Community Benefits Report to the Attorney General

FY 2011

Beth Israel Deaconess Medical Center
330 Brookline Avenue
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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 Benefit 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

Low income medically underserved in Greater Boston and Cape Cod Regions, medically underserved due to access barriers related to sexual orientation, gender identity, race ethnicity, geographic distance.

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

- Supported increased capacity of primary care and OB/GYN practices at 7 affiliated health centers
- Increased community-based specialty care services at CHCs
- Strengthened efforts to provide care for diverse patients through Cancer Navigator, Interpreter Services, multilingual patient education and cultural competence initiatives
- Supported 2 statewide EOHHS Patient-Centered Medical Home pilot projects, including participation of 3 BIDMC-affiliated CHC sites
- Participated in Faith-Based Cancer Disparities Network, including new Walking for Wellness: The Faith-Based Way program
- Increased number of underrepresented minority applicants to BIDMC residency programs as well as number of applicants ranked to match
- Expanded Bowdoin Street Health Center's Healthy Food Equity Project with new CSA program
- Launched new violence prevention and intervention programs in Bowdoin/Geneva neighborhood that dramatically decreased incidents of violence in area
- Implemented new case management services within CHCs, aligned with payment reform efforts, and focused on decreasing hospital re-admission rate.

Plans for Next Reporting Year

BIDMC's FY 2012 priorities will focus on improving the health status of the medically underserved by increasing access to primary and specialty care services both in the community and at the medical center. Through our collaborations with individual health centers, and collectively through Community Care Alliance (BIDMC's seven affiliated health centers), we will address health disparities (related to race, ethnicity, sexual orientation/gender, and physical attributes) and implement targeted public health programs and chronic disease management programs. The Patient-Centered Medical Home is the service delivery model (accompanied by payment reform) that we will support to accomplish these ends, including a focused emphasis on prevention and wellness activities. Another focus this year will be preparing BIDMC and our affiliate health centers for the formation of Accountable Care Organizations, with an eye towards maintaining and improving care for traditionally disenfranchised and vulnerable patient populations. Efforts to ensure equitable care for all patients will also continue, including our initiatives to enhance providers' and the institution's cultural competence.

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) recommend broad guidelines by with the Corporation's programs and policies serve its communities; (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) 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; (v) encourage collaborative relationships with other providers and government entities to support and enhance rational and effective public health policies and programs; (vi) discuss public policy issues and relevant legal and regulatory matters related to public health and community benefits and advise the Board of Trustees of the implications for the Corporation; and (vii) educate trustees, 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 our 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 our structure, reflected in how we provide care here at the medical center and in affiliated practices in urban neighborhoods and rural areas.

Providing direction for our 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 of Community Affairs, with direct access to the President/CEO. It is the responsibility of these three 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, 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 minorities and other populations traditionally underserved.*
- *Our efforts focus primarily, but not exclusively on health care, so that our financial resources are leveraged with our clinical, academic, and administrative strengths. The health care 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. That is, rather than abandon any of these fundamental missions when budget restraints tempt us, 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 Team Meetings

December 12, 2010

March 9, 2011

May 10, 2011

September 19, 2011

Community Partners

The Community Benefits Plan is developed in concert with community partners, based on community self-definition of particular health concerns and issues, and integrated with available data on public health indicators. In most circumstances, our community collaborators are our seven affiliated health centers that collectively serve approximately 98,000 patients in 14 sites. These centers are:

- Bowdoin Street Health Center
- The Dimock Center
- Fenway Heath
- Joseph M. Smith Community Health Center
- Outer Cape Health Services
- Sidney Borum Jr. Health Services
- South Cove Community Health Center

In turn, each of these community health centers is part of a larger network of community-based health, social service and resident organizations, facilitating BIDMC's collaboration with these groups. The Diabetes Program at Bowdoin Street is an excellent example of how this process is successfully implemented. Originally begun as the Community Healthy Heart Partnership to address cardiovascular disease, Bowdoin's providers became increasingly concerned about the co-morbid condition of diabetes. By reconfiguring its chronic disease management program to include a focus on diabetes, Bowdoin established a relationship with the world renowned Joslin Diabetes Center and was subsequently chosen as one of four health cet4ners to receive $1.2 million to develop "best practice" models of care for underserved patients with diabetes. The collaboration now includes input from community and specialty care providers as well as patients, community residents and a funding Foundation that is committed to bringing national resources to improving care for diabetes. Additional stakeholders' voices and resources have subsequently shaped Bowdoin's development of a Healthy Food Equity Strategic Plan to sustain the Farmer's Market and implement a Corner Store Initiative.

Other community constituencies are involved in the planning and execution of BIDMC's community benefits programming. BIDMC is 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, Massachusetts Department of Public Health, and academic partners, we are striving to create a vision for both city-wide and neighborhood-based health improvement planning and action. Another important partnership is BIDMC's involvement with the Faith-Based Cancer Disparities Network. A coalition of 10 churches, the Black Ministerial Alliance, the American Cancer Society, and the Dana-Farber/Harvard Cancer Center (of which BIDMC is a founding member), we are collectively addressing the unequal burden of cancer within communities of color.

Community participation is an important operational component in many other medical center venues. The Multicultural Cancer Task Force helps shape the way in which cancer care is delivered in the hospital as well as outreach programing. Community voices resonate in the hospital-wide Patient and Family Advisory Council (PFAC) which joins existing PFACs in the Neonatal Intensive Care Unit (NICU), the Intensive Care Unit (ICU), the Universal Access Council and our new Health Education Council. In all these groups, there is an intentional, deliberate strategy to ensure our many diverse communities—ethnic, racial, linguistic, physical ability, gender, age, sexual orientation/gender identity—are represented and included.

