Community Benefits Report

Fiscal Year 2024

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

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SECTION I: SUMMARY AND MISSION STATEMENT

Beth Israel Deaconess Medical Center (BIDMC) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

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

While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

- ***W****ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E****mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C****ollaboration - We work together to achieve extraordinary results*
- ***A****ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R****espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E****quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

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. This mission is supported by BIDMC's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining our financial health. The Medical Center is

also committed to being active in the community as well. Service to the community is at the core and an important part of our mission. BIDMC has a covenant to care for the underserved and to work to change disparities in access to care; to be successful, BIDMC needs to learn from those it serves.

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

- **Involving BIDMC's staff**, including its leadership and dozens of community partners in the Community Health Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout BIDMC's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in BIDMC's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

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

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

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

Priority Cohorts

Beth Israel Deaconess Medical Center's CBSA includes the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and

Roxbury, the City of Chelsea, and the towns of Brookline, Burlington, Lexington, Needham, Newton (Chestnut Hill) and Peabody. In FY 2022, BIDMC conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BIDMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BIDMC is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BIDMC's FY 2023 - 2025 Implementation Strategy (IS) is focusing its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BIDMC's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2023 – 2025 IS, BIDMC is working with its community partners, with a focus on Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BIDMC's Community Benefits investments and resources focus on the improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+; and
- Families Affected by Violence and/or Incarceration.

Basis for Selection
Community health needs assessments; public health data available from government (public school districts, Massachusetts Department of Public Health, federal agencies) and private resources (foundations, advocacy groups); engagement with BIDMC's Community Benefits Advisory Committee (CBAC); and BIDMC's areas of expertise.

Key Accomplishments for Reporting Year

The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in BIDMC's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS).

Program accomplishments include:

- Continued to support increased capacity of primary care and OB/GYN practices at five affiliated health centers
- Continued community-based specialty care services
- Provided culturally and linguistically appropriate care for patients through cancer navigation, interpreter services, and multilingual patient education
- Addressed social determinants of health, particularly violence prevention, through the Center for Violence Prevention and Recovery (CVPR), Bowdoin Street Health Center's (BSHC) Community Healing Response Network and other initiatives
- Increased access to behavioral health services through the implementation of the Collaborative Care model and offered Mental Health First Aid trainings to community members
- Continued workforce development through summer internships for underserved youth, pipeline programs, and training programs for adults
- Addressed food insecurity through BSHC's purchase and distribution of fresh fruits and vegetables to patients and community members and donations of food
- Funded four organizations to address housing affordability, four organizations to address jobs and financial security, and three organizations to address behavioral health through BIDMC's Community-based Health Initiative
- Funded five neighborhood-specific collectives in Boston and Chelsea through the Healthy Neighborhoods Initiative
- Launched a digital literacy/health equity program in partnership with BSHC to promote access to digital tools and resources
- Conducted research that supports the understanding of health disparities

Plans for Next Reporting Year

In FY 2022, BIDMC conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BIDMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, BIDMC will focus its FY 2023 - 2025 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in BIDMC's CBSA who face the greatest health disparities. These four priority areas are:

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

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 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BIDMC's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BIDMC, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BIDMC's FY 2023 - 2025 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BIDMC's Community Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; LGBTQIA+; and families affected by violence and/or incarceration.

BIDMC partners with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - BIDMC will work with the Bowdoin Street Health Center to support its Community Health Worker program
  - BIDMC will continue to partner with CCA health centers to increase access to primary care and specialty care services, including OB/GYN and maternal and child health services
  - BIDMC will work to provide and promote career support services and career mobility programs in partnership with Conexión, The Partnership, Inc., and other organizations
  - BIDMC's Center for Diversity, Equity, and Inclusion will support research aimed at providing more equitable care for patients and community members by working with organizations including the Student National Medical Association and Harvard Medical School

- **Social Determinants of Health**

- BIDMC will work with grantees such as Boston Housing Authority and HomeStart to invest in housing programs that stabilize or create access to affordable housing
- BIDMC will partner with grantees such as Casa Myrna and Tech Goes Home to strengthen the local workforce and address unemployment and underemployment
- BIDMC will promote thriving neighborhoods and enhance community cohesion and resilience through partnerships with Healthy Neighborhoods Initiative Collectives and organizations including the Louis D. Brown Peace Institute and the Boston Public Health Commission
- BIDMC will work to increase mentorship, leadership, training, and employment opportunities for youth and young adults through partnerships with organizations such as African Bridge Network, the Boston Private Industry Council, and the YMCA of Greater Boston
- BIDMC's Center for Violence Prevention and Recovery partners with the Louis D. Brown Peace Institute, Jane Doe, Inc., The Network/La RED, Casa Myrna, and other organizations to build community awareness, advocate for policy change, and provide supportive care for victims of violence and trauma
- BIDMC will promote healthy eating and active living through partnerships with community-based organizations like the Dorchester Food Co-op and Jose Mateo Ballet Theatre, among other organizations

- **Mental Health and Substance Use**
  - BIDMC will work with grantees such as Children's Services of Roxbury and Greater Boston Chinese Golden Age Center to invest in community behavioral health services
  - BIDMC will implement evidence-based programs such as the Collaborative Care Model and Mental Health First Aid trainings for community members

- **Complex and Chronic Conditions**
  - BIDMC will provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs through programs in partnership with the CCA health centers, Dana Farber Cancer Institute, the Joslin Diabetes Center, and other organizations and institutions

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BIDMC Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 60). The BIDMC Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the Office of the AGO.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BIDMC's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA 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 Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BIDMC's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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The BIDMC Community Benefits program is spearheaded by a team of Community Benefits senior leaders including the Vice President and Manager of Community Benefits. The Vice President of Community Benefits has direct access and is accountable to the Divisional

President, Metro Boston for BILH and BIDMC President and also reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of BILH and BIDMC's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The BIDMC Community Benefits Advisory Committee (CBAC) works in collaboration with BIDMC's hospital leadership, including the hospital's governing board and senior management to support BIDMC's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BIDMC's community. The CBAC provides input into the development and implementation of BIDMC's Community Benefits programs in furtherance of BIDMC's Community Benefits mission. The membership of BIDMC's CBAC aspires to be representative of the constituencies and priority cohorts served by BIDMC's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The BIDMC CBAC met on the following dates:
December 12, 2023
March 26, 2024
June 25, 2024
September 24, 2024

Community Partners
BIDMC recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BIDMC's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with BIDMC's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. BIDMC's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BIDMC's mission.

