental performance by balancing economic viability with environmental responsibility.

Public safety is of concern within BIDMC's local neighborhoods as well as the Bowdoin area. BIDMC's police and public safety presence contribute to a sense of well-being. The medical center has an excellent, cooperative working relationship with the Boston Police Department (BPD) and essentially serves as their "eyes and ears" in the Longwood Medical Area and on Bowdoin Street. BIDMC's security technology and apparatus, including cameras and a BPD shot-spotter at Bowdoin, have been used to identify perpetrators and assist BPD investigators.

Social Determinants and Health Risk Factors - Environmental Sustainability and Stability (Continued)

Goal Description	Goal Status
Increase recycling rate to 29% by FY 2019	FY 2017 recycling rate was 14.4%.
Increase local and/or sustainable food & beverage spend to 18% by FY 2019	Local and/or sustainable food & beverage spend rate was 15.2% in FY 2017.
Increase healthy beverage spend to 53% by FY 2019	Healthy beverage spend rate was 40.1% in FY 2017.
Reduce amount of meat and poultry served per meal	Amount of meat and poultry served per meal increased from 0.14lbs in FY 2016 to 0.7lbs in FY 2017.

Social Determinants and Health Risk Factors - Healthy Aging

Brief Description or Objective

Keeping older adults healthy and out of the hospital is increasingly important as the population ages. Each year, millions of adults aged 65 and older fall. These falls can provide moderate and severe injuries, including hip fractures and head traumas.

In FY 2014, Bowdoin Street Health Center partnered with Harvard Medical School to offer Tai Chi classes for older adults, in order to increase strength and reduce the risk of falls. Participants are over 65 and referred to the program by their primary care provider because they had a history of or were at-risk for falls. The program consisted of patients participating in hour-long Tai Chi classes, twice per week, for 6 months. In addition to teaching Tai Chi, classes addressed footwear, home safety, stretching, medication review, and what to do in the event of a fall. BSHC continued these Tai Chi classes through the Wellness Center in FY 2017.

Goal Description

Reduce falls among at-risk older adults

Goal Status

29 older adults enrolled in Tai Chi classes in FY 2017. Participants completed a baseline gait and balance test, and complete a follow up test at the conclusion of the program.

Social Determinants and Health Risk Factors –
Violence Intervention and Prevention Program in Bowdoin/Geneva Neighborhood

Brief Description or Objective

Unchecked violence and gang-related activity continue in the Bowdoin/Geneva neighborhood. Over the past six years, Bowdoin Street Health Center (BSHC) has joined with community partners to lead the Violence Intervention and Prevention (VIP) program of the Boston Public Health Commission. VIP's goals are to organize and engage residents in building a sense of community, knowing your neighbor and identifying environmental issues ("broken window theory"). The VIP outreach team includes resident Block Captains, engaged in a door-to-door campaign and community organizing activities. VIP focus areas include strengthening resident and community engagement; increasing youth access to employment, summer and afterschool opportunities, coordinating community responses to homicides and shootings to promote peace, and a commitment to changing the expectation of violence in the community, and ensuring access of residents in the Bowdoin Geneva neighborhood to health services and support. In FY 2017, the VIP Coordinator worked with Boston Public Health Commission (BPHC) to create a social norms campaign for the Bowdoin Geneva neighborhood. The "Our Bowdoin Geneva, Many Cultures, One Neighborhood" campaign involved a year-long planning process that included Bowdoin Geneva residents and several neighborhood agencies known as the Design Team. Through the leadership of the VIP Coordinator and BPHC staff, the Design Team provided input to create a campaign that reflects the vibrant, resilient, and powerful personality of the Bowdoin Geneva community. To date the campaign has been featured on billboards, the MBTA, and over 80 lamp posts that runs through the Bowdoin Street and Geneva Avenue area.

In FY 2017, VIP collaborated to work with the Trauma Recovery Team within the BSHC Behavioral Health Department, which, in partnership with the Boston Public Health Commission and as part of a network in Boston, is staffed with licensed clinicians trained in evidence-based trauma treatment and Family Partners/Community Health Workers. These trauma recovery teams assess community need in order to support and deliver both short and long-term trauma recovery services. VIP worked to connect residents to area agencies and to opportunities for community engagement and leadership.

Additionally, in FY 17 VIP continued the theme of community connectedness by further engaging residents on issues impacting their community. Some of this year's program highlights include two events that targeted diverse men and families to help them create vision boards identifying health improvement goals.