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

ABCD Parker Hill/Fenway Neighborhood Service Center
ABCD Health Services
AIDS Action Committee
Albert Schweitzer Fellowship Program
American Cancer Society
American Heart Association
American Parkinson Disease Association, MA chapter
American Red Cross
American Stroke Association
Atrius/Harvard Vanguard
Bay Cove Human Services
Bird Street Community Center
BlueCross BlueShield of MA Foundation
Body by Brandy
Boston Alliance for Community Health
Boston Area Rape Crisis Center
Boston Center for Youth and Families-Street workers Program
Boston Collaborative for Food and Fitness
Boston Emergency Medical Service
Boston Green Ribbon Commission/Healthcare sector
Boston Healthcare Careers Consortium
Boston Inspectional Services
Boston Natural Areas Network/Youth Conservation Corps
Boston Police Department
Boston Private Industry Council
Boston Public Health Commission
Boston Public Schools
Boston Red Sox Foundation
Boston Regional Domestic Violence Providers
Boston R.O.C.K.S Out City Program
Boston Senior Home Care
Boston Urban Asthma Coalition
Boston Visiting Nurses Association
Bowdoin Geneva Planning Group
Bowdoin Street Geneva Avenue Main Streets Program
Bowdoin Street Health Center
Brookline Health Department
Brookline Public Schools
Brookline Senior Center
Buckle Up Boston
Bunker Hill Community College
Cambridge College
Cape Verdean Adult Day Health Program
Center for Community Health Education and Research (CCHER)
Child Witness to Violence Project
Children's Hospital Boston
College Bound
Combined Jewish Philanthropies
Commonwealth Corporation
Community Care Alliance
Compass School
Cradles to Crayons
CVC Unido
Conference of Boston Teaching Hospitals
Dana-Farber Cancer Institute
Dana Farber/Harvard Cancer Center
Deaf, Inc.
Dorchester Bay Economic Development Corporation
Dorchester CARES
Dorchester Environmental Health Coalition
Dorchester Housing Action Team
Dorchester Lead-Safe Yard Project
Dorchester Youth Collaborative
Dream Big!
Ecumenical Social Action Committee
EPA New England
Evercare
Ethos
Family Nurturing Program
Fenway Health
Fenway Community Development Corporation
Fenway High
School
Federated Dorchester Neighborhood House
Fitness in the City
Friends of Geneva Cliffs
Friendship Works
Gay Men's Domestic Violence Program
Geneva Avenue Head Start
GOTCHA (Get Off The Corner Hanging Around)
Youth Summer Program
GLBT Domestic Violence Coalition
Greater Boston Environmental Justice Network
Greater Bowdoin/Geneva Neighborhood Association
Greater Four Corners Action Collaborative
Harvard CATALYST
Harvard Cooperative Program on Aging
Harvard Medical School
Harvard School of Public Health
Health Care for All
Healthcare Without Harm
Health Resources in Action
Healthy Homes Partnership
Healthy Weight Initiative
Hebrew Senior Life
Hospitality Homes
Hyde Square Task Force
Jane Doe, Inc.
Jewish Children's and Family Services
Jewish Community Housing for the Elderly
Jewish Community Relations Council
Jewish Domestic Violence Coalition
Jewish Vocational Services
John D. O'Bryant School of Math and Science
Joseph M. Smith Community Health Center
Joslin Diabetes Center
Kit Clark Senior Services
Lead Action Collaborative
Leventhal Sidman Jewish Community Center
Louis D. Brown Peace Institute
Massachusetts Attorney General Office
Massachusetts Bay Community College
Massachusetts Comprehensive Cancer Control Coalition
Massachusetts Commission for the Deaf and Hard of Hearing
Massachusetts Department of Children and Families
Massachusetts Department of Public Health
Massachusetts Department of Transitional Assistance
Massachusetts Division of Medical Assistance
Massachusetts Executive Office of Health and Human Services
Massachusetts Hospital Association
Massachusetts Immigration and Refugee Advocacy Coalition
Massachusetts League of Community Health Centers
Massachusetts Prostate Cancer Coalition
Massachusetts Workforce Investment Board
MassCONECT
Match-Up Interfaith Volunteers
Mattapan Collaborative for Food and Fitness
Mayhim Hayyim
Medical Academic and Scientific Community Organization, Inc. (MASCO)
Mission Hill Main Streets Elder Friendly Business Initiative
Mission Hill Youth Collaborative
Multicultural Coalition on Aging
National Parkinson Foundation
Neighborhood Diabetes Program
Neighborhood Health Plan
Newton Senior Center
New England Baptist Hospital
Northeastern University
Operation ABLE
Outer Cape Health Services
Peterborough Senior Center
Project H.O.P.E.
Reach Out and Read
Rock, Roll & Ride/BCYF Recreation Commission
Roxbury Community Alliance for Health
Safe Neighborhoods Initiative, Office of the Attorney General
SAGE-Boston (Stop Abuse Gain Empowerment)
Second Step
Sexual Assault Nurse Examiner Program
Sidney Borum Jr. Health Center
Silent Spring Institute
Sociedad Latina, Inc.
South Cove Community Health Center
St. Peter's Church
St. Peter's Teen Center/Catholic Charities
Sportsman's Tennis Club
Squashbusters
St. Mary's Center for Women and Children
Steps to Success
Street Safe Boston
Suffolk Law School Battered Women's Advocacy Clinic
Suffolk County District Attorney's Office
Teen Empowerment
The Boston Foundation
The City School
The Dimock Center
The Food Project
The Network/La Red
The Partnership, Inc.
The Work Place
UMASS Boston
Uphams Corner WIC
Victims Rights Law Center
Vietnamese American Civic Association
YMCA Black Achiever's Program
YMCA Training, Inc.

Section III: Community Health Needs Assessment

Date Last Assessment Completed and Current Status

Beth Israel Deaconess Medical Center's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. Our 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 are 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 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 our decision-making about priorities for community benefits efforts. Following the Guiding Principles described above, for each priority area, we work 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 Findings

The community partners with which Beth Israel Deaconess Medical Center works most closely are our seven affiliated community health centers (CHC). The 2009 Needs Assessment conducted with these collaborators provides the foundation for our work plan that is reviewed and updated annually with the CHC administrative and clinical leadership. The major findings articulated systems-level needs and strategies to optimize the health of underserved communities by strengthening our vertically-integrated system of care. To deliver quality care across the continuum of settings, the needs assessment supported:

- Building the capacity of the CHC's through recruitment, retention, and education of a skilled, linguistically and culturally competent workforce (providers and staff); capital infrastructure needs; and quality improvement initiatives;
- Ensuring access to specialty and Emergency Department care at BIDMC;
- Enhancing health information exchange processes and technologies;
- Expanding community-based residency training and research opportunities
- Conjointly developing population-based public health improvement strategies and programs;
- Supporting efforts to position BIDMC/CHC for new models of health care delivery and payment reform associated with state and federal health care reform.

