Community Benefits Report
to the Attorney General

FY 2015
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION I: MISSION STATEMENT</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Populations and Basis for Selection</td>
<td>3</td>
</tr>
<tr>
<td>Key Accomplishments</td>
<td>3</td>
</tr>
<tr>
<td>Plans for Next Reporting Year</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION II: COMMUNITY BENEFITS PROCESS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Benefits Leadership/Team</td>
<td>5</td>
</tr>
<tr>
<td>Guiding Principles</td>
<td>5</td>
</tr>
<tr>
<td>Community Benefits Committee Meetings</td>
<td>6</td>
</tr>
<tr>
<td>Community Partners</td>
<td>7</td>
</tr>
<tr>
<td>Community Partners</td>
<td>7-8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Last Assessment Completed and Current Status</td>
<td>9</td>
</tr>
<tr>
<td>Summary of Findings</td>
<td>9</td>
</tr>
<tr>
<td>Summary of Findings</td>
<td>9-10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION IV: COMMUNITY BENEFITS PROGRAMS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Descriptions, Goal Descriptions and Goal Status</td>
<td>11-50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION V: EXPENDITURES</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPENDITURES</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION VI: CONTACT INFORMATION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT INFORMATION</td>
<td>52</td>
</tr>
</tbody>
</table>
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. However, BIDMC’s community health needs assessment’s findings clearly show that low income and racial/ethnic minority populations living in Boston’s urban core 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. In addition, the assessment identified two smaller but high need segments of the population that are also underserved, at-risk, and face disparities, namely disconnected youth and the LGBT community. Collectively, these population segments are BIDMC’s priority target populations.

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 six affiliated health centers
- Continued community-based specialty care services
- Provided care for diverse patients through Cancer Navigator, Interpreter Services, and multilingual patient education
- Facilitated increased community cohesion and engagement of residents in Bowdoin/Geneva neighborhood through a Community Advisory Board
- Increased 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
- Expanded 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 Market, CSA, Bowdoin Bike School, The Daily Table and Bounty Bucks
- Promoted health of elderly residents through fitness classes and falls prevention
- Conducted research that supports understanding of health disparities
- Expanded access to wellness programming including exercise classes and healthy cooking demonstrations with the completion of 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 will conduct its next Community Health Needs Assessment during FY 2016, while still focusing on its existing priorities identified during the last CHNA and included in BIDMC’s corresponding community health implementation plan (CHIP). Every priority and goal area in BIDMC’s CHIP is structured to address health disparities and inequities in some way. In addition to this underlying priority, the BIDMC Community Benefits Committee identified the following as the leading community health priorities:

1) Healthy living, obesity - physical exercise, and nutrition, environmental sustainability and safety,
2) Disease management and prevention,
3) Access to care, and
4) Behavioral health

Focusing its efforts on these areas of common need, will allow BIDMC to ensure that it has the greatest possible impact on those most at-risk. It should be noted that BIDMC will also invest in and support a handful of other issues that fall outside of these priority areas as special opportunities and health issues/crises arise or based on historical commitments. BIDMC’s community benefits efforts will always be focused where there is need and opportunity for impact. These priority areas include a 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 BIDMC’s collaborations with individual health centers, and collectively through the Community Care Alliance (BIDMC’s six affiliated health centers), 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 of Clinical Program Strategy and Planning and the Chief Operating Officer with direct access to the President/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, 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 Committee Meetings

December 9, 2014
March 3, 2015
June 9, 2015
September 17, 2015

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 Boston’s urban core 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 108,000 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 communities of color 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:

