Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

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SECTION I: SUMMARY AND MISSION STATEMENT

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

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

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

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

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

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

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

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

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

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

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

Target Populations

BIDMC's CBSA includes the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury, the City of Chelsea, and the towns of Brookline, Burlington, Lexington, Needham, Newton (Chestnut Hill) and Peabody.[1] BIDMC's FY19 Community Health Needs Assessment's (CHNA) findings, on which this report is based, clearly show that low-income and racially/ethnically diverse populations living in Boston's neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury, as well as the adjacent City of Chelsea, face the greatest health disparities and have the highest level of need. As a result, these Boston neighborhoods and the City of Chelsea have been identified and prioritized as the focus for community health efforts.

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

[1] In August 2021, BIDMC expanded its licensed sites causing Burlington and Peabody to be added to BIDMC's Community Benefits Service Area. These municipalities are not included in the FY 19 CHNA or current FY 20-22 Implementation Strategy.

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

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

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

- Continued to support increased capacity of primary care and OB/GYN practices at six affiliated health centers
- Continued community-based specialty care services
- Provided culturally and linguistically appropriate care for patients through cancer navigation, interpreter services, and multilingual patient education
- Addressed social determinants of health, in particular violence prevention, through the Center for Violence Prevention and Recovery (CVPR) and Bowdoin Street Health Center's (BSHC) Neighborhood Trauma Team
- Increased access to behavioral health services through the implementation of the Collaborative Care model
- Continued workforce development through summer internships for underserved youth, pipeline programs, and training programs for adults
- Supported programming to address food insecurity in light of COVID-19. For example, BIDMC, as part of Beth Israel Lahey Health's (BILH) investment in a Gateway Municipality, funded *ChelseaEats*, an innovative pilot program launched by the City of Chelsea that provides residents with monthly debit cards for assistance purchasing food and other essential items
- Conducted research that supports the understanding of health disparities
- Supported youth in developing leadership skills to prevent violence and create change in their community through the Youth Leadership Program at BSHC
- BIDMC dedicated significant time and resources to respond to COVID-19 needs; similarly to FY20 this led to some changes in programming

Plans for Next Reporting Year

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

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

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

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

BIDMC partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses. BIDMC also partners with numerous community health centers through the Community Care Alliance (CCA, BIDMC's health center network) to implement programs that address health disparities (related to race, ethnicity, sexual orientation, gender identity, and physical attributes, socio-economic status, etc.) and implement focused public health and chronic disease management programs.

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the BIDMC Community Benefits team completed a hospital self-assessment form (Section VII, page 57). The BIDMC Community Benefits team also shared the Community Representative Feedback Form with CBAC members and community stakeholders who participated in BIDMC's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

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

The membership of BIDMC's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by BIDMC's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations. CBAC membership also includes designees by the BIDMC Board of Trustees and the hospital President. This ensures the bidirectional information exchange between the community and the executive levels within BIDMC so that hospital policies and resources are allocated to support Community Benefits activities.

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

BIDMC is a member of Beth Israel Lahey Health (BILH). While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities, and have a focus on fostering health equity. Likewise, this structure and methodology ensures that Community Benefits is not the purview of one office alone maximizes efforts across the organization to fulfill the mission and goals of Community Benefits.

The BIDMC Community Benefits program is spearheaded by a team of Community Benefits senior leaders including the Vice President and Director of Community Benefits. The Vice President of Community Benefits has direct access to and is accountable to the BIDMC President and also reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. These leaders ensure that Community Benefits is addressed by the entire organization and that the needs of historically underserved populations are considered every day in discussions on resource allocation, policies, and program development. Additionally, BIDMC's Board of Trustees 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 the mission overseen by the Board of Trustees.

Community Benefits Advisory Committee Meetings
December 15, 2020
March 23, 2021
June 22, 2021
September 28, 2021

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

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

BIDMC currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In this work, BIDMC collaborates with many of Boston's leading healthcare, public health, and social service organizations. BIDMC has particularly strong relationships with many of the community health centers that operate in its CBSA. These health centers, that are part of the CCA, are critical components of the health care safety net in the communities in which they operate. In 2021, the CCA health centers provided primary care medical, dental, behavioral health, and enabling services to approximately 92,485 patients. The CCA health centers include:

- Bowdoin Street Health Center[2]
- Charles River Community Health (formerly Joseph M. Smith Community Health Center)
- The Dimock Center
- Fenway Health
- Sidney Borum Jr. Health Center (part of Fenway Health)
- South Cove Community Health Center

These health centers are ideal Community Benefits partners because they are rooted in their communities and, as they are predominantly federally qualified health centers, are mandated to serve low-income, historically underserved populations.

[2] Bowdoin Street Health Center, a member of CCA, is owned and licensed by BIDMC and is not a federally qualified health center.

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

BIDMC is also an active participant in the Integrated North Suffolk Community Health Needs Assessment (iCHNA) and Boston CHNA- Community Health Improvement Plan (CHIP) Collaborative (B3C). Joining with such grassroots community groups and residents, the Boston Public Health Commission (BPHC), Massachusetts DPH, and academic partners, BIDMC strives to create a vision for both city-wide and neighborhood-based health improvement. Another important partnership is BIDMC's involvement with the Initiative to Eliminate Cancer Disparities (IECD) through the Dana-Farber/Harvard Cancer Center (DF/HCC), of which BIDMC is a founding member. Collectively the IECD, the DF/HCC, BIDMC and others are working to address the unequal burden of cancer within diverse communities by facilitating research in disparities and minority clinical trial education and enrollment.

See Appendix A on page 63 for a comprehensive listing of the community partners with which BIDMC joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy.

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Approach and Methods

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

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

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

The articulation of each specific community's needs (done in partnership between BIDMC and community partners) is used to inform BIDMC's decision-making about priorities for its Community Benefits efforts. BIDMC works in concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BIDMC's Community Benefits Plan that is adopted by the Board of Trustees.

Summary of FY19 CHNA Key Health-Related Findings

Access to Care

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

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

Chronic Disease Management

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

- **Limited Access to Cancer Screening for Racial/Ethnic Diversity and Other At-risk populations.** Many of the communities that are part of BIDMC's CBSA have high cancer mortality rates. This is particularly true for certain cancers in specific communities in specific Boston neighborhoods, such as Roxbury, Dorchester, and Chinatown that have a high proportion of racial/ethnic diversity. At the root of addressing high mortality is screening, early detection and access to timely treatment.

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

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

Social Determinants and Health Risk Factors

- **Social Determinants of Health (e.g., economic stability, education, and community/social context) Continue to Have a Tremendous Impact on Many Segments of the Population:** The dominant theme from the assessment's key informant interviews and community forums was the continued impact that the underlying social determinants of health are having on the CBSA's low-income, historically underserved, diverse population cohorts. More specifically, determinants such as poverty, employment opportunities, violence, transportation, racial segregation, literacy, provider linguistic/cultural competency, social support, and community integration limit many people's ability to care for their own and/or their families' health.

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

national, Commonwealth, and local data sources, including data from the Boston Public Health Commission's 2016-2017 Health of Boston Report. It is crucial that these disparities be addressed and, to this end, BIDMC's Implementation Strategy continues to include a myriad of programs, strategic interventions, and services that are carefully targeted to address these disparities. However, it is critical to note that there are a multitude of individual, community and societal factors that work together to create these inequities. The underlying issue is not only race/ethnicity, racism, income, or language but rather a broad array of interrelated social issues including economic opportunity, education, crime, transportation, and community cohesion.

