Community Benefits Report to the Attorney General

FY 2018

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

April 1, 2019

Table of Contents

Section I: MISSION STATEMENT

Summary

The mission of Beth Israel Deaconess Medical Center (BIDMC) is to serve our patients compassionately and effectively, and to create a healthy future for them and their families. Our mission is supported by our commitment to personalized, excellent care for our patients; a workforce committed to individual accountability, mutual respect and collaboration; and a commitment to maintaining our financial health. BIDMC is also committed to being active in its community. Service to community is at the core and an important part of our mission. The Medical Center's founders made a covenant to care for the underserved in their service area, attend to unmet need, and address disparities in access to care and health outcomes. Our commitment to this covenant and the people we serve 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, and community partners, as well as detailed descriptions of its community benefits programs and their impacts.

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

- **Involving the Medical Center's staff**, including its leadership, and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the implementation strategy;

- **Engaging and learning from residents** from throughout the Medical Center's service area in all aspects of the community benefits process, including assessment, planning, implementation, and evaluation. In this regard, special attention is given to engaging diverse perspectives from those who are not patients of the Medical Center and those who are often left out of these 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 Community Benefits Service Area that is geared towards improving 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 the leading health issues;

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

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

Name of Target Population

BIDMC's FY 2016 Community Health Needs Assessment's (CHNA) findings, on which this report is based, clearly show that low income and racially/ethnically diverse populations living in Boston's neighborhoods of Allston/Brighton, Chinatown, Dorchester, Fenway/Kenmore, Roxbury, and the South End, as well as the adjacent City of Quincy and the isolated areas on the Outer Cape portion of Cape Cod are the most at-risk. As a result, this geographic region has been identified as the Medical Center's Community Benefits Service Area (CBSA). In addition, the assessment identified two smaller but high need segments of the population that are also underserved, at-risk, and face disparities, namely older adults and the LGBTQ community. Collectively, these geographic, demographic, and socio-economic population segments are BIDMC's priority target populations. While BIDMC is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated community benefits guidelines, the Medical Center's Implementation Strategy will focus on these priority populations most at risk, as defined by those living in its CBSA as well as older adults and LGBTQ populations.

Basis for Selection

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

Key Accomplishments of Reporting Year

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

- Continued to support increased capacity of primary care and OB/GYN practices at six affiliated health centers
- Continued community-based specialty care services
- Provided care for diverse patients through Cancer Navigator, Interpreter Services, and multilingual patient education
- Addressed social determinants of health, in particular violence prevention through the Center for Violence Prevention and Recovery (CVPR) and Bowdoin Street Health Center's (BSHC) Neighborhood Trauma Team
- Continued case management support services for residents with complex physical and behavioral health issues who are patients at CHCs to keep them in their community
- Increased capacity of primary care clinicians at CHCs to provide needed behavioral health services through integration of behavioral health with primary care and office-based opioid treatment
- Continued workforce development through summer internships for disadvantaged youth, partnerships with local community colleges, and training programs for adults
- Promoted healthy lifestyles through the Walking Club, Farmers Markets, T2 Diabetes Prevention Program, and the CSA
- Conducted research that supports understanding of health disparities
- Provided access to wellness programming including exercise classes and healthy cooking demonstrations at the Wellness Center at Bowdoin Street Health Center
- Empowered youth to develop leadership skills, prevent violence and create change in their community through the Youth Leadership Program at Bowdoin Street Health Center

Plans for Next Reporting Year

In FY 2016, 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 FY 2018 Community Benefits requirements and were also well aligned with the updated Community Benefits Guidelines for FY 2019. In response to the FY16 CHNA, BIDMC focused its FY 17-FY 19 Implementation Strategy on the following four priority areas. These four priority areas collectively address the broad range of health and social issues facing residents living in BIDMC's CBSA. These four priority areas are:

1) Social Determinants, Health Risk Factors and Equity;
2) Chronic Disease Management and Prevention;
3) Access to Care; and
4) Behavioral Health (mental health and substance use)

It should also be noted that 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 FY 16 CHNA provided new guidance and invaluable insight on quantitative trends and community perceptions that are being used to inform and refine BIDMC's efforts. In completing the FY 2016 CHNA and FY 2017-FY 2019 Implementation Strategy, BIDMC, along with its other health, public health, social service, and community health partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the assessment's quantitative and qualitative findings, including discussions with a broad range of community participants, there was an agreement that BIDMC's FY 17-19 CHIP should prioritize certain demographic, socio-economic and geographic population segments that have complex needs, face barriers to care and service gaps, 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 FY 2016 CHNA identified the importance of supporting initiatives that targeted low income populations, older adults, racially/ethnically diverse 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. However, the bulk of the Medical Center's Community Benefits investments are made in collaboration with individual health centers, and collectively through the Community Care Alliance (BIDMC's health center network). BIDMC partners with numerous community health centers to implement programs that address health disparities (related to race, ethnicity, sexual orientation/gender identity, and physical attributes) and implement targeted public health programs and chronic disease management programs, including efforts to address health risk factors such as health eating and active living. BIDMC also partners with these health centers to implement, strengthen, and leverage the patient-centered medical home service delivery model to promote coordinated, cost-effective, high quality care for the community.

In FY 2019, BIDMC is undertaking its triannual community health needs assessment (CHNA) in partnership with the Boston CHNA/CHIP Collaborative.

Section II: Community Benefits Process

Community Benefits Leadership/Team

The Board of Directors has charged its permanent Community Benefits Committee with authority and oversight of activities to fulfill BIDMC's Community Benefits mission. Specifically, the responsibilities of the Committee are to:

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

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

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

Providing direction for BIDMC's collective commitment and effort are The Community Benefits Guiding Principles that follow below. Adopted by a broad-based constituency of Board, senior leadership and staff, these principles provide the framework for the execution of the plan, spearheaded by the Director of Community Benefits. The Director is accountable to the Senior Vice President and General Counsel with direct access to the President and CEO. It is the responsibility of these four senior managers to ensure that community benefits is addressed by the entire organization and the needs of the underserved populations are considered every day in discussions on resource allocation, policies, and program development.

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

Guiding Principles of BIDMC's Community Benefits Program

I. Why?

Our community benefits program is designed to ensure that:

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

II. What and for Whom?

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

III. How?

- *We partner with community leaders and community-based organizations; they serve as links to the community and teachers of how we can better serve the populations they represent. In addition, we collaborate with a wide variety of organizations because healthcare services by themselves are not adequate to maximize improvement of health status.*
- *Improving the community's health requires more than clinical services. We look to public health, prevention, and other health-related approaches not traditionally provided by many acute care hospitals.*
- *Our commitment to the community benefits mission is as fundamental as our commitment to our patient care and academic missions. We will constantly seek ways to fulfill all of them in as effective and efficient a manner as possible.*

- *Community benefits programs are most successful when implemented organization-wide, just as are quality and respect. Community benefits cannot succeed as a stand-alone activity. The importance of these principles and the efforts that result must be embraced by trustees, senior management and providers alike, as well as by the communities served.*

Community Benefits Committee Meetings

December 5, 2017
March 6, 2018
June 5, 2018
September 6, 2018

Community Partners

The Medical Center recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BIDMC's Community Health Needs Assessment (CHNA) and the associated 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 Allston/Brighton, Chinatown, Bowdoin-Geneva, Fenway/Kenmore, and Roxbury. BIDMC also serves residents in the City of Quincy and has historical ties with the underserved segments that reside here as well as with many of the City's community-based organizations. Combined, these communities have been formally designated as BIDMC's Community Benefits Service Area (CBSA).

BIDMC currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In so doing, the Medical Center 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 Community Benefits Service Area, seven of these clinics are formally affiliated with BIDMC and are part of BIDMC's Community Care Alliance (CCA). These seven health centers are critical components of the health care safety nets in the communities in which they operate. In 2018, the CCA health centers provided primary care medical, dental, behavioral health, and enabling services to approximately 121,816 patients. The CCA health centers include:

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

These health centers are ideal community benefits partners as they are rooted in their communities and, as federally qualified health centers, are mandated to serve low income, underserved populations.

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

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

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

The following is a 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.