This systems-level analysis facilitates clinical quality improvement efforts that help patients navigate care from the community to the hospital and back, and enhance communication between providers, resulting in safer and better health outcomes. With the implementation of the Commonwealth's historic health care reform legislation, the CHCs underscored the urgency for CHC and BIDMC to participate in all insurance products so continuity of care is not disrupted. The recommendations informed by the needs assessment speak to clinical, administrative and

fiscal efficiencies and economies of scale as well as the safer and more effective health outcomes that derive from the vertical integration of the health care delivery system jointly crafted over three decades of working together.

While the CHC needs assessment detailed systems-level needs, BIDMC has also conducted targeted assessments that address specific population needs that contribute to the community benefits plan. Examples of these assessments include:

- Healthy Food Access Project: The unprecedented rates of obesity (58%), hypertension (22%), and diabetes (8%) of adults living in the North Dorchester area prompted Bowdoin Street Health Center (BSHC) to develop a Healthy Food Equity strategic plan based on a comprehensive needs assessment. In the Bowdoin-Geneva neighborhood where more than one-third of households are car-free, there are no full-service grocery stores and limited places for residents to purchase fresh produce. Like other small corner market enterprises, the 11 food/convenience stores are not equipped to store and sell fresh, healthy foods but rather carry lower-priced pre-packaged foods. Recommendations currently being implemented include: sustaining BSHC's Farmer's Market, launching a Corner Store Initiative; and enhancing education about healthy eating.

- The Latino Health Needs Assessment: a collaborative undertaking of BIDMC, the Latino Health Institute and seven Latino community-based organizations that included focus groups and health data analysis, culminating in a major symposium to develop an Action Agenda. Several program initiatives derive from this assessment and planning process including BIDMC's Latino mental health team and Sobremesa, the city's only networking group for Spanish speaking mental health clinicians that meets quarterly at BIDMC.

- The Parkinson Support Network (PSN) of Cape Cod: BIDMC forged an alliance of three major healthcare providers, local community-based organizations (senior-serving organizations, hospice) and individuals/families living with Parkinson Disease (PD) to complete a needs and resource assessment of PD programs on Cape Cod. And area with a documented burden of disease, the Cape region is woefully underserved, particularly in education, psychosocial support and wellness/exercise programming. The PSN now offers quarterly and annual educational symposiums; started a new support group in Barnstable (so there are now support groups in each of the four areas of the Cape); and provides wellness activities including dance and choral singing.

- Community Benefits Strategic Planning Process: In 2009 BIDMC completed the first phase of a multi-pronged strategic planning process. Phase I included key informant interviews with BIDMC Board members, Chiefs of Service and senior leaders as well as Community Health Center executive directors and community leaders. Recommendations of this study are integrated into the community Benefits Plan, including enhance integration of services between the medical center and community so we truly offer a seamless continuum of care for patients that is safe, equitable, efficient, effective, and of the highest quality; recognize the crisis in primary care by encouraging medical students/residents to pursue careers in primary care, expose residents to community health experience during their training; frame the delivery of health care as not only caring for individuals but also healthy communities by addressing social determinants of health and incorporating more of a preventative/wellness orientation.

Targeted assessments such as these, in concert with ongoing dialogue with community-based organizations and the various quantitative demographic and health data publicly available drive the direction of our public health program priorities. Of special note is the work with the Health Equity Task Force and Boston Public Health Commission work groups collectively execute public health initiatives such as the city-wide H1N1 vaccination program undertaken in 2010. Similarly, BIDMC is a strong collaborator with the Commonwealth's Executive Office of health and Human Services and the Massachusetts league of community Health Centers in two Patient-Centered Medical Homes (PCMH) Projects, aimed at transforming the way health care is delivered and reimbursed. Several of BIDMC's affiliated health Center re implementing the PCMH model as is BIDMC's ambulatory Health Care Associates department.

Massachusetts landmark health care reform legislation also informs our understanding of the communities' health needs and directs our community benefits plan. Of the estimated 450,000 uninsured residents, a significant number are those cared for in our affiliated health centers, our hospital-based primary care clinic, and BIDMC's Emergency Department. The new health insurance products have provided access to comprehensive care for thousands and BIDMC has been actively engaged in the implementation process at both the community level and within the medical center. BIDMC's community benefits plan incorporates the research and recommendations of public policy and health departments, advocacy groups (e.g. Health Care for All), industry leaders (e.g. Massachusetts League of Community Health Centers) and our health center partners in helping existing patients transition from the Uncompensated Care Pool into these new Medicaid and Commonwealth Care managed care programs, and enrolling new patients in health care plans.

Section IV: Community Benefits Programs

Community Based Primary and Specialty Care

Brief Description or Objective

BIDMC believes that community health centers (CHC) are in a unique position to provide accessible primary care and specialty services to medically underserved diverse inner city and rural communities. These health centers understand the needs and cultural sensitivities of their communities and know best how to translate them into effective programs. BIDMC is committed to strengthening the capacity of its seven affiliated CHCs including: Bowdoin Street, Dimock, Fenway, Joseph M. Smith, Outer Cape, Sidney Borum and South Cove. The partnership takes many forms: recruitment, retention, financial support and credentialing of physicians and mid-level providers; BIDMC admitting privileges and access to managed care contracts; Harvard Medical School appointments and teaching opportunities; and BIDMC-sponsored educational programs and access to *Up-to-Date*. BIDMC's commitment to community-based care translates into a growing number of specialists providing care at CHCs, and a range of procedures (e.g. high-resolution anoscopy) and ancillary services (radiology) performed on-site. In addition to clinical expertise, BIDMC also makes available to health centers a wide array of administrative support services which include marketing, public relations, information systems, legal, purchasing, human relations and program development assistance.