BIDMC currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BIDMC collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. BIDMC has a particularly strong relationship with many of the community health centers that operate in its CBSA. These health centers, part of the Community Care Alliance (CCA), are critical components of the health care safety net in the communities they operate. In 2024, the CCA

health centers provided primary care medical, dental, behavioral health, and enabling services to approximately 101,132 patients. The CCA health centers include:

- Bowdoin Street Health Center[1]
- Charles River Community Health
- The Dimock Center
- Fenway Health
- South Cove Community Health Center

These health centers are ideal Community Benefits partners because they are rooted in their communities and, as they are predominantly federally qualified health centers, are mandated to serve low-income, historically underserved populations. These community partners have been a vital part of BIDMC's community health strategy since 1968. Historically, BIDMC has relied heavily on its CCA partners, as well as a number of other key community health partners, to implement its Community Benefits initiatives. In this regard, BIDMC has leveraged CCA's expertise and the vital connections that these organizations have with the residents and other community-based organizations that operate in the communities they serve.

BIDMC is also an active participant in the Integrated North Suffolk Community Health Needs Assessment (iCHNA) and the Boston Community Health Collaborative. Joining with such grassroots community groups and residents, the Boston Public Health Commission (BPHC), Massachusetts DPH, and academic partners, BIDMC strives to create a vision for both city-wide and neighborhood-based health improvement.

See Appendix A on page 66 for a full listing of the community partners with which BIDMC collaborated on its FY 2023-2025 IS and its FY 2022 CHNA.

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

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. 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 BIDMC's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by BIDMC's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BIDMC's most recent CHNA was completed during FY 2022. FY 2023 Community Benefits programming was informed by the FY 2022 CHNA and aligns with BIDMC's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed BIDMC to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and BIDMC's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

BIDMC's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that BIDMC serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically

underserved. BIDMC's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, BIDMC, in collaboration with three other regional assessment efforts, conducted 85 one-on-one interviews with key collaborators in the community, facilitated 22 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,400 residents from BID Needham's and LHMC's CBSAs, including 346 residents from Needham, 155 residents of Burlington, and 180 residents of Peabody. BID Needham and LHMC shared this information with BIDMC and organized two community listening sessions. The Boston Public Health Commission fielded a COVID-19 Health Equity Survey in December 2020/January 2021; as such, BIDMC, based on recommendations from the Boston CHNA-CHIP Collaborative Steering Committee, opted not to field the BILH Community Health Survey in Boston. This survey of a random sample of over 1,650 residents in multiple languages examined issues related to job loss, food insecurity, access to services, mental health, vaccination, and perceptions of risk around COVID-19. The North Suffolk Public Health Collaborative also fielded a community health survey. The survey collected data from 1,401 respondents from Chelsea, Revere, and Winthrop. Results were stratified by community, age group, gender, race, ethnicity, and language.

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

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.
- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2022 BIDMC Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, patients will receive primary care, OB/GYN, and specialty care at Community Care Alliance (CCA) health centers.	In FY24, 101,132 patients were seen at Community Care Alliance (CCA) health centers.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BIDMC specialists will practice at CCA health center sites.	In FY24, 26 BIDMC specialists practiced at CCA health center sites.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Primary Care Navigation

Brief Description or Objective	In collaboration with Beth Israel Lahey Health, primary care sites within the BIDMC network are enhancing their existing care model at the sites serving the largest number of Black and Hispanic patients with uncontrolled diabetes. These sites will embed a clinical pharmacist and a patient navigator within the care team to improve patient access and reduce barriers to implementing diabetes care plans.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Achieve a 25% reduction in the disparities for diabetes among Black and Hispanic patients in FY24	As of October 2024, the percentage of Black patients with A1c >9 increased by 6.7%. The percentage of Hispanic patients with A1c >9 decreased by 0.8%.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Outcome Goal
Achieve a 25% reduction in the disparities for hypertension among Black and Hispanic patients in FY24	As of October 2024, the percentage of Black patients with BP >140/90 increased by 0.6%. The percentage of Hispanic patients with BP >140/90 decreased by 9.0%.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Outcome Goal

Priority Health Need: Access to Care **Program Name: Community Care Alliance**	
Brief Description or Objective	BIDMC was instrumental in helping its affiliated and/or licensed health centers form a network called the Community Care Alliance (CCA). By collaborating on clinical and administrative issues, the CCA helps its members continue to provide high-quality, cost-effective healthcare services by collectively contracting for services and funding, as well as sharing resources and expertise for the benefit of their patients and communities. BIDMC is committed to strengthening the capacity of its five affiliated CHCs in the CBSA: Bowdoin Street Health Center (BSHC), The Dimock Center, Fenway Health, Charles River Community Health (CRCH), and South Cove Community Health Center. The partnership takes many forms: recruitment, retention, financial support and credentialing of physicians and advanced practice providers, access to managed care contracts, BIDMC-sponsored fellowships and continuing education programs, and access to clinical care resources.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC specialists will practice at CCA health centers.	In FY24, 26 BIDMC specialists practiced at CCA health centers.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BIDMC will conduct 12 Office of the Inspector General (OIG) reviews on CCA CHC employee and vendor lists, to ensure compliance with state and federal standards.	BIDMC has continued monthly regulatory OIG reviews for all CCA CHC personnel and vendors.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

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

Program Goal(s)	Goal Status	Goal Year and Type
In FY24, Emergency Management will participate in a community-based hazardous materials (hazmat) exercise to assist in uncovering vulnerabilities in the hospital and region's response to a no-notice hazmat event.	BIDMC Emergency Management participated in a joint Tabletop Exercise managed by the Conference of Boston Teaching Hospitals (COBTH). This exercise tested Boston hospital and community (Boston EMS, Boston Fire, Boston Police) response to the release of an unknown hazmat at the Center for Life Science Building in the Longwood Medical Area. An after-action report was generated and shared with community participants where BIDMC participated in developing strategies and prioritizing those strategies to enhance regional hazmat capabilities.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC will increase Interpreter Services department interactions.	The number of interpreter services interactions (in-person, telephone, video, and ASL) totaled 311,031 in FY24 compared to 298,022 in FY23.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
By the end of FY24, BIDMC Interpreter Services will improve average response time for staffed languages.	In FY24 BIDMC achieved its goal of decreasing average response time to under 4 minutes for staffed languages.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
BIDMC will continue to address unmet medical needs for rural Cape Cod.	In FY24, BIDMC continued to address unmet needs for rural Cape Cod.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will continue to provide access for remote communities to quaternary care.	In FY24, BIDMC continued to provide access for remote communities to quaternary care.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year the BIDMC Social Work Department will provide housing support to patients in need of short- or long-term housing. BIDMC will also provide short-term housing for bone marrow transplant patients.	Goal partially achieved due to lack of available emergency housing and low and moderate-income housing in the Greater Boston Area.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
BIDMC will continue to contribute to the Mass HIWay initiative.	BIDMC continues to contribute to the Mass HIWay initiative.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will continue sending inpatient and ED discharge summaries with the expanded primary care network.	BIDMC continues sending inpatient and ED discharge summaries with the expanded primary care network.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Brief Description or Objective	BIDMC utilizes BILH retail and specialty pharmacies to offer a Patient Assistance Program for patients with family income at or below 300% of the federal poverty level. The pharmacies are registered as Health Safety Net (HSN) pharmacies and provide courtesy fills for low-income BIDMC patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, BIDMC contracts with the BILH pharmacies to employ patient assistance staff. BIDMC also subsidizes inpatient psychiatric services for those most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others, or who are unable to care for themselves due to mental illness. Additionally, throughout BIDMC's Community Benefits Service Area, BIDMC subsidizes primary care services provided by Beth Israel Lahey Health Primary Care (BILH-PC), Healthcare Associates (HCA) and Bowdoin Street Health Center. BIDMC's robust Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when family income is at or below 400% of the current Federal Poverty Level). BIDMC Financial Counseling staff screen patients and assist patients in applying for all eligible financial assistance programs.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Each year, BIDMC will screen and enroll eligible patients into entitlement programs.	In FY24, staff screened 2,866 patients for eligibility and submitted 1,301 applications for entitlement programs. Of these applications, 947 patients were approved for a State Assistance program and overall 9,044 uninsured patients utilized Health Safety Net.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, the Retail pharmacy will aim to meet 100% of requests for talking scripts and provide home delivery for patients with difficulty accessing the medical center for pick up.	The Retail pharmacy is meeting requests for talking scripts and providing home delivery.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Boston Healthy Start Initiative and Birth Center Grant