ABCD Health Services
ABCD Parker Hill/Fenway Neighborhood Service Center
Aerobics and Fitness Association of America/National Academy of Sports Medicine
AIDS Action Committee
Albert Schweltzer Fellowship Program
Affiliated Physicians Group, Beth Israel Deaconess HealthCare
American Cancer Society
American Diabetes Association
American Heart Association
Artists for Humanity
Associated Industries of Massachusetts
Atrius Health/Harvard Vanguard Medical Associates
Bay Cove Human Services
Berkshire Group
BIDCO
BIDH Milton
BIDH Needham
BIDH Plymouth
BIDMC, Interpreter Services
Biomedical Sciences Career Program
Blue Cross Blue Shield Foundation
Blue Cross, Blue Shield of MA
Boston ABCD Family Planning Division
Boston Alliance for Community Health
Boston Area Rape Crisis Center
Boston Athletic Association
Boston Basics
Boston Career Link
Boston Community Centers
Boston Center for Independent Living
Boston Cyclists Union
Boston Elder Services
Boston Emergency Medical Services
Boston Fire Department
Boston Green Ribbon Commission
Boston Healthcare Careers Consortium
Boston Medical Center
Boston MedFlight
Boston Natural Areas Network/Youth Conservation Corps
Boston Police Department
Boston Private Industry Council
Boston Public Health Commission
Boston Public Schools
Boston Red Sox Foundation
Boston Regional Domestic Violence Providers
Boston Regional Mental Health Providers serving Latinos
Boston Senior Home Care
Boston University Institute for Nonprofit Management
Boston Visiting Nurses Association
Bottom Line
Bowdoin Bike School
Bowdoin Geneva Alliance
Bowdoin Geneva Main Streets Program
Bowdoin Street Health Center
Brigham and Women's Hospital
Brookline Community Mental Health Center
Brookline High School Work Connections for Youth
Brookline Senior Center
Bunker Hill Community College
Cape Verdean Adult Day Health Program
Cambridge Health Alliance
Casa Myrna
Career Collaborative
Charles River Community Health
Centering Healthcare Institute
Child Witness to Violence Project
Children's Hospital Boston
COBTH Domestic Violence Advisory Council
College Bound Dorchester
Combined Jewish Philanthropies
Community Care Alliance
Community Servings
COMPASS
Conference of Boston Teaching Hospitals: COBTH
Dana Farber/Harvard Cancer Center
Dana-Farber Cancer Institute
Daily Table
Dorchester Bay Economic Development Corporation
Dorchester Cares
Dorchester Community Food Co-op
Dorchester Lead Safe Yard Project
Dorchester House Community Health Center
Dorchester Neighborhood Service Center
Dorchester North WIC Office
Dorchester Youth Collaborative
Dream Big
EPA New England
ESAC
Ethos
Evercare
Family Nurturing Center
Fenway Community Development Corporation
Fenway Health
Fresh Truck
Fitness in the City
Found in Translation
Friends of Geneva Cliffs
Friendship Works
Geneva Avenue Head Start
Gertrude E. Townsend Head Start
GLAD
Greater Boston Interfaith Organization
Greater Boston Food Bank
Greater Four Corners Action Coalition
Harvard CATALYST
Harvard Medical School
Harvard School of Public Health
Harvard Street Community Health Center
Health Care for All
Health Law Advocates
Health Resources in Action
Healthcare Without Harm
Healthworks at Codman Square
Healthy Kids Healthy Futures
Healthy Waltham
Hebrew Senior Life
Holland Community Center
Hospitality Homes
Hyde Square Task Force
International Institute of New England
Jamaica Plain Neighborhood Development Corporation
Jane Doe, Inc.
JCG
Jewish Community Centers of Greater Boston
Jewish Community Housing for the Elderly
Jewish Community Relations Council
Jewish Domestic Violence Coalition
Jewish Family Service of Metrowest
Jewish Vocational Services
John D. O'Bryant School of Math and Science
Journey to Safety a Program of the JFCS
Joslin Diabetes Center
Kit Clark Senior Services
Keshet
Krokidas and Bluestein, LLP
Leventhal Sidman Jewish Community Center
Louis D. Brown Peace Institute
Mary Lyon Pilot High School
Massachusetts Attorney General Office
Massachusetts Commission for the Deaf and Hard of Hearing
Massachusetts Department of Children and Families
Massachusetts Department of Environmental Protection
Massachusetts Department of Public Health
Massachusetts Department of Transitional Assistance
Massachusetts Department of Transportation
Massachusetts Executive Office of Health and Human Services
Massachusetts General Hospital
Massachusetts Hospital Association
Massachusetts Immigrant and Refugee Advocacy Coalition
Massachusetts Office for Victim Assistance
Massachusetts League of Community Health Centers
Massachusetts Prostate Cancer Coalition
Massachusetts State Police
Massachusetts Taxpayers Foundation
Massachusetts Workforce Investment Board
Massachusetts Senior Action Council
Mattapan Community Health Center
Mayhim Hayim
Mayor's Office of Emergency Management
Mayor's Office of Food Initiatives
Mayor's Office of Neighborhood Services
Mayor's Office of Workforce Development
Mayor's Office, Boston
Medical Academic and Scientific Community Organization, Inc. (MASCO)
Medical Intelligence Center
Mount Auburn Hospital
Multicultural Coalition on Aging
New England Baptist Hospital
Network for Excellence in Health Innovation
Outer Cape Health Services
Partners HealthCare
Project Health CV Inc.
Putnam Investments
Practice Green Health
Pine Street InnRed's Best Seafood
Rose's Bounty/Strafford St United Church
Roxbury Presbyterian Church
Schwartz Center for Compassionate Healthcare
Sexual Assault Nurse Examiner Program
Sidney Borum Jr. Health Center
Silent Spring Institute
Sociedad Latina, Inc.
South Cove Community Health Center
St. Mary's Center for Women and Children
St. Peter's Teen Center
Suffolk County District Attorney's Office, Victim Witness Advocates
Suffolk County District Sheriff's Department
The Boston Foundation
The Dimock Center
The Fenway Institute
The Network, La Red
The Partnership, Inc.
The Trustees of Reservations (City Harvest and Powisset Farm)
Tufts Health Plan
Tufts Medical Center
Unitarian Universalist Urban Ministry
United Way of Massachusetts
UMASS Boston
Upham's Corner Health Center
Upham's Corner WIC
Urban League of Eastern Massachusetts
Urban Farming Institute of Boston
US Environmental Protection Agency
Victim Rights Law Center
Vietnamese American Civic Association
Violence Intervention and Prevention Initiative
Victory Programs
WalkBoston
WGBH
Ward's Berry Farm
W/S Development/S.R. Weiner & Associates
WIC
YearUP
YMCA Black Achiever's Program
YMCA of Greater Boston
YMCA Training, Inc.
Youth Connect
Youth Villages
YWCA Boston

Section III: Community Health Needs Assessment

Date Last Assessment Completed and Current Status

The FY 2016 Community Health Needs Assessment (CHNA) along with the associated FY 2017 - 2019 community benefits implementation strategy was developed over a ten-month period from October 2015 to August 2016. 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 the Medical Center's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop a community health improvement plan or 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 is in the process of conducting a new CHNA but its FY 18 community benefits programming was informed by the FY 2016 CHNA. The following is a summary description of the FY 2016 CHNA approach, methods, and key findings.

Approach and Methods

The FY 2016 CHNA was conducted in three phases, which allowed BIDMC to: 1) compile an extensive amount of quantitative and qualitative data, 2) engage and involve key stakeholders, BIDMC clinical and administrative staff, and the community at-large, 3) develop a report and detailed strategic plan, and 4) comply with all Commonwealth Attorney General and Federal IRS community benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, and four community forums.

Beth Israel Deaconess Medical Center's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. BIDMC's understanding of these communities' needs is derived from discussions with and observations by healthcare and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. 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 Beth Israel Deaconess Medical Center and community partners) is used to inform BIDMC's decision-making about priorities for community benefits efforts. Following the Guiding Principles described above, for each priority area, BIDMC works in concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is thus developed and eventually woven into the annual goals and agenda for the medical center's Community Benefits Plan that is adopted by the Board of Director's Community Benefits Committee.

Summary of Key Health-Related Findings from FY 2016 CHNA

Access to Care

- **Limited Access to Primary Care Medical, Medical Specialty, and Oral Health Care Services for Low Income, Medicaid Insured, Uninsured, and Other Vulnerable Populations Facing Health Care Disparities and Barriers to Care.** Despite the fact that 1) Massachusetts has one of the highest rates of health insurance and 2) the communities that make up BIDMC's CBSA have strong, robust safety net systems there are still substantial numbers of low income, Medicaid insured, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical and oral health services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care medical, medical specialty, and oral health services.
- **Barriers to Access and Disparities in Health Outcomes Continue to Challenge Three Special Populations (Infants/Mothers/Fathers, Frail Older Adults, and Lesbian, Gay, Bi-sexual, and Transgender (LGBT) Populations.** Based on information gathered primarily from the interviews and community forums, the assessment identified a number of special populations that face barriers to care and disparities in access. More specifically, infants/mothers/fathers, frail older adults, and the lesbian, gay, bi-sexual, and transgender (LGBT) populations face disparities in access and outcome and are particularly at-risk. If these disparities are going to be addressed, then care needs to be taken to tailor identification/screening and preventive services as well as acute and chronic disease management services for these special populations.

Chronic Disease Management

- **High Rates of Chronic and Acute Physical Health Conditions (e.g., heart disease, hypertension, cancer, and asthma).** The assessment's quantitative data clearly shows that many communities in BIDMC's CBSA have high rates for many of the leading physical health conditions (e.g., heart disease, hypertension, cancer, and asthma). In many communities these rates are statistically higher than Commonwealth rates, indicating a particularly significant problem. However, even for those communities where the rates are not statistically higher, these conditions are still the leading causes of premature death.
- **Limited Access to Cancer Screening for Racial/Ethnic Diversity and Other At-risk Populations.** Many of the communities that are part of BIDMC's CBSA have high cancer mortality rates. This is particularly true for certain cancers in specific communities in specific Boston neighborhoods, such as Roxbury, Dorchester, and South End/Chinatown that have a high proportion of racial/ethnic diversity. At the root of addressing high mortality is screening, early detection and access to timely treatment.
- **High Rates of HIV/AIDS Particularly on the Outer Portion of Cape Cod and in a Number of Boston Neighborhoods that are Part of BIDMC's CBSA.** Great strides have been made in controlling and managing HIV/AIDS, and for many it is managed as a chronic condition with medications. Rates of illness, death, and HIV transmission declined overall in the past decade. However, HIV/AIDS still has a major impact on certain segments of the population, including men who have sex with men and injection drug users. In BIDMC's CBSA, rates of HIV/AIDS are particularly high in the outer portion of Cape Cod and a number of Boston's neighborhoods.

Social Determinants and Health Risk Factors

- **Social Determinants of Health (e.g., economic stability, education, and community/social context) Continue to Have a Tremendous Impact on Many Segments of the Population:** The dominant theme from the assessment's key informant interviews and community forums was the continued impact that the underlying social determinants of health are having on the CBSA's low income, underserved, diverse population cohorts. More specifically, determinants such as poverty, employment opportunities, violence, transportation, racial segregation, literacy, provider linguistic/cultural competency, social support, and community integration limit many people's ability to care for their own and/or their families' health. Large proportions of individuals residing within Boston and BIDMC's Community Benefits Service Area live in poverty, have limited formal education, are unemployed, and struggle to afford food and other essential household items. These populations are disproportionately from racially/ethnically diverse groups and, partly as a result of their poverty, face disparities in health and access to care outcomes. It is critical to note that there is a multitude of individual, community and societal factors that work together to create these inequities. It is insufficient to talk solely about race/ethnicity, immigration status, or language; as the underlying and correlative issues related to health and well-being involve economic opportunity, education, crime, and community cohesion.