Goal Description	Goal Status
Increase number of patients receiving primary care, OB/GYN and specialty care at affiliated CHCs	Number of patients served increased by 11%. New Outer Cape Health Services site opened in Harwich.
Increase number of specialists practicing at CHC sites	New specialty services added including pulmonology, emergency medicine and radiologic services.
Increase number of residents with CHC preceptors	Training sites added, number of resident sessions increased, preceptors compensated.
Increase capacity of CHC pharmacies	New pharmacy added at Outer Cape Health Services.

Community Care Alliance

Brief Description or Objective

In 1997, BIDMC was instrumental in helping its seven-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 funds, as well as sharing resources and expertise for the benefit of their patients and communities. With formal recognition by the federal government through the Health Resources and Services Administration's (HRSA) Health Center Controlled Network Initiative (HCCN), CCA has received financial and technical assistance support for system-wide infrastructure enhancements as well as integrated clinical programming. Beth Israel Deaconess Medical Center's Community Benefits staff are actively engaged

Goal Description	Goal Status
Identify opportunities for administrative and fiscal savings.	Implemented monthly regulatory OIG review for all CHC personnel; created CCA Facebook page and supported CHC efforts to learn and utilize social media
Conduct "Mystery Shopping" to address QI issues around access and patient experience.	Mystery shopped ten clinics monthly with reports back to CHC managers.
Administer ASK development evaluation program	Continued to provide monthly developmental assessments at two health centers for school-aged children with learning and behavioral issues.

Diabetes Chronic Disease Management Programs

Brief Description or Objective

With more than 50% of disease attributable to health behaviors, BIDMC and our CHC providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. The Bowdoin Street Health Center's (BSHC) Diabetes Initiative is a comprehensive care management program, caring for more than 600 adults diagnosed with diabetes through individual appointments, group medical visits, self-care management visits, exercise and behavioral health programs. Bowdoin was Boston's first health center to earn recognition by the American Diabetes Association. BIDMC also supports Joseph M. Smith CHC's (JMSCHC) *Live and Learn Diabetes Program*, including a collaboration with The Joslin Clinic for both JMSCHC and BSHC patients.

Goal Description	Goal Status
Target is 100% of patients with DM will test HbA1c < 9	82% of patients achieved targeted goal
Target is 100% of patients with DM, age 18-75 will have one HbA1c test/ year	94% of patients had one HbA1c test
Target is 84% of patients with DM, age 18-75, will have LDL-C screening/ yr.	96% of patients had LDL-C screening
Target is 84% of DM patients will have one eye exam/ yr.	80% of patients had eye exam
Collaboration with The Joslin Clinic sustained at BSHC and JMSCHC	Joslin continues involvement with both health centers

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 at the right time in the right setting by the right provider," both our CHC and BIDMC's ambulatory primary care (HCA) sites are actively engaged in comprehensive and intense practice transformation activities. BIDMC has partnered with the Massachusetts Executive Office of Health and Human Services (EOHHS) and the Massachusetts League of CHCs in two initiatives to support implementation of the PCMH within our CHC and HCA practices. The first pilot involved 14 CHC sites in collaboration with the Commonwealth Fund, providing the foundation for EOHHS' spread of the PCMH to an additional 30+ primary care practices. In 2011, Bowdoin Street Health Center earned recognition by the National Committee on Quality Assurance as a Level 3 PCMH, the highest accreditation level.

Goal Description	Goal Status
Support the Commonwealth Fund's PCMH Project for 14 sites in MA	All pilot sites have implemented PCMH to varying degrees; all now participating in expanded EOHHS pilot.

Seek NCQA recognition as a Level 3 PCMH for Bowdoin Street Health Center	Bowdoin Street earned Level 3 NCQA certification.
Participate in the EOHHS PCMH Council to spread implementation to 40 additional practices.	New sites added to EOHHS project; associated payment reform implemented.

Healthy Food Equity Project

Brief Description or Objective	Obesity has reached epidemic levels and disproportionately affects low-income African-American, Caribbean Islanders and Latino communities. The Boston Public Health Commission found that 64% of adults living in Dorchester are overweight or obese, increasing the risk of diabetes, high blood pressure, heath disease, stroke, asthma, arthritis and certain cancers. Bowdoin Street's assessment of healthy, affordable food options revealed no full-service supermarkets in the neighborhood but rather small corner stores not equipped to store and sell fresh fruits and vegetables. Bowdoin's Health Food Equity plan articulated three strategies to provide access to healthier food choices: sustaining a weekly Farmer's Market during the spring-autumn months; launching a Healthy Corner Store Initiative to work with local vendors on profitably supporting different food choices; and implementing a community education campaign. Key to the Healthy Food Equity Project are the Healthy Champions—a cadre of youth who created a community garden, sold their produce at the Farmer's Market, and who educated their peers and families about healthier eating habits. This year, staff from BIDMC joined with Bowdoin Street in the Farm to Family Program, a CSA (Community Supported Agriculture) project. CSA shares were purchased, resulting in a subsidy to underwrite a weekly carton of fresh fruits and vegetables for a local family.
Goal Description	**Goal Status**
Provide access to fresh fruits and vegetables	Farmer's Market held weekly from June through September; implemented CSA program involving 82 shares sold and 86 families receiving subsidized cartons of fruits and vegetables.
Expand Healthy Champions Program	Youth participated in Healthy Champions program, tending garden, participating in Farmer's Market, working with local restaurant on "special Healthy Champions" meals, education peers and adults on healthy eating habits.
Implement Healthy Corner Store Initiative	Implemented work plan with new partnerships in two stores, helping merchants find profitable ways to offer more fresh produce and healthy foods; plans to institutionalize program in FY 12.