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

Behavioral Health

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

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

Implementation Strategy

As stated above, BIDMC focuses its Community Benefits efforts on those geographies and cohorts who experience the greatest health disparities. Outlined below and in the BIDMC FY20-22 Implementation Strategy are the programs, strategic interventions, and services to address these disparities and prioritized needs.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Access to Care **Program Name: Community Based Primary and Specialty Care**		
Brief Description or Objective	Community Health Centers (CHC) are in a unique position to provide accessible, culturally sensitive, linguistically appropriate primary care and specialty care services, including outreach, preventive, and enabling services to diverse medically underserved communities. The health centers that BIDMC supports are rooted in their communities, understand the unique social, cultural, and health-related needs of those they serve, and are better equipped than any organization to meet these needs. A number of BIDMC specialties (e.g., OB/GYN, Infectious Disease, etc.) and ancillary services (e.g., radiology, lab) are provided on-site at the health centers. The CHCs also have access to teaching and growth opportunities including the Linde Family Fellowship Program (LFFP). The LFFP provides early and midcareer physician leaders with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
By the end of FY21, BIDMC will increase the number of patients receiving primary care, OB/GYN, and specialty care at affiliated CHCs from 126,733 patients in FY20.	During FY21, 119,184 patients were seen at affiliated CHCs. Many health centers did not increase the number of patients served due to COVID-19 testing and vaccination efforts.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, BIDMC will increase the number of specialists practicing at CHC sites from 26 in FY20.	31 BIDMC specialists practiced at CHC sites in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Community Care Alliance

Brief Description or Objective	BIDMC was instrumental in helping its affiliated and/or licensed health centers form a network called the Community Care Alliance (CCA). By collaborating on clinical and administrative issues, the CCA helps its members continue to provide high-quality, cost-effective healthcare services by collectively contracting for services and funding, as well as sharing resources and expertise for the benefit of their patients and communities. BIDMC is committed to strengthening the capacity of its five affiliated CHCs in the CBSA: Bowdoin Street Health Center (BSHC), The Dimock Center, Fenway Health and Sidney Borum Jr. Health Center, Charles River Community Health (CRCH), and South Cove Community Health Center. The partnership takes many forms: recruitment, retention, financial support and credentialing of physicians and mid-level providers, BIDMC admitting privileges and access to managed care contracts, Harvard Medical School appointments and teaching opportunities, BIDMC-sponsored educational programs, and access to Up-to-Date. BIDMC's Mystery Shopping process ensures that ambulatory sites, as well as participating CCA health centers are adhering to quality standards related to patient safety and satisfaction. By engaging a team of "mystery shoppers" to monitor incoming patient calls, BIDMC provides prompt feedback to health center staff in order to improve responsiveness and the ability to provide efficient, patient-focused assistance at every interaction. **COVID-19 Activities** BIDMC has supported the CCA health centers throughout the COVID-19 pandemic by increasing testing and vaccination efforts, sharing BILH protocols, procedures, and guidelines in real-time, and providing clinical and other supports to the community.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, BIDMC's Mystery Shopping team will shop BSHC four times each month, totaling 48 shops per year.	The Mystery Shopping team shopped BSHC four times each month, totaling 48 shops per year.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

In FY21, BIDMC specialists will practice at CCA health centers.	31 BIDMC specialists practiced at BSHC, The Dimock Center, Fenway Health and South Cove Community Health Center. CRCH did not indicate a need for any specialty care.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC will conduct 12 Office of the Inspector General (OIG) reviews on CHC employee and vendor lists, to ensure compliance with state and federal standards.	BIDMC has continued monthly regulatory OIG reviews for all CHC personnel and vendors.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Trauma, Emergency Management and Public Health Surveillance

Brief Description or Objective	BIDMC's robust Emergency Management program is highly involved in local, city, state, and regional emergency preparedness systems and a leader in the hospital emergency management field. BIDMC is a regular participant in citywide committees, drills, task forces, project and plan development, and meetings including those for citywide mass casualty events. This program includes BIDMCs health center partners in planning, training, and exercises. During the COVID-19 pandemic response, BIDMC Emergency Management has continuously been in contact with citywide hospitals, public health entities, education partners, and first responder agencies.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
BIDMC will continue to collaborate with city, state and federal emergency management programs to ensure preparedness of the medical center and CHCs for untoward emergencies.	BIDMC Emergency Management has updated the required documents for BIDMC, CHCs, and offsite clinics under the BIDMC license and continues to represent these facilities in city, state, and federal programs.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Culturally and Linguistically Responsive Care

Brief Description or Objective	BIDMC was one of the first hospitals with an Interpreter Services Department and has a proven track record in helping patients overcome linguistic barriers to care, expanding interpreter services capacity and resources every year. Free interpreter services (IS) are available to non-English speaking, limited-English speaking, deaf, and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team, and an interpreter; and through a video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By FY23, BIDMC Interpreter Services will decrease their average response time to below 5 minutes for staffed languages.	In FY21, the average response time was slightly above 5 minutes.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC will increase Interpreter Services department interactions.	The number of interpreter services interactions (in-person, telephone, video, and ASL) totaled 271,357 in FY21 compared to 222,396 in FY20.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Geographically Isolated Communities

Brief Description or Objective	To address access to care challenges in the Outer Cape region, BIDMC continues to offer on-site medical specialty care services, including infectious disease services, digital radiology and mammography screening. BIDMC continues to support the Med-Flight helicopter program which transports those living in isolated areas that need emergency medical services. For patients and families who are a long distance from home, BIDMC provides housing assistance through programs such as Hospitality Homes or specially adapted apartments for those undergoing bone marrow transplantation. A staff member helps patients find lodging with Room Away from Home.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
BIDMC will continue to address unmet medical needs for rural Cape Cod.	In FY21, BIDMC continued to address unmet needs for rural Cape Cod.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will continue to provide access for remote communities to quaternary care.	In FY21, BIDMC continued to provide access for remote communities to quaternary care.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year the BIDMC Social Work Department will provide housing support to patients in need of short- or long-term housing.	In FY21 housing support was provided to 74 individuals.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Care Connection**	
Brief Description or Objective	Care Connection is a dedicated resource to help patients and/or their referring physicians connect to primary and specialty care service. A number of services benefit the Community Health Centers (CHC) and their patients, including the Find a Doctor call center, the Doctor-to-Doctor call center, and Care Connections Inpatient Discharge Follow Up program that helps CHC patients who were admitted to BIDMC arrange follow-up care after discharge.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
The Care Connection department offers a number of services that benefit the CHCs and aims to provide consistent level of service.	The Care Connection department is currently in the process of installing Salesforce application software for more efficient workflows and consistent levels of service.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC's Care Connection Department will facilitate access through referrals to and from community primary care providers.	The Care Connection call center made 1,058 appointments/referrals to/or from CHCs in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
In the Doc-to-Doc Group, BIDMC's Care Connection Department will answer 90% of calls with an abandonment rate of 1.4% in FY21.	In the Doc-to-Doc group, the BIDMC Care Connection Department processed 2,653 calls with a service level of 90% and an abandonment rate of 1.4%.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In the Find a Doc group, BIDMC's Care Connection Department will answer 77% of calls with an abandonment rate of 6.4% in FY21.	In the Find a Doc group, the BIDMC Care Connection Department processed 12,721 calls with a service level of 77% and abandonment rate of 6.4%.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Seamless Continuity of Care**	
Brief Description or Objective	As patients move between community-based and hospital-based care (ambulatory specialty care, Emergency Department (ED) or inpatient hospitalization), it is imperative that providers in both settings have accurate, real-time clinical information. BIDMC has harnessed technology to ensure this communication through Health Information Exchange (HIE) enhancements. BIDMC also remains an important part of the Governor's launch of the state healthcare information exchange (Mass HIWay). BIDMC provides ongoing reference lab services to The Dimock Center and South Cove Community Health Center, with results being delivered directly to each site's electronic health record (EHR) via an electronic interface.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Through FY22, BIDMC will continue to contribute to the Mass HIWay initiative.	BIDMC continues to share Meaningful Use data, including immunizations and public health surveillance data with the state via the Mass HIWay. BIDMC continues to work with the CHCs on their connections to the HIWay.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Through FY22, BIDMC will continue sending inpatient and ED discharge summaries with the expanded primary care network.	BIDMC continues to share patient's daily discharge information with an expanded primary care network including BIDHC and Atrius Health.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Care to Uninsured and Underinsured in Underserved Communities

Brief Description or Objective	BIDMC's on-site retail pharmacy and specialty pharmacy has a patient co-payment assistance program for patients with family income at or below 300% of the federal poverty level. The retail pharmacy is registered as a Health Safety Net (HSN) pharmacy and provides courtesy fills for low-income patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, BIDMC employs patient assistance staff. BIDMC also subsidizes inpatient psychiatric services for those most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others, or who are unable to care for themselves due to mental illness. Additionally, BIDMC subsidizes primary care services provided by BIDMC's Affiliated Physicians Group throughout BIDMC's Community Benefits Service Area.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, BIDMC will screen and enroll all eligible patients into entitlement programs and continue to provide medication assistance and no-cost pharmaceutical prescriptions to low-income patients.	Staff screened 161,593 patients for eligibility and enrolled 24,221 patients into entitlement programs. Of these patients 16,942 were enrolled in MassHealth and 7,279 uninsured patients utilized Health Safety Net.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
The Retail pharmacy will aim to meet 100% of requests for adherence packaging and talking scripts and provide home delivery for patients with difficulty accessing the medical center for pick up.	BIDMC Pharmacy is meeting goal standards.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
BIDMC Pharmacy will expand services to Bowdoin Street Health Center including Medication Authorization, patient assistance, and an ambulatory clinical pharmacist.	The Bowdoin Street Health Center Pharmacy opened in February 2022. Since opening, the pharmacy has served 1,171 patients (5,744 prescriptions).	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Boston Healthy Start Initiative