- **Disparities in Health Outcomes Exist in BIDMC CBSA by Race/Ethnicity, Foreign Born Status, and Language:** As was established in the FY 2013 BIDMC Community Benefits CHNA Report, there are major health disparities for residents living in BIDMC's CBSA. This continues to be particularly true for racially/ethnically diverse, foreign-born, and non-English speaking residents living in the neighborhoods in Boston that are part of BIDMC's CBSA (i.e., Allston/Brighton, Dorchester, Fenway, Roxbury, and South End/Chinatown). The impact of racism, barriers to care, and disparities in health outcomes that these populations face are widely documented in the literature and are confirmed by numerous national, Commonwealth, and local data sources, including data from the Boston Public Health Commission's 2014-15 Health of Boston Report.

- **It is crucial that these disparities be addressed and, to this end, BIDMC's FY 17-19 CHIP continues to include a myriad of programs, strategic interventions, and services that are carefully targeted to address these disparities.** However, it is critical to note that there is a multitude of individual, community and societal factors that work together to create these inequities. The underlying issue is not only race/ethnicity, foreign born status, or language but rather a broad array of inter-related issues including economic opportunity, education, crime, and community cohesion. Arguably, these are the leading determinants of health for all urban communities in the United States, and they are daunting challenges. Many of Boston's major academic and healthcare institutions, including BIDMC, have been at the heart of this national dialogue for decades. BIDMC is committed to doing what it can to address these factors and every priority area and goal in BIDMC's FY 16-19 CHIP is structured to address health disparities and inequities in some way.

- **Limited Access to Primary Care Medical and Specialty Care, Oral Health, and Behavioral Health Services for Low Income, Medicaid Insured, Uninsured, and Other Population Segments Facing Barriers to Care.** Despite the fact that Massachusetts has one of 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.

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

Behavioral Health

- **High rates of Substance Use (e.g., Alcohol, Prescription Drug/Opioids, Marijuana) and Mental Health Issues (e.g., Depression, Anxiety, and Stress).** If the impact of social determinants was the leading finding, a close second was the profound impact that behavioral health issues (i.e., substance use and mental health) are having on individuals, families and communities in every geographic region and every population segment in BIDMC's CBSA. Depression/anxiety, suicide, opioid and prescription drug dependency, and alcohol and marijuana use, particularly in youth, are major health issues and are having a tremendous impact on the population as well as a burden on the service system. The fact that physical and behavioral health are so intertwined compounds the impact of these issues. Of particular concern are the increasing rates of opioid abuse in the Commonwealth.
- **Limited Access to Behavioral Health Services, Particularly for Low Income, Medicaid Insured, Uninsured, and those with Complex, Multi-faceted Issues**. Despite the burden of mental health and substance use on all segments of the population, there is an extremely limited service system available to meet the needs that exist for those with all mild to moderate episodic issues or those with more serious and complex, chronic conditions. Efforts need to be made to expand access, reduce barriers to care (including stigma), and improve the quality of primary care and specialized behavioral health services.

Section IV: Community Benefits Programs

Access to Care - Community Based Primary and Specialty Care

Brief Description or Objective

Greater Boston has one of the strongest and most comprehensive healthcare systems in the world. This system is expansive and spans the full healthcare continuum including primary care medical and medical specialty care services. There are limited gaps in services across the continuum, even for low income and racially/ethnically diverse populations that often struggle with access to health care services. However, this does not mean that all segments of the population receive the culturally sensitive care they need when and where is best. Despite the success of the Affordable Care Act and the Commonwealth's heath reform efforts, data shows that segments of the population, particularly low income, racially/ethnically diverse populations, non-English speakers, undocumented immigrants, isolated rural residents, and LGBTQ populations face significant barriers to care and struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and shortages of providers willing to serve Medicaid insured or low income, uninsured patients.

BIDMC believes that community health centers (CHCs) are in a unique position to provide accessible, culturally sensitive, linguistically appropriate primary care medical and specialty care services, including outreach, preventive, and enabling services, to diverse medically underserved communities in its CBSA. The health centers that BIDMC supports are rooted in their communities, understand the unique social, cultural, and health-related needs of those they serve, and are better equipped than any organization to meet these needs.

With this in mind, BIDMC is committed to strengthening the capacity of its six affiliated and/or licensed Community Health Centers in the greater Boston region, along with the rural, isolated outer portion of Cape Cod to the South of Boston, including: Bowdoin Street Health Center, Dimock Health Center, Fenway Health, Charles River Health, Sidney Borum Jr. Health Center (Part of Fenway Health), South Cove Community Health Center, and Outer Cape Health Services. These partnerships take many forms and BIDMC makes available many services to its affiliated health centers including risk management, compliance, credentialing of physicians, access to managed care contracts, Harvard Medical School appointments and teaching opportunities. Additionally, the health centers have access to BIDMC-sponsored educational programs and access to teaching and growth opportunities including the Linde Family Fellowship Program (LFFP). The LFFP provides physicians with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation.

BIDMC's commitment to community-based care translates into a number of BIDMC specialties (e.g., OB/GYN, Infectious Disease, etc.) and ancillary services (i.e., radiology, lab) being provided on-site at the health centers. Recognizing the need for increased access to mental health services, during FY 18, BIDMC psychiatrists continue to strengthen the capacity of CHC primary care physicians (PCPs) so that these PCPs can provide appropriate and responsive mental and behavioral health care to patients in their medical homes.

Goal Description	Goal Status
Increase number of patients receiving primary care, OB/GYN and specialty care at affiliated CHCs	110,268 patients were served by BIDMC-affiliated FQHC health centers in FY 2018.
Increase number of specialists practicing at CHC sites	30 BIDMC specialists practiced at CHC sites in FY 2018.
Increase number of residents with CHC preceptors	31 residents were assigned to CHCs during Academic Year 2018. 7 residents started in Academic Year 2018 along a primary care residency track.

Access to Care - Community Care Alliance

Brief Description or Objective

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

Since 1997, BIDMC has been actively engaged on an annual basis to help manage and strengthen this network with an eye towards promoting partnership, leveraging resources, improving quality of care, coordinating care within and outside of this network, and ensuring that Network providers are fully prepared to participate in value-based payment and emerging service delivery and payment reform mechanisms. Additionally, partnering with the Community Care Alliance, BIDMC makes available many administrative services to its affiliated health centers including marketing, media services, interpreter services, risk management, compliance, access to managed care contracts, trainings, assessment, Conexion, The Partnership, as well as financial support, and other program and technical assistance. For example, in FY 2018, BIDMC and its partner the Beth Israel Deaconess Care Organization (BIDCO) worked with some CCA health centers to support their participation in the MassHealth Accountable Care Organization (ACO) model.

Goal Description	Goal Status
Identify opportunities for administrative and fiscal savings	Continue monthly regulatory OIG review for all CHC personnel and vendors.
Conduct “Mystery Shopping” to address QI issues around access and patient experience	Mystery shopped six clinics monthly with reports back to CHC managers, Medical Directors and Operations Managers. Completed 72 surveys. Note: the BIDMC Mystery Shopping team instituted a new electronic system this year, some shops between the months of December – March were not reported out to the health centers.
Administer ASK development evaluation program (Advocating Success for Kids)	Continued to provide monthly developmental assessments at two health centers for school-aged children with learning and behavioral issues.

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

Brief Description or Objective

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

BIDMC is a regular participant in citywide drills, taskforces, and projects, and plan development meetings including those for citywide planned mass casualty events which also includes BIDMC's health center partners in simulations. The Trauma team provides numerous in-service trainings throughout the year, including the semi-annual Advanced Trauma Support classes for New England-wide hospital personnel. Annually, the emergency management team supports two planned major events in Boston, the July 4th celebration, and the Boston Marathon. In FY 2018, BIDMC collaborated with city, state and/or federal partners BIDMC on 20 drills/exercises and responded to 67 events. BIDMC Emergency Management participates in the following city and state committees:

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

BIDMC also participates in the ASPR hospital preparedness program.

Goal Description	Goal Status
Collaborate with city, state and federal emergency management programs to ensure preparedness of medical center and CHCs for untoward emergencies	Participated in trainings, simulations and planning meetings. BIDMC collaborated with city, state and/or federal partners on 20 drills/exercises and 67 events. Housed the Emergency Medical Services Station serving Boston's Longwood, Mission Hill, and Roxbury neighborhoods.

Access to Care – Culturally Responsive Care

Brief Description or Objective

A growing body of literature emphasizes the importance of cultural factors in providing appropriate care to patients. Cultural influences determine cognitive constructs including how patients define health, illness, and well-being, even dictating when and if an individual seeks medical care. Certainly understanding one's cultural background provides guidance for developing health promotion strategies as well as influencing the design of treatment interventions and patients' adherence to medical protocols.

Providing culturally responsive, human-centered care is integral to BIDMC's mission, vision, and service delivery approach. The Medical Center has focused on these issues in a highly intentional manner for more than 25 years. Over the years, BIDMC has developed a set of tools and approaches to ensure delivery of culturally-responsive care that are regularly updated and enhanced. From intake assessment forms to multilingual patient satisfaction questionnaires, to health education and navigation assistance materials in multiple languages, BIDMC has tried to apply "culture eyeglasses" to facilitate communication with, and understanding of the patients' orientation and experience.

Those for whom English is not their first language are particularly challenged and at risk. Data shows that there is an increasing number of residents and families in Boston who do not speak English or who have Limited-English Proficiency (LEP). With this in mind, BIDMC was one of the first hospitals with an Interpreter Services Department and has a proven track record in helping patients overcome linguistic barriers to care, expanding interpreter services capacity and resources every year.