Brief Description or Objective	The Boston Healthy Start Initiative (BHSI) is a grant-funded program designed to improve birth outcomes and eliminate birth outcome disparities among women in Boston. BHSI allows Bowdoin Street Health Center (BSHC) to provide a dedicated Community Health Worker (CHW) to support its high-risk prenatal patients. As one of five sites funded by the Boston Public Health Commission, BSHC serves pregnant Black women by providing support and case management, making connections to a skilled public health nurse, engaging and supporting fathers or significant others, and providing support around maternal and child nutrition, including breastfeeding support. In September 2023, the Neighborhood Birth Center was awarded funding to create a birth center that would focus on low-resourced and diverse patients. The Neighborhood Birth Center is expected to break ground on the building in Nubian Square in Spring 2025.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Each year, the Healthy Start Family Partner will serve 100 clients total including 50 pregnant and 50 others (interconception/parenting).	In FY24, the Family Partner served 83 prenatal mothers, 72 postnatal mothers, and 130 children.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care
Program Name: Medical-Legal Partnership for Immigrants

Brief Description or Objective	A Medical-Legal Partnership (MLP) functions as a touchpoint between the medical and legal systems, providing access to critical yet typically unaffordable legal advice through patients' relationship with their healthcare provider. The Medical-Legal Partnership for Immigrants (MLPI) provides BIDMC's patients with direct access to legal services, which allows for much more effective and efficient resolution of immigration-related barriers to receiving healthcare benefits to which they are entitled. This, in turn, will increase these patients' access to care and improve their health.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Each year, resolve immigrant related barriers that BIDMC patients face when accessing health care and health coverage.	Health Law Advocates has served 31 BIDMC patients to date and 5 patients have maintained services as a result of services provided.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal

Priority Health Need: Access to Care **Program Name: Digital Literacy for Health Equity**		
Brief Description or Objective	The increasing use of mobile devices in healthcare offers novel opportunities to expand treatment options and reach these underserved populations. Too often, however, the gap in digital literacy makes it difficult for low-income patients to navigate technology and benefit from it. New approaches are needed to make digital mental health accessible and equitable. Through community activation and training based on published protocols, our program empowers and teaches people in the community to use their mobile phones and computers as tools to advance their healthcare and thrive. The program, Digital Opportunities for Outcomes in Recovery Services (DOORS), offers free services, including free device distribution, digital literacy training, digital skills office hours, and community training. Of note, these services are available in both English and Spanish, with the expansion of Cape Verdean offerings in development.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	**Goal Status**	**Goal Year and Type**
By end of FY24, we will have created sharable digital literacy manuals, handouts, slides, and assessments that can allow the program to expand to more sites. This will represent over 250 pages of resources to share.	A suite of training resources has been completed, which other teams have already asked to use.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
By end of FY24, establish a Digital Navigator (digital literacy skill teacher) at Bowdoin Street Health Center that serves at least 30 patients in the first month (as defined by providing services, consultation, or training).	Averaged one contact per day in our first month and expect more uptake of the service in FY25 as the program becomes more established and well known in the community.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

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

Brief Description or Objective	With more than 50% of disease attributable to health behaviors, BIDMC and its affiliated and/or licensed Community Health Center (CHC) providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. BIDMC's affiliated federally qualified health centers (FQHC) also screen and educate patients for diabetes, hypertension and asthma, provide evidence-based care and treatment, and work with BIDMC to ensure access to needed specialty care. BIDMC also supports Charles River Community Health's (CRCH) team-based care management program for patients with chronic conditions, including diabetes and hypertension. The BIDMC Cardiovascular Institute has a longstanding partnership with the American Heart Association and sponsors community education and awareness building events. In FY24, BIDMC donated 500 blood pressure monitors to the Latinx Cardiovascular Clinic in Chelsea and throughout the medical center to patients who needed them.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By 9/30/25, <30% of CRCH patients ages 18-75 with a diagnosis of diabetes will have HBA1c > 9% or no test recorded.	Goal met in FY24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
By 9/30/25, 75% of CRCH patients 18-85 years of age with hypertension will have hypertension controlled (<140/90).	This goal is at 69% in FY24, an improvement over FY23 at 66.5%; and FY22 (55%), due to an increase in the use of interdisciplinary care teams.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
100% of CRCH Medical Assistants (MAs) will be trained to use EMR prompts to identify health center patients with diabetes when they come in for care for any reason.	Goal met in FY24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, CRCH will hold at least one Diabetes Nurse Education session in Brighton and Waltham.	Goal met in FY24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