Social Determinants and Health Risk Factors – Violence Intervention and Prevention Program in Bowdoin/Geneva Neighborhood (Continued)

Goal Description	Goal Status
Strengthen resident and community engagement	Continue door-to-door campaign with resident Block Captains. Engage residents in improving their neighborhood and planning community-wide events.
Identify environmental issues that diminish sense of community	Engage residents in working on issues that matter to them including improving the neighborhood's environment; and offer opportunities and support to residents to lead on addressing community issues and/or be included in decisions that affect their community.
Increase youth access to employment and afterschool/summer activities	Partnered with Boston Youth Fund to increase awareness of summer employment. Information related to after-school and out-of-school time was distributed at the annual Bowdoin Geneva CommUNITY Day event. Employed 6 youth from Bowdoin Geneva in paid summer jobs at BIDMC in FY 2017.

Social Determinants and Health Risk Factors – Center for Violence Prevention and Recovery

Brief Description or Objective

Domestic violence, sexual assault and community violence 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, BIDMC has led the way in developing a continuum of education, outreach, and treatment interventions to respond to victims of violence.

The Rape Crisis service and post-HIV exposure prophylaxis program provide follow-up care at no cost to sexual assault victims. BIDMC also offers a free overnight stay for domestic violence and/or sexually assaulted patients without a safe shelter or home.

BIDMC also pledges its commitment to preventing violence and fostering peace in Boston through annual participation in the Louis D. Brown Peace Institute (LDBPI) Mother's Day Walk for Peace. BIDMC employees, along with their families and friends, show their support for the mission of the LDBPI by walking each year, alongside community members from neighborhoods throughout Boston.

Social Determinants and Health Risk Factors – Center for Violence Prevention and Recovery (Continued)

Goal Description	Goal Status
Provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence	Continue to provide individual and group therapy for survivors of violence.
Provide rape crisis services	Provide services, including counseling for 75 sexual assault victims. Provide post-HIV exposure prophylaxis medications to 49 sexual assault victims.
Provide free overnight stay for domestic violence and/or sexual assault victims without safe shelter	Provide 59 Safe Bed overnight stays.
Create opportunities for grieving, support, and healing	Held 57 healing circles that benefitted over 500 men, women and children in the aftermath of community violence.

Social Determinants and Health Risk Factors- 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. In FY 2017, BIDMC offered incumbent employees four "pipeline" programs to train for the following professions: Central Processing Technician, Third Party Associate, Patient Care Technician and Research Administrator. BIDMC's Employee Career Initiative provides career and academic counseling, on-site academic assessment, and on-site pre-college and college-level science courses to employees at no charge. Tuition reimbursement and competitive scholarships as well as ESOL, basic computer skills and citizenship classes are additional offerings. BIDMC also offers employees the opportunity to take the course "Financial Fitness Program," which helps employees build financial literacy skills and offers them three one-on-one planning sessions with a financial counselor. In FY 17 BIDMC selected two employees to participate in The Partnership, Inc.'s year-long leadership program. The Partnership program is designed to facilitate career growth and networking for multicultural professionals in Massachusetts.

The annual YMCA Black Achievers event and Latino Achievement Award, event are other ways in which BIDMC celebrates the accomplishments of its diverse staff. BIDMC also encourages its staff, faculty and community members to support community events around Boston, such as the Boston Heart Walk, and the Pride Parade, in which a group from BIDMC marches alongside friends and LGBT allies.

BIDMC is committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies such as St. Mary's Center for Women and Children and YMCA Training, Inc. BIDMC also provides feedback to community organizations such as International Institute of Boston, Bottom Line, and Career Collaborative on adults applying to jobs at BIDMC.

The Train4Change program at Bowdoin Street Health Center (BSHC) is a workforce and leadership development opportunity around wellness programming, offered to residents in the Bowdoin/Geneva community. Participants receive training to become group fitness instructors, and are engaged in learning and developing exercise curriculum.