Nutrition and Wellness Programs

Brief Description or Objective	Obesity has reached epidemic levels and disproportionately affects low-income African American, Caribbean Islander and Latino communities. With 38% of children, ages 6-18, found to be overweight or obese, BIDMC's Bowdoin Street Health Center (BSHC) developed a bevy of coordinated approaches to address this most significant health concern. The Fitness in the City includes activities and measurements for all children who are obese or at-risk for obesity. Complementing this effort is The Optimal Weight for Life Programs (OWL on the Road) that offer a multidisciplinary team of pediatrician, nutritionist and wellness coach for those who are significantly overweight. Through the Healthy Champions program, youth are both educated and in turn, teach the community about the benefits of incorporating healthy and affordable foods into their daily lives. In FY 2011, Bowdoin Street launched its Campaign for Wellness to expand capacity by increasing the number of exam rooms but as importantly, to create a demonstration kitchen for healthy cooking classes; a large exercise room to accommodate dance and group programming, and a gym with work-out equipment.

Goal Description	**Goal Status**
Collect measurements on all pediatric patients	BMIs collected on all patients
Provide 5-2-1 counseling during routine well-child visits.	Nutrition, healthy eating, and exercise information shared at routine pediatric appointments.
Engage children in exercise programs	Refer children to subsidized exercise programs at community locations (the Y, Body by Brandy)
Develop fund raising and programmatic plan for Wellness Center	Initiated fund raising; held 3 planning groups of patients, volunteers and staff to develop programmatic plans for new center.

Violence Intervention Program in Bowdoin/Geneva Neighborhood

Brief Description or Objective

After years of unchecked violence and gang-related activity in the Bowdoin/Geneva neighborhood, FY 11 saw fewer incidents and a growing sense of hope. Over the past two years, Bowdoin Street Health Center has joined with St. Peter's Teen Center 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 (the "broken window theory"). The VIP outreach team includes five resident Block Captains, engaged in a door-to-door campaign in these community-organizing activities. A particular focus of VIP are middle school-aged youth (of which there are 600 in the B/G neighborhood) to ensure that they have access to after-school and summer programs as well as health services.

In FY 2011, the Bowdoin Geneva Planning Group (B/GPG) was convened to bring together local service providers to identify unmet needs and to learn new ways of working together. The Group has also sponsored a Resource Fair and developed a Resource Guide to help local residents with jobs and housing, both key factors in creating a safer neighborhood. To aid in these kinds of efforts, Mayor Menino designated departmental representatives to form a Neighborhood Response Team (NRT) that meets bi-weekly with residents and community groups. Together, they conduct neighborhood "walk-arounds" to address problems.

Goal Description	Goal Status
Create sense of community and engagement to decrease violence	Implemented door-to-door campaign with neighborhood captains
Identify environmental issues that diminish sense of community ownership	Act on "broken window theory" and address neglected housing, trash, abandoned cars, etc.
Host Healing Services, Especially after incidents violence	Several healing services held, attended by hundreds of residents

MY CHILD: Serving families with children with severe emotional disturbance

Brief Description or Objective	In understanding the root of the epidemic of violence in the Bowdoin/Geneva neighborhood, much attention has been devoted to supporting families with children birth to five years, and creating a nurturing holding environment for parents and these youngsters. Supported by a federal grant from the Substance Abuse and Mental Health Administration in partnership with the Massachusetts Executive Office of Health and Human Services and the City of Boston, Bowdoin joined with other community organizations to plan implementation of this important new initiative. In FY 11, MY CHILD outreach and behavioral health staff enrolled 19 families who could benefit from intensive intervention and case management.

Goal Description	**Goal Status**
Implement processes and protocols for MY CHILD project	Referral processes articulated with appropriate referrals made by primary care providers
Implement intensive case management and intervention	19 families enrolled with defined intervention plans underway.

Center for Violence Prevention & Recovery

Brief Description or Objective	Domestic violence, sexual assault and community violence are addressed through Beth Israel Deaconess' 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 lead 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 provides 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. The Center's community violence initiatives include neighborhood-based support groups as well as targeted programs for the advocates and supervisors who work with victims of crime and violence who develop Secondary Traumatic Stress (STS) and strategies to prevent those exposed to secondary violence from developing STS.

Goal Description	Goal Status
Provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence	Continued to provide individual and group therapy
Provide rape crisis services	Provided rape counseling as well as Post HIV exposure prophylaxis medications
Provide free overnight stay for domestic violence and/or sexual assault victims without safe shelter	Provided 31 Safe Bed stays
Diminish effects of secondary traumatic stress in advocates and supervisors	Provided educational programs and support groups for affected workers

Healing the Community

Brief Description or Objective	Responding to traumatic incidents on a community level requires skilled mental health clinicians who support children and families who are coping with the after-effects of violence. Bowdoin Street Health Center expanded its team of counselors who offer individual and group sessions at the health center as well as a series of Healing Services at St. Peter's Teen Center. BIDMC's Center for Violence Prevention and Recovery (CVPR) collaborates closely with the Louis B. Brown Peace Institute and the Massachusetts Office of Victim Assistance to provide bereavement services that help shocked, grieving homicide survivors deal with a crime's immediate aftermath and ongoing issues of traumatic grief. But it is not only community residents who are affected by violence—those advocates and supervisors who work with victims of crime and violence may develop Secondary Traumatic Stress (STS). The Advocate Education and Support Project is a series and support group created specifically for staff from different settings—district attorney's offices, health centers, shelters—to come together to discuss the challenges of this work, to identify sources of STS, and to create a network of support.