BIDMC led the way in employing an American Sign Language interpreter full time and installed multiple Sorenson public videophones to increase communication access by the Deaf and Hard-of-Hearing. By developing and translating patient information and educational materials, BIDMC has also facilitated access to care, helped patients understand their course of treatment, and adhere to discharge instructions and other medical regimens.

BIDMC continues to use a licensed online catalog of patient information (Lexicomp). The patient fact sheets in this collection are available in multiple languages, with select fact sheets available in more than a dozen translations. While BIDMC will continue to provide its clinicians with customized patient fact sheets when needed, it is increasingly directing clinicians to the online collection as a way to dramatically increase its capacity to ensure that patients who do not speak English have access to printed materials about their condition or treatment.

For customized, original translations that require internal vetting, BIDMC has developed an enhanced collaboration between the BIDMC Learning Center fact sheet program and the BIDMC translation team, for the purpose of effectively and efficiently vetting newly translated materials.

In FY 2018, BIDMC completed translation of its "Welcome packet" of materials for inpatients. This involved 14 individual fact sheets/brochures going to five languages (Spanish, Portuguese, Simplified Chinese, Traditional Chinese, Russian), based on the demographics of the medical center's patient population. At the advice of the Director of Interpreter Services, BIDMC added an additional target language of Simplified Chinese to accommodate the increasing number of BIDMC patients from mainland China.

In addition, BIDMC completed an update of its Welcome video that is shown to all patients on admission, and as part of that update BIDMC is in the final stages of completing a version that has voice-over translations in four languages.

Goal Description	Goal Status
Increase understanding of cultural impacts on health care delivery, health status and health outcomes	In FY 2018, BIDMC continued to incorporate information on cultural competence in New Employee Orientation, departmental in-services and Grand Rounds presentations and annual Comprehensive Employee Education programs. BIDMC continued to increase capacity of Interpreter Services through"just in time" service delivery model for large staff language groups.
Make available tools and resources to facilitate cross-cultural communication	In FY 2018, BIDMC Interpreter Services rolled out 22 interpreter iPads throughout the medical center and identified a software vendor to improve dispatching of interpreters. By the end of FY19, interpreter services will have rolled out the new dispatching software.
Increase capacity of Interpreter Services department	Number of interpreter services interactions (face-to-face and phone encounters) totaled 229,547 in 81 languages.
Translate patient education and informational materials	23 new documents were translated in FY 2018, including an All Welcome Statement, Patient Rights Posters, OBGYN Consent Forms, ED Satisfaction Surveys, HIPAA Authorization, an Inclusion Statement, Immigration Tables, Social Media Proof Reading, and Radiology Survey Questions. These documents were translated into 7 languages: Spanish, Russian, Vietnamese, Cape Verdean, Chinese, Haitian Creole and Portuguese.

Access to Care- Geographically Isolated Communities

Brief Description or Objective

Although many assume that Cape Cod is a well-resourced, wealthy community, in fact, it is one of the Commonwealth's most medically underserved areas, challenged by geography and economics. This is particularly true for those who live on the Outer Cape, near the end of the Cape Code Peninsula. For those living on this portion of Cape Cod, health care services are extremely limited, which limits access to care and is extremely dangerous for those experiencing medical emergencies. The nearest hospital could be as many as 50 miles away on a two-lane highway, frequently referred to as "suicide alley."

To address these issues, BIDMC continues to offer on-site medical specialty care services, including infectious disease services (e.g., high resolution anoscopies), pulmonary services, oncology and oncology services, including digital radiology and mammography screening. BIDMC also continues to support the Med-Flight helicopter program which transports those living in isolated areas that are in need of emergency medical services. For those patients and families who are long distances from home, BIDMC provides housing assistance through programs like Hospitality Homes or specially adapted apartments for those undergoing bone marrow transplantation (Galleria Apartments). BIDMC has a staff member who helps patients find lodging with Room Away from Home. The Medical Center also provides temporary housing to BMT patients.

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

Access to Care – Care Connection

Brief Description or Objective

For many years, BIDMC has dedicated resources to helping patients and/or their referring physicians connect to both primary and specialty care services. BIDMC's Care Connection department offers a number of services that benefit the Community Health Centers (CHC) and their patients, including:

- The Find a Doctor call center where detailed information about Community Health Centers, their services and availability of appointments is updated monthly to facilitate timely appointments for patients. The Find a Doctor services are specifically marketed to patients without a PCP who come through the Emergency Department, a BIDMC specialty department, or BIDMC Urgent Care locations (Chestnut Hill, Chelsea).

- The Doctor to Doctor call center supports the CHC providers with their specialty referral needs, especially for urgent and complex care needs. Care Connection RN staff work closely with referring CHC physicians to arrange specialty consult appointments that meet the clinically needed timeline for safe, quality patient care.

- Care Connection's Inpatient Discharge Follow Up program helps CHC patients who were admitted to BIDMC arrange post discharge follow up care. Patients are always booked to see their PCP after an inpatient stay. Staff identifies all members of the patient's care team and work to preserve established specialty relationships, ensuring timely, clinically appropriate follow up care is booked prior to discharge.

Goal Description

Facilitate access through referrals to and from community primary care providers

Goal Status

Call center made 923 appointments/referrals to/from CHCs in FY 2018.

Access to Care - Seamless Continuity of Care

Brief Description or Objective

As patients move between community-based and hospital-based care (ambulatory specialty care, Emergency Department or inpatient hospitalization), it is imperative that providers in both settings have accurate, real-time clinical information. BIDMC has harnessed technology to ensure this communication through Health Information Exchange (HIE) enhancements and BIDMC remains an important part of the Governor's launch of the state healthcare information exchange (Mass HIWay). In 2009, the health centers and BIDMC collaborated on a HRSA-funded project to "push" emergency department (ED) and inpatient discharge summaries to primary care providers. This HIE project was the foundation of subsequent IT solutions that now provide timely communication and enhance continuity of care across settings and providers. With rising concern about unnecessary ED visits and re-admissions, information technology provides data that make possible immediate follow-up care in the community while decreasing errors, unnecessary re-admissions, and duplicate tests and procedures. BIDMC implemented the interfaces for the downloading of lab and radiologic reports as well as notes from specialists directly into the electronic health records of community practitioners. In FY 18, BIDMC continued its participation in the statewide Mass HIWay initiative, providing the technical interfaces for the Community Health Centers to share information with quality measure databases and other data sharing initiatives. BIDMC continues to work with the CHCs to provide bidirectional viewing of clinical information and care management, and provide support to Bowdoin Street Health Center for data exchange to immunization registries and meaningful use projects. In FY 2018, BIDMC continued to work with the CHCs on their connections to the HIWay.

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

Access to Care – Care to Uninsured and Underinsured in Underserved Communities

Brief Description or Objective

Despite health care reform, roughly one in six (16%) patients seen at a Massachusetts federally qualified health center is uninsured according to the CY 2017 Uniform Data System (UDS) data. For many who continue to be without coverage, they may qualify for assistance from the Health Safety Net Program, a fund to which BIDMC makes a significant annual contribution. A team of financial benefits counselors work with uninsured and underinsured patients to facilitate access to entitlement programs, while Medication Assistance Counselors aid patients with obtaining no-cost pharmaceutical prescriptions. BIDMC also maintains a free-care pharmacy to help needy patients.

BIDMC's Community Resource Specialists connect low income patients to resources such as transportation, housing, support groups, food assistance, financial assistance, insurance, Social Security Disability Insurance, unemployment benefits, etc. They determine what resources would optimally meet patients' and families' needs, including beds in continuing care facilities, homemakers, transportation, Meals on Wheels, financial assistance, Medicaid, special housing, special funds, etc. The medical center covers the cost of handling remains of indigent patients. BIDMC also pays the transportation costs for patients discharged from inpatient units and the Emergency Department when they do not have the means to return home. For low income patients being discharged from the medical center with a newborn child, BIDMC links them to services that may provide infant car seats to these families at no cost.

Goal Description	Goal Status
Subsidize Health Safety Net (HSN) Trust Fund	Continue to make annual contribution to the HSN. During FY 2018, BIDMC served 3,025 HSN patients.
Provide financial benefits and medication assistance counseling	Staff screened 10,265 patients for eligibility and enrolled 9,152 patients into entitlement programs. Continue to provide medication assistance and no-cost pharmaceutical prescriptions to needy patients.
Provide free-care pharmacy medications	Provided 5,452 medication prescriptions to indigent patients in FY 18.

Access to Care- Boston Healthy Start Initiative (BHSI)

Brief Description or Objective

In April of 2014, Bowdoin Street Health Center (BHSC) became an official site of the Boston Healthy Start Initiative (BHSI) with grant funding through the Boston Public Health Commission. Becoming a BHSI site in 2014 allowed the health center to provide dedicated Community Health Worker support to health center prenatal patients and better support their needs through frequently high risk pregnancies.

The Boston Healthy Start Initiative (BHSI) is a federally funded program designed to improve birth outcomes and eliminate birth outcome disparities among Boston women. BHSI works closely with clinical sites, consumers, and partners outside the traditional health sector to achieve these aims through five federally-defined approaches: 1) Improving the health of women, 2) Promoting quality of health services to women and families, 3) Strengthening the resilience of families, 4) Achieving collective impact through enhanced collaboration, and 5) Increasing mutual accountability across the BHSI system of care, through quality improvement, performance monitoring and evaluation.