Brief Description or Objective	The Boston Healthy Start Initiative (BHSI) is a grant funded program designed to improve birth outcomes and eliminate birth outcome disparities among women in Boston. BHSI allows Bowdoin Street Health Center (BSHC) to provide a dedicated Community Health Worker (CHW) to support its high-risk prenatal patients. As one of five sites funded by the Boston Public Health Commission, BSHC serves pregnant Black women by providing support and case management, making connections to a skilled public health nurse, engaging and supporting fathers or significant others, and providing support around maternal and child nutrition, including breastfeeding support.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By the end of FY21, the Healthy Start Family Partner will serve 100 clients total including 50 pregnant and 50 others (interconception/parenting).	In FY21, the Family Partner served 140 total patients including 49 prenatal mothers, 41 postnatal mothers, and 50 children.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Disease Management
Program Name: Diabetes, Hypertension, and Asthma

Brief Description or Objective	With more than 50% of disease attributable to health behaviors, BIDMC and its affiliated and/or licensed Community Health Center (CHC) providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. BIDMC's affiliated federally qualified health centers (FQHC) also screen and educate patients for diabetes, hypertension and asthma, provide evidence-based care and treatment, and work with BIDMC to ensure access to needed specialty care. BIDMC also supports the Live and Learn Diabetes Program at Charles River Community Health (CRCH), which proactively contacts diabetes patients who are overdue for care.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By 9/30/21, 100% of CRCH Medical Assistants (MAs) will be trained to use EMR prompts to identify health center patients with diabetes when they come in for care for any reason.	In FY21, CRCH had significant turnover in MAs, CRCH continues to train MAs and providers on the use of the CRCH prevention and wellness template to identify care gaps. In addition, 100% of MAs are trained to use the CRCH Pre-Visit Planning (PVP) document during all visits that alert them to actions they can take during any visit.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By 9/30/21, CRCH MAs will proactively reach out to patients in need of care by using diabetes registry and documentation of HbA1C checks within the last 12 months, with a goal of 69%.	68.5% of HbA1C levels were checked within the last 12 months.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

By 9/30/2021, <30% of CRCH patients ages 18-75 with a diagnosis of diabetes will have HBA1c > 9% or no test recorded.	In FY21, 31.5% of CRCH patients ages 18-75 with a diagnosis of diabetes had an HBA1c>9% or no test recorded. COVID-19 halted/delayed most in-clinic screenings.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
By 9/30/2021, 75% of CRCH patients 18-85 years of age with hypertension will have hypertension controlled (<140/90).	In FY21, 58.2% of CRCH patients 18-85 years of age with hypertension had hypertension controlled (<140/90).	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
In FY21, the percent of CCA FQHC adults with diabetes whose condition is controlled (HbA1c < 9) will be higher than 70%.	73% of adults with diabetes had HbA1C < 9 in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
In FY21, the percent of CCA FQHC adults with hypertension whose blood pressure is < 140/90 will increase from 71% in FY20.	51% of patients with hypertension had blood pressure < 140/90 in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
The affiliated federally qualified health centers will serve patients with diabetes, hypertension, and asthma.	The health centers collectively served 4,857 diabetic patients (of which 19% were Hispanic/Latino and 10% were Black/African American); 12,359 patients with hypertension (of which 14% were Hispanic/Latino and 10% were Black/African American); and 4,237 patients with persistent asthma in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Disease Management
Program Name: Community Health Workers

Brief Description or Objective	The Community Health Worker (CHW) program at Bowdoin Street Health Center (BSHC) involves integrating a CHW into the care of patients with complex medical and social needs who often struggle with adherence to care. CHWs work alongside medical home team-based nurse care managers and social workers to provide integrated care management to existing high risk patients referred by the multi-disciplinary Care Management Team (CMT) and providers.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By the end of FY21, BSHC CHWs will provide supportive intervention to at least 200 referred patients.	In FY21, CHWs responded to 438 patient referrals.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, CHWs will respond to at least 100 on-call requests for intervention.	In FY21, CHWs responded to 85 on-call requests for intervention.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Throughout FY21, each CHW will carry a case load of at least 30 patients and provide ongoing support and intervention to those 30 patients.	In FY21, CHWs carried an average case load of at least 74 patients and provided ongoing support and intervention to those patients.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Diseases Management
Program Name: Reducing Disproportionate Burden of Cancer in Diverse Communities

Brief Description or Objective	BIDMC participates in the Dana Farber/Harvard Cancer Center (DF/HCC) and its' Faith-Based Cancer Disparities Network, facilitating educational and outreach programs with 10 churches and the Black Ministerial Alliance (now known as BMA TenPoint). BIDMC also participates in the Dana Farber/Harvard Cancer Center (DF/HCC)'s Initiative to Eliminate Cancer Disparities 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. BIDMC's Social Work department supports cancer patients by helping them understand social security benefits, disability benefits, insurance coverage and other financial programs. Additionally, they provide temporary housing to individuals undergoing treatment. Patients and families are also connected to individuals who have been in similar circumstances for support.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, BIDMC will increase the number of mammograms done at CHCs from 495 mammograms at Fenway Health, and 4,727 mammograms at South Cove Community Health Center in FY20.	On-site mammography services were offered at Fenway Health and South Cove Community Health Center. In FY21, 350 patients received mammograms at Fenway Health and 756 patients received mammograms at South Cove Community Health Center. These totals were impacted by COVID-19.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC patients will have access to a Cancer Patient Navigator.	In FY21 the BIDMC Cancer Patient Navigators worked with 421 unique patients and totaled 1,953 encounters.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC's Social Work Department will offer cancer support groups.	BIDMC hosted 6 different types of cancer support groups in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC will provide low-income individuals with mammograms.	1,855 low-income individuals received a mammogram at BIDMC in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

In FY21, BIDMC will provide low-income individuals with colon cancer screenings.	1,331 low-income individuals received a colon cancer screening at BIDMC in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, the Faces of Faith photo exhibit will be displayed publicly at BIDMC.	COVID-19 pre-empted on-site displays featuring Faces of Faith in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC will participate in the Patient Navigator Network.	In FY21, the Patient Navigator Network met virtually to discuss barriers and solutions to ensure quality and effective integration of navigation services.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Diseases Management
Program Name: HIV/HCV Coinfection Screening, Prevention, and Treatment

Brief Description or Objective	A BIDMC infectious disease consultant is contracted with The Dimock Center to provide screening, care, and education regarding Human Immunodeficiency Virus (HIV)/Hepatitis C Virus (HCV) co-infection on-site at The Dimock Center every week. The care and service include a special focus on access to care, initiation, and completion of state-of-the-art HCV therapy. Making these services available at The Dimock Center reduces access barriers for patients who are particularly vulnerable and who otherwise might not receive the latest regimen or be able to access or complete treatment. This program also has a BIDMC infectious disease liaison from The Dimock Center to the BIDMC Liver Center for full engagement and advocacy for vulnerable patients to promote successful treatment outcomes.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By the end of FY21, The Dimock Center will screen over 80% of HIV+ patients for HCV.	98% of HIV+ patients were screened for HCV.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, the number of visits to The Dimock Center attended by an infectious disease physician will be 50 visits over 6 months.	55 visits with 110 patients were attended by an infectious disease physician.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, the number of HIV/HCV co-infected patients who have begun HCV treatment will be at least 4.	The number of HIV/HCV co-infected patients who have begun HCV treatment was 3.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Active Living and Healthy Eating Programs

Brief Description or Objective	The Wellness Center at Bowdoin Street Health Center (BSHC) contains a demonstration kitchen, a large exercise room for dance and physical activity classes, and a gym with work-out equipment. The Wellness Center offers Bowdoin/Geneva residents the opportunity to learn and practice healthy habits in their own neighborhood. The Fitness in the City (FITC) program offered by BSHC is a team-based approach to weight management that actively involves a provider, nutritionist, and case manager in ongoing care planning for each participant. The intervention includes referrals to physical activities, connection to nutrition resources, and referral to mental health counseling when appropriate. BMI check-ups for all children who are obese or at-risk for obesity are monitored on a regular basis. To address food insecurity caused and/or exacerbated by COVID-19, BIDMC partnered with Community Health Centers (CHC) and other organizations to improve food access. BSHC delivered bi-weekly food boxes for health center patients who identified as food insecure. The Dimock Center addressed food insecurity among patients and community residents through a gift-card based program which provides flexibility and independence for individuals to purchase necessary food and household items.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, BSHC will provide case management for youth ages 5 - 18 to address issues related to childhood obesity.	In FY21, youth met virtually and participated in facilitated group discussions with topics ranging from healthy eating to stress caused by COVID-19.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BSHC will provide food boxes to 125 unique families.	BSHC provided 2,925 boxes to 125 unique families in FY21.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Public Safety**		
Brief Description or Objective	Public safety is of concern within BIDMC's local neighborhoods, including the Bowdoin/Geneva area. BIDMC's police and public safety presence contributes to a sense of well-being. The medical center has an excellent cooperative working relationship with the Boston Police Department (BPD) and provides support in the Longwood Medical Area and to Bowdoin Street Health Center (BSHC). BIDMC's officers are deputized by the Suffolk County Sheriff's Department and granted special police powers by the Massachusetts State Police.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Public Safety will implement a preventive maintenance schedule for all exterior call boxes, parking garage call boxes and panic switches at nurse's stations and admin areas.	Preventive maintenance continues to take place to ensure the safety of patients, employees, and the community.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Environmental Sustainability