Goal Description	Goal Status
Create opportunities for grieving and support	Held several Healing Services for community residents
Expand mental health services at Bowdoin Street Health Center	Added capacity of professional mental health team
Support Advocate Education and Support Project	Implemented educational series for advocates and supervisors

Reducing Disproportionate Burden of Cancer in Communities of Color

Brief Description or Objective

As a Cancer Center of Excellence recognized by the American College of Surgeon's Commission on Cancer, BIDMC is a leader in translating bench science into clinical care and community practice—"bench to trench." Community-based prevention and screening programs include events such as skin-cancer screenings and mobile mammography as well as support of community health fairs. In FY 01, BIDMC again participated in a Department of Public Health/American GI Association free screening event in which six uninsured patients received free colonoscopies. BIDMC co-leads the Faith-Based Cancer Disparities Network, facilitating the educational and outreach programs within 10 churches and the Black Ministerial Alliance. When cancer specialty care or inpatient hospitalizations are necessary, BIDMC offers the services of Patient Navigators (Chinese and Latina albeit serve other ethnicities also) who bridge the gulf between community providers and the medical center. To provide support for our Patient Navigators, BIDMC sponsors a city-wide Patient Navigator Network that meets quarterly for education and support. Often times hearing from others "in the same boat" can be very therapeutic and BIDMC offers numerous groups on-site as well as Tea Time (for Chinese women with breast cancer), Facing Cancer Together(for Black women with cancer), and the Look Good Feel Better Program. BIDMC also supports the Mayor's Cancer Crusade that provides transportation for Boston residents for treatment sessions and support groups. The Multicultural Cancer Task Force and HIV/AIDS-Related Cancer Community Advisory Board provide community input and patient "voice" to guide our outreach and internal efforts.

Goal Description	Goal Status
Increase number of mammograms in CHCs and mobile van	Continued to provide screening at CHCs and on van
Co-lead Faith Based Cancer Disparities Network	Strengthened Network through monthly meetings, educational programs at churches, health fairs at Black Ministerial Alliance and Walk for Wellness Program, enrolling 300 church members in weekly exercise program
Coordinate and host city-wide Patient Navigator Network	Quarterly luncheons held for networking support and education to city-wide cancer navigators.
Participate in DPH/American GI Association free colonoscopy screening day	Provided free colonoscopy screening for six uninsured men and women
Provide cancer support groups	Launched new support group with Facing Cancer Together; continued Tea Time group for Chinese women with breast cancer, Tea Time and on-site cancer groups as well.
Support the Mayor's Cancer Crusade Transportation Program	Provide annual subsidy to the Mayor's Cancer Crusade to provide transportation for Boston residents to treatment and support groups
Lead Multicultural Cancer Task Force and HIV/AIDS-Related Cancer CAB	Chaired regular meetings of Task Force.
Cancer Patient Navigator	Latina and Chinese Cancer Navigators provided service to more than 975 patients in FY 11

Wellness Program: The Walking Club

Brief Description or Objective

Not only does BIDMC's CardioVascular Institute have expertise in heart disease, but also they are in the vanguard with prevention programs to promote heart healthy behaviors. The Walking Club provides free kits that include workout logs, information sheets, eCards and even a smartphone app. The Walking Kits have been adapted for corporate entities, patients with special needs, and middle school students. Adopted by seven schools, the curriculum contains information on the benefits of walking, a look at which parts of the anatomy are used during this exercise, and some basic science and math work—calculating heart rate and steps into miles. 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 is given two pedometers—one for him/herself and one for a parent or guardian.

Goal Description	Goal Status
Expand pilot Walking Club project to additional middle schools	Walking Club in 7 middle schools with 117 pairs of children and adults enrolled
Provide printed materials, pedometers, smartphone app to all participants	20-page School Walking kit enhanced; smartphone app created and publicized; 1000 pedometers distributed to participating schools

Access to Care for Uninsured and Underinsured

Brief Description or Objective

Massachusetts' landmark health care reform law has proven to be a boon to the estimated 475,000 uninsured in the Commonwealth with more than 98% of residents now participating in insurance products. 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 through the Virtual Gateway, while Medication Assistance Councilors aid patients with obtaining no-cost pharmaceutical prescriptions. BIDMC also maintains a free-care pharmacy to help needy patients until other resources are available.

Goal Description	Goal Status
Subsidize Health Safety Net Trust Fund	Annual contribution to HSN
Ensure continuity of care for Aliens with Special Status	Relationship established that allows for continuity of care for Commonwealth Care Bridge patients
Provide financial benefits and medication assistance counseling	Staff continued to provide service to enroll patients through Virtual Gateway and receive medications through PAP programs
Provide fee-care pharmacy medications	Provided medications to indigent patients

Access to Care for 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. Almost 40% of the Outer Cape's year-round residents are unemployed in the winter months. The nearest hospital is 50 miles away on a two-lane highway, frequently referred to as "suicide alley." In an effort to meet the needs of the Outer Cape, BIDMC supported the opening of Outer Cape Health Services third site in Harwich, MA. We also expanded on-site infectious disease (including high resolution anoscopies) and pulmonary services, and offered support for the new digital radiology service. The summer-season Urgent Care program continued in FY 11, staffed by BIDMC-affiliated Emergency Medicine physicians. BIDMC also continued it 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 or specially adapted apartments for those undergoing bone marrow transplantation.

Goal Description	Goal Status
Address unmet needs for rural Cape Cod	Supported opening of new site in Harwich; expanded on-site specialty and urgent care services
Provide access for remote communities to quaternary care	Ongoing support for Medflight

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. Three years ago, the health centers and BIDMC collaborated on a HRSA-funded project to "push" emergency department and inpatient discharge summaries to primary care providers. This HIE project was the foundation of subsequent IT solutions that now provide timely communication and enhance continuity of care across settings and providers. With rising concern about unnecessary emergency department visits and re-admissions, information technology provides data to community-based providers that make possible immediate follow-up care in the community, decreasing errors, unnecessary re-admissions, and duplicate tests and procedures. BIDMC is building interfaces for the downloading of lab and radiologic reports as well as notes from specialists directly into the electronic health records of community practitioners. In FY 11, a multi-disciplinary BIDMC team joined with the Boston Public Health Commission to develop the NeighborCare Initiative to encourage adoption of communication strategies (including those piloted at BIDMC) by all Boston hospitals and to publicize the capabilities of community health centers.