Recognizing its commitment to the Boston area's student population, the medical center provides summer jobs and mid-year internships to introduce high school students and out-of-school youth to careers in the medical field. In partnership with the Boston Private Industry Council (PIC), BIDMC hosts students from Boston public high schools in an annual Job Shadow Day with additional student groups touring the skills lab throughout the year. BIDMC is also a presenting sponsor of the Red Sox Scholars Program that pairs BIDMC Medical Champions with 10 academically talented, economically disadvantaged 8th grade students from Boston Public Schools. The program includes opportunities for professional development such as Job Shadow Day at BIDMC clinical sites. Additionally in FY 2017, BIDMC Workforce Development hosted a Job Search workshop for 11 students in the Bowdoin Street Community Health Center's Youth Leadership program. Six of these students were among those hired into paid summer jobs at BIDMC.

Finally, BIDMC hosts high school students (age 14-17) for seven weeks during the summer, where the teens can explore various careers while gaining experience in a hospital setting. BIDMC's Summer Health Corps Program is a six-week educational hands-on program for high school students. Through this program, teens can explore various careers while gaining experience in a hospital setting. In FY 2017, 41 students assisted hospital personnel in various administrative and direct patient contact positions and attended weekly tours of various departments at BIDMC.

BIDMC senior leaders are active in advocating on behalf of educational and job opportunities. Joanne Pokaski, Director of Workforce Development, 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. She is a member of the Massachusetts Workforce Development Board and co-chairs its Labor Market and Workforce Information Committee. Ms. Pokaski also serves on the Executive Committee of CareerSTAT, a project of the National Fund for Workforce Solutions to encourage health care employers nationally to invest in the skills and careers of their front line workers.

Social Determinants and Health Risk Factors- Education and Workforce Development (Continued)

Goal Description	Goal Status
Provide pipeline programs to enhance skills and career advancement	Offered four pipeline programs with 31 participants and 21 graduates in FY 2017.
Provide opportunities through Employee Career Initiative (ECI) for college-level courses as well as counseling	707 employees received ECI services including classes offered on site in partnership with Bunker Hill Community College.
Offer ESOL classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class	19 employees were enrolled in ESOL classes; 107 employees participated in a 10-week computer skills class; 11 attended citizenship classes; and 123 attended a financial literacy class.
Provide job and career introductory opportunities for community residents	Hosted 8 adults in training internships, three of whom were subsequently hired; offered feedback and advice to community organizations on 81 adults who applied for jobs. Enrolled four participants in BSHC's Train4Change Program. Hired one intern from Bunker Hill Community College's Learn and Earn Program.
Provide job and career introductory opportunities for middle and high school students	Provided 41 paid summer job opportunities; 3 school-year internships; numerous tours of medical center and skills lab; hosted 31 Boston Public School students for PIC's annual Job Shadow Day. Medical Champions mentored 10 academically talented, economically disadvantaged 8th graders from BPS. Hosted 41 high school students in Summer Health Corps Program.

Social Determinants and Health Risk Factors – Boston Alliance for Community Health

Brief Description or Objective

Through the Department of Public Health's Community Health Network Alliance (CHNA) program, Beth Israel Deaconess participates in the planning and support of CHNA 19's (Boston) activities.

In FY 2014, BIDMC awarded the Boston Alliance funding for facilitated engagement of residents of the Bowdoin/Geneva community. BACH partnered with community organizations, Bowdoin Geneva Neighborhood Alliance, Bowdoin Street Health Center (BSHC), Violence Intervention Program, and Family Nurturing Center and formed a Community Advisory Board (CAB). In FY 2015 BACH trained the CAB on racial equity, social determinants, community health data, participation in a CAB, and how to request, write, and evaluate proposals. The CAB's mission/vision statement was finalized, an excerpt of which is: "…We must support one another individually for the good of the whole community…We go through difficulties and we see our neighbors going through the same, knowing that we all just want the right things for our families. We want to see our community be successful. Having access to this funding gives us the opportunity to support community driven projects that are chosen by residents." In FY 2017 the CAB continued to meet and focus on issues affecting residents in surrounding communities.

Additionally in FY 16, BACH began the planning of a partnership with Parent/Professional Advocacy League/ (PPAL) Youth MOVE Massachusetts. BACH began to recruit youth and young adult participants by attending community fairs, reaching out to the Bowdoin Geneva residents and distributing flyers to community organizations and markets. This partnership continued in FY 17.

Goal Description	Goal Status
Build a Community Health Improvement Planning process	Support BACH initiatives through DON funding.
Increase engagement of residents in community health	Continue partnership with PPAL. Assisted CAB in discussing how to engage residents and organizations in improving the health of their communities.