Brief Description or Objective	BIDMC is actively engaged in creating a vibrant, sustainable community that fosters healthy lifestyles, enhances quality of life, and improves environmental conditions. BIDMC collaborates with grass-roots level partners and city and state government to address environmental 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, BIDMC is implementing an Environmental Strategic Plan, spearheaded by BIDMC's multi-departmental Sustainability Committee. BIDMC's operational practices will have a direct impact on its communities and BIDMC will always have the responsibility to evaluate business practices to ensure that "we do no harm" for the future of our patients and our staff. BIDMC is committed to conserving natural resources, reducing its carbon footprint, fostering a culture of sustainability, and advancing cost-saving opportunities. BIDMC pledges to continually improve environmental performance by balancing economic viability with environmental responsibility.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By the end of FY21, BIDMC will decrease greenhouse gas emissions related to anesthetic gases by over 50% by transitioning away from desflurane, a potent greenhouse gas.	This was achieved through the removal of desflurane from BIDMC's inventory and a focus on reducing sevoflurane usage. BIDMC is continuing to evaluate strategies to reduce nitrous oxide.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
By the end of FY21, BIDMC will decrease greenhouse gas emissions related to employee commuting by 5% due to transitioning to support remote work and decrease single occupied vehicles during COVID-19.	Fewer employees commuted to work in FY21; remote work policies are being monitored.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
By the end of FY21, BIDMC Food Services will increase total sustainable and local food & beverage spend to over 20%.	In FY21, BIDMC Food Services achieved 16.16% sustainable and local food & beverage spend.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcomes Goal
By 2030, BIDMC will have achieved Zero Waste (80% diversion from landfill or incineration).	In FY21, BIDMC developed a Zero Waste Strategic Action Plan through a yearlong cross-departmental planning effort.	Program Year: Year 2 Of X Years: Year 9 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Village in Progress Program in Bowdoin/Geneva Neighborhood**	
Brief Description or Objective	Bowdoin Street Health Center's (BSHC) Village in Progress (VIP) program supported by the Boston Public Health Commission works to prevent violence by building knowledge, capacity, and community cohesion, while also providing tools and improving health care access. The Bowdoin/Geneva VIP outreach team includes a resident Block Captain and a VIP Coordinator who engage in a door-to-door campaign and community organizing activities. Particular focus areas of VIP are to strengthen resident and community engagement; increase access to leadership opportunities for youth; coordinate community actions in the event of homicides and shootings to promote peace and non-violence; and a commitment to changing the expectation of violence in the community to ensure residents in the Bowdoin/Geneva neighborhood have access to quality services, resources, and support.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
By the end of FY21, VIP will continue to sustain communities and empower residents by building knowledge, capacity, and community.	VIP continues to sustain communities and uplift residents.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY22, VIP will develop 5 new community leaders that are dispersed throughout the area through partnerships with civic associations.	VIP is in the process of recruiting 3 adult community members and 2 youth community members.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Center for Violence Prevention and Recovery**	
Brief Description or Objective	Through its Center for Violence Prevention and Recovery (CVPR), BIDMC leads the way in developing a continuum of education, outreach, and treatment interventions to respond to victims of interpersonal, sexual, community violence, and homicide bereavement. It is also a leader in developing programming to address secondary traumatic stress among domestic violence and medical service providers. In response to sexual, domestic, and/or interpersonal violence, CVPR provides individual and group support and counseling (inpatient and outpatient), trauma-informed policies and programs, and advocacy. For those patients with severe safety concerns following interpersonal assault, BIDMC provides Safebeds, a place for a survivor to remain in the hospital overnight. CVPR's community violence initiatives include neighborhood-based support groups, individual counseling, outreach, training, and advocacy. CVPR's human trafficking intervention program will provide training to medical professionals and offer identification and acute intervention for patients entering the medical system.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
By the end of FY21, CVPR will provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence in the Greater Boston Area.	CVPR provided support to 619 victims of domestic, sexual, and community violence in the Greater Boston area in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, CVPR will provide services to survivors of sexual violence in the Emergency Department.	CVPR provided direct services to 26 survivors of sexual violence in the Emergency Department.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
CVPR will provide free overnight stays for domestic violence victims without safe shelter.	In FY21 CVPR provided free overnight stays to 11 domestic violence victims who were without safe shelter.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, CVPR will provide education and outreach services to 50 health centers, colleges and universities, and other community groups around	Training was provided to approximately 41 groups in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

sexual assault, interpersonal violence, community violence, secondary traumatic stress, and human trafficking.		
By the end of FY21, CVPR will provide 50 peace circles to community members in the Greater Boston area.	64 peace circles took place in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, CVPR will provide services to one or more community groups around issues of secondary traumatic stress.	CVPR provided services to one community group on a monthly basis around issues of secondary traumatic stress.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Neighborhood Trauma Team**	
Brief Description or Objective	Bowdoin Street Health Center (BSHC) plays the lead agency role for the Bowdoin Geneva Greater Four Corners Neighborhood Trauma Team (NTT). As the lead healthcare agency, BSHC partners with Greater Four Corners Action Coalition (GFCAC) and provides outreach to individuals, families, and neighborhoods impacted by community violence. The NTT functions as a hub team comprised of a licensed clinical social worker, a Family Partner/Community Health Worker, other staff members throughout the health center, and community organizers from GFCAC. The NTT assesses trauma-related community needs to support and deliver prevention, response, and short- and long-term recovery services. These services are intended to support existing neighborhood strategies and all services are free and private to residents impacted by community violence.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
By the end of FY21, NTT will respond to every incident of homicide or stabbing within BSHC's catchment area and offer outreach to victims and impacted residents.	NTT responded to 100% (36 total) of incidents occurring within the BSHC catchment area.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, BSHC will provide direct therapeutic sessions to children, adults, and their families who have been impacted by violence.	BSHC provided over 800 therapeutic sessions to children, adults, and families impacted by violence.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Youth Leadership**		
Brief Description or Objective	The Youth Leadership Program (YLP) at Bowdoin Street Health Center (BSHC) serves youth ages 14-17 and is focused on helping teens in the Bowdoin/Geneva neighborhood develop strong personal leadership skills, contribute to positive community change and violence prevention, while earning a stipend in the process.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
At the end of FY21, YLP will graduate at least 25 youth leaders.	10 youth leaders graduated in FY21.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, BSHC will seek and obtain additional philanthropic funding to continue and sustain the program through year seven.	BSHC obtained additional philanthropic funds to support the program through year seven.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Education and Workforce Development

Brief Description or Objective	BIDMC is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BIDMC offers incumbent employees pipeline programs to train for professions such as a Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BIDMC's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BIDMC is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs. Lastly, BIDMC provides paid summer jobs to introduce high school students to careers in the medical field.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, Workforce Development will increase the number of community referrals and hires each year.	In FY21 over 200 job seekers were referred to BIDMC and 40 referrals from our community partners were hired.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, Workforce Development will continue to hire young people from the community despite COVID-19 barriers.	In FY21 Workforce Development hired 32 young people for paid, virtual, summer jobs.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, Volunteer Services will rebuild the volunteer program after having been suspended due to the pandemic; 200 volunteers will be on-boarded by the end of FY21, with at least 25% of new volunteers being from the Community Benefits Service Area (CBSA).	Volunteer Services on-boarded 218 volunteers by the end of FY21, 90 of whom were from the CBSA.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Community-based Health Initiative: Housing Affordability Grants

Brief Description or Objective	BIDMC, through its Community-based Health Initiative (CHI), is investing in local organizations to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families. To date, BIDMC has awarded funds to seven organizations for a three-year grant period which began January 2021. The funded organizations are: • Asian Community Development Corporation (ACDC): Working with the Chinese Progressive Association (CPA) to help low-income immigrants in Chinatown achieve housing stability and reduce displacement • BAGLY: Launching Host Homes (HH) program to support unstably-housed and homeless LGBTQ+ youth between the ages of 18-24 • Bridge Over Troubled Waters: Expanding outreach efforts to homeless youth and young adults (YYA) to provide housing interventions to those reached • City Life/Vida Urbana: Working to stabilize low-income families by halting a wave of current and expected no-fault evictions caused by rapid development through its Anti-Displacement Zones for Health: Roxbury program • Fenway Community Development Corporation (FCDC): Changing city and state housing policy to stop displacement through coalition-based tenant and resident organizing • Metro Housing|Boston: Conducting a rigorous study to determine if modifying the rent calculation in the Housing Choice Voucher Moving to Work program will have an impact on reducing cliff effects for working families • Opportunity Communities: Piloting a home ownership program to benefit households harmed by housing discrimination
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Over the grant period, CHI grantees will make progress toward reducing homelessness, reducing displacement, increasing homeownership, and implementing advocacy/policy change to address housing affordability for residents who live, work, and play in Boston.	CHI grantees are beginning program implementation and data collection to measure progress against this goal.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcomes Goal

Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by: • Developing logic models • Attending 6 Evaluation Learning Collaborative sessions • Participating in monthly individual technical assistance meetings with CHI independent evaluator	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal
In FY21, CHI grantees will set up data infrastructure and establish common measures of program impact.	CHI grantees: • Selected common implementation and outcome measures as part of a collaborative effort during the 6-month evaluation planning process • Completed data use agreements • Finalized the data collection process/ to share data with CHI independent evaluator	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Community-Based Health Initiative: Jobs and Financial Security Grants

Brief Description or Objective	BIDMC, through its Community-based Health Initiative, is investing in local organizations to increase employment and earnings and increase financial security. To date, BIDMC has awarded funds to six organizations for a three-year grant period which began January 2021. The funded organizations are: • BAGLY: Providing wraparound services to Host Home participants including, but not limited to, job preparedness and skill building • Bridge Over Troubled Waters: Providing evidence-based services to homeless youth for acquisition of job-specific and soft skills • Community Servings: Launching a food-based social enterprise as part of the re-design of its Teaching Kitchen culinary training transitional jobs program • English for New Bostonians: Expanding the English for Immigrant Entrepreneurs program that enables business owners/employees/aspiring entrepreneurs to improve English, expand customer markets, access business assistance, and support recovering local economies • Metro Housing|Boston: Reimbursing the difference between pre-tax gross and post-tax net income on a monthly basis to show the long-term financial impact of providing equal financial opportunity to working families • Sociedad Latina: Expanding its Latino, English Learner, and Immigrant Youth program which allows youth to participate in year-round paid internships
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Over the grant period, CHI grantees will make progress toward increasing employment and earnings and increasing financial security for residents who live, work, and play in Boston.	CHI grantees are beginning program implementation and data collection to measure progress against this goal.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcomes Goal

Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by: • Developing logic models • Attending 6 Evaluation Learning Collaborative sessions • Participating in monthly individual technical assistance meetings with CHI independent evaluator	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal
In FY21, CHI grantees will set up data infrastructure and establish common measures of program impact.	CHI grantees: • Selected common implementation and outcome measures as part of a collaborative effort during the 6-month evaluation planning process • Completed data use agreements • Finalized the data collection process/ to share data with CHI independent evaluator	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community-based Health Initiative: Healthy Neighborhoods**		
Brief Description or Objective	BIDMC, through its Community-based Health Initiative, launched its Healthy Neighborhoods Initiative (HNI) to build neighborhood and resident capacity and facilitate collective action to address neighborhood-specific concerns that may vary depending on geography, demographics, resource availability, and other factors. Selected collectives will use funds awarded through HNI to address specific opportunities in their community, drawing on the strengths found in each neighborhood.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
In FY21, BIDMC's Allocation Committee will select two community collectives, one each from the Boston neighborhoods of Bowdoin/Geneva and Fenway/Kenmore.	In FY21, BIDMC selected one collective in Bowdoin/Geneva and one in Fenway/Kenmore.	Program Year: Year 1 Of X Years: Year 2 Goal Type: Process Goal`
In FY21, two community collectives in Boston engaged with the community to determine priority areas for investment.	In FY 21, the community collectives: • Healthy Bowdoin/Geneva: Administered a 40 question community survey available online and in print in four languages, gathering 280 responses; held 2 community meetings attended by 49 individuals; and held 4 focus groups • We're Here for You: Fenway/Kenmore: Began planning process for community engagement for activities to begin in early FY22	Program Year: Year 1 Of X Years: Year 2 Goal Type: Process Goal`

Priority Health Need: Social Determinants of Health **Program Name: Chelsea Programs Addressing Social Determinants of Health**		
Brief Description or Objective	BIDMC, as part of Beth Israel Lahey Health's (BILH) investment in a Gateway Municipality (GwM), funded Chelsea Eats and the Chelsea Legal Aid Bureau. Chelsea Eats is an innovative pilot program launched by the City of Chelsea that provides residents with monthly debit cards. The Chelsea Legal Aid Bureau provides legal services and representation to Chelsea residents, regardless of their income, immigration, or citizenship status, who are facing eviction and landlord disputes. BIDMC also supported GreenRoots in establishing the Health Equity Corps in 2020 to address the social determinants of health in the City of Chelsea and assess the impact of COVID-19 in the City. The Health Equity Corps work to support their community by providing stipends to those in need. Stipends were provided for housing needs and other requests.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
In FY21, BIDMC, as part of Beth Israel Lahey Health's (BILH), will invest in programs to address food insecurity and housing instability.	In FY21, BIDMC provided funding support for the Chelsea Eats program and the Chelsea Legal Aid Bureau.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
In FY21, GreenRoots Health Equity Corps will provide financial support to residents in need who reside in the City of Chelsea.	In FY21, 31 families, a total of 65 individuals, who are immigrant and/or undocumented families received funding from GreenRoots Health Equity Corps.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Boston CHNA-CHIP Collaborative

Brief Description or Objective	The Boston CHNA-CHIP Collaborative, of which BIDMC is a founding member, is an initiative among a number of stakeholders - community organizations, health centers, hospitals and the Boston Public Health Commission - formed to undertake the first city-wide Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) for the City of Boston. This Collaborative aims to achieve the benefits of broad partnership around a Boston-based CHNA and CHIP, including deeper engagement of key community and organizational stakeholders; enhanced alignment of defined priorities and strategies; maximal allocation of resources; coordination of implementation strategies for collective impact and a healthier Boston.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, maximize resources from all entities and encourage collaborative initiatives.	Collaboration is taking place across working groups.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcomes Goal
BIDMC will participate in a City-wide CHNA-CHIP process that was transparent, inclusive and comprehensive.	CHNA Completed in 2019.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
In FY21, conduct an annual meeting to share CHNA-CHIP progress and get feedback on strategy Development.	In early December 2020, the virtual annual meeting was attended by 125 people with translation available in 4 languages. Closed Captioning was also provided in the meeting.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
Establish and implement 4 subcommittees on CHNA priorities with diverse, cross-sectoral representation to engage Boston residents and organizational representatives in strategy development and action plan implementation.	All working groups are established and are working to implement the CHIP.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Outcomes Goal

Priority Health Need: Social Determinants of Health
Program Name: Infrastructure to Support Community Benefits Collaborations across BILH Hospitals

Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with Mass General Brigham (MGB), has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By September 30, 2021, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits Committee data to more accurately capture and quantify CB/CR activities and expenditures.	All 20 BILH Community Benefits staff were trained on the Community Benefits Database and began data entry for FY20 regulatory reporting.	Program Year: Year 1 Of X Years: Year 2 Goal Type: Process Goal
By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies.	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement.	Program Year: Year 1 Of X Years: Year 2 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Community-Based Health Initiative: Behavioral Health Grants**	
Brief Description or Objective	BIDMC, through its Community-based Health Initiative, is investing in local organizations to increase access to high-quality and culturally and linguistically appropriate mental health and substance use services. To date, BIDMC has awarded funds to nine organizations: • African Community Development of New England (ACEDONE): Enhancing its current capacity to serve the mental health needs of the African immigrant community in Roxbury in culturally-informed ways • BAGLY: Providing free mental health and behavioral health wraparound services to Host Home participants • Boston Chinatown Neighborhood Center (BCNC): Expanding its capacity to provide Mental Health First Aid (MHFA) and hosting a series of virtual workshops to raise awareness on mental health issues and reduce the cultural stigma about seeking support services • Bridge Over Troubled Waters: Providing evidence-based behavioral health care, harm reduction, motivational interviewing, cognitive behavioral therapy, dialectical behavior therapy, and crisis prevention to homeless youth • Charles River Community Health (CRCH): Launching a bi-lingual/bi-cultural program to build its capacity to provide integrated care with the primary care providers that serve Limited English Proficient (LEP) patients • Fathers' Uplift: Providing a combination of emotional, behavioral, and physical health support for fathers struggling with substance abuse, trauma, racism, a history of incarceration, and/or systemic barriers • Greater Boston Chinese Golden Age Center (GBCGAC): Implementing Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), a depression self-management system designed to detect and reduce the severity of depressive symptoms in older adults with chronic conditions and functional limitations • North Suffolk Mental Health Association: Providing intensive case management exclusively for uninsured and underinsured Chelsea immigrant residents • The Family Van: Adapting and delivering Problem Management Plus (PM+), an evidence-based behavioral health intervention led by Community Health Workers for people experiencing mild to moderate depression and anxiety