Specifically, BSHC and BHSI provide:

a. Support and case management from a family partner with specialized skills and training around pregnancy and parenting support, including confidential support related to family social and emotional concerns;
b. Collaborate with and offer connection to enhanced support from a skilled public health nurse over the short-term or for up to five years postpartum if risk assessment at any point in care indicates the presence of chronic health conditions or social needs requiring more intensive care;
c. Engage and support father or significant other who plays or could play a positive role in pre and post-partum parenting;
d. Personalized support around maternal and child nutrition, including but not limited to breastfeeding support;
e. Ongoing implementation of Centering Pregnancy

An important partner to BSHC and Boston families with young children, The Family Nurturing Center provides neighborhood-based and city-wide programs to reach parents or caregivers through home visits, playgroups, and parenting education. Helps parents better understand the vital role they have in their child's early brain development, kindergarten readiness, and later school success.

Goal Description	Goal Status
Enroll at least 44 newly pregnant women in the BSHI program at Bowdoin Street Health Center who identify as Black and live in Boston	Exceeded goal: Number of enrolled BHSI pregnant patients in 2018: 51
Provide support and case management to at least 88 prenatal or post-natal patients over the course of the year	Exceeded goal: Total Family Partner Caseload in 2018: 96
OBGYN Team will reengage in offering Centering Pregnancy group care model once new Provider Champion is hired	In FY18, the Centering Pregnancy was combined with BHSI.

Chronic Disease Management – Diabetes, Hypertension, and Asthma

Brief Description or Objective

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

With more than 50% of disease attributable to health behaviors, BIDMC and its affiliated and/or licensed community health center providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. Bowdoin Street Health Center's (BSHC) Diabetes Initiative is a comprehensive care management program, caring for more than 900 adults diagnosed with diabetes. As part of the Patient Centered Medical Home model, members of a multidisciplinary team collaborate to promote improved health outcomes through disease prevention, detection, education and treatment. Individual appointments with a dietitian, nurse or physician, plus group medical visits, self-care management visits, exercise and behavioral health programs are available to patients and are sensitive to their language, education and learning needs.

The Bowdoin Street Wellness Center provides patients with diabetes access to a range of exercise and nutrition counseling classes conveniently located in their neighborhood. BSHC has received positive feedback from patients who report making lifestyle changes around exercise and diet. Bowdoin Street's Diabetes Education Program is recognized by the American Diabetes Association.

BIDMC also supports the diabetes management programs at its other affiliated community health centers such as the Charles River Community Health (CRCH) Live and Learn Diabetes Program. Through the Live and Learn Program, CRCH providers proactively contact diabetes patients who are overdue for care. These patients are able to attend a Diabetes Day event, during which they have multiple appointments (dental, vision, nutrition, nursing self-management support, podiatry, and lab work) in one day with only one co-pay. Additionally, CRCH offered provider-led group diabetes visits, including a Spanish-speaking and Portuguese-speaking group. Both CRCH and BSHC continue to collaborate with Joslin Diabetes Center on diabetes management programs.

BIDMC's affiliated federally qualified health centers screen and educate patients for diabetes, hypertension and asthma, provide evidence-based care and treatment, and work with BIDMC to ensure access to needed specialty care. These health centers served 6,333 diabetic patients (14% are Hispanic/Latino; 9% are Black/African American); 15,035 with hypertension (10.6% are Hispanic/Latino; 8.8% are Black/African American); and 1,623 with persistent asthma in FY 18.

At Bowdoin Street Health Center, the Prevent T2, developed by the Centers for Disease Control (CDC), is a health literacy and lifestyle modification program focused on preventing or delaying an individual's risk of developing Type 2 diabetes through dietary changes, increased physical activity and stress reduction. The evidence-based CDC curriculum consists of 26 classes offered over the course of one year to participants who are at risk for developing Type 2 diabetes. Risk is determined through blood work and/or the completion of a risk assessment survey. The aim of the program is to help participants lose 5-7% of their weight through diet and 150 minutes of moderate physical activity per week. BSHC's Prevent T2 also includes cooking classes and group exercise classes.

Goal Description	Goal Status
Target is 83% of BSHC patients with diabetes, age 18-75, will have one HbA1c test per year	83.9% of BSHC patients had one HbA1c test within six months during FY 2018.
Target is 85% of BSHC patients with diabetes, age 18-75, will have one LDL screening per year	66% of BSHC patients had LDL cholesterol screening during FY 2018.
Target is 58% of BSHC diabetes patients will have one eye exam per year	50.2%: Goal was not met but during FY 18, the percentage of patients with diabetes completing an eye exam increased from 42% to 50.2%. There was a change in optometry staff during FY 18 with a period of no optometry provider being on-site.
An additional internal medicine provider will offer a group medical visit for patients with Type 2 diabetes	Goal met as Dr. Killian started a monthly group in February with 8 patients attending. This group continues to meet with attendance ranging from 6-7 patients.
Increase number of adults with diabetes whose condition is controlled (HbA1c $\leq$ 9)	4,848 (76.6%) adults with diabetes had HbA1C < 9 in FY 2018; 4,435 (70%) patients with diabetes had HbA1C < 8 in FY 2018.
Increase number of FQHC adults with hypertension whose blood pressure is < 140/90	9,852 patients with hypertension (65.5%) had blood pressure < 140/90 in FY 2018.
Increase number of adults with persistent asthma whose condition is controlled	1,537 (94.7%) of patients with persistent asthma had their asthma under control in FY 2018.
Collaboration with the Joslin Center	Joslin Center continues involvement with Bowdoin Street Health Center and Charles River Community Health.

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

Brief Description or Objective

In 2016, Cancer was the second leading cause of death in the United States and the first leading cause of death in Massachusetts. Quantitative and qualitative data from the FY 2016 CHNA assessment corroborated these findings with data showing great disparities on the Outer Cape and in Boston neighborhoods that are part of BIDMC's CBSA. As with other health conditions, there are major disparities in outcomes and death rates across all forms of cancer, which are directly associated with race, ethnicity, income, and whether one has comprehensive medical health insurance coverage.

As a Cancer Center of Excellence recognized by the American College of Surgeon's Commission on Cancer, BIDMC is a leader in translating research into clinical care and community practice—"bench to trench." BIDMC participates in both the Dana Farber/Harvard Cancer Center (DF/HCC) and the Faith-Based Cancer Disparities Network, facilitating the educational and outreach programs within 10 churches and the Black Ministerial Alliance. Building on the partnership with the faith-based community, beginning in FY 2013, the DF/HCC incorporated a new strategy that provided cancer survivors within the faith community an opportunity to break through the silence. Through self-portraits and testimonies, 19 survivors told their stories of hope and resilience which promoted awareness about cancer in their communities and showed that life with and beyond cancer can be glorious and fulfilling. In FY 2014, an additional 14 portraits and stories of patients from diverse backgrounds were added to the installation. BIDMC hosted the installation in FY 2017 and did so again in FY 2018.

When cancer specialty care or inpatient hospitalizations are necessary, BIDMC offers the services of bilingual and bicultural Cancer Patient Navigators who bridge the gulf between community providers and the medical center. One Patient Navigator specializes in serving the Latino community and the other in serving the Chinese community, though both also serve patients from other ethnic groups. These Patient Navigators also lead support groups for cancer patients such as Tea Time (for Chinese women with breast cancer) and the Latinas with Cancer group. To provide support for its Patient Navigators, BIDMC hosts a city-wide Patient Navigator Network that meets quarterly for education, support, networking, and sharing of resources.

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

Goal Description	Goal Status
Increase number of mammograms in CHCs and mobile van	Offer on-site mammography services at Fenway Health, Outer Cape Health Services, and South Cove Community Health Center. In FY 2018, 26 patients received mammograms at Outer Cape Health Services, 639 patients received mammograms at Fenway Health, and 4,657 patients received mammograms at South Cove Community Health Center.
Coordinate and host city-wide Patient Navigator Network	24 patient navigators representing 10 healthcare institutions participated in four network luncheons in FY 2018.
Offer Cancer Patient Navigators	The Chinese Patient Navigator saw 495 active patients of which 152 were new patients, providing a total of 2,350 encounters during FY 2018. The Latina Patient Navigator ended in FY 18.
Provide Cancer Support Groups	Continued Tea Time group for Chinese women with breast cancer (21 sessions with an average of 3 participants per session) and Look Good, Feel Better groups for women undergoing cancer treatments hosted by the Latina Patient Navigator (6 groups with 29 participants).
Increase number of low-income individuals who received a mammogram	2,705 low-income individuals received a mammogram at BIDMC in FY 2018.
Increase number of low-income individuals receiving colon cancers screening	1,896 low-income individuals received a colon cancer screening at BIDMC in FY 2018.

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

Brief Description or Objective

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

A BIDMC infectious disease consultant collaborates with The Dimock Center to provide screening, care, and education regarding HIV/HCV co-infection on-site at The Dimock Center every week. This care and service includes a special focus on access to care, initiation, and completion of state-of-the-art HCV therapy. Making these services available at Dimock reduces access barriers for patients who are particularly vulnerable and who otherwise might not receive the latest regimen or be able to access or complete treatment. This program also adds a BIDMC infectious disease liaison from The Dimock Center to the BIDMC Liver Center for proper engagement and advocacy for vulnerable patients to promote successful treatment outcomes.

Goal Description	**Goal Status**
Screen HIV positive patients for HCV	98% of HIV positive patients (138 of 140) screened for HCV. Of these, 30% were co-infected with HCV.
Ensure access to treatment	Infectious disease physician saw 117 patients across 237 visits in FY 2018.
Get at least 4 people to begin HCV treatments	3 patients began HCV treatments.

Chronic Disease Management - HIV Support Groups

Brief Description or Objective

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

For 20 years, BIDMC has offered a support group called Experienced and Positive for gay men who have advanced AIDS. These long-term survivors, many of whom were first diagnosed in the 1980s, are coping with multiple stressors including the death of partners, significant complications from medications, and reoccurring hospitalizations. Recognizing that women with HIV are an underserved population who often feel socially isolated and stigmatized due to their diagnosis, BIDMC formed the Support Group for HIV+ Women seven years ago. Both of these support groups focus on helping patients cope with their diagnosis, providing a welcoming environment that fosters mutual support and encourages patients as they continue with treatment.