By 9/30/25, the percent of CCA FQHC adults with diabetes whose condition is controlled (HbA1c < 9) will be higher than 70%.	In FY24, the percent of CCA FQHC adults with diabetes whose condition was controlled (HbA1c < 9) was 75%.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
By 9/30/25, the percent of CCA FQHC adults with hypertension whose blood pressure is < 140/90 will increase from the year before.	In FY24, the percent of CCA FQHC adults with hypertension whose blood pressure was < 140/90 was 61%.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
The affiliated federally qualified health centers will continue to serve patients with diabetes, hypertension, and asthma.	The health centers collectively served 9,586 patients with diabetes, 21,922 patients with hypertension and 4,781 patients with persistent asthma in FY24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BSHC CHWs will provide supportive intervention to at least 200 referred patients.	In FY24, CHWs provided supportive intervention to 900 referred patients.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, CHWs will respond to at least 50 on-call requests for intervention.	In FY24, CHWs responded to 50 on-call requests for intervention.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, each CHW will carry a case load of at least 30 patients and provide ongoing support and intervention to those 30 patients.	In FY24, CHWs carried an average case load of 115 patients and provided ongoing support and intervention to those patients.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Brief Description or Objective	BIDMC's Social Work department supports cancer patients by helping them understand social security benefits, disability benefits, insurance coverage and other financial programs. Additionally, they provide temporary housing to individuals undergoing treatment. Patients and families are also connected to individuals who have been in similar circumstances for support.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Each year BIDMC patients will have access to a Cancer Patient Navigator.	In FY24, patients had access to cancer patient navigators but volume data is not available due to a transition in Electronic Health Record system.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC's Social Work Department will offer cancer support groups.	In FY24, BIDMC offered 3 types of cancer support groups.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC will provide low-income individuals with mammograms.	In FY24, BIDMC provided 2,019 mammograms to low-income individuals.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC will provide low-income individuals with colon cancer screenings.	In FY24, BIDMC provided 2,771 colon cancer screenings to low-income individuals.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

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

Program Goal(s)	Goal Status	Goal Year and Type
Each year, The Dimock Center will screen over 90% of HIV+ patients for HCV.	95% of HIV+ patients were screened for HCV.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, the number of visits to The Dimock Center attended by an infectious disease physician will be 90 visits over 12 months.	94 visits were attended by an infectious disease physician in the last 12 months of FY24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, the number of HIV/HCV co-infected patients who have begun HCV treatment will be at least 2.	The number of HIV/HCV co-infected patients who have begun HCV treatment was 1.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Brief Description or Objective	The Wellness Center at Bowdoin Street Health Center (BSHC) contains a demonstration kitchen, a large exercise room for dance and physical activity classes, and a gym with work-out equipment. The Wellness Center offers Bowdoin/Geneva residents the opportunity to learn and practice healthy habits in their own neighborhood. The Healthy in the City program offered by BSHC is a team-based approach to weight management that actively involves a provider, nutritionist, and case manager in ongoing care planning for each participant. The intervention includes referrals to physical activities, connection to nutrition resources, and referral to mental health counseling when appropriate. To address food insecurity, BSHC partners with local organizations to increase access to healthy foods. Fair Foods is a community-based organization that works with other non-profits, community groups and religious organizations to distribute fruits and vegetables to Boston-area residents. BSHC has partnered with the Boston Public Health Commission to distribute Farmers Market coupons that can be used at any City of Boston Farmers Market during summer and fall. Information about additional food-related resources such as food distribution sites and EBT and SNAP is also made available in multiple languages.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Each year, BSHC will provide case management for youth ages 5 - 18 to address issues related to childhood obesity.	In FY24, youth met virtually and participated in facilitated group discussions with topics ranging from healthy snacking to how to use a grow kit. 63 patients were enrolled in the Healthy in the City case management program. 176 patients and community members were reached through after school programs, basketball clinics, school vacation activities, and summer camps.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC will distribute farmer's market coupons for individuals to use at City of Boston Farmers Markets.	BPHC provided 387 booklets of $25 coupons that could be used at any City of Boston Farmers Market during the summer and fall. BSHC distributed all of the coupons between October 1, 2023 and September 30, 2024.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC will distribute healthy food to Boston-area residents.	In FY24, BSHC purchased 958 bags through Fair Foods and distributed them free to patients and community members. BSHC CHWs also distributed 573 grocery store vouchers to patients.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Public Safety

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

Program Goal(s)	Goal Status	Goal Year and Type
Conduct a yearly analysis of the Laura's Law regulations and compliance. Provide Laura's Law training to all staff and security.	Public Safety currently monitors cameras and exterior access points to the Emergency Department in accordance with Laura's Law. All officers received training on how to assist people with disabilities to access emergency health care.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

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

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

Program Goal(s)	Goal Status	Goal Year and Type
By 2030, BIDMC will reduce organizational emissions by 50% and achieve net-zero by 2050 from a baseline of 2016.	BIDMC reduced organizational emissions by 14.6% % in FY24 from a baseline of 2016.	Program Year: Year 5 Of X Years: Year 9 Goal Type: Outcome Goal
By 2030, BIDMC will have achieved Zero Waste (80% diversion from landfill or incineration).	BIDMC achieved 55.8% diversion in FY24 (decreased1.0% from FY23).	Program Year: Year 5 Of X Years: Year 9 Goal Type: Outcome Goal
By the end of FY24, BIDMC Food Services will increase total sustainable and local food & beverage spend to over 20%.	BIDMC purchased 17.0% sustainable and local food & beverage in FY24 (decreased 0.3% from FY23).	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, VIP will continue to sustain communities and empower residents by building knowledge, capacity, and community.	VIP continues to sustain communities and uplift residents.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Center for Violence Prevention and Recovery

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

Program Goal(s)	Goal Status	Goal Year and Type
Each year, CVPR will provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence in the Greater Boston Area.	CVPR provided support to 626 victims of domestic, sexual, and community violence in the Greater Boston area in FY24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, CVPR will provide services to survivors of sexual violence in the Emergency Department.	In FY24, CVPR provided direct services to 63 survivors of sexual violence who came to the BIDMC Emergency Department.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, CVPR will provide free overnight stays for domestic violence victims without safe shelter.	In FY24, CVPR provided free overnight stays for 27 clients who were without safe shelter.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, CVPR will provide free overnight stays in the hospital (Safebed) for victims of violence without safe shelter.	In FY24, CVPR provided 14 free overnight stays in the hospital (Safe bed) for victims of violence without safe shelter.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, CVPR will provide education and outreach services to over 200 employees in health centers, colleges and universities, and other community groups around sexual assault, interpersonal violence, community violence, secondary traumatic stress, and human trafficking.	In FY24, CVPR hosted 12 events that provided training to 489 employees in health centers, colleges and universities, and other community groups around sexual assault, interpersonal violence, community violence, secondary traumatic stress, and human trafficking.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Each year, CVPR will provide 50 peace circles to community members in the Greater Boston area.	In FY24, CVPR provided 24 peace circles attended by 92 community members in the Greater Boston area.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community Healing Response Network (fka Neighborhood Trauma Team)**	
Brief Description or Objective	Bowdoin Street Health Center (BSHC) is the lead agency for the Bowdoin Geneva Greater Four Corners Community Healing Response Network. As the lead healthcare agency, BSHC partners with Greater Four Corners Action Coalition (GFCAC) and provides outreach to individuals, families, and neighborhoods impacted by community violence. The Community Healing Response Network 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 Community Healing Response Network assesses trauma-related community needs to support and deliver prevention, response, and short- and long-term recovery services. These services are intended to support existing neighborhood strategies and all services are free and private to residents impacted by community violence.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, Community Healing Response Network will respond to every incident of homicide, shooting, or stabbing within BSHC's catchment area and offer outreach to victims and impacted residents.	The Community Healing Response Network Coordinator responded to 11 instances of violence that were level 4 and 5 in FY 2024. (Note: Levels 4 and 5 include gun related homicide, any shooting or stabbing incident that impacts more than one victim and/or someone under the age of 18, any traumatic event that impacts a broader community).	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC will provide direct therapeutic sessions to children, adults, and their families who have been impacted by violence.	BSHC staff supported 5 new clients in FY24. There were a total of 5 client visits to the Case Manager. Staff reached 400 people through events and outreach, including a backpack drive during which 300 backpacks were given out.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, YLP will recruit youth leaders to participate in a 12-week session to learn about creating peaceful communities, financial literacy, civics, healthy eating and nutrition and health education for teens. YLP will run two programs in the fiscal year.	The two 12-week sessions graduated 18 participants in the fall, 2022 session and 17 in the spring, 2023 session for a total of 35 youth served through YLP in FY 24.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: BILH Workforce Development