- A Better City
- ABCD Health Services
- ABCD Parker Hill/Fenway Neighborhood Service Center
- AIDS Action Committee
- Albert Schweitzer Fellowship Program
- American Association of Medical Colleges
- American Cancer Society
- American Diabetes Association
- American Gastroenterological Association
- American Heart Association
- American Kidney Fund
- American Parkinson Disease Association, MA chapter
- Arthritis Foundation
- Associated Industries of Massachusetts
- Atius/Harvard Vanguard
- Beyond Benign
- Boston Alliance for Community Health
- Boston Area Rape Crisis Center
- Boston Career Link
- Boston Center for Independent Living
- Boston Center for Youth & Families- Street Workers Program
- Boston Collaborative for Food and Fitness
- Boston Elder Services
- Boston Emergency Medical Service
- Boston Fire Department
- Boston Healthcare Careers Consortium
- Boston Medical Center
- 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 Regional Mental Health Providers serving Latinos
- Boston Senior Home Care
- Boston Visiting Nurses Association
- Boston Youth Fund
- Bottom Line
- Bowdoin Bike School
- Bowdoin Geneva Alliance
- Bowdoin Geneva Main Streets Program
- Bowdoin Street Health Center
- Breast Cancer Research Foundation
- Bridges Together
- Brigham and Women’s Hospital
- Brookline Community Mental Health Center
- Brookline Emergency Food Pantry
- Brookline Health Department
- Brookline Public Schools
- Brookline Senior Center
- Brookside Community Health Center
- Bunker Hill Community College
- Cambridge Health Alliance
- Cambridge Office of Workforce Development
- Casa Myrna Medical Legal Partnership
- Career Collaborative
- Charles River Community Health
- Child Witness to Violence Project
- Children’s Hospital Boston
- City Growers
- Cleveland Community Center
- Codman Square Health Center
- College Bound Dorchester
- Combined Jewish Philanthropies
- Community Care Alliance
- Conference of Boston Teaching Hospitals: COBTH
- Cooking Matters, Boston
- Cradles to Crayons
- Dana Farber/Harvard Cancer Center
- Dana-Farber Cancer Institute
- Dorchester Bay Economic Development Corporation
- Dorchester Cares
- Dorchester Community Food Co-op
- Dorchester House Community Health Center
- Dorchester Neighborhood Service Center
- Dorchester North WIC Office
- Ecumenical Social Action Committee
- EPA New England
- Ethis
- Evercare
- Family Nurturing Center
- Fenway Community Development Corporation
- Fenway Health
- Fenway High School
- Fitness in the City
- Found in Translation
- Friends of Geneva Cliffs
- Friendship Works
- Geneva Avenue Head Start
- Gertrude E. Townsend Head Start
- GLAD
- Greater Boston Interfaith Organization
- Greater Bowdoin/Geneva Neighborhood Association
- Hamilton Street Resident Group
- Harvard CATALYST
- Harvard Center for Primary Care
- Harvard Medical School
- Harvard School of Public Health
- Harvard Street Community Health Center
- Health Care for All
- Health Resources in Action
- Healthcare Without Harm
- Healthworks at Codman Square
- Healthy Kids Healthy Futures
- Healthy Waltham
- Hebrew Senior Life
- Hope Funds for Cancer Research
- Holland Community Center
- Hyde Square Task Force
- International Institute of Boston
- Jane Doe, Inc.
- Jewish Family and Children’s Services
- Jewish Community Housing for the Elderly
- Jewish Community Relations Council
- Jewish Domestic Violence Coalition
- Jewish Vocational Services
- Jobs for Massachusetts
- Joslin Diabetes Center
- Kit Clark Senior Services
- L byłenthal Sidman Jewish Community Center
- Louis D. Brown Peace Institute
- Mary Lyon Pilot High School
- Massachusetts Association of Mental Health
- Massachusetts Attorney General Office
- Massachusetts Commission for the Blind
- 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 Executive Office of Health and Human Services
- Massachusetts General Hospital
- Massachusetts Hospital Association
- Massachusetts Immigrant and Refugee Advocacy Coalition
- Massachusetts Office for Victim Assistance
- Massachusetts League of Community Health Centers
- Massachusetts Prostate Cancer Coalition
- Massachusetts State Police
- Massachusetts Taxpayers Foundation
- Massachusetts Workforce Investment Board
- Massachusetts Senior Action Council
- Mattapan Community Health Center
- Mayhim Hayim
- Mayor’s Office of Emergency Management
- Mayor’s Office of Food Initiatives
- Mayor’s Office of Neighborhood Services
- Mayor’s Office of Workforce Development
- Mayor’s Office, Boston
- Medical Academic and Scientific Community Organization, Inc.
- Medical Intelligence Center
- Mission Hill Youth Collaborative
- Mount Auburn Hospital
- Multicultural Coalition on Aging
- National Alliance for Mental Illness
- National Parkinson Foundation
- Neighborhood Health Plan
- New England Baptist Hospital
- Northeastern University
- Oakdale Farms
- One Fund Boston
- Outer Cape Health Services
- Partnership for Community Health
- Powisset Farm
- Practice Green Health
- Project Bread
- Red’s Best Seafood
- Roxbury Community Alliance for Health
- SAGE-Boston (Stop Abuse Gain Empowerment)
- Sexual Assault Nurse Examiner Program
- Sidney Borum Jr. Health Center
- Sociedad Latina, Inc.
- South Cove Community Health Center
- Southern Jamaica Plain Health Promotion Center
- Sportsman’s Tennis and Enrichment Center
- St. Mary’s Center for Women and Children
- St. Peter’s Teen Center
- Suffolk County District Attorney’s Office, Victim Witness Advocates
- Suffolk County Sheriff’s Department
- Sustainability Guild
- TechBoston Academy
- The Ancient Bakers
- The Boston Foundation
- The Daily Table
- The Dimock Center (Health Center and Head Start)
- The Network, La Red
- The Partnership, Inc.
- The Trustees of Reservations (City Harvest and Powisset Farm)
- Unitarian Universalist Urban Ministry
- United Way of Massachusetts
- UMASS Boston
- Upham’s Corner Health Center
- Upham’s Corner WIC
- US Substance Abuse and Mental Health Services Administration
- Urban Farming Institute of Boston
- Veterans Affairs Healthcare System- Boston
- Victim Rights Law Center
- Vietnamese American Civic Association
- Violence Intervention and Prevention Initiative
- Ward’s Berry Farm
- Whittier Street Health Center
- YearUP
- YMCA Black Achiever’s Program
- YMCA of Greater Boston
- YMCA Training, Inc.
- Youth Connect
- Youth Villages
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 nine months (November 2012 – July 2013) 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 will undertake its next CHNA during FY 2016.

**Approach and Methods**

The CHNA was conducted by the BIDMC Community Benefits Department in three phases, which allowed BIDMC to: 1) compile an extensive amount of quantitative and qualitative data, 2) engage and involve key stakeholders, BIDMC senior staff, and the community at-large throughout the process, 3) Develop a report and detailed strategic plan, and 4) comply with all Commonwealth Attorney General and Federal IRS Community Benefits requirements.

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 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 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 Findings**

- **Limited Access and Barriers to Community-Based Care for Many Residents in Boston.** According to the Boston Public Health Commission, nearly one in five (17% (2008)) Boston residents did not have a personal health care provider; and nearly one in four (23%) Boston residents had not had a medical visit in more than a year (2010). Despite the overall success of the Commonwealth’s health reform efforts, segments of the population, particularly low income and racial/ethnic minority populations, face significant barriers to care and struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and shortages of community-based primary care providers.
• **High Rates of Obesity, Limited Physical Exercise, and Poor Nutrition.** Nearly two-thirds of Boston adults (18+) are either obese or overweight. According to the CHNA survey, rates for specific demographic, socio-economic and geographic population segments living in neighborhoods within BIDMC’s Community Benefits Service Area are even higher. High proportions of residents in Boston’s urban core do not exercise and have poor nutrition, which are the leading factors associated with obesity and chronic diseases, such as heart disease, hypertension, diabetes, cancer, and depression.

• **High Chronic Disease and Cancer Rates.** Rates of illness and death vary by condition, but overall racial/ethnic minority groups are more likely to have chronic health conditions and die from them than their non-Hispanic, white counterparts. This puts a disproportionate burden on communities with high proportions of racial/ethnic minorities, such as Roxbury, North and South Dorchester, and the South End which are neighborhoods within BIDMC’s Community Benefits Service Area. 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 across all three of these geographic areas. According to the Commonwealth’s Hospital Discharge Database residents of North and South Dorchester, Roxbury, and Chinatown/South End were more likely to receive inpatient services for hypertension, heart failure, asthma, pneumonia, and chronic obstructive pulmonary disease than residents of Boston and Massachusetts overall. Service for these conditions are often considered preventable or avoidable with regular, primary care services and therefore are indicative of poor or limited access to primary care.

• **High Rates of Mental Health and Substance Abuse Issues:** According to MassCHIP (2010) and the Massachusetts Substance Abuse Bureau, Boston has statistically higher rates of substance abuse treatment admissions, including cocaine, heroin and other opioids, when compared to the Commonwealth. Rates are particularly high in South Dorchester and Roxbury. According to Behavioral Risk Factor Surveillance System data, 10% of Boston residents reported having poor mental health status for more than 15 days in a given month. According to data from the BIDMC CHNA survey, approximately 30% of respondents were deemed at risk for depression and needed additional mental health assessment because they screened positive for a short screening tool for depression.