Goal Description

Provide support groups for HIV positive patients

Goal Status

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

Social Determinants and Health Risk Factors - The Walking Club

Brief Description or Objective

Not only does BIDMC's Cardiovascular Institute have expertise in heart disease, but they are also in the vanguard with prevention programs to promote heart healthy behaviors. The Walking Club provides free kits that include workout logs and information sheets to participants. The Walking Kits have been adapted for corporate entities, patients with special needs, and Boston Public School students. While the kit is used by science/health and gym teachers, one of the primary goals of the program is to encourage students to walk during non-school hours with a parent/guardian in an effort to combat childhood obesity and inculcate healthy lifestyle behaviors. Each child in the Walking Club is given a pedometer to track their steps.

Adopted by many Boston public schools, the Walking Club kit includes a booklet that has information sheets to promote healthy behaviors, including: workout logs, an examination of the anatomical parts utilized while walking, and basic math and science exercises, such as calculating heart rates and steps into miles. The kits also include booklets for staff at the schools. BIDMC staff again collaborated with staff from Tufts University's Child Obesity 180 program. The organization provided access to grade 3-5 teachers who offered feedback on ways to rewrite and redesign the Walking Club information packet for a younger target audience.

Historically, BIDMC provided the Walking Club supplies to the schools in the spring semester. In addition to sending these supplies in Spring 2018, BIDMC also distributed kits in Fall 2017 so that the students would be able to use them throughout the entire school year. This effort was a centerpiece of BIDMC's plan to refocus and concentrate its efforts on the population that has far and away made the best use of the Walking Club materials, and provided the most demand: Boston Public Schools. Throughout the last fiscal year, 46 elementary and middle schools (including K-8 schools), and17 after school programs, implemented the Walking Club program.

Goal Description	Goal Status
Expand Walking Club to additional middle schools	The Walking Club curriculum was used by a total of 46 public schools plus 17 after school programs with 4,335 children and 1,000 school staff participating in FY 2018.
Provide educational materials, pedometers, and smartphone app to Walking Club members	Distributed 5,200 pedometers to Walking Club members. Provided kits including workout logs and printed educational materials.

Social Determinants and Health Risk Factors - Healthy Food Equity Project

Brief Description or Objective

Bowdoin Street Health Center's (BSHC) assessment of healthy, affordable food options revealed no full-service supermarkets in the neighborhood. Instead, there are small corner stores which are unequipped to store and sell fresh fruits and vegetables.

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

The Food Prescription (Food Rx) Program served as an integral component of nutrition education and food access programming at Bowdoin Street Health Center in FY 2018 providing patients with opportunities to purchase fresh and affordable produce in locations convenient to their needs. To enroll in the program, patients met with the BSHC Dietitian for an initial nutrition consult, and to receive an overview of the benefits of each of the participating healthy food resources. Upon completion of this visit, patients received Food Rx vouchers which could be redeemed at various locations convenient to the health center. In addition to these successes, staff from BIDMC continued to support BSHC's Farm to Family Program, a Community Supported Agriculture (CSA) project. Over 60% of BIDMC employees who purchased CSA shares volunteered to subsidize a weekly carton of fresh fruits and vegetables for a low income family.

Goal Description	**Goal Status**
Provide access to fresh fruits and vegetables in Boston neighborhoods	Bowdoin Geneva Farmers' Market held weekly from July through October 2018. Vendors at the Farmers' Market accept SNAP, WIC, and Senior Farmers' Market Nutrition Program benefits. CSA project provided 30 families with subsidized cartons of fruits and vegetables.
Expand Healthy Champions Program	15 Healthy Champions program youth participated in healthy cooking classes and nutrition education workshops.

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

Brief Description or Objective

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

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

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

Goal Description	Goal Status
Engage children in exercise programs	In FY 2018, 43 children/youth enrolled in Fitness in the City. A new FITC Case Manager was hired in FY18, and BSHC anticipate seeing a sizeable increase in participant enrollment in FY 19.
Increase number of children seen at affiliated health centers that were screened for BMI	10,245 children (65%) who are receiving care from affiliated federally qualified health centers were screened for BMI.
Provide 5-2-1 counseling recommended by the AAP during routine well-child visits at BSHC	Nutrition, healthy eating, and exercise information shared at routine pediatric appointments. In FY 2018, pediatric providers encouraged patients and families to attend "Healthy Weight" clinical check-ins, which include direct referral to Wellness Center programming.
Develop programmatic plan for Wellness Center	The BSHC Wellness Center includes an exercise studio, weight room, and demonstration kitchen for healthy cooking education. BSHC Wellness Center programs promote healthy lifestyles through healthy cooking and physical activity initiatives accessible to residents of the Bowdoin/Geneva neighborhood.

Social Determinants and Health Risk Factors - Environmental Sustainability and Public Safety

Brief Description or Objective

Like any good neighbor, BIDMC is actively engaged in creating a vibrant, sustainable community that fosters healthy lifestyles, enhanced quality of life, and improved environmental conditions—be it improved air quality, green spaces, and parks and recreational facilities. BIDMC joins with colleagues at both the grass-roots level and city and state government to reduce detriments to public health and address determinants that impact health status. As part of BIDMC's commitment to enhancing the physical environment, BIDMC maintains bus stops, Joslin Park, and other green spaces near its campus.

Within the hospital itself, BIDMC is implementing its Environmental Strategic Plan, spearheaded by BIDMC's multi-departmental Sustainability Committee. BIDMC is committed to conserving natural resources, reducing our carbon footprint, fostering a culture of sustainability, and advancing cost-saving opportunities through:

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

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

Public safety is of concern within BIDMC's local neighborhoods as well as the Bowdoin area. BIDMC's police and public safety presence contribute to a sense of well-being. The medical center has an excellent, cooperative working relationship with the Boston Police Department (BPD) and essentially serves as their "eyes and ears" in the Longwood Medical Area and on Bowdoin Street. BIDMC's security technology and apparatus, including cameras and a BPD shot-spotter at Bowdoin, have been used to identify perpetrators and assist BPD investigators. In FY 18, there were a total of 14 officers including the Police Chief. Officers are deputized by the Suffolk County Sherriff's Department and granted special police powers by the Massachusetts State Police.

Goal Description	Goal Status
Increase recycling rate to 29% by FY 2019	The recycling rate was 13% in FY 2018.
Increase percentage of total food and beverage spend on local products to 12% by 2019	Total food and beverage spend on local products was 4.5% in FY 2018.
Increase healthy beverage spend to 50% by FY 2019	Healthy beverage spend rate was 43.6% in FY 2018.

Social Determinants and Health Risk Factors - Improving Healthy Foods in the Allston-Brighton Community

Brief Description or Objective

The overarching goal of the Improving Healthy Foods in the Allston-Brighton Community project is to provide hunger relief and improve nutrition for Charles River Community Health (CRCH) patients by increasing access to a variety of fruits and vegetables. The funds provided by BIDMC allow CRCH staff to connect patients and their families to high-quality healthy food, connect them with necessary health and support services and to teach the principles of a healthy lifestyle. The Mobile Market allows CRCH to round out the comprehensive, culturally competent and affordable care offered to patients, who are among the most vulnerable in the community.

Goal Description	Goal Status
Serve at least 200 unduplicated individuals through the Mobile Market in the 1-year grant period	Served 445 unduplicated individuals during grant period.
Provide mobile market assistance to an average of 90 people each month for an overall reach of over 1,000 assistances	Provided mobile market assistance to an average of 141 people each month for an overall reach of 1685 assistances.

Social Determinants and Health Risk Factors - Healthy Aging

Brief Description or Objective

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

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

Originally started through a partnership with Harvard Medical School's Agents of Change program, five years later, Bowdoin Street Health Center's Wellness Center continues to offer its Tai Chi program to older adults. The Tai Chi program helps older adults increase strength and reduce the risk of falling. Although many participants are over 65 and referred by their primary care provider because they had a history of or were at risk of falls, the program is open to any patient or community resident as Tai Chi programming provides assistance with mindfulness and stress reduction.

Goal Description	Goal Status
Increase access to physical activity and reduce social isolation among older adults	CRCH held 32 Zumba classes with an average of 10 people attending each class. CRCH held 3 sessions of cooking classes for 6 classes each for a total of 18 classes. A total of 24 individuals completed a full session.
Increase access for healthy living for older adults	BSHC held 104 Tai Chi classes with an average of 10 people attending each advanced Tai Chi class.

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

Brief Description or Objective

Over the past ten years, Bowdoin Street Health Center has joined with other community partners to lead the Violence Intervention and Prevention (VIP) program of the Boston Public Health Commission. Known as "Village in Progress" in many neighborhoods, VIP's mission is to prevent violence through building and sustaining strong communities where residents are knowledgeable and empowered. VIPs over-arching goals are to build, knowledge, capacity, community, provide tools, and improve access.

The Bowdoin Geneva VIP outreach team includes a resident Block Captain and a VIP Coordinator, engaged in a door-to-door campaign and community organizing activities. Particular focus areas of VIP are to strengthen resident and community engagement; Increase access to leadership opportunities for youth; Coordinate community actions in the event of homicides and shootings to promote peace and non-violence and a commitment to changing the expectation of violence in the community; Ensure access of residents in the Bowdoin Geneva neighborhood to quality services, resources and support.

Some of FY 18's highlights include the Bowdoin Geneva Community Healing Walk to pay homage to those lost throughout the city through gun violence. BSHC hosted eight street by street meetings to engage residents in meeting their neighbors; discussed visions and action steps to keep their community safe, healthy, and vibrant. The VIP Coordinator has provided technical assistance to help residents and management in a HUD senior building in the Bowdoin Geneva area organize regular resident meetings, a resident board structure and activities for its residents. Lastly the VIP organized an eight week walking group (100 people signed up) of community residents, BSHC staff, and C-11 Boston Police Department to create several safe walking routes that the community can use to increase physical activity and community cohesion.