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits		
Program Goal(s)		**Goal Status**	**Goal Year and Type**
Over the grant period, CHI grantees will make progress toward improving mental health and substance use outcomes for residents who live, work, and play in Boston.		CHI grantees are beginning program implementation and data collection to measure progress against this goal.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcomes Goal
Over the grant period, CHI grantees will increase their evaluation capacity.		CHI grantees increased their evaluation capacity by: • Developing logic models • Attending 6 Evaluation Learning Collaborative sessions • Participating in monthly individual technical assistance meetings with CHI independent evaluator	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal
In FY21, CHI grantees will set up data infrastructure and establish common measures of program impact.		CHI grantees: • Selected common implementation and outcome measures as part of a collaborative effort during the 6-month evaluation planning process • Completed data use agreements • Finalized the data collection process/ to share data with CHI independent evaluator	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use
Program Name: Facilitating Access

Brief Description or Objective	To increase access to mental health services, BIDMC has implemented the Collaborative Care model, a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a Beth Israel Lahey Health licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions. Bowdoin Street Health Center (BSHC) also works to integrate behavioral health services into their primary care clinic through the Integrated Behavioral Health Clinician (IBHC). The IBHC provides co-located, collaborative care within the primary care clinic and serves as a consultant to primary care staff to provide clinical interventions for patients that are based on brief, functional assessments rather than traditional specialty mental health assessments and interventions. BIDMC's Social Work department provides support groups to individuals to help establish a community of support. The hospital provides over 10 different support groups to provide a network for individuals experiencing medical difficulties ranging from cancer, to pregnancy loss to COVID-19 survivors.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, BIDMC will increase access to behavioral health services through the Collaborative Care model.	BIDMC provided behavioral health services to 208 patients in FY21 through the Collaborative Care model.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, BSHC's Behavioral Health (BH) Team will provide at least 150 Integrated Behavioral Health Consultations in Primary Care Clinic.	The BH Team provided 71 integrated Behavioral Health consultations in the Primary Care Clinic.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, the BSHC Primary Integrated Behavioral Health Clinician will provide at least 600 individual therapy sessions.	Primary Integrated Behavioral Health Clinician provided 736 individual therapy sessions.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Every year the BIDMC Social Work Department will provide a total of 12 support groups.	In FY21, the Social Work team held 12 support groups that met 192 times, serving a total of 1,281 patients.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Substance Use Services**	
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 youth and people with substance use disorders and those at risk of developing substance use disorders. SBIRT screening quickly assesses severity of substance use and helps providers identify appropriate treatments. SBIRT is recommended by the Institute of Medicine. Patients are asked about alcohol use, and those with an identified issue are provided discharge instructions including contacts for alcohol use counseling. BIDMC also has an Opioid Care Committee that works to prevent Opioid Use Disorder and to improve the care of patients with an Opioid Use Disorder. The goals of the committee includes implementing a comprehensive team approach to addiction treatment; achieving best practices for opioid use in assessment, treatment, and continuity of care for acute and chronic pain management; improving management and control systems for opioid use and misuse; and complying with Federal and State regulatory requirements regarding opioid management.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
By the end of FY21, increase collaboration with 3 community providers to improve access to addiction services.	Active collaboration with community providers has been impacted by COVID-19, however, an addictions social worker has expanded access to addiction services through community outreach.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Focus on prevention in collaboration with trauma coordinator and provide education and outreach to two community service agencies on a quarterly basis.	Trauma prevention coordinator continues to provide educational workshops to community agencies on a regular basis; COVID-19 has required workshops be conducted virtually.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Equitable Care
Program Name: Center for Diversity, Equity, and Inclusion

Brief Description or Objective	The Center for Diversity, Equity, and Inclusion, formerly the Office for Diversity and Inclusion, was created and charged with working with Department Chairs to increase recruitment and retention of under-represented minority and women faculty, and to oversee data collection on health care disparities at BIDMC. The Center for Diversity, Equity, and Inclusion actively participates in unconscious bias training and works with the Center for Education to improve recruitment and retention of medical professionals from underrepresented groups. The Center for Diversity, Equity, and Inclusion also participates in several informal activities and events aimed at increasing awareness of the relevance of professional diversity for the expert and compassionate treatment for BIDMC's diverse family of patients. Beth Israel Lahey Health (BILH), has also created a multi-year plan to guide its efforts to nurture and sustain a diverse, equitable and inclusive organizational culture and to make meaningful and lasting change for its patients, employees, and communities.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By the end of FY21, a professional Underrepresented in Medicine (UriM) recruitment video will be made with trainees from all departments.	The professional UriM recruitment video is 50% completed.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, a strategic institution-wide DEI assessment plan will be created.	Currently using the data from the DEI assessment plan for data analysis. Also sending out follow-up surveys to departments.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Equitable Care
Program Name: Evidence-Based Strategies and Research

Brief Description or Objective	The Institute of Medicine's report, *Unequal Treatment*, focused the nation's attention on disparate care and health outcomes among the U.S. populace. BIDMC's clinical and research community embraced the challenges of advancing knowledge about the root causes of racial and ethnic health disparities, and developing evidence-based strategies to improve health status of affected groups. 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. BIDMC also participates in the Boston Breast Cancer Equity Coalition (BBCEC), which is made up of Boston hospitals, MA Department of Public Health, Boston Public Health Commission and various other organizations that serve racially/ethnically diverse populations in Boston. The vision of the BBCEC is to eliminate the differences in breast cancer care and outcomes by promoting equity and excellence in care among all women of different racial/ethnic groups in the City of Boston.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
In FY21, BIDMC will advance knowledge about causes and remedies of health disparities.	Researchers/clinicians engaged in health disparities research efforts through 51 unique research studies.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY21, Nurse Navigators will identify and enroll 85 medically underserved patients with breast cancer in the social needs assessment program.	In FY21, Nurse Navigators enrolled 104 BIDMC patients in Translating Research Into Practice.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY21, BIDMC will participate in multi-institutional collaborations to reap synergies and share knowledge.	In FY21, BIDMC faculty and staff participated in DF/HCC, Harvard Catalyst, Harvard School of Public Health, BBCEC, and other multi-institutional collaborations.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$6,336,526	$0
Community-Clinical Linkages	$5,037,119	$0
Total Population or Community Wide Interventions	$7,513,809	$3,780,044
Access/Coverage Supports	$20,043,620	$3,339,787
Infrastructure to Support CB Collaborations	$97,250	$31,250
Total Expenditures by Program Type	**$39,028,324**	**$7,151,081**
CB Expenditures by Health Need		
Chronic Disease	$19,923,836	
Mental Health/Mental Illness	$5,705,824	
Substance Use Disorders	$3,420,043	
Housing Stability/Homelessness	$1,825,016	
Additional Health Needs Identified by the Community	$8,153,605	
Total Expenditures by Health Need	**$39,028,324**	
Total Community Benefits Program Expenditures	**$39,028,324**	
Leveraged Resources		
Total Leveraged Resources	$4,733,673	
Net Charity Care Expenditures		
HSN Assessment	$13,021,079	
Free/Discounted Care	N/A	
HSN Denied Claims	($5,767,040)	
Total Net Charity Care	$7,254,039	
Total CB Expenditures	**$51,016,036**	

Additional Information	
Net Patient Services Revenue	$1,557,400,000
CB Expenditure as % of Net Patient Services Revenue	3.28%
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	$39,028,324
Bad Debt	$12,152,530
Bad Debt Certification	
Optional Supplement	Total Charity Care is $99,953,887and includes BIDMC's payment of $13,021,079 to the Health Safety Net; $45,826,725 in unreimbursed Medicare Services; $28,953,553 in unreimbursed MassHealth Services; $12,152,530 in bad debt. In addition, BIDMC made a contribution of $3,503,682 representing BIDMC's voluntary PILOT payment to the City of Boston, which contributes to the health and well-being of individuals residing in its Community Benefits Service Area. Additionally, BIDMC paid $780,280 to the Center for Health Information and Analysis (CHIA) and $238,318 to the Health Policy Commission (HPC).
Comments	In FY 21, Beth Israel Lahey Health and its member hospitals, in collaboration with Mass General Brigham, designed, built, and launched a new Community Benefits Reporting Tool (CBRT). The CBRT allows our teams and community partners to more accurately capture, track, and report data related to community benefits programs and initiatives. As part of our design and launch of the CBRT, the BILH and MGB teams undertook a multi-faceted quality improvement project to improve the alignment of definitions and categories for program expenditure reporting across our member hospitals; this may be a contributing driver for differences in trend with AGO reporting categories.