Goal Description	**Goal Status**
Enhance health information exchange between BIDMC and community practices	Enhancements effected through NEHEN and the PUSH projects
Build SOFT interfaces with CHCs	SOFT implementation ongoing; go-live expected in July 2012
Standardize sending of inpatient and ED discharge summaries	Pilot study with Dimock extended for QI changes; NeighborCare Initiative launched to standardize process across all Boston hospitals.
Implement Web OMR Lite for viewing results and specialist reports	More CHC providers using Web OMR in FY 2011

Primary Care Access Project

Brief Description or Objective

For more than six years, BIDMC has dedicated resources to helping patients connect with community-based primary care physicians. This initiative began in the Emergency Department, concerned initially with efforts to ensure that patients received the necessary follow-up care after an ED visit. The ED visit is also the opportunity to help those without insurance or without a primary care provider find the care to which they are entitled and in need. BIDMC maintains the Find-A-Doc Call Center where detailed information about our CHCs, their services and availability of appointments is updated monthly to facilitate timely appointments for patients. Our outreach efforts expanded beyond the Emergency Department to help local residents learn about neighborhood-based primary care options and to help enroll residents and employees of local businesses in insurance products and other entitlement programs.

Goal Description	Goal Status
Facilitate referrals to community PCPs	Find-A-Doc Call Center triages calls from both providers, patients, and community-at-large to connect with community providers. Call Center listing is updated monthly so accurate, timely information is available.
Conduct community outreach activities to enroll local residents and employees of local businesses	Community outreach activities are ongoing

Parkinson Support Network of Cape Cod

Brief Description or Objective

The Parkinson Support Network of Cape Cod (PSN) is an alliance of individuals/families living with Parkinson disease (PD), health care providers, and senior serving institutions to bring much-needed services and programs to Cape Cod residents. Based on a needs assessment and resource inventory, the PSN is committed to building a Cape-wide coordinated and comprehensive network that stimulates educational programs,

Goal Description	Goal Status
Build suitable coalition with shared vision, mission and work plan	Organizational structure solidified with statement of mission, visions, Board recruitment and Operating Guidelines.
Host Spring Fling! Dinner Dance to provide opportunities for socialization	Event held with 80 guests
Sponsor wellness/exercise programs	Offered dance and choral group singing classes
Implement educational series for Cape residents	Education classes offered in Hyannis and Orleans.

Office of Multicultural Affairs

Brief Description or Objective

Knowing the importance of provider/patient cultural concordance in providing quality care, in FY 2010 BIDMC inaugurated The Office of Multicultural Affairs (OMA), naming Dr. Rafael Campo as its Director. The OMA was created to reaffirm the institution's ongoing commitment to diversity and specifically charged the OMA recruitment of diverse residents and fellows, retention of junior faculty of color and education of house staff and faculty. Evidence of this successful organizational change and strategy was seen in the FY 2011 residency recruitment efforts where we experienced a 25% increase in the number of underrepresented (URM) applications interviewed and a 47% increase in the number of URM applicants ranked to match at BIDMC.

Goal Description	Goal Status
Increase diversity of residents and fellows in training	25% increase in number of underrepresented minority (URM) applicants interviewed; 47% increase in number of URM applicants ranked to match at BIDMC.
Increase knowledge about diversity and cultural competence	Created "Road Map" of recruitment process that increased knowledge, skills and success of residency directors in diversifying resident applications
Participate in recruitment fairs targeting diverse medical students	Attended annual meetings of Student National Medical Association & Latino National Medical Association; participated in Mass League of CHC medical student programs

Ensuring equitable care through 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, James Rodrique, PhD, leads a five-year study to identify the most effective approach for increasing African-American patients' willingness to consider living donor kidney transplants. The 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) illustrates the synergies reaped from collaborative ventures as this is the nation's largest comprehensive center funded by the National Cancer Institute. The 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 our hospitals. Other research collaborations are the three MassCONECT projects with Harvard School of Public Health and three community coalitions. These projects aim to develop community-based cancer education, prevention and early identification programs in Boston, Lawrence and Worcester, including transformation of the NCI's cancer information website into a more community-friendly portal and Breathe Free for Kids, an intervention to reduce second-hand exposure to smoke in the homes of infants and toddlers. The Harvard Catalyst is the latest collaboration, bringing together the expertise of Harvard University's ten schools and 18 academic healthcare centers and other partners to aid the translation of scientific advances into clinical practice and public health policy. BIDMC investigators and clinicians are engaged in many Catalyst programs but of particular relevance to Community Benefits are the Community Health Improvement Research Program and the Health Disparities Committee.

Goal Description	Goal Status
Advance knowledge about causes and remedies of health disparities	Growing number of research/clinicians engaged in health disparities research efforts
Participate in multi-institutional collaborations to reap synergies and share knowledge	Increasing representation of BIDMC faculty and staff in DC/HCC, Catalyst, HSPH, etc. collaborations

Access to Culturally Competent 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 more than 15 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, we have tried to apply "culture eyeglasses" to facilitate communication with, and understanding of, the patients' orientation and experience. Among the most underserved are those for whom English is not the 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, reflecting the growing non-English speaking patient population. 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, we have also facilitated access to care, helped patients understand their course of treatment, and adhere to discharge instructions and other medical regimens.

Goal Description	Goal Status
Increase understanding of cultural impacts on health care delivery, health status and health outcomes	Incorporated information on cultural competence into New Employee Orientation, departmental in-services and Grand Rounds presentations, annual Comprehensive Employee Education programs.
Make available tools and resources to facilitate cross-cultural communication	Augmented existing written materials and computer resources to aid patient/provider communication.
Understand the experiences of diverse patients	Patient satisfaction data from multilingual surveys and focus groups.
Increase capacity of Interpreter Services department	Number of interpreter services interactions totaled 168,280 in 63 languages
Translate patient educational and informational materials	100 documents translated this year into top volume languages

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 our diverse employees and provide career advancement opportunities. In FY11, BIDMC offered incumbent employees four "pipeline" programs to train for the following professions: Nurse, Nurse RN to BSN, Research Administrator, and Medical Laboratory Technician to Medical Technologist. BIDMC's Employee Career Initiative (ECI) provides career and academic counseling, on-site academic assessment, on-site pre-college and college-level science courses to employees at no charge. Tuition reimbursement and competitive scholarships as well as ESOL, GED prep, basic computer skills and citizenship classes are additional offerings.