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

Program Goal(s)	Goal Status	Goal Year and Type
Each year, Workforce Development will continue to encourage community referrals and hires.	In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, Workforce Development will continue to hire young people from the community for summer jobs, returning to an in-person format.	In FY24, Workforce Development hired 26 high school aged young people referred by our community partners for paid summer jobs.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, Workforce Development will attend events and give presentations about employment opportunities to community partners.	In FY24, 33 events and presentations were conducted with community partners across the BILH service area.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY24, Workforce Development will offer employees career development services.	In FY24, 1,044 BILH employees received career development services.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will offer internships	In FY24, 107 community members placed in internships	Program Year: Year 2 Of X Years: Year 3

in BILH hospitals to community members over the age of 18.	across BILH hospitals to learn valuable skills. BIDMC participated in offering these internships.	Goal Type: Process Goal
Each year, Workforce Development will hire interns after internships and place in BILH hospitals	In FY24, 37 interns were hired permanently in BILH hospitals. BIDMC participated in these hirings.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.	In FY24, 82 employees across BILH were enrolled in ESOL classes. BIDMC employees participated in these classes.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.	In FY24, 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. BIDMC employees participated in these offerings.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will offer paid trainings for community members across BILH.	In FY24, BILH trained a total of 99 community members to Patient Care Technician or Nursing Assistant (41), Pharmacy Tech (22), Medical Assistant (29), Behavioral Health roles (3) or into the Associate Degree Nursing Residency program (4). BIDMC participated in offering these trainings.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
In FY24, Workforce Development will offer pipeline programs to community members.	In FY24, Workforce Development recruited 99 community members into pipeline programs and hired 100% of them.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
In FY24, Workforce Development will establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.	In FY24, Workforce Development established 10 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 47 high school students in paid cooperative education placements and 11 into unpaid	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

	clinical placements. BIDMC participated in offering these trainings.	
Each year, BIDMC will host at least 20 students in the Summer Health Corps program which provides teenagers with education about healthcare careers through service, career panels, mentoring and tours. 25% of participants will be from the Community Benefits Service Area.	BIDMC hosted 24 high school students in summer 2024. At the time of the program, 75% of these students resided in the CBSA. The students participated in service assignments, career panels, and tours, gaining experience and exposure to a variety of healthcare careers.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Brief Description or Objective	BIDMC, through its Community-based Health Initiative (CHI), is investing in local organizations to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families. To date, BIDMC has awarded funds to four organizations for a three-year grant period, which began January 2024. The funded organizations are: • Boston's Higher Ground: The Family-Led Stability Initiative links education and affordable housing delivery systems to achieve the dual goals of reducing family homelessness and improving health and educational outcomes for families served by the target schools. • Boston Housing Authority (BHA): BHA will expand the First Home Program to provide increase down payment assistance to BIDMC high priority neighborhood residents, increase homeownership education for BHA residents through outreach events and materials, and expand the number of lenders who understand the process of working with subsidized low and moderate income applicants. • HomeStart: Growing the eviction prevention program in Eastern Housing Court to prevent nonpayment evictions. • International Institute of New England (IINE): The Families First Initiative will allow IINE to help immigrants in Greater Boston over the next three years obtain shelter, create greater housing stability, and avoid housing court. BIDMC also provided funding to the Upstream Fund of the Innovative Stable Housing Initiative (ISHI). The Upstream Fund invests in organizing and coalition building efforts that are geared towards advancing policy and systems change, within and across four areas of focus: anti-displacement; tenant protections; community control of land; and asset building. In FY24 BIDMC also contributed to a pooled investment in a mixed-use affordable homeownership project. The project seeks to build 18 affordable condos and approximately 2,900 SF of ground floor commercial space, creating modern, energy efficient homes and opportunities for wealth building for local families in Boston's rapidly gentrifying Roxbury/Dorchester neighborhood.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Over the grant period, CHI grantees will make progress toward reducing homelessness, reducing displacement, increasing	CHI grantees are implementing their programs and collecting data to measure progress against this	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal

homeownership, and implementing advocacy/policy change to address housing affordability for residents who live, work, and play in Boston.	goal. As of the end of FY24, the housing grantees had enrolled 263 participants, hired 6 staff, and trained 4 staff/volunteers.	
Over the grant period, CHI grantees will improve participants' level of housing stability, housing instability, and housing control.	In progress; endpoint data not yet available.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by attending 3 Evaluation Learning Collaborative sessions and participating in quarterly individual technical assistance meetings with CHI independent evaluator.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal

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

Brief Description or Objective	BIDMC, through its Community-based Health Initiative, is investing in local organizations to increase employment and earnings and increase financial security. In 2024, BIDMC awarded funds to four organizations for a three-year grant period which began January 2024. The funded organizations are: • Building Pathways: The Pre-Apprenticeship Program (PAP) provides a pathway for low-income Boston area residents to enter the construction trades while creating a pipeline of new talent to replace an aging construction workforce and meet labor demands for the Boston area's construction market. • Casa Myrna Vasquez: Expand the Savings and Employment Incentive Program (SEIP) to support youth and adults fleeing domestic and sexual violence (SDV) in obtaining and maintaining permanent housing through progressive engagement, housing search, and rental assistance for up to two years. • Tech Goes Home (TGH): TGH partners with organizations in the identified neighborhoods across the City of Boston to offer a comprehensive digital inclusion program to residents who have been systematically excluded from the digital world and the economic opportunities it offers. • YMCA of Greater Boston: Through the ECE Apprenticeship program, participants complete 150 learning and development hours, and 2,000 hours of paid on-the-job training work experience at a YMCA Early Education center. In addition, BIDMC awarded a three-year grant beginning January 2022 to La Colaborativa's year-round youth employment program.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Over the grant period, CHI grantees will make progress toward increasing employment and earnings and increasing financial security for residents who live, work, and play in Boston.	CHI grantees are implementing their programs and collecting data to measure progress against this goal. As of the end of FY24, the jobs and financial security grantees had enrolled 222 participants, hired 9 staff, and trained 77 staff/volunteers.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will increase utilization of skills and resources, goal orientation, financial well-being and program successes.	In progress; endpoint data not yet available.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal

Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by attending 3 Evaluation Learning Collaborative sessions and participating in quarterly individual technical assistance meetings with CHI independent evaluator.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal

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

Program Goal(s)	**Goal Status**	**Goal Year and Type**
In FY24, five community collectives will implement projects informed by community engagement efforts.	In FY24, the Chelsea HNI, Chinatown HOPE, Allston Brighton Connectors, Mission Hill Healthy Neighborhoods Collective and Roxbury Collective for Housing Affordability collectives either began or continued implementation of their neighborhood-specific projects.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Boston Community Health Collaborative**	
Brief Description or Objective	The Boston Community Health Collaborative (previously known as the Boston CHNA-CHIP Collaborative), of which BIDMC is a founding member, brings together institutions and organizations contributing to the health and well-being of residents in Boston to build a shared understanding of the most important health needs, strengths, and priorities through a coordinated city-wide Community Health Needs Assessment (CHNA) and by developing and implementing a Community Health Improvement Plan (CHIP). This Collaborative aims to achieve the benefits of broad partnership around a Boston-based CHNA and CHIP, including deeper engagement of key community and organizational stakeholders; enhanced alignment of defined priorities and strategies; maximal allocation of resources; coordination of implementation strategies for collective impact and a healthier Boston.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, maximize resources from all entities and encourage collaborative initiatives.	Collaboration is taking place across working groups.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will participate in a city-wide CHNA-CHIP process that is transparent, inclusive and comprehensive.	BIDMC continues to actively participate in the steering committee and workgroups to implement the City of Boston CHNA and CHIP.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Community Benefits Administration and Infrastructure

Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Each year, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise.	All 10 BILH Community Benefits hospitals participated in community engagement workshops.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.	Goal complete.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Process Goal
Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.	BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use
Program Name: Community-Based Health Initiative: Behavioral Health Grants

Brief Description or Objective	BIDMC, through its Community-based Health Initiative, is investing in local organizations to increase access to high-quality and culturally and linguistically appropriate mental health and substance use services. In 2024, BIDMC awarded funds to three organizations: • Children's Services of Roxbury: The Front Porch program recruits, trains, coaches and expands a team of multilingual, multicultural Family Partners (community health workers) to increase access to mental health care for parents with complex trauma, increase awareness of peer-to-peer programs, and advocate to expand the use of Family Partners. • Greater Boston Chinese Golden Age Center (GBCGAC): Elevating the Healthy Ideas program to create a dedicated behavioral health division. The initiative comprises three core components: educating about mental health awareness, offering individual counseling sessions for Chinese-speaking adults, and facilitating support groups to foster ongoing peer assistance and enhance mental wellness. • Simmons University: Using a train the trainer model to educate high school students about evidence-based strategies, including Mindfulness, Yoga, Health and Wellness Behaviors, that they can utilize to prevent and manage behavioral health problems.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Over the grant period, CHI grantees will make progress toward improving mental health and substance use outcomes for residents who live, work, and play in Boston.	CHI grantees are implementing their programs and collecting data to measure progress against this goal. As of the end of FY24, the behavioral health grantees had reached 104 participants, hired 1 staff, and trained 8 staff/volunteers.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will report an improvement in mental health literacy, stigma, and mental health symptoms for a majority of participants.	In progress; endpoint data not yet available.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Outcome Goal

Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by attending 3 Evaluation Learning Collaborative sessions and participating in quarterly individual technical assistance meetings with CHI independent evaluator.	Program Year: Year 1 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Facilitating Access**	
Brief Description or Objective	To increase access to mental health services, BIDMC has implemented the Collaborative Care model, a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a Beth Israel Lahey Health licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions. At Bowdoin Street Health Center, psychiatrists, the nursing team, and the Community Health Worker collaborate as an integrated team to address the complex behavioral health needs of our patients. The Community Health Worker, a State-Certified professional trained in mental health first aid, bridges the gap between health and social services, ensuring patients have access not only to mental health and emotional support but also to substance use services and essential community resources. Together, this multidisciplinary team addresses both the immediate and long-term needs of patients, providing comprehensive care that goes beyond traditional mental health treatment to support overall well-being and stability. BIDMC's Social Work department provides support groups to individuals to help establish a community of support. The hospital provides 8 different support groups to provide a network for individuals experiencing medical difficulties ranging from cancer to pregnancy loss to COVID-19 survivors.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC will increase access to behavioral health services through the Collaborative Care model.	BIDMC provided behavioral health services to 978 patients at 7 practices in FY24 through the Collaborative Care model, compared to 495 patients in FY23.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC's behavioral health Community Health Worker will accept referrals.	In FY24, 96 referrals were made to the behavioral health Community Health Worker and there were 128 patient visits.	Program Year: Year 1 Of X Years: Year 2 Goal Type: Process Goal
Every year the BIDMC Social Work Department will provide a total of 8 support groups	In FY24, the Social Work team held 8 support groups that met from 9-28 times, serving about 63 patients.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Substance Use Services**	
Brief Description or Objective	Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to the delivery of early intervention and treatment services for youth and people with substance use disorders and those at risk of developing substance use disorders. SBIRT screening quickly assesses severity of substance use and helps providers identify appropriate treatments. SBIRT is recommended by the Institute of Medicine. Patients are asked about alcohol use, and those with an identified issue are provided discharge instructions including contacts for alcohol use counseling. BIDMC also has an Opioid Care Committee that works to prevent Opioid Use Disorder and to improve the care of patients with an Opioid Use Disorder. The goals of the committee 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. BILH is supporting The Dimock Center's Restoring Hope Campaign through a grant that will allow for the renovation and expansion of the historic Dr. Marie E. Zakrzewska Building, a focal point of The Dimock Center's campus, to house Boston's first post-detox clinical stabilization program for men. The building will also be renovated to accommodate The Dimock Center's existing women's clinical stabilization program. Together the 16-bed men's and 16-bed women's programs will reach more than 1,000 people annually. In FY24 BIDMC received multi-year grant funding to expand the Addiction Consultation service to include the BIDMC Emergency Department. The expanded, multidisciplinary service will enable patients with substance use disorders to be seen by clinicians in-person 7 days per week. The expansion also involves a partnership with The Gavin Foundation, a nonprofit substance use disorder education, prevention and treatment agency that provides access to recovery coaches in the Emergency Department and the medical floors. Addiction Consultation clinicians also continue to offer education opportunities for other healthcare professionals and local coalitions. Bowdoin Street Health Center also received multi-year grant funding to implement substance use disorder (SUD) treatment and services, including community education and engagement, organizational policy change, diverse staff hiring, and low threshold clinical SUD service expansion.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, Social Work will collaborate with the trauma care	In FY 2024 the program exceeded American College of Surgeons	Program Year: Year 2 Of X Years: Year 3