SECTION VI: CONTACT INFORMATION

Robert Torres
Office of Community Benefits
Beth Israel Deaconess Medical Center
330 Brookline Ave, RP-802E, Boston, MA 02115
617-754-8064
Robert.Torres@bilh.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      BIDMC has worked to align its Community Benefits Advisory Committee (CBAC) membership to reflect the demographics included in BIDMC's Community Benefits Service Area (CBSA). BIDMC added the following members to the CBAC: Alberte Altine-Gibson (replacing Phillomin (Philly) Laptiste), Flor Amaya (replacing Luis Prado), Maia Betts (replacing Holly Oh), Alexandra Chéry Dorrelus (replacing Tina Chéry), Shondell Davis, Kira Khazatsky (replacing Jerry Rubin), and Melody Route-Satchell.

      BIDMC Community Benefits Advisory Committee Members: Alberte Altine-Gibson, Manager of Community Health, Bowdoin Street Health Center; Flor Amaya, Director of Public Health, Department of Human Services and Public Health, City of Chelsea; Walter Armstrong, Senior Vice President, Capital Facilities and Engineering, BIDMC; Maia Betts, Chief Behavioral Health Officer, The Dimock Center; Elizabeth Brown, Chief Executive Officer (CEO), Charles River Community Health; Alexandra Chéry Dorrelus, Co-Director, Louis D. Brown Peace Institute; Shondell Davis, Community Trauma Healing Specialist, Cory Johnson Center for Post-Traumatic Healing; Lauren Gabovitch, Case Manager, BIDMC; Richard Giordano, Director of Policy and Community Planning, Fenway Community Development Corporation; Nancy Kasen, Vice President, Community Benefits and Community Relations, Beth Israel Lahey Health (BILH); Barry Keppard, Public Health Director, Metropolitan Area Planning Council; Kira Khazatsky, Chief Operating Officer, Jewish Vocational Services; Angie Liou, Executive Director, Asian Community Development Corporation; James Morton, President and CEO, YMCA of Greater Boston; Sandy Novack, Social Worker, Universal Access Council; Alex Oliver-Davila, Executive Director, Sociedad Latina; Triniese Polk, Director of Racial Equity and Community Engagement, Boston Public Health Commission; Joanne Pokaski, Senior Director of Workforce Development and Community Relations, BIDMC; Jane Powers, Chief of Staff, Fenway Health; Richard Rouse, Advisory Board Member and former Executive Director, Mission Hill Main Streets; Melody Route-Satchell, Practice Manager, BIDMC; Robert Torres, Director of Community Benefits, BIDMC; LaShonda Walker-Robinson, Community Resource Specialist, BIDMC; Fred Wang, Executive Director, The Wang Foundation

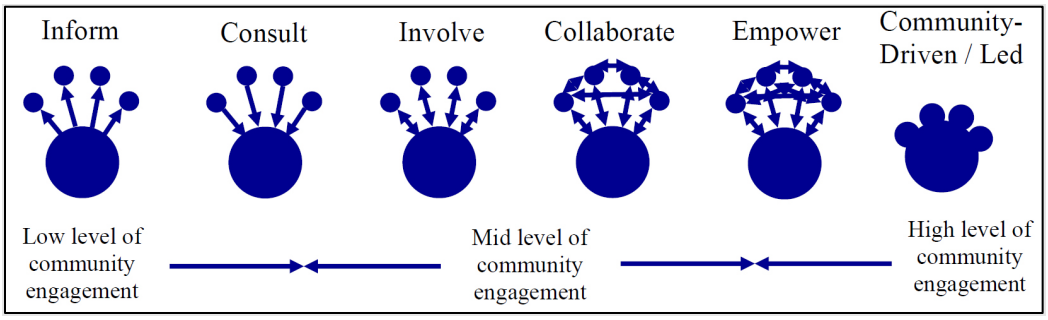
II. Community Engagement:

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

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Community Care Alliance	Maia Betts, Chief Behavioral Health Officer, The Dimock Center; Samantha Taylor, Executive Director, Bowdoin Street Health Center; Elizabeth Browne, Executive Director, Charles River Community Health; Ellen LaPointe, Chief Executive Officer, Fenway Health; Eugene Welch, Executive Director, South Cove Community Health Center	Community Health Centers	The Community Care Alliance (CCA) is a partnership among the community health centers licensed and/or affiliated with BIDMC. BIDMC supports the CCA and its health centers through technical assistance, resource sharing, and direct financial support. CCA community health centers assisted in expanding BIDMC's community engagement efforts in high need and historically underserved communities during the Community Health Needs Assessment (CHNA) and IS process. CCA community health center leadership hold positions on the committee overseeing the CHNA process.
YMCA of Greater Boston	Karina Teixera, Executive Director of Teen Development	Social service organizations	BIDMC is partnering with the YMCA on a paid program that actively involves teens who live, work, and play in BIDMC's Community Benefits Service Area (CBSA) in the CHNA and Implementation Strategy (IS) process. Youth involved in the process are actively participating to amplify youth voice in identifying opportunities and assets in their community for the CHNA and IS.
Boston Public Health Commission (BPHC)	Bisola Ojikutu, MD, Executive Director; Triniese Polk, Director of Racial Equity and Community Engagement	Local Health Department	BIDMC engages with BPHC on a number of programs, including the Cancer Ride Program, Safe Routes to Schools, emergency preparedness efforts, the Boston Healthy Start Initiative, and the Trauma Team at Bowdoin Street Health Center (BSHC). Additionally, BPHC is actively involved in the Boston CHNA-CHIP Collaborative, of which BIDMC is a founding partner and active member.

The Dimock Center	Danielle Wall; Resource Care Manager	Community Health Centers	BIDMC is collaborating with the Dimock Center to address food and economic insecurity among patients and community residents, which has been exacerbated due to the COVID-19 pandemic.
Bridge Over Troubled Waters	Peter Ducharme, Clinical Director; Arlene Snyder, Director of Program Development	Social service organizations	BIDMC is funding Bridge Over Troubled Waters to expand outreach to homeless youth and young adults (YYA) and provide housing, jobs/employment, and behavioral health interventions to those reached.

- Please use the spectrum below from the Massachusetts Department of Public Health[3] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



Category	**Level of Engagement**	**Did Engagement Meet Hospital's Goals?**	**Goal(s) for Engagement in Upcoming Year(s)**
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	BIDMC involved community members by hosting an annual meeting and four public CBAC meetings. Each meeting had time allocated for public comment, BIDMC posted all meeting materials online, and sent out community newsletters.	Collaborate

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

Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	BIDMC works closely with its' CBAC by seeking input during meetings to decide how community benefits resources should best be allocated. BIDMC also holds a public comment period during all CBAC meetings to ensure community members can share their communities' priorities. Community residents and local organizations are involved in reviewing Request for Proposals (RFP) and grant proposals.	Collaborate
Implementing Community Benefits programs	Empower	BIDMC worked with their CBAC and the Boston CHNA-CHIP Collaborative to craft the IS and continues their involvement through the CHNA-CHIP workgroups and CBAC meetings. BIDMC provides updates and solicits input from the CBAC to guide the implementation of Community Benefits programs that align with the IS. Through its grant-making process, the CBAC empowers local organizations to implement programs to address needs identified in the CHNA.BIDMC grant proposals are reviewed and selected by an Allocation Committee made up of residents and local stakeholders.	Empower
Evaluating progress in executing Implementation Strategy	Empower	The BILH Community Benefits department is refining data and metrics to better evaluate programming for the FY20 – 22 IS and preparing evaluation tools for the next IS cycle. In FY22, BIDMC will provide quarterly updates to the CBAC about program progress. BIDMC is also working closely with grantees and other community and program partners to provide evaluation training to enhance their capacity to evaluate their progress.	Empower
Updating Implementation Strategy annually	Consult	In FY20, BIDMC consulted the CBAC about recent and future updates to the IS. BIDMC will continue to consult the CBAC and community partners to review the IS and update it as needed.	Collaborate

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

  BIDMC remains committed to community engagement. During FY22, BIDMC will undertake its triennial CHNA and prioritization process. Guided by BIDMC's CBAC and conducted in collaboration with community partners, this initiative's guiding principles include community engagement, equity, collaboration and capacity building. In FY22, BIDMC will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, BIDMC will continue to engage with the community through the Community-based Health Initiative (CHI). The CHI Healthy Neighborhoods Initiative funds neighborhood collectives (existing or new) to develop and implement a community-driven and community-led project on behalf of their neighborhood. In FY22, BIDMC will fund two additional neighborhoods.