• **Maternal and Child Health Needs.** According to the Massachusetts Behavioral Risk Factor Surveillance System and Boston Public Health Commission the infant death rate for Hispanics/Latinos in Boston is twice the rate of non-Hispanic, whites, and for African Americans/blacks the rate is three times the rate of non-Hispanic, whites. According to the Massachusetts Vital Records Natality Infant Deaths dataset, residents of North Dorchester and Roxbury have higher rates of infant mortality compared to Boston overall. Hispanic/Latino adolescents in Boston are three times more likely to give birth to a baby as non-Hispanic, white adolescents.

• **HIV/AIDS and Other Infectious Diseases Still a Major Burden on Small But High Need Segments of Population.** Rates of HIV/AIDS illness, death, and transmission have declined dramatically over the past decade. However, HIV/AIDS and other sexually transmitted infections still has a major impact on the lesbian, gay, bisexual and transgender (LGBT) community, disconnected, at-risk youth, certain Boston neighborhoods (Fenway/Kenmore, Roxbury, North Dorchester), and the communities on the Outer Cape (Wellfleet, Truro, and Provincetown). Hepatitis B continues to impact the Asian community and HCV is also an issue.

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 racial/ethnic minority 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, foreign born status, or language; as the underlying and correlative issues related to health and well-being involve economic opportunity, education, crime, and community cohesion.
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 and medical specialty care services. However, segments of the population, particularly low income and racial/ethnic minority populations, face significant barriers to care and struggle to access services due to lack of insurance, high cost of care, transportation, cultural/linguistic barriers, and shortages of providers willing to serve Medicaid insured or low income, uninsured patients.

BIDMC believes that community health centers (CHC) 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 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 (i.e. CPI Violence Prevention trainings), 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) and the social justice and community health curriculum for medical residents. The LFFP provides physicians with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation. In FY 2015, Elizabeth Molina, MD, Medical Director of Charles River Community Health (CRCH) was a Linde Fellow and led a team-oriented primary care project to improve diabetes care management at CRCH.
In FY 2015, BIDMC developed a social justice and community health curriculum as an elective for medical residents. Staff, including six members of the behavioral and community health teams at Bowdoin Street Health Center, shared how they had come to work for the health center and also shared stories to give the residents a sense of some of the challenges patients face daily. Conversation about the social determinants of health and the health center’s role in addressing some of these served as a gateway to more social justice and health equity dialogue. Each participant also toured the Bowdoin/Geneva community. Eleven residents completed this curriculum in FY 2015.

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 15 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**

- Increase number of patients receiving primary care, OB/GYN and specialty care at affiliated CHCs
- Increase number of specialists practicing at CHC sites
- Increase number of residents with CHC preceptors

**Goal Status**

- 98,988 patients were served by BIDMC-affiliated health centers in 2015.
- Number of specialists remained steady at 25 in FY 2015.
- 37 residents were assigned to CHCs during Academic Year 2015. There were 12 residents in the Fenway HIV/LGBT residency in Academic Year 2015, consistent with the prior year. Two interns and nine (an increase of five) junior residents started in Academic Year 2015 along a primary care residency track.
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.

In FY 2015, CCA continued work on a grant to increase the health centers’ capacity to achieve population management by building data connectivity and infrastructure, and training health centers on the use of data to reduce costs, and improve quality and patient outcomes. Additionally, CCA members participated in the MassHealth Innovations Stakeholder workgroups.

### Brief Description or Objective

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<tr>
<td>Identify opportunities for administrative and fiscal savings</td>
<td>Improved monthly regulatory OIG review for all CHC personnel and vendors; maintain CCA Facebook page; jointly building data repository infrastructure.</td>
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<tr>
<td>Conduct “Mystery Shopping” to address QI issues around access and patient experience</td>
<td>Mystery shopped six clinics monthly with reports back to CHC managers, Medical Directors and Operations Managers. Completed a total of 72 surveys.</td>
</tr>
<tr>
<td>Administer ASK development evaluation program (Advocating Success for Kids)</td>
<td>Continued to provide monthly developmental assessments at two health centers for school-aged children with learning and behavioral issues.</td>
</tr>
<tr>
<td>Train CCA staff on Quality Data Center (QDC) tools and reports</td>
<td>The Board of Managers, CMOs, care coordinators and nurse case managers received training on the QDC in FY 2015.</td>
</tr>
<tr>
<td>Connect health centers to QDC Develop report templates to track utilization, outcome, and cost data</td>
<td>All six affiliated health centers have been connected to the QDC. Development of templates is in process now that all health centers are connected to the QDC.</td>
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</table>
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 BIDMC routinely plans range from natural disasters and terrorist scenarios to outbreaks of widespread illness like last year’s Ebola response. In FY 2015, BIDMC continued to function as one of several Ebola Centers in the state. BIDMC agreed to identify an isolated area to care for one Ebola patient for the course of their care. The medical center coordinated with the city and state to develop plans and protocols, identify highly trained staff to provide complex care in a highly hazardous environment for the one Ebola patient and two suspected cases. This planning and response is highly resource and labor intensive, to date BIDMC has cared for two suspect cases.

BIDMC is a regular participant in citywide drills and includes its health center partners in the 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 three planned major events in Boston including the July 4th celebration, First Night, and the Boston Marathon. BIDMC collaborated with city, state and/or federal partners on 19 drills/exercises and responded to 31 events.

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

BIDMC also participates in the ASPR hospital preparedness program.

**Goal Status**

Participated in trainings, simulations and planning meetings.

BIDMC collaborated with city, state and/or federal partners on 19 drills/exercises and 31 events. Housed the Emergency Medical Services Station serving Boston’s Longwood, Mission Hill, and Roxbury neighborhoods.
**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 20 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.

**Goal Description**

Increase understanding of cultural impacts on health care delivery, health status and health outcomes

Make available tools and resources to facilitate cross-cultural communication

Increase capacity of Interpreter Services department

Translate patient education and informational materials

**Goal Status**

Continue to incorporate information on cultural competence in New Employee Orientation, departmental in-services and Grand Rounds presentations, annual Comprehensive Employee Education programs, etc.

In FY 2015, Phones On a Pole were added to the Eye Unit and the OB/GYN Department for patient registration and check-in.

Number of interpreter services interactions (face-to-face and phone encounters) totaled 209,311 in over 76 languages.

Seven new documents were translated in FY 2015, including patient consent forms for obstetrical care, a notice of privacy practices, radiology and ED patient satisfaction surveys, a brochure on Skilled Nursing Facilities, information on Indwelling Ports, Metamucil and Imodium and the flu. These documents were translated into 6 languages: Spanish, Russian, Chinese, French, Haitian Creole and Portuguese.
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. 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. In 2015, BIDMC continued its telephonic psychiatric consultation for primary care providers at Outer Cape Health Services.