department to assure the ongoing management of SBIRT data and clinical assessment of patients with substance use disorders.	mandated screening rate of 80% with a 93% outcome. Social Workers provide motivational counseling to support patients moving along the continuum of change to help optimize health outcomes. This year, integrating a Recovery Support Navigator has enhanced relationships with community treatment programs to reduce barriers to treatment.	Goal Type: Process Goal
In FY24, BIDMC will establish multidisciplinary hospital-based Addiction Consultation Service with recovery coaches.	Goal met.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use
Program Name: BILH Behavioral Health Access Initiative

Brief Description or Objective	To support increased access to mental health and substance use services and supports, Beth Israel Deaconess Medical Center (BIDMC) participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA)	More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification.	Program Year: Year 1 Of X Years: Year 2 Goal Type: Process Goal
Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

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

Brief Description or Objective	The Center for Diversity, Equity, and Inclusion, formerly the Office for Diversity and Inclusion, was created and charged with working with Department Chairs to increase recruitment and retention of under-represented minority and women faculty, and to oversee data collection on health care disparities at BIDMC. The Center for Diversity, Equity, and Inclusion actively participates in unconscious bias training and works with the Center for Education to improve recruitment and retention of medical professionals from underrepresented groups. The Center for Diversity, Equity, and Inclusion also participates in several informal activities and events aimed at increasing awareness of the relevance of professional diversity for the expert and compassionate treatment for BIDMC's diverse family of patients. Beth Israel Lahey Health's Diversity, Equity, and Inclusion (DEI) office develops and advocates for policies, processes and business practices that benefit the communities we serve and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent."
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By the end of FY24, a data-driven approach to the recruitment of URiM faculty will be developed. We expect a 15% increase in the number of URiM faculty recruited.	While the goal was not met in FY24, BIDMC continues to take a holistic and mission-driven approach to URiM faculty recruitment and selection. This includes: considering a broad range of experiences, attributes, and metrics when evaluating applicants, actively recruiting through national professional societies and organization, and fostering an inclusive learning environment where all physicians have the resources and support necessary to thrive.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Process Goal
Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation.	Across BILH, 18% of new hires in leadership (directors and above) and clinical (physicians and nurses) positions identified as BIPOC.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, increase spend with diverse businesses by 25% over the	More than $70 million was contracted to Women and Minority-owned	Program Year: Year 2 Of X Years: Year 3

previous fiscal year across the system.	Business Enterprises (WMBE) in FY24. This is a 28% increase over FY23.	Goal Type: Outcome Goal
Each year, expand system-wide DEI learning, in alignment with enterprise learning management solution.	In FY24, BILH developed and implemented a system-wide DEI training for bias and disability awareness.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, support creation or expansion of local DEI committees/resource groups.	BIDMC formed a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for our patients, our employees and our communities.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Equitable Care **Program Name: Evidence-Based Strategies and Research**	
Brief Description or Objective	The Institute of Medicine's report, Unequal Treatment, focused the nation's attention on disparate care and health outcomes among the U.S. populace. BIDMC's clinical and research community embraced the challenges of advancing knowledge about the root causes of racial and ethnic health disparities and developing evidence-based strategies to improve health status of affected groups. This research enterprise frequently extends beyond BIDMC's campus, involving collaboration with other Harvard Medical School (HMS) affiliates. The Dana Farber/Harvard Cancer Center (DF/HCC)'s Initiative to Eliminate Cancer Disparities is one example where seven institutions are working together on community education and outreach campaigns as well as efforts to make state-of-the-art cancer care accessible to communities of color through clinical trial enrollment and enhanced culturally competent care in hospitals.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC will advance knowledge about causes and remedies of health disparities.	Researchers/clinicians engaged in health disparities research efforts through 56 unique research studies.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal
Each year, BIDMC will participate in multi-institutional collaborations to reap synergies and share knowledge.	In FY24, BIDMC faculty and staff participated in DF/HCC, Harvard Catalyst, Harvard T.H. Chan School of Public Health, and other multi-institutional collaborations.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$9,336,099
Community-Clinical Linkages	$3,624,300
Total Population or Community Wide Interventions	$13,012,421
Access/Coverage Supports	$33,179,926
Infrastructure to Support CB Collaborations	$238,419
Total Expenditures by Program Type	$59,391,165
CB Expenditures by Health Need	
Chronic Disease	$25,459,651
Mental Health/Mental Illness	$10,470,775
Substance Use Disorders	$4,695,512
Housing Stability/Homelessness	$2,744,580
Additional Health Needs Identified by the Community	$16,020,647
Total by Health Need	$59,391,165
Leveraged Resources	
Total Leveraged Resources	$7,410,628
Net Charity Care Expenditures	
HSN Assessment	$10,347,322
Free/Discounted Care	N/A
HSN Denied Claims	$9,859,360
Total Net Charity Care	$20,206,682
Total CB Expenditures	$87,008,475

Additional Information	
Net Patient Services Revenue	$2,113,645,678
CB Expenditure as % of Net Patient Services Revenue	4.12%
Approved CB Budget for FY25 (*Excluding expenditures that cannot be projected at the time of the report)	$67,128,530
Bad Debt	$9,657,720
Bad Debt Certification	Yes

Optional Supplement	Total Charity Care is $83,640,851 and includes BIDMC's payment of $10,347,322 to the Health Safety Net; $63,635,809 in unreimbursed Medicare Services; and $9,657,720 in bad debt. In addition, BIDMC made a contribution of $3,788,017 representing BIDMC's voluntary PILOT payment to the City of Boston, which contributes to the health and well-being of individuals residing in its Community Benefits Service Area. Additionally, BIDMC paid $956,790 to the Center for Health Information and Analysis (CHIA) and $134,706.35 to the Health Policy Commission (HPC).
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒Yes ☐No
    - If so, please list updates:

BIDMC added the following members to the CBAC: Pat Folcarelli (replacing Jane Foley), Jean McClurken (replacing Jane Powers) and Leonardo Ruiz Sanchez (replacing Richard Giordano).