Goal Description	Goal Status
Strengthen resident and community engagement	VIP continued to sustain communities and empower residents by hosting a series of 8 street meetings where residents shared their concerns and discussed preliminary actions to address these issues in FY 18.
Identify environmental issues that diminish sense of community	In FY 19, VIP will host 4 community meetings based on the themes brought up by residents by the initial street by street meetings in FY 18.
By the end of FY 20 develop at least 10 new community leaders	Civic engagement began in FY 18.

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

Brief Description or Objective

Domestic violence, sexual assault, community violence and homicide bereavement are addressed through Beth Israel Deaconess Medical Center's Center for Violence Prevention and Recovery (CVPR). As one of the founders of the Domestic Violence Council of the Conference of Boston Teaching Hospitals and one of the oldest hospital-based rape crisis intervention programs in the country, BIDMC has led the way in developing a continuum of education, outreach, and treatment interventions to respond to victims of interpersonal, sexual, community violence, and homicide bereavement. It is also one of the leaders in developing programming to address secondary traumatic stress in service providers in the domestic violence and medical communities.

In response to sexual violence, CVPR provides individual and group support and counseling – medical, legal, and personal advocacy - and develops trauma-informed policies and programs with medical providers throughout the Medical Center. In FY 2018, BIDMC provided emergency medical care to 62 sexual assault survivors in the Emergency Department. The Medical Center provided follow up care to 35 survivors in the Infectious Disease Clinic at a cost to the hospital of approximately $25,000. These services include an average of three physician visits, blood draws, and appropriate vaccinations.

In response to Domestic and Interpersonal violence, CVPR provides outpatient and inpatient counseling and advocacy. For those patients with severe and acute safety concerns following interpersonal assault, BIDMC provides a Safebed – a place for a survivor to remain in the hospital overnight -- if no safe shelter option can be identified. BIDMC supported 33 Safebed patients in FY 18. In addition, CVPR provides advocacy and follow up care to those who utilize Safebeds.

CVPR's community violence initiatives include neighborhood-based support groups, individual counseling, outreach, training, and advocacy. Additionally, BIDMC provides clinical support and counseling through community-based partnerships.

Goal Description	Goal Status
Provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence	Continued to provide individual and group therapy for survivors of violence.
Provide free overnight stay for domestic violence and/or sexual assault victims without safe shelter	Provided 33 Safebed overnight stays.
Create opportunities for grieving, support, and healing	Held 58 healing circles that benefitted over 2100 men, women and children in the aftermath of community violence.

Social Determinants and Health Risk Factors – Neighborhood Trauma Team (NTT)

Brief Description or Objective

In collaboration with and funding from the City of Boston/Boston Public Health Commission, Bowdoin Street Health Center plays the lead agency role for the Dorchester Neighborhood Trauma Team (NTT). As the lead healthcare agency, Bowdoin Street partners with a community organizing agency, Greater Four Corners Action Coalition (GFCAC), and provides outreach to individuals, families, and neighborhoods impacted by community violence. The NTT functions as a "hub" team comprised of a licensed clinical social worker, a Family Partner/Community Health Worker, other staff members throughout the health center, and community organizers from GFCAC. The NTT team assesses community need related to trauma in order to support and deliver prevention, response, and short and long term recovery services. These services are intended to support existing neighborhood strategies.

The Boston Neighborhood Trauma Team (NTT) Network offers the following services for individuals, families, and communities impacted by community violence:

- Access to a support hotline 24/7 365 days a year
- Immediate support services for any individual impacted by community violence
- Support for individuals and families during community events including vigils, memorial, and funeral services
- Referral to ongoing behavioral health services for individuals and families
- Trauma education and support at community meetings
- Community outreach to distribute basic health information on trauma
- Community coping/healing groups

Support is available to ALL residents who feel impacted by community violence and all services are free and private.

Goal Description	Goal Status
Respond to all incidents of homicide or stabbing within catchment area that meet criteria as established by the BPHC	Responded to 91% of incidents within catchment area. There were 35 incidents within catchment area, and 32 of these incidents received a response in FY 18.
Provide informal consultation around issues of trauma and violence in the community	Participated in 10 consultations around issues of trauma and violence in the community.
Provide direct therapeutic services to children, adults, and their families who have been impacted by violence	149 clients that included children and adults, completed a first-time visit for supportive services in FY 18.

Social Determinants and Health Risk Factors- Education and Workforce Development

Brief Description or Objective

As an academic medical center, BIDMC's mission includes a strong commitment to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. In FY 2018, BIDMC offered incumbent employees six "pipeline" programs to train for the following professions: Central Processing Technician, Third Party Associate, Patient Care Technician, and Research Administrator. BIDMC's Employee Career Initiative provides career and academic counseling, on-site academic assessment, and on-site pre-college and college-level science courses to employees at no charge. Tuition reimbursement and competitive scholarships as well as ESOL, basic computer skills and citizenship classes are additional offerings. BIDMC also offers employees the opportunity to take the course "Financial Fitness Program," which helps employees build financial literacy skills and offers them three one-on-one planning sessions with a financial counselor. In FY 18, BIDMC selected employees to participate in The Partnership, Inc.'s and Conexion's leadership programs. The Partnership program and Conexion are designed to facilitate career growth and networking for multicultural professionals in Massachusetts.

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

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

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

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

Recognizing its commitment to the Boston area's student population, the medical center provides summer jobs and mid-year internships to introduce high school students and out-of-school youth to careers in the medical field. In partnership with the Boston Private Industry Council (PIC), BIDMC hosts students from Boston Public high schools in an annual Job Shadow Day with additional student groups touring the skills lab throughout the year. BIDMC is also a presenting sponsor of the Red Sox Scholars Program that pairs BIDMC Medical Champions with 12 academically talented, economically disadvantaged 8th grade students from Boston Public Schools. The program includes opportunities for professional development such as Job Shadow Day at BIDMC clinical sites. Additionally in FY 2018, BIDMC Workforce Development hosted a Job Search workshop for 11 students in the Bowdoin Street Community Health Center's Youth Leadership program. Six of these students were among those hired into paid summer jobs at BIDMC.

Finally, BIDMC hosts high school students (age 14-17) for seven weeks during the summer, where the teens can explore various careers while gaining experience in a hospital setting. BIDMC's Summer Health Corps Program is a six-week educational hands-on program for high school students. Through this program, teens can explore various careers while gaining experience in a hospital setting. In FY 2018, 41 students assisted hospital personnel in various administrative and direct patient contact positions and attended weekly tours of various departments at BIDMC.

BIDMC senior leaders are active in advocating on behalf of educational and job opportunities. Joanne Pokaski, Director of Workforce Development, is a member of the Boston PIC and chairs the PIC's Boston Health Care Careers Consortium, which brings together healthcare employers, the workforce system and educational institutions in the greater Boston area. She is a member of the Massachusetts Workforce Development Board and co-chairs its Labor Market and Workforce Information Committee. Ms. Pokaski also serves on the Executive Committee of CareerSTAT, a project of the National Fund for Workforce Solutions to encourage healthcare employers nationally to invest in the skills and careers of their front line workers.

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

Goal Description	Goal Status
Provide pipeline programs to enhance skills and career advancement	Offered 6 pipeline programs with 25 graduates in FY 2018.
Provide opportunities through Employee Career Initiative (ECI) for college-level courses as well as counseling	A pre-college math class was piloted at Bowdoin Health Center for staff and community members. 10 people started the program and 7 successfully passed the course.
Offer ESOL classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class	30 employees were enrolled in ESOL classes; 98 employees participated in a 10-week computer skills class; 12 attended citizenship classes; and 20 attended a financial literacy class.
Provide job and career introductory opportunities for community residents	Hosted 8 adults in training internships, one of which was subsequently hired; offered feedback and advice to community organizations on 38 adults who applied for jobs. Enrolled 4 participants in BSHC's Train4Change Program. Hired 2 interns from Bunker Hill Community College's Learn and Earn Program.
Provide job and career introductory opportunities for middle and high school students	Provided 43 paid summer job opportunities; 1 school-year internship; five tours of medical center and skills lab; hosted 31 Boston Public School students for PIC's annual Job Shadow Day. Medical Champions mentored 12 academically talented, economically disadvantaged 8th graders from BPS. Hosted 42 high school students in Summer Health Corps Program.

Social Determinants and Health Risk Factors – Community Health

Brief Description or Objective

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

In FY 2014, BIDMC awarded the Boston Alliance for Community Health (BACH) funding to facilitate a highly participatory community engagement process in the Bowdoin Geneva Community. In FY 2014, a BACH organizer partnered with community organizations, Bowdoin Geneva Alliance, BSHC, Violence Intervention Program, and Family Nurturing Center to determine recruitment for the Community Advisory Board (CAB). Four community residents were recruited to the CAB and trained on racial equity, social determinants, community health data, participation in a CAB, and how to request, write, and evaluate proposals. The CAB released a request for proposals for a small community health improvement project that promote racial equity in the neighborhood and focus on key social determinants of health: employment, food access, or housing (expanded to mental health and criminal justice in 2016, and economic development in 2017). In FY 2017, under the direction of the BACH organizer, the CAB reorganized to support more neighborhood-centered allocation of resources. In FY 2018, the Cape Verdean Community UNIDO Youth Leadership Academy was funded to bring together teenagers to complete community and civic engagement projects in the Bowdoin-Geneva neighborhood. Additionally, in FY 2018 Bowdoin Geneva Main Streets was funded to support and leverage 0% interest revolving loans through Kiva to help small business owners purchase needed equipment to increase sales.

Additionally in FY2018, BIDMC participated in the Social Determinants of Health Collaborative and is supporting the Bowdoin/Geneva Alliance Strategic Planning.