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. We also provide feedback to community organizations such as The Work Place and Crittenton Women's Union on adults applying to jobs at BIDMC. Recognizing our 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, we host Boston Public High School students in the annual Job Shadow Day with additional student groups touring our skills lab.

Senior leaders are active in advocating on behalf of educational and job opportunities. Lisa Zankman, Senior VP of Human Resources, is a member of the Commonwealth's Workforce Investment Board. Joanne Pokaski, Director of Workforce Development, is a member of the Boston Private Industry Council and chairs the PIC's Boston Health Care Careers Consortium

Goal Description	Goal Status
Provide pipeline programs to enhance skills and career advancement	Offered four pipeline programs, graduating 15 who were promoted to new positions
Provide opportunities through Employee Career Initiative (ECI) for college-level courses as well as counseling	187 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 and citizenship classes	33 employees were enrolled in ESOL classes; 4 were enrolled in GED prep; 15 employees successfully completed a 10-week computer skills class; and 16 attended citizenship classes.
Provide Job and career introductory opportunities for community residents	Hosted 12 adults in training internships, four of whom were subsequently hired; offered feedback and advice to community organizations on 57 adults who applied for jobs.
Provide job and career introductory opportunities for middle and high school students	Provided 41 paid summer job opportunities; 5 mid-year internships; numerous tours of medical center and skills lab; hosted 20 BPS students for PIC's annual Job Shadow Day

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 thirteen program sites across the US with more than 450 Fellows providing more than 98,000 hours of service over two decades. This year, the Boston program sponsored 25 fellows who are addressing a wide range of health disparities from Rapid HIV counseling and screening to an adolescent pregnancy and parenting group. BIDMC's affiliated community partners are frequent sites for Schweitzer Fellows including a fatherhood engagement program at The Dimock Center.

Goal Description	**Goal Status**
Support ASF's mission of developing leaders in service	Administrative and financial support of the program
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.

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. Crises for which we routinely plan range from natural disasters and terrorist scenarios to outbreaks of widespread illness like last year's H1N1 epidemic. BIDMC is a regular participant in citywide drills, also including our health center partners in the simulations. The Trauma team provides numerous in-service trainings throughout the year, including semi-annual Advanced Trauma Support classes for New England-wide hospital personnel. The emergency management team supports planned major events in Boston including the July 4th celebration, First Night, Hub on Wheels and the Boston Marathon. This year, BIDMC continued its pilot of new software with the Boston Public Health Commission to submit syndromic surveillance, reportable lab results and immunization data to public health registries there and at the Department of Public Health.

Goal Description	Goal Status
Collaborate with city and state emergency management programs to ensure preparedness of medical center and CHCs for untoward emergencies	Participated in trainings, simulations and planning meetings.

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Healthier Neighborhoods and Environmental 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 lead-free homes; 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 social determinants that impact health status. As part of our commitment to enhancing the physical environment BIDMC maintains pocket parks and open, green spaces while also partnering in the Bowdoin/Geneva neighborhood to create the Geneva Urban Wild.

Public safety is of concern within our local neighborhoods as well as the Bowdoin area, and 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 security technology and apparatus, including cameras and a BPD shot-spotter at Bowdoin, have been used to identify perpetrators and assist BPD investigators. Within the hospital itself, BIDMC is implementing its Environmental Strategic Plan, spearheaded by our Environmental Sustainability Coordinator and multi-departmental committee. Significant improvements were made in reducing energy and water consumption and increased recycling efforts. Most impressively, BIDMC reduced its fuel consumption within BIDMC-owned vehicles by 2% and reduced CO2 emissions by almost 200,000 pounds annually, a result of shuttle consolidation undertaken collaboratively with our Longwood Avenue medical colleagues.

Goal Description	**Goal Status**
Increase recycling rate	Overall recycling rate increased from 20.4% in FY 09 to 26.2% in FY 11
Decrease fuel consumption	Fuel consumption decreased 34% from 18,914 gal in FY 09 to 12,445 gal in FY 11
Achieve fiscal savings through environmental sustainability efforts	Realized $442,656 savings, 65% increase from FY 10

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 as well as the programs of the Roxbury Community Alliance for Health. In FY 10, BIDMC participated in a year-long strategic planning process that resulted in a significant reorganization of the CHNA with implementation undertaken in FY 11. BIDMC remains an active participant in Roxbury Community Alliance for Health (RCAH), supporting its two signature programs—the Roxbury Weigh-In and Jazz in the Park.

Goal Description	**Goal Status**
Build a Community Health Improvement Planning process	Participated in implementation of BACH's strategic plan and contributed through DON in funding this initiative.
Improve the health status of Roxbury residents.	RCAH offered 3 sessions of Roxbury Weigh-In; began needs assessment for community health improvement plan to be implemented in FY 12.

Section V: Expenditures

Community Benefits Programs

Expenditures	Amount
Direct Expenses	$6,328,899
Associated Expenses	$0.00
Determination of Need Expenditures	$40,500
Employee Volunteerism	$0.00
Other Leveraged Resources	$3,607,329

Net Charity Care

Expenditures	Amount
HSN Assessment	$9,646,340
HSN Denied Claims	$7,648,493
Free/Discount Care	$0.00
Total Net Charity Care	$17,294,833

Corporate Sponsorships	$29,025
Total Expenditures	$27,354,786
Total Revenue for 2011	$1,063,772,129
Total Patient Care-related expenses for 2011	$933,871,457
Approved Program Budget for 2013 (*Excluding expenditures that cannot be projected at the time of the report.)	$28,000,000
Bad Debt	$5,220,889 Certified

Comments: Total Charity Care is $53,382,715 and includes BIDMC's payment of $17,294,833 to the Health Safety Net, plus $6,073,029 in unreimbursed Medicare Services; $24,793,964 in unreimbursed MassHealth services; and bad debt of %5,220,889.

Section VI: Contact Information

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