BIDMC also continued 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**

Address unmet medical needs for rural Cape Cod

Provide access for remote communities to quaternary care

**Goal Status**

A BIDMC psychiatrist provided weekly telephonic psychiatric consultation to primary care providers at Outer Cape.

Ongoing support for Med-Flight.
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<td>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 facilitate 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.</td>
<td>Call center made 812 appointments/referrals to/from CHC in FY 2015.</td>
</tr>
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</table>
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 15, 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 2015, BIDMC continues to work with the CHCs on their connections to the HIWay.

**Goal Description**

**Goal Status**

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<tr>
<td>Enhance health information exchange between BIDMC and community practices</td>
<td>CCA health centers have “magic buttons” with full viewing of BIDMC data.</td>
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<tr>
<td>Contribute to Mass HIWay initiative</td>
<td>BIDMC shares Meaningful Use data, including immunizations and public health surveillance data with the state via the Mass HIWay.</td>
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<tr>
<td>Implement lab integration</td>
<td>In the process of implementing this integration with Fenway Health</td>
</tr>
<tr>
<td>Standardize sending of inpatient and ED discharge summaries</td>
<td>BIDMC is able to share patient’s daily discharge information with an expanded primary care network including Affiliated Physicians Group and Atrius Health.</td>
</tr>
<tr>
<td>Increase accessibility of discharge instructions for patients</td>
<td>Collaborating with Apple to create novel functionality that will make discharge instructions available on iPhones.</td>
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### Access to Care - Uninsured and Underinsured

**Brief Description or Objective**

Despite health care reform, roughly one in six (15%) patients seen at a Massachusetts federally qualified health center is uninsured according to the CY 2014 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 provides infant car seats to these families at no cost.

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<tr>
<td>Subsidize Health Safety Net (HSN) Trust Fund</td>
<td>Continue to make annual contribution to HSN. During FY 2015, BIDMC served 5,534 HSN patients.</td>
</tr>
<tr>
<td>Provide financial benefits and medication assistance counseling</td>
<td>Staff screened 8,480 patients for eligibility and enrolled 7,236 patients into entitlement programs. 80% of those enrolled patients were enrolled into MassHealth. Continue to provide medication assistance and no-cost pharmaceutical prescriptions to needy patients.</td>
</tr>
<tr>
<td>Provide free-care pharmacy medications</td>
<td>Provided 3,344 medication prescriptions to indigent patients.</td>
</tr>
<tr>
<td>Provide infant car seats at no-cost to low income families with newborn children</td>
<td>Provided 14 car seats to patients, most of whom have MassHealth insurance.</td>
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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 racial/ethnic minority 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 Dorchester neighborhood, is improving maternal and child health by providing group visits for expectant mothers. 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.

In FY 2015, Ebonie Woolcock, MD, an obstetrician at Bowdoin Street Health Center, established Money Matters – Incorporating Financial Literacy into Centering Pregnancy Prenatal Care. Dr. Woolcock integrated financial literacy into group prenatal care visits by providing expectant mothers with financial planning education to help them proactively plan for impending financial challenges. In 2015, Bowdoin Street Health Center continued to provide comprehensive family planning counseling, education, and medical care for women and men.

**Goal Description**

Provide health assessments, health education, and support for pregnant women in a group visit setting

**Goal Status**

10 pregnant women (ages 17 to 36) participated in a series of 10 group visits.
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. Residents from Boston’s urban core of Dorchester, Roxbury, and the South End are more likely to be hospitalized for chronic diseases and cancer than residents of Boston and Massachusetts overall. In some cases, hospitalization rates were two to three times higher. According to the Health of Boston Report, 2012-13, Boston’s African American/Black and Hispanic/Latino residents had higher rates of diabetes, heart disease and cerebrovascular disease hospitalizations, and cancer death rates than non-Hispanic, White residents.

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 800 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. With the opening of the Bowdoin Street Wellness Center in May 2015, patients with diabetes now 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 Charles River Community Health (CRCH) Live and Learn Diabetes Program. Both CRCH and BSHC continue to collaborate with Joslin Diabetes Center on diabetes management programs. In 2014, Outer Cape Health Services implemented a diabetic retinopathy screening program in partnership with Joslin Diabetes Center. In FY 2015, Outer Cape has continued to offer on-site retinopathy screening.

Additionally, 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 4,703 diabetic patients (14.7% are Hispanic/Latino; 13.2% are African American); 14,249 with hypertension (9.1% are Hispanic/Latino; 10.6% are African American); and 2,026 with persistent asthma.
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<tr>
<td>Target is 83% of BSHC patients with diabetes, age 18-75, will have one HbA1c test per year</td>
<td>92% of BSHC patients had one HbA1c test during FY 2015.</td>
</tr>
<tr>
<td>Target is 85% of BSHC patients with diabetes, age 18-75, will have one LDL cholesterol screening per year</td>
<td>83% of BSHC patients had LDL cholesterol screening during FY 2015.</td>
</tr>
<tr>
<td>Target is 72% of BSHC diabetes patients will have one eye exam per year</td>
<td>68% of BSHC patients had an eye exam during FY 2015.</td>
</tr>
<tr>
<td>Increase number of FQHC adults with diabetes whose condition is controlled (HbA1c ≤ 9)</td>
<td>3,562 (75.7%) adults with diabetes had Hba1C &lt; 9 in 2015. 3,133 (66.6%) patients with diabetes had Hba1C &lt; 8 in 2015, down from 83.4% and 75.6%, respectively in FY 2014.</td>
</tr>
<tr>
<td>Increase number of FQHC adults with hypertension whose blood pressure is &lt; 140/90</td>
<td>9,044 patients with hypertension (63.5%) had blood pressure &lt; 140/90 in 2015, consistent with FY 2014.</td>
</tr>
<tr>
<td>Increase number of FQHC adults with persistent asthma whose condition is under control (meaningful use defined)</td>
<td>1,866 (92%) of patients with persistent asthma had their asthma under control in 2015, an increase from FY 2014 (66%).</td>
</tr>
<tr>
<td>Collaboration with the Joslin Center sustained at BSHC and CRCH.</td>
<td>Joslin Center continues involvement with Bowdoin Street Health Center and Charles River Community Health.</td>
</tr>
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Disease Management and Prevention - 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 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 15 and will do so again in FY 2016.