Goal Description	Goal Status
BACH and CAB will revise community engagement/ outreach process for grant making	CAB members decided to do more targeted outreach to potential organizational partners, rather than a broader RFP. This allowed for a more meaningful, community-based process with organizations working historically and directly with Bowdoin Geneva residents
BACH to identify 5-8 new community partners doing SDOH work in Bowdoin Geneva and recruit 3-5 new CAB members.	CAB identified 4 new partners. BACH staff had 1-1 conversations with each regarding mission and programs. BACH staff asked these organizations to apply for a grant - 3 applications received, 2 funded. 4 new CAB members have been recruited and were trained by the end of CY 18.

Behavioral Health and Substance Use– Facilitating Access

Brief Description or Objective

Mental illness and substance use have a profound impact on the health of people living in Massachusetts and the Boston area. Mental health and substance use hospitalization and death rates are higher for a number of Boston's neighborhoods, in particular Roxbury and parts of Dorchester. These two neighborhoods have a high percentage of Hispanic/Latino residents (nearly 30% of Roxbury's population is Hispanic/Latino). BIDMC formed an Opioid Care Committee in FY 2017, whose members include clinical and nonclinical staff. The newly formed addictions team includes Kevin Hill, MD, Addiction Specialist, Psychiatry; Joanne Devine, APN, Specialist in Addictions; Leslie Bosworth, LICSW, Specialist in Addictions; and Allison Borrelli, LICSW, Inpatient/Outpatient Psychotherapy. This committee is working to prevent Opioid Use Disorder and to improve the care of patients with Opioid Use Disorder. The goals of the committee include implementing a comprehensive team approach to addiction treatment; achieving best practices for opioid use in assessment, treatment, and continuity of care for acute and chronic pain management; improving management and control systems for opioid use and misuse; and complying with Federal and State regulatory requirements regarding opioid management.

In response to the mental health needs of the Latino community, BIDMC established and continues to offer the Latino Mental Health Service. The program provides individual and group psychotherapy and psychopharmacologic services to Hispanic/Latino patients in a manner that is sensitive to their language and culture.

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

Goal Description	Goal Status
Increase provider awareness and utilization of Behavioral Health Services	Completed two-year evaluation of BSHC Behavioral Health Services including ways to better collaborate with primary care providers. Education and consultation were provided to physicians and in-house referral patterns were studied.
Provide culturally competent mental health services to Latino patients and their families	Continued to offer the Latino Mental Health initiative providing bilingual and bi-cultural mental health services.
Establish Bridging Clinic	With the opening of the new Addiction Psychiatry clinic space and the addition of several staff members, Dr. Kevin Hill and his team are able to offer expanded access to bridge clinic services for patients beginning treatment for opioid use disorder with medication assisted therapy. An additional bridge clinic is available with providers at Health Care Associates.
Establish Dashboard Metrics	The Inpatient Opioid Prescribing Dashboard is now live. The metrics included in the dashboard were derived based on the recommendations of the Massachusetts Health and Hospital Association and the Consensus Statement by the Society of Hospital Medicine on safe opioid use for acute pain in hospitalized patients. Individuals will be able to compare their prescribing to that of peers in their division or department, as well as set goals for adherence to recommended practices.

Behavioral Health and Substance Use – Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Brief Description or Objective

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing substance use disorders. The SBIRT screening quickly assesses severity of substance use and helps providers to identify appropriate treatments. SBIRT is recommended by the Institute of Medicine. BIDMC's Emergency Department (ED) implemented an SBIRT program. All patients are asked about alcohol use, and those with an identified issue are provided discharge instructions including contacts for alcohol use counseling. Additionally, two large primary care practices are notified by secure messaging if their patient is seen in the ED for substance use.

Per the American College of Surgeons, universal screening for alcohol use must be performed for all trauma patients and must be documented. At Level I trauma centers, all patients who have screened positive must receive an SBIRT intervention by appropriately trained staff, and this intervention must be documented. It has been demonstrated that trauma centers can use the teachable moment generated by an injury to implement an effective injury prevention strategy; alcohol and/or drug use counseling for patients presenting to the hospital because of a substance use. BIDMC's Level I Trauma Center works collaboratively with Social Work, Nursing, Physicians, and all members of the care team to ensure screening, intervention, education, and referral to treatment is provided to every patient.

As part of the SBIRT implementation, BIDMC developed a teaching module to educate providers about patients who may be at-risk for alcohol use, and taught residents, attending physicians and nurses the skills to assess and intervene on patients at risk for alcohol use. This additional training prepares providers to assess a patient's motivation to alter behavior and/or seek additional assistance for care. In FY 2018, BIDMC's ED continued to utilize resources available to providers in the electronic database. These include documentation, literature, and other tools available to providers for real-time interventions using SBIRT.

Goal Description	Goal Status
Utilize SBIRT in the BIDMC Emergency Department	SBIRT protocol was incorporated into workflow and fully adopted by BIDMC's Emergency Department.
Screen patients in the ED	264 trauma patients were screened in the BIDMC ED as of September, 2018.

Equitable Care- Office of Diversity and Inclusion

Brief Description or Objective

BIDMC recognizes the importance of provider/patient cultural concordance in providing quality care. BIDMC's on-going commitment to diversity and inclusion has evolved over the past decade. Inaugurated, in FY 2010, The Office of Multicultural Affairs worked to recruit, retain, and advance diverse residents and fellows, junior faculty, and in-house staff and faculty. In January 2015, a new Office for Diversity and Inclusion (ODI), headed by a senior faculty member was created and charged with working with Department Chairs to increase recruitment and retention of under-represented minority and women faculty, and to oversee data collection on health care disparities at BIDMC. Finally, in FY 18, BIDMC's Human Resources Department added a senior leader to focus on Diversity and Inclusion efforts around creating a welcoming workplace environment.

Goal Description	Goal Status
Increase diversity of residents and fellows in training	URM applicants have remained steady in FY 2018. ODI hosted three visiting students from traditionally black medical schools for a one-month elective course.
Invite two distinguished speakers from underrepresented groups to speak about health care disparities	Two speakers gave lectures on healthcare disparities.
Provide 4 lectures on unconscious bias and healthcare disparities to members of the medical, nursing, and social work staff. Additionally, develop a lecture on the biological basis of racism and how to combat it	Provided 6 lectures on unconscious bias and healthcare disparities to members of the medical and social work staff. Developed a lecture on the biological basis of racism and gave the lecture to several groups in the medical center and at the university.

Equitable Care - Evidence-Based Strategies and Research

Brief Description or Objective

The Institute of Medicine's report, *Unequal Treatment,* focused the nation's attention on disparate care and health outcomes among the U.S. populace. BIDMC's clinical and research community embraced the challenges of advancing knowledge about the root-causes of racial and ethnic health disparities, and developing evidence-based strategies to improve health status of affected groups. For example Sarah Berry, MD, MPH leads a study on neighborhood risk factors for falls in the elderly. Suzanne Bertisch, MD, MPH continues to lead a study on adapting sleep and yoga interventions for use in low-income populations to improve quality of life for those who have sleep disorders. Wendy Stead, MD, examines educational interventions to improve communication with patients who have Opioid-Use Disorder.

This research enterprise frequently extends beyond BIDMC's campus, involving collaboration with other Harvard Medical School (HMS) affiliates. The Dana Farber/Harvard Cancer Center (DF/HCC)'s Initiative to Eliminate Cancer Disparities is one example where seven institutions are working together on community education and outreach campaigns as well as efforts to make state-of-the-art cancer care accessible to communities of color through clinical trial enrollment and enhanced culturally competent care in hospitals. The Harvard Catalyst is the latest collaboration, bringing together the expertise of Harvard University's 10 schools and 18 academic healthcare centers and other partners to aid the translation of scientific advances into clinical practice and public health policy.

BIDMC is also part of the Boston Breast Cancer Equity Coalition (BBCEC), which is made up of Boston hospitals, MA Department of Public Health, Boston Public Health Commission and various other organizations that serve racially/ethnically diverse populations in Boston. The vision of the BBCEC is to eliminate the differences in breast cancer care and outcomes by promoting equity and excellence in care among all women of different racial/ethnic groups in the City of Boston.

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

Section V: Expenditures

Community Benefits Programs

Expenditures	Amount
Direct Expenses	$ 14,392,971
Associated Expenses	$ 0
Determination of Need Expenditures	$ 24,000
Employee Volunteerism	$ 24,744
Other Leveraged Resources	$ 3,510,532

Net Charity Care

Expenditures	Amount
HSN Assessment	$ 7,927,233
HSN Denied Claims	$ 8,246,836
Free/Discount Care	$ 0
Total Net Charity Care	$ 16,174,069

Corporate Sponsorships	$ 12,500
Total Expenditures	$ 34,138,816
Total Revenue for FY 2018	$ 1,392,999,027
Total Patient Care-related Expenses for FY 2018	$ 1,264,652,050
Approved Program Budget for FY 2018	$ 34,000,000
(*Excluding expenditures that cannot be projected at the time of the report.)	
Bad Debt	$7,453,060 (Certified)

Comments: Total Charity Care is $97,112,129 and includes BIDMC's payment of $16,174,069 to the Health Safety Net; $33,492,068 in unreimbursed Medicare Services; $35,778,658 in unreimbursed MassHealth Services; $7,453,060 in bad debt; and $3,253,517 in BIDMC's voluntary PILOT payment to the City of Boston, which contributes to the health and well-being of individuals residing in its Community Benefits Service Area. Additionally, BIDMC paid $741,195 to the Center for Health Information and Analysis (CHIA) and $219,562 to the Health Policy Commission (HPC).

Section VI: Contact Information

Nancy Kasen
Director
Office of Community Benefits
Beth Israel Deaconess Medical Center
330 Brookline Avenue, BR 270
Boston, MA 02215
617.667.2602
nikasen@bidmc.harvard.edu