Behavioral Health and Substance Use– Facilitating Access

Brief Description or Objective

Mental illness and substance use have a profound impact on the health of people living in Massachusetts and the Boston area. Mental health and substance use hospitalization and death rates are higher for a number of Boston's neighborhoods, in particular Roxbury and parts of Dorchester. These two neighborhoods have a high percentage of Hispanic/Latino residents (nearly 30% of Roxbury's population is Hispanic/Latino).

BIDMC formed an Opioid Care Committee in FY2017, whose members include clinical and nonclinical staff. This committee is working to prevent Opioid Use Disorder and 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.

In response to the mental health needs of the Latino community, BIDMC established and continues to offer the Latino Mental Health Service. The program provides individual and group psychotherapy and psychopharmacologic services to Hispanic/Latino patients in a manner that is sensitive to their language and culture. In FY 2017, the Latino Mental Health Service's bilingual neuropsychologist continued to administer testing in Spanish, to improve testing accuracy in patients whose primary language is Spanish. The Latino Mental Health Service also sponsors a quarterly symposium called Sobremesa, Boston's premier networking and educational forum on cultural psychiatry for Spanish-speaking mental health professionals.

In FY 2017, BIDMC continued to offer a transgender support group facilitated by a licensed speech-language pathologist and a clinical social worker to help transgender individuals work on voice modification and emotional issues as they transition. Five sessions of the group were held in FY 2017.

Bowdoin Street Health Center (BSHC) continues to integrate behavioral health services into their primary care clinic. A Behavioral Health Care Manager is on-site to provide mental health assessment, intervention, and consultation to patients and providers during primary care visits. Results of the behavioral health integration show that more high-risk patients are accessing mental health services, an increase in kept appointments by patients who receive a "warm-hand off" by their provider to therapists, and reduced wait time for mental health appointments. Starting in FY 2014, BSHC partnered with the Brookline Community Mental Health Center on a Healthy Lives Program. The Healthy Lives pilot utilizes an efficient, community-based "care connection" model that engages high-cost patients right where they live, assesses patients' needs and provider realities; strengthens connections with their current providers to build a durable system in which patients can assume responsibility for their own care in less than a year. In FY 2017, the program provided comprehensive care to 11 new residents and maintained contact with 7 participants from last year with two or more chronic medical problems and serious behavioral health needs.

Behavioral Health and Substance Use– Facilitating Access (Continued)

Goal Description	Goal Status
Provide culturally competent mental health services to Latino patients and their families	Provided 2,000 individual and group psychotherapy visits and psychopharmacologic visits, reaching 300 patients.
Provide educational symposium for bilingual/bicultural Spanish-speaking mental health clinicians	Provided a Sobremesa symposium attended by approximately 50 clinicians.

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 an 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.

As part of the SBIRT implementation, BIDMC developed a teaching module to educate providers about patients who may be at-risk for alcohol use, and taught residents, attending physicians and nurses the skills to assess and intervene on patients at risk for alcohol use. This additional training prepares providers to assess a patient's motivation to alter behavior and/or seek additional assistance for care. In FY 2017, BIDMC's ED continued to utilize resources available to providers in the electronic database. These include documentation, literature and other tools available to providers for real-time interventions using SBIRT.

Goal Description	Goal Status
Utilize SBIRT in the BIDMC Emergency Department	SBIRT protocol was incorporated into workflow and fully adopted by BIDMC's Emergency Department.
Screen patients in the ED	63 trauma patients were screened in the BIDMC ED as of January, 2017. 16 of those patients screened positive for alcohol use and of those seven had brief intervention and referral to treatment by BIDMC Social Work.

Equitable Care- Office of Diversity and Inclusion

Brief Description or Objective

The BIDMC Office for Diversity and Inclusion (ODI) was established in FY 2015. The ODI is headed by a senior faculty member. This faculty member works with Department Chairs to increase recruitment and retention of under-represented minority and women faculty, and oversees data collection on health care disparities at BIDMC. Dr. Albert M. Galaburda, Emily Fisher Landau Professor of Neurology at Harvard Medical School, and former Chief of Cognitive Neurology in the Department of Neurology at Beth Israel Deaconess Medical Center, is the founding director of the Office for Diversity and Inclusion.