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.
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<tr>
<td>Increase number of mammograms in CHCs and mobile van</td>
<td>Offer on-site mammography services at Fenway Health and Outer Cape Health Services. In 2015, 458 patients received mammograms at Outer Cape Health Services and 437 patients received mammograms at Fenway Health (CY 2014).</td>
</tr>
<tr>
<td>Coordinate and host city-wide Patient Navigator Network</td>
<td>Twenty-five patient navigators representing eight healthcare institutions participated in two network luncheons in 2015.</td>
</tr>
<tr>
<td>Offer Cancer Patient Navigators</td>
<td>The Chinese Patient Navigator saw 401 active patients of which 156 were new patients, providing a total of 2,324 encounters during FY 2015. In FY 2015, the Latina Patient Navigator saw 344 patients for a total of 450 requests.</td>
</tr>
<tr>
<td>Provide Cancer Support Groups</td>
<td>Continued Tea Time group for Chinese women with breast cancer (twice per month, 23 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 16 participants).</td>
</tr>
<tr>
<td>Increase number of low income women who received a mammogram</td>
<td>2,633 low income women received a mammogram at BIDMC in FY 2015 down from 3,406 in FY 2014.</td>
</tr>
<tr>
<td>Increase number of low income individuals receiving colon cancer screening</td>
<td>1,825 low income patients received a colon cancer screening at BIDMC in FY 2015, down from 2,157 in FY 2014.</td>
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</table>
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. Several of the BIDMC affiliated health centers will renew their PCMH recognition in FY 2016. In FY 15, sharing their knowledge and expertise, The Dimock Center and BIDMC’s Bowdoin Street Health Center and Health Care Associates, partnered with Harvard Medical School’s Academic Innovations Collaborative (AIC). The foci on this most recent two-year AIC is to use team-based care to manage individuals who have psychosocial and substance abuse issues, psychiatric comorbidity and psychosocial complexity; offer immediate links to behavioral health networks; and empower patients by providing access to medical information online.

As noted previously, in FY 15, BIDMC continued working with the Community Care Alliance to increase the health centers’ capacity to achieve population management by building data infrastructure and training health centers on the use of data to reduce costs, and improve quality and patient outcomes.

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<tr>
<td>Spread implementation of PCMH</td>
<td>All CCA health centers have achieved patient center medical home recognition. The Dimock Center and Bowdoin Street Health Center continue to integrate behavioral health and primary care.</td>
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</table>
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 Status**

100% of HIV positive patients (123 of 123) screened for HCV. Of these, 41% were co-infected with HCV.

Infectious disease physician saw 63 patients across 195 visits in 2015.
Disease Management and Prevention - 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 16 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 four 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**

Provide support groups for HIV positive patients

**Goal Status**

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.
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, 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 19 Boston public schools, the curriculum contains information on the benefits of walking, explains which parts of the body are used for walking, and some basic science and math lessons—calculating heart rate and the conversion of 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.

The Walking Club continued in FY 2015. Registered individuals received a pamphlet with walking tips and an official Walking Club wristband. BIDMC held a group walk at Jamaica Pond in May 2015.

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<td>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, 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 19 Boston public schools, the curriculum contains information on the benefits of walking, explains which parts of the body are used for walking, and some basic science and math lessons—calculating heart rate and the conversion of 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.</td>
<td>Expand Walking Club to additional middle schools</td>
<td>The Walking Club curriculum was used by a total of 19 public schools with 3,485 children and 490 school staff participating in FY 2015, down from 4,176 children and 585 staff in FY 2014.</td>
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<tr>
<td>Expand the Walking Club’s adult membership</td>
<td>2,112 adults enrolled in the Walking Club in FY 2015, up from 1,999 in FY 2014.</td>
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<td>Provide educational materials, pedometers, and smartphone app to Walking Club members</td>
<td>Distributed 9,835 pedometers to Walking Club members. Provided printed educational materials, publicized smartphone app, and disseminated a YouTube video.</td>
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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 Sustainability Program Manager and multi-departmental committee. Significant improvements have been made in reducing energy and water consumption and increasing recycling rates.

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.

**Goal Description**

By FY 2013, maintain a 35% recycling rate

Between FY 2010 and FY 2013 reduce energy use by 8%

Between FY 2010 and FY 2013 reduce water use by 8%

Between FY 2010 and FY 2013 achieve 30% reduction in fuel consumption

**Goal Status**

Recycling rate increased from 23% in 2014 to 30% in 2015.

Reduced energy use by 5% between 2008 and 2015.

Reduced water use by 7.0% between 2008 and 2015.

Reduced fuel use by 31% in FY 13. A 30% reduction in fuel usage was maintained in 2015.
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. Addressing this issue, The Daily Table opened in June 2015. The Daily Table is a not-for-profit grocery store that offers residents of the Dorchester community affordable and convenient healthy food options. BIDMC is proud to support The Daily Table.

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 five 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 addition to these successes, staff from BIDMC continued to support BSHC’s Farm to Family Program, a Community Supported Agriculture (CSA) project. Over 69% 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 supported the Boston Collaborative for Food and Fitness (BCFF) to increase the amount of fresh, healthy, and affordable food available to residents in food-insecure neighborhoods, increase awareness of and support for local farmers markets, and expand their potential as community hubs. Working with BCFF and the Healthier Roxbury Coalition, BIDMC participated in Roxbury Rises Against Diabetes (RRAD). This month long event occurred in FY 15, when BIDMC staff offered workshops and supported the culminating event – a Seafood Throwdown, which drew more than 200 attendees.
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<tr>
<td>Provide access to fresh fruits and vegetables in Boston neighborhoods</td>
<td>Bowdoin Geneva Farmers’ Market held weekly from July through October 2015. Vendors at the Farmers’ Market accept SNAP, WIC, and Senior Farmers’ Market Nutrition Program benefits. CSA project provided 38 families with subsidized cartons of fruits and vegetables.</td>
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<tr>
<td>Expand Healthy Champions Program</td>
<td>Five Healthy Champions program youth participated in healthy cooking classes and nutrition education workshops.</td>
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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 more than half of the Boston population (59.5%) is overweight or obese, with nearly one-quarter being obese; less than half engage in regular physical activity and less than one-third consume the recommended five daily servings of fruits and vegetables. Obesity disproportionately affects low income African American, Caribbean Islander and Latino communities. In some neighborhoods served by the CCA health centers, more than three-quarters of BIDMC’s survey respondents were overweight or obese. Lack of access to healthy food, nutrition education, and physical activity within these neighborhoods hinder patients’ abilities to be and stay healthy. This is especially true for individuals with chronic conditions.