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

  For the FY21 reporting year, BIDMC dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. BIDMC was intentional when assessing risk factors within our CBSA and worked closely with local health department(s). Clinical staff provided infection control expertise to local health departments during their reopening plans. BIDMC worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. BIDMC redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. Additionally, working with BILH, BIDMC opened 2 vaccination sites in the community to vaccinate thousands of individuals including those disproportionately impacted by the pandemic. BIDMC also supported The Dimock Center by funding extra staff to help administer vaccines.

  While in-person meetings were hindered in the community, BIDMC sought creative ways of engaging with the community which included emailing quarterly newsletters, providing a public comment period at all CBAC meetings, and posting all CBAC meeting materials (agenda, slides, minutes, etc.) on BIDMC's website.

  Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the pandemic.

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

In FY21, BIDMC held four CBAC meetings that were open to the public. These meetings were held via Zoom on December 15, 2020, March 23, 2021, June 22, 2021, and September 28, 2021. BIDMC is committed to having transparent and open CBAC meetings. In an effort to engage the community during these meetings, each CBAC meeting had a dedicated time for public comments. BIDMC also accepted written public comments up to five business days prior to a meeting. Meeting agendas were

posted online seven business days prior to each meeting and all meeting materials (slides, minutes, etc.) were posted on the website within five business days after a meeting. Additionally, three newsletters were sent out to inform the community about the CHI and other Community Benefits updates. One of the newsletters informed the community about BIDMC's first cohort of grantees.

Additionally, BIDMC shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the 2019 triennial CHNA.

III. Updates on Regional Collaboration:

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

Nancy Kasen, Vice President, Community Benefits and Community Relations, BILH, served as founding Co-Chair for the 19-member Steering Committee that was formed to oversee the Boston CHNA-CHIP Collaborative and provide strategic direction on the Boston Community Health Improvement Plan. At the end of FY21, Nancy transitioned out of her role as co-chair, but remains an active member of the Collaborative. The Boston CHNA-CHIP Collaborative continues to meet virtually through its workgroups; BIDMC Community Benefits staff sit on the CHIP working groups to help carry out the goals outlined in the IS.

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

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

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

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

Appendix A: Partners

FY21 Partner	Level of Community Engagement	FY21 Partner	Level of Community Engagement
A Better City	Consult	HMS Diversity Affiliates	Collaborate
A Room to Grow	Involve	Hospitality Homes	Consult
About Fresh	Collaborate	Jane Doe Inc.	Collaborate
Adcare Treatment Center	Collaborate	Jewish Community Center (JCC) of Greater Boston	Collaborate
AIDS Action Committee	Consult	Jewish Family and Children's Services	Consult
AIDS Support Group of Cape Cod	Consult	Jewish Vocational Services	Involve
Alzheimer's Association of MA (Waltham)	Consult	Joe Andruzzi Cancer Fund	Involve
American Chinese Christian Education & Social Services, Inc.	Inform	Joslin Diabetes Center	Collaborate
Asian American Civic Association	Inform	Justice Resource Institute (JRI) in Boston	Involve
Asian Community Development Corporation	Community Driven/Led	La Alianza Hispana (Boston)	Consult
Audubon Circle Neighborhood	Consult	Leukemia & Lymphoma Society	Inform
Atrius Health	Collaborate	Louis D. Brown Peace Institute	Empower
BAGLY, Inc.	Community Driven/Led	Massachusetts Department of Environmental Protection (MassDEP)	Delegate
Brockton Area Multi Service Inc. (BAMSI)	Consult	Massachusetts Department of Transportation (MassDOT)	Inform
Boston Area Rape Crisis Center (BARCC)	Collaborate	Massachusetts Department of Public Health	Collaborate
Beth Israel Deaconess Healthcare	Community Driven/Led	Massachusetts Department of Public Health COVID-19 Pandemic Response	Collaborate
Beth Israel Deaconess Healthcare Chelsea	Community Driven/Led	Massachusetts Health Information Highway	Involve
Boston Children's Hospital	Collaborate	Mainspring	Inform
Boston Chinatown Neighborhood Center	Community Driven/Led	Medical Academic and Scientific Community Organization (MASCO)	Collaborate
Boston Elder Services	Involve	Mass College of Art and Design	Collaborate
Boston Emergency Medical Services	Empower	Massachusetts Insurance Commission	Consult
Boston Fire Department	Collaborate	Massachusetts Commission for the Blind	Community Driven/led
Boston Green Academy	Empower	Massachusetts Commission for the Deaf and Hard of Hearing	Involve
Boston Health Care for the Homeless Program	Consult	Massachusetts Department of Children and Families	Involve

FY21 Partner	Level of Community Engagement	FY21 Partner	Level of Community Engagement
Boston Hospital Collaboration for Community Violence	Involve	Massachusetts Department of Transitional Assistance	Inform
Boston Living Center	Involve	Massachusetts General Hospital	Collaborate
Boston Medical Center	Collaborate	Massachusetts HIV Drug Assistance Program	Involve
Boston MedFlight	Involve	Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA)	Inform
Boston Private Industry Council (PIC)	Collaborate	Massachusetts Institute of Technology	Empower
Boston Police Department	Collaborate	Massachusetts State Police	Collaborate
Boston Public Health Commission	Collaborate	Medical Intelligence Center	Collaborate
Boston University School of Public Health	Collaborate	Meetinghouse Hill Civic Association	Community Driven/Led
Brigham and Women's Hospital	Collaborate	Metro Housing|Boston	Community Driven/Led
Bowdoin Street Health Center	Empower	Mount Auburn Hospital	Collaborate
Cambridge Health Alliance	Collaborate	New England AIDS Education and Training Center	Consult
Cape Verdean Association of Boston	Community Driven/Led	Northeastern University	Inform
Cancer Care	Inform	Opportunity Communities	Community Driven/Led
Casa Myrna	Delegate	Operation P.E.A.C.E.	Consult
CHADD Mentoring Course, HMS	Inform	Outer Cape Health Services	Collaborate
Charles River Community Health	Collaborate	Partners for World Health	Collaborate
Circle of Hope	Collaborate	Peer Health Exchange	Empower
City of Boston Emergency Management Office	Collaborate	Pine Street Inn	Community Driven/Led
City of Boston's Green Ribbon Commission	Inform	Practice Green Health	Inform
City Life/Vida Urbana	Community Driven/Led	Private Industry Council	Collaborate
Conference of Boston Teaching Hospitals (COBTH)	Collaborate	RIA, Inc.	Collaborate
Community Research Initiative	Involve	Ryan White Dental Program	Involve
Community Servings	Community Driven/Led	Sexual Assault Nurse Examiner (SANE) Program	Collaborate
Cradles to Crayons	Involve	Sexual Assault Unit of Disabled Persons Protection Commission	Consult
Dana Farber Cancer Institute	Collaborate	Sociedad Latina	Community Driven/Led
Dorchester Catholic Parishes	Community Driven/Led	South Cove Community Health Center	Collaborate
Dorchester Food Co-Op	Community Driven/Led	Sportsmen Tennis and Enrichment Center	Collaborate
Ellie Fund	Inform	St. Peter's Teen Center	Collaborate
English for New Bostonians	Community Driven/Led	St. Mary's Center for Women and Children	Community Driven/Led

FY21 Partner	Level of Community Engagement	FY21 Partner	Level of Community Engagement
Eversource	Consult	Tasty Burger	Inform
Fair Foods (Boston)	Inform	The Family Van	Community Driven/Led
Family Nurturing Center	Collaborate	The Dimock Center	Collaborate
Father Bill's	Inform	The Latino Medical Student Association	Collaborate
Fathers' Uplift	Community Driven/Led	The Network/La Red	Collaborate
Fenway Alliance	Consult	The Partnership, Inc.	Empower
Fenway Civic Association	Consult	The Student National Medical Association, National and NE Chapter	Collaborate
Fenway Community Center	Consult	Training, Inc.	Collaborate
Fenway Health	Community Driven/Led	Trustees of Reservations	Collaborate
Found in Translation	Consult	Tufts Medical Center	Collaborate
Friends of Geneva Cliffs	Community Driven/Led	UP Academy Dorchester School	Community Driven/Led
Friends of Ronan Park	Community Driven/Led	U.S. Environmental Protection Agency (EPA)	Collaborate
GLAAD	Inform	United Cerebral Palsy (Watertown)	Involve
Greater Boston Chinese Golden Age Center	Community Driven/Led	Victim Rights Law Center	Consult
Greater Boston Food Bank	Inform	Victory Programs	Involve
Greater Four Corners Action Coalition	Empower	Viridian Apartments	Involve
HallKeen Management	Involve	WilmerHale Legal Services (also known has the Legal Service Center)	Collaborate
Health Care for All	Collaborate	Wonderfund of Massachusetts	Empower
Healthcare Without Harm	Inform	YMCA of Greater Boston	Community Driven/Led