In FY 2017, the BIDMC ODI supported various efforts emphasizing the importance of diversity in medicine. The ODI director and BIDMC physicians attended the annual meetings of Student National Medical Association and the Latino Medical Students Association.
The Office of Diversity and Inclusion grants the Faculty and Fellow Research Career Development Award, which provides funding for two years of research to a URM faculty member or fellow at BIDMC. In FY 2016-2017, Dr. Jorge Rodriguez utilized this sponsorship while researching how technology impacts the health of low literacy and limited English proficient patients, including evaluating online health content for these patients. Finally, in FY 2017, the BIDMC ODI hosted four visiting students from traditionally black medical schools for a one-month elective course.

Goal Description	Goal Status
Increase diversity of residents and fellows in training	URM applicants have remained steady in FY 2017.
Participate in recruitment fairs targeting diverse medical students	Director of the ODI and BIDMC physician representatives attended annual meetings of Student National Medical Association & Latino Medical Students Association.

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 US 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, Ellen McCarthy, PhD, MPH leads a study on the association between gender minority status, such as transgender and gender-nonconforming individuals and self-reported physical and mental health. Suzanne Bertisch, MD, MPH continues to lead a study on adapting sleep and yoga interventions for use in low-income populations to improve quality of life for those who have sleep disorders. James Rodrigue, PhD, examines the effectiveness of house calls and peer mentorship to reduce racial disparities in live donor kidney transplantation.

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 is also part of 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.

Goal Description	**Goal Status**
Advance knowledge about causes and remedies of health disparities	Researchers/clinicians engaged in health disparities research efforts.
Participate in multi-institutional collaborations to reap synergies and share knowledge	Representation of BIDMC faculty and staff in DF/HCC, Harvard Catalyst, Harvard School of Public Health, BBCEC, etc. collaborations.

Albert Schweitzer Fellowship

Brief Description or Objective

The Albert Schweitzer Fellowship (ASF) is a nonprofit organization, hosted at Beth Israel Deaconess Medical Center, whose mission is to improve the health and well-being of vulnerable people by developing Leaders in Service: individuals who are dedicated and skilled in meeting the health needs of underserved communities, and whose example influences and inspires others. The Boston Schweitzer Fellows Program, founded in 1992 by BIDMC's Dr. Lachlan Forrow, is the oldest of 12 program sites across the US with 3,091 fellows nationwide, roughly 500 of who served in Massachusetts over the past two decades. This year, the Boston program sponsored 15 Massachusetts fellows who are addressing a wide range of health disparities including nutrition and access to healthy foods, access to oral health for students with disabilities, dermatologic wellness and skin cancer prevention among the homeless population, and continuity of care for recently released detainees. BIDMC's affiliated community partners are frequent sites for Schweitzer Fellows.

Goal Description	**Goal Status**
Support ASF's mission of developing leaders in service	Administrative and financial support of ASF Program.
Design sustainable projects that improve community health and increase community capacity	Fellows design projects to address community need, implement a direct service project that improves health and well-being of underserved communities, and augment clinical, social, and/or capital resources through a Community-Based Organization. Fellows ensure sustainability through development of curricula and tools, etc.
Partner with ASF to host students at BIDMC-affiliated sites	Created opportunities for students to learn about and work in BIDMC-affiliated community health centers and partner organizations.

Section V: Expenditures

Community Benefits Programs

Expenditures	Amount
Direct Expenses	$ 15,338,147
Associated Expenses	$ 0
Determination of Need Expenditures	$ 24,000
Employee Volunteerism	$ 13,226
Other Leveraged Resources	$ 4,472,885

Net Charity Care

Expenditures	Amount
HSN Assessment	$ 8,888,825
HSN Denied Claims	$ 4,935,439
Free/Discount Care	$ 0
Total Net Charity Care	$ 13,824,264

Corporate Sponsorships	$ 20,600
Total Expenditures	$ 33,679,896
Total Revenue for FY 2017	$ 1,335,825,773
Total Patient Care-related Expenses for FY 2017	$ 1,228,584,721
Approved Program Budget for FY 2017	$ 37,000,000
(*Excluding expenditures that cannot be projected at the time of the report.)	

Bad Debt $7,867,362 Certified

Comments: Total Charity Care is $103,833,743 and includes BIDMC's payment of $13,824,264 to the Health Safety Net; $24,617,418 in unreimbursed Medicare Services; $54,311,343 in unreimbursed MassHealth Services; $7,867,362 in bad debt; and $3,213,356 in 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 $971,914 to the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC).

Section VI: Contact Information

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