Bowdoin Street Health Center (BSHC) continues its work with the Optimal Weight for Life (OWL) program. The OWL program offers a multidisciplinary team of specialists- pediatrician, nutritionist and behaviorist- for those children who are significantly overweight. In FY 2015, OWL continued to offer a group visit model, engaging 14 OWL patients and their families. Youth and families were able to interact both separately and together, and worked with the team of providers on goal setting on a monthly basis.

In 2014, BSHC launched the REACH Obesity Prevention Initiative to provide opportunities for residents to come together in active ways to improve health and well-being as well as strengthen relationships with neighbors. The goal is to empower residents to make improvements in the physical neighborhood, with the double goals of improving health and reducing violence. In FY 2015, BSHC continued to house some aspects of the REACH program under the umbrella of Violence Intervention. These included access to various play equipment, pop-up playgrounds and offering Playways as a form of supporting resident organizing, community cohesion and reducing violence. In FY 2016, the REACH program will be fully incorporated into the Violence Intervention Program at BSHC.
Additionally, BIDMC’s Active Living and Healthy Eating three-year (2013, 2014 and 2015) grant program partnered with Bowdoin Street Health Center, The Dimock Center, and Charles River Community Health to implement creative, evidence-based practices to increase the number of children, youth, and 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.

The Dimock Center’s health center and Head Start early childhood education program have teamed up to provide more nutrition education, healthy foods, and physical activity opportunities for the Head Start students (three to six years old) and their parents. Head Start teachers are receiving additional training and support to help them incorporate active living and healthy eating into their lesson plans. In addition, children are getting healthy snacks made from fresh produce, parents are invited to participate in healthy lifestyle workshops, some of which are taught by BIDMC staff, and the center is making improvements to its Children’s Garden where students grow vegetables. Lastly, Charles River Community Health continues its partnership with Charlesview Apartments, an affordable housing community, to provide Zumba exercise classes, for adults and seniors, and cooking classes to local residents. Zumba class participants also have the opportunity to go on a supermarket tour to learn about healthy food choices, receive one-on-one counseling from a dietician, or join a cooking class held in the Charlesview Apartments Community Center’s kitchen.

BSHC’s Wellness Center opened in May, 2015. The Wellness Center contains a demonstration kitchen, a large exercise room for dance and physical activity classes, and a gym with work-out equipment.
### Healthy Living – Active Living and Healthy Eating Programs (continued)

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<th>Goal Description</th>
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<tr>
<td>Engage children in exercise programs</td>
<td>In FY 2015, 6 new patients enrolled in the OWL Program and 14 OWL patients engaged in group visits. Also in FY 2015, 100 children/youth enrolled in Fitness in the City.</td>
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<tr>
<td>Increase number of children seen at affiliated health centers who were screened for BMI and provided with counseling</td>
<td>7,932 children (79.1%) who are receiving care from affiliated federally qualified health centers were screened for BMI and given counseling.</td>
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<tr>
<td>Demonstrate maintenance or improvement of BMI among Active Living/Healthy Eating program participants</td>
<td>Among 11 participants at BSHC, 1 child had an improved BMI and 5 children had a maintained BMI after group visits were completed. Among 39 adults at CRCH, 11 improved BMI and 28 maintained BMI after two years. Among 64 participants at Dimock, 5 children improved and 52 maintained BMI.</td>
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<tr>
<td>Provide 5-2-1 counseling recommended by the AAP during routine well-child visits at BSHC</td>
<td>Nutrition, healthy eating, and exercise information shared at routine pediatric appointments. In FY 2015, pediatric providers encouraged patients and families to attend “Healthy Weight” clinical check-ins, which will soon involve direct referral to Wellness Center programming.</td>
</tr>
<tr>
<td>Develop fund raising and programmatic plan for Wellness Center</td>
<td>The BSHC Wellness Center opened in May, 2015.</td>
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As the population ages, keeping older adults healthy and out of the hospital is increasingly important. 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 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 of 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 were held on footwear, home safety, stretching, medication review, and what to do in the event of a fall.

BSHC continued the Tai Chi classes in FY 2015 and will expand offerings through the Wellness Center in FY 2016.

Additionally, Bowdoin Street Health Center is collaborating with the Prevention Wellness Trust Fund to reduce elderly falls among residents of the Bowdoin/Geneva neighborhoods.

Goal Description

Reduce falls among at-risk older adults

Goal Status

Twenty older adults enrolled in Tai Chi classes in FY 2015. Participants completed a baseline gait and balance test, and complete a follow up test at the completion of the program.
Years of unchecked violence and gang-related activity continue in the Bowdoin/Geneva neighborhood. Over the past five 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 2015, 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. Through a partnership with the Family Nurturing Center, VIP assisted in a successful three part Fatherhood Engagement Dialogue series. Additionally, VIP helped to facilitate the Chlamydia Outreach Initiative with the North Dorchester Coalition. Particular attention was paid to resident leadership development and inclusion in community decisions.

**Goal Description**

Strengthen resident and community engagement

Identify environmental issues that diminish sense of community

Increase youth access to employment and afterschool/summer activities

**Goal Status**

Continue door-to-door campaign with resident Block Captains. Engage residents in improving their neighborhood and planning community-wide events.

Engage residents in working on issues that matter to them including improving the neighborhood’s environment and offering opportunities and support to lead on community issues be included in decisions that affect the community.

Partner 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 4 youth from Bowdoin Geneva in paid summer jobs at BIDMC in FY 2015.
### 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 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 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. To support community healing, the CVPR offered individual and group counseling in the aftermath of the Boston Marathon bombing.

The CVPR conducts outreach and training to providers serving victims of violence through the Advocacy Education & Support Project (AESP). AESP’s goal is to increase the productivity, longevity, and vitality of those who work with survivors of violence by ameliorating the effects of secondary traumatic stress often experienced by service providers. AESP “helps the helpers” to ensure survivors of violence receive quality care.

### Goal Description

- **Provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence**
- **Provide rape crisis services**
- **Provide free overnight stay for domestic violence and/or sexual assault victims without safe shelter**
- **Diminish effects of secondary traumatic stress in advocates and supervisors**
- **Create opportunities for grieving, support, and healing**

### Goal Status

- **Continue to provide individual and group therapy for survivors of violence.**
- **Provide counseling as well as post-HIV exposure prophylaxis medications to sexual assault victims. Provided services for 62 sexual assault victims.**
- **Provide 59 Safe Bed overnight stays.**
- **Provided educational programs and support groups for approximately 58 advocates, consistent with FY 2014.**
- **Held 45 healing circles that benefitted approximately 473 men, women and children in the aftermath of community violence.**
Children’s exposure to violence, whether as victims or witnesses, is often associated with long-term physical, psychological, and emotional harm. Children exposed to violence are also at higher risk of engaging in criminal behavior later in life. Skilled mental health clinicians who support children and families coping with the after-effects of violence can help break the cycle of violence. Through the Defending Childhood initiative funded by the U.S. Department of Justice, Bowdoin Street Health Center expanded its team of counselors who offer therapeutic services and conduct home visits to children and their families impacted by violence. This initiative seeks to prevent and reduce in particular the impact of children’s exposure to violence. A priority of the Defending Childhood Initiative is to increase the capacity of Boston’s workforce and community based organizations to provide trauma-informed, evidence-based programs and services to Boston’s children and families. This includes supporting direct clinical and family support services and comprehensive training and quality improvement opportunities for the mental health, afterschool, and education systems.

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<td>Expanded mental health services at Bowdoin Street Health Center</td>
<td>Provide therapeutic services to children and families affected by violence</td>
<td>Increased the capacity of BSHC’s mental health team through the continued work of a clinical social worker who is trained in Attachment, Regulation, Competency (ARC) and a site administrator/clinical supervisor.</td>
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<td>There were 313 referrals for patients to receive therapeutic services through 1,158 encounters, including direct service visits, therapeutic intervention, phone outreach, assistance with concrete resources and case management, and advocacy.</td>
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According to MassCHIP and the Massachusetts Substance Abuse Bureau, Boston has statistically higher rates of substance abuse treatment admissions, including cocaine, heroin, and other opioids, when compared to the Commonwealth. Rates are particularly high in South Dorchester and Roxbury.

Since 2007, The Dimock Center has offered an Office-Based Opioid Treatment program (OBOT) embedded within its primary care clinic. This allows clients to obtain opioid addiction treatment in a community health setting. The Dimock OBOT program provided services to 143 patients in FY 2015.

The Dimock Center’s Women’s Renewal-Clinical Stabilization Services (CSS) provides intensive clinical services and support for women who have ongoing issues with substance abuse. In FY 2015, BIDMC began supporting a pilot between The Dimock Center’s Women’s Health in OB-GYN and the CSS to integrate preventive health approaches with substance abuse care. Upon admission to the CSS program, women have offered a screening “passport visit” in The Dimock Center’s OB/GYN department during which the patient’s health history is reviewed, vital signs including weight and body mass index are recorded, and the patient is offered an exam and cervical cancer screening.
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<td>Continue role redefinition of staff to improve program capacity</td>
<td>A part-time medical assistant supports outreach and engagement of patients.</td>
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<td>Provide opioid treatment in a primary care setting</td>
<td>Served a total of 143 patients in FY 2015.</td>
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<td>Decrease Do Not Keep Appointment rates</td>
<td>DNKA rates increased to 31% in FY 2015.</td>
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<td>Hire providers to head the CSS-OB/GYN collaboration and coordination</td>
<td>Hired clinician and nurse coordinator to lead CSS/OB-GYN collaboration.</td>
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<tr>
<td>Create patient preventative health “passport”, visit templates and marketing materials</td>
<td>Health passport and visit templates have been drafted and loaded into the electronic health record system. Created a brochure to facilitate CSS discussions with patients regarding the health visit.</td>
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Mental Health and Substance Abuse – Facilitating Access

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<td>Mental illness and substance abuse have a profound impact on the health of people in living in Massachusetts and the Boston area. Mental health and substance abuse 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).</td>
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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 2015, 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 2015, the Latino Mental Health Service continued its partnership with the BIDMC Department of Cardiology’s Latino Cardiovascular Clinic.

In FY 2015, BIDMC established 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. Six sessions are planned for FY 2016.

The 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 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 2015, the program provided comprehensive care to 14 residents with two or more chronic medical problems and serious behavioral health needs.
Goal Description

Provide culturally competent mental health services to Latino patients and their families.

Provide educational symposium for bilingual/bicultural Spanish-speaking mental health clinicians.

Goal Status

Provided 2,100 individual and group psychotherapy visits and psychopharmacologic visits, reaching 319 patients.

Provided quarterly Sobremesa symposiums; each symposium was attended by approximately 30 clinicians.
**Mental Health and Substance Abuse – 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 abuse counseling. Additionally, two large primary care practices are notified by secure messaging if their patient is seen in the ED for substance abuse.

As part of the SBIRT implementation, BIDMC developed a teaching model to educate providers about at-risk alcohol abuse, and taught residents, attending physicians and nurses the skills to assess and intervene on patients at risk for alcohol use. This additional training will prepare providers to assess a patient’s motivation to alter behavior and/or seek additional assistance for care. In FY 2015, BIDMC’s ED expanded the number of resources available to providers in the electronic database. These include documentation, literature and other tools available to providers for real-time interventions using SBIRT. |
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<td>Implement SBIRT screening</td>
<td>SBIRT screening protocol was utilized in BIDMC’s Emergency Department.</td>
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<td>Train providers about at-risk alcohol use</td>
<td>45 attending physicians and 39 residents, as well as 2 social workers were trained in motivational interviewing and substance abuse counseling in FY 2014 and continued to use these skills in FY 2015.</td>
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<td>Engage social workers to facilitate referrals</td>
<td>Relationship with social workers has been established. The social workers will be engaged throughout the training of providers.</td>
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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. After a competitive search, Dr. Albert M. Galaburda, Emily Fisher Landau Professor of Neurology at Harvard Medical School, and then Chief of Cognitive Neurology in the Department of Neurology at Beth Israel Deaconess Medical Center, was appointed as the founding director of the Office for Diversity and Inclusion, and started his tenure in January of 2015.

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<td>Increase diversity of residents and fellows in training</td>
<td>Increase knowledge about diversity and cultural competence</td>
<td>URM applicants have remained steady since FY 2011.</td>
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<td>Participate in recruitment fairs targeting diverse medical students</td>
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<td>Established the Office of Diversity and Inclusion</td>
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<td>Director of the ODI and BIDMC physician representatives attended annual meetings of Student National Medical Association &amp; Latino Medical Students Association.</td>
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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, Eileen McCarthy, PhD, MPH continues to lead a study to better understand the factors influencing Asian Americans with advanced cancer and their choice(s) for end of life care; Christina Wee, MD, MPH continues to lead a study to understand the interplay of race and obesity on four outcomes including mortality, cardiovascular risk, delays in diagnosis and control of cardiovascular risk factors and health care expenditures. In a separate study, Dr. Wee is also examining our understanding of how patients value bariatric surgery, specifically the decision making process for African American and Hispanic/Latino patients. Mara Schonberg, MD, MPH leads a number of studies on the benefits and burdens of breast cancer screenings among older women. Additionally, Laura Burke, MD is leading a study on understanding disparities in patient-centered hospital care as well as an examination on the impact of insurance expansion on Medicaid patients.

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.
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 2015, BIDMC offered incumbent employees five “pipeline” programs to train for the following professions: Centering Processing Technician, Pharmacy Technician, Medical Coder, Patient Care Technician and Medical Laboratory Technician to Medical Technologist. 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 “From Debt to Assets,” which helps employees build financial literacy skills. Each year, BIDMC selects two employees to participate in The Partnership, Inc.’s year-long leadership program. In FY 15, the invitation to apply was again extended to all six affiliated health centers. The Partnership program is designed to facilitate career growth and networking for professionals of color 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 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. In FY 2015, BIDMC Interpreter Services, Workforce Development, and Human Resources partnered with a community-based organization called Found in Translation to provide a career workshop for bilingual low income women pursuing a career in medical interpreting.

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 certified group fitness instructors, and are engaged in learning and developing exercise curriculum. The participants will become properly licensed in fitness instruction, and collaborate with staff to identify the types of programs they would like to lead in the Wellness Center.
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 Shadow Day at BIDMC clinical sites. 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 2015 31 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 Investment Board and 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.
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<tr>
<td>Provide pipeline programs to enhance skills and career advancement</td>
<td>Offered six pipeline programs with 22 participants and 12 graduates in FY 2015.</td>
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<td>Provide opportunities through Employee Career Initiative (ECI) for college-level courses as well as counseling</td>
<td>558 employees received ECI services including classes offered on site in partnership with Bunker Hill Community College; this is a 63% increase over FY 2014.</td>
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<tr>
<td>Offer ESOL classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class</td>
<td>22 employees were enrolled in ESOL classes; 16 employees participated in a 10-week computer skills class; 12 attended citizenship classes; and 20 attended a financial literacy class.</td>
</tr>
<tr>
<td>Provide job and career introductory opportunities for community residents</td>
<td>Hosted 13 adults in training internships, two of whom were subsequently hired; offered feedback and advice to community organizations on 63 adults who applied for jobs. Enrolled five participants in BSHC’s Train4Change Program. Hired two interns from Bunker Hill Community College’s Learn and Earn Program.</td>
</tr>
<tr>
<td>Provide job and career introductory opportunities for middle and high school students</td>
<td>Provided 43 paid summer job opportunities; 6 school-year internships; numerous tours of medical center and skills lab; hosted 32 Boston Public School students for PIC’s annual Job Shadow Day. Medical Champions mentored 10 academically talented, economically disadvantaged 8th graders from BPS. Hosted 31 high school students in Summer Health Corps Program.</td>
</tr>
</tbody>
</table>
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 whom 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, as well as the lack of inclusive recreational opportunities for children with disabilities, the mental health needs and social-emotional wellbeing of children who have experienced trauma or witnessed violence and homelessness. BIDMC’s affiliated community partners are frequent sites for Schweitzer Fellows including a health literacy program at The Dimock Center.

**Goal Description**

Support ASF’s mission of developing leaders in service

Design sustainable projects that improve community health and increase community capacity

Partner with ASF to host students at BIDMC-affiliated sites

**Goal Status**

Administrative and financial support of ASF Program.

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.

Created opportunities for students to learn about and work in BIDMC-affiliated community health centers and partner organizations such as The Dimock Center and Sociedad Latina.
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 Healthier Roxbury Coalition. In FY 15, BIDMC was an active participant in Roxbury Community Alliance for Health (RCAH) / Greater Boston Aligning Forces for Quality (GB AF4Q).

In FY 2015, BIDMC again 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.” The CAB awarded one grant to Bowdoin Bike School in FY 2015 to recruit and hire three Dorchester residents, facilitate clinics on bike repair, distribute helmets, lights and locks, implement a community cycling event, and increase partnerships within the Bowdoin Geneva community.

**Goal Description**

**Goal Status**

<table>
<thead>
<tr>
<th>Brief Description or Objective</th>
<th>Goal Description</th>
<th>Goal Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build a Community Health Improvement Planning process</td>
<td>Improve the health status of Roxbury residents</td>
<td>Worked with Healthier Roxbury Coalition to plan Roxbury Rises Against Diabetes (RRAD) which was held in October 2015.</td>
</tr>
<tr>
<td>Increase engagement of residents in community health</td>
<td>Expand Community Advisory Board (CAB) to four members, and awarded one grant to Bowdoin Bike School.</td>
<td>Continue to participate in GB AF4Q. Support BACH initiatives through DON funding.</td>
</tr>
</tbody>
</table>
Section V: Expenditures

Community Benefits Programs

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Expenses</td>
<td>$13,606,537</td>
</tr>
<tr>
<td>Associated Expenses</td>
<td>$0</td>
</tr>
<tr>
<td>Determination of Need Expenditures</td>
<td>$34,000</td>
</tr>
<tr>
<td>Employee Volunteerism</td>
<td>$0</td>
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<tr>
<td>Other Leveraged Resources</td>
<td>$6,088,585</td>
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Net Charity Care

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSN Assessment</td>
<td>$8,848,420</td>
</tr>
<tr>
<td>HSN Denied Claims</td>
<td>$7,265,019</td>
</tr>
<tr>
<td>Free/Discount Care</td>
<td>$0</td>
</tr>
<tr>
<td>Total Net Charity Care</td>
<td>$16,113,439</td>
</tr>
</tbody>
</table>

Corporate Sponsorships $13,750
Total Expenditures $35,842,561
Total Revenue for 2015 $1,198,785,551
Total Patient Care-related Expenses for 2015 $1,045,247,568
Approved Program Budget for 2015 $37,000,000

(*Excluding expenditures that cannot be projected at the time of the report.)

Bad Debt $5,701,473 Certified

Comments: Total Charity Care is $78,929,488 and includes BIDMC’s payment of $16,113,439 to the Health Safety Net; $12,670,670 in unreimbursed Medicare Services; $40,982,312 in unreimbursed MassHealth Services; $5,701,473 in bad debt; $2,510,795 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; and $950,799 in BIDMC’s contribution to the Distressed Hospital Fund and Prevention and Wellness Trust Fund, established by the Commonwealth to ensure access to community-based health care, and to strengthen prevention and wellness efforts, consistent with the Commonwealth’s broad health care reform goals and the needs identified in the Community Health Needs Assessment.
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