BIDMC Community Benefits Advisory Committee Members as of the end of FY24:
Flor Amaya, Director of Public Health, Department of Human Services and Public Health, City of Chelsea; Elizabeth Browne, Chief Executive Officer (CEO), Charles River Community Health; Alexandra Chéry Dorrelus, Co-Director, Louis D. Brown Peace Institute; Lynne Courtney, Program Administrator, Workforce Planning and Development, Beth Israel Lahey Health (BILH); Shondell Davis, Community Trauma Healing Specialist, Cory Johnson Center for Post-Traumatic Healing; Pat Folcarelli, Chief Nursing Officer and Senior Vice President for Patient Care Services, BIDMC; Lauren Gabovitch, Case Manager, BIDMC; Leonardo Ruiz Sanchez, Lead Community Organizer, Fenway Community Development Corporation; Shantel Gooden, Senior Director of Behavioral Health Administration and Operations, The Dimock Center; Nancy Kasen, Vice President, Community Benefits and Community Relations, BILH; Barry Keppard, Public Health Director, Metropolitan Area Planning Council; Angie Liou, Executive Director, Asian Community Development Corporation; Amy Nishman, Senior Vice President of Strategy, JVS Boston; Sandy Novack, Social Worker, Patient Family Advisor; Alex Oliver-Davila, Executive Director, Sociedad Latina; Kelina (Kelly) Orlando, Executive Director, Ambulatory Operations, BIDMC; Triniese Polk, Director of Racial Equity and Community Engagement, Boston Public Health Commission; Jean McClurken, Director of Behavioral Health, Fenway Health; Richard Rouse, Advisory Board Member and former Executive Director, Mission Hill Main Streets; Samantha Taylor, Executive Director, Bowdoin Street Health Center; Robert Torres, Director of Community Benefits, BIDMC; LaShonda Walker-Robinson, Community Resource Specialist, BIDMC; Fred Wang, Executive Director, The Wang Foundation

II. Community Engagement

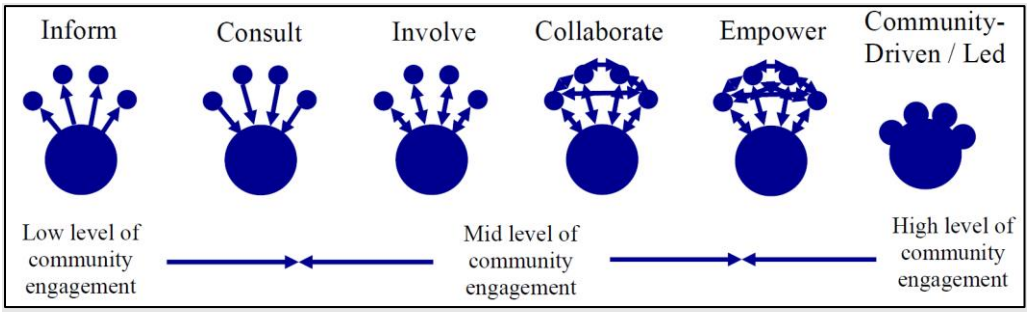
- Organizations Engaged in CHNA and/or Implementation Strategy

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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Community Care Alliance	Dr. Charles Anderson, President and Chief Executive Officer, Dimock Center; Samantha Taylor, Executive Director, Bowdoin Street Health Center; Elizabeth Browne, Chief Executive Officer, Charles River Community Health; Jordina Shanks, Chief Executive Officer, Fenway Health; Eric Tiberi, Chief Executive Officer, South Cove Community Health Center	Community health centers	The Community Care Alliance (CCA) is a partnership among the community health centers affiliated with BIDMC. BIDMC supports CCA-affiliated health centers through technical assistance, resource sharing, and direct financial support. CCA-affiliated community health centers assisted in expanding BIDMC's community engagement efforts in high need and historically underserved communities during the CHNA and IS process. Representatives from CCA health centers serve on the Community Benefits Advisory Committee.
GreenRoots	Roseann Bongiovanni, Executive Director; Cecelia Del Cid-Liccardi, Director of Food Justice and Youth Programs	Social service organizations	BIDMC funded a new hydroponic freight farm that will produce fresh produce and make it available to Chelsea residents and area agencies working to combat food insecurity.
Fenway CDC	Iris Tan, Marketing and Development Director; Leonardo Ruiz Sanchez, Lead Community Organizer	Social service organizations	BIDMC collaborates closely with Fenway CDC around housing affordability and workforce development.
Boston Public Health Commission	Triniese Polk, Director of Racial Equity and Community Engagement and Tibrine da Fonseca, Project Director, Community Health Needs Assessment /Community Health Improvement Plan	Local health department	BIDMC engages with BPHC on a number of initiatives, including the Farmer's Market Coupon program, emergency preparedness efforts, Boston Healthy Start Initiative and the Boston Community Health Collaborative.

- Level of Engagement Across CHNA and Implementation Strategy

Please use the spectrum below from the Massachusetts Department of Public Health[2] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-Profit Hospitals.

A. Implementation Strategy

Please assess the hospital's level of engagement in developing and implementing its plan to address the significant needs documented in its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal met – significant engagement took place in order to assess community needs for the FY25 CHNA and develop a robust IS to address them.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal met – BIDMC collaborates with its CBAC to determine the allocation of resources for the FY 2023 – 2025 IS	Collaborate
Implementing Community Benefits programs	Empower	Goal met – BIDMC, through its close collaboration with the CBAC, empowers grantees to implement programs aligned to the FY 2023 – 2025 IS.	Empower

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

Evaluating progress in executing Implementation Strategy	Empower	Goal met – Multiple evaluation workshops were held to build the evaluation and data capacity of grantees.	Empower
Updating Implementation Strategy annually	Consult	Goal met – BILH and BIDMC track and share data on a routine basis with the CBAC. This informs whether the Implementation Strategy needs to be updated.	Collaborate

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

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

  In FY24, BIDMC held four CBAC meetings that were open to the public (of which one was designated the annual meeting). These meetings were held via Zoom on December 12, 2023, March 26, 2024, June 25, 2024, and in person on September 24, 2024 (the annual meeting). BIDMC is committed to having transparent and open CBAC meetings. In an effort to engage the community during these meetings, each CBAC meeting had a dedicated time for public comments. BIDMC also accepted written public comments up to five business days prior to a meeting. Meeting agendas were posted online seven business days prior to each meeting and all meeting materials (slides, minutes, etc.) were posted on the website within five business days after a meeting. Additionally, three newsletters were sent out to inform the community about the Community-based Health Initiative and other Community Benefits updates.

  3) Maternal Health Focus
  a. How does your organization assess maternal health status in the Community Health Needs Assessment Process? (150-word limit)

  BIDMC's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under Reproductive Health and include low birth weight (%), Mothers with late or no prenatal care (%), Births to

adolescent mothers (%, and mothers receiving publicly funded prenatal care (%) as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA BIDMC engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

b. How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)

BIDMC partners with The Dimock Center, Fenway Health and South Cove Community Health Center on maternal health initiatives and has done so since 1968 (Dimock), the 1980s (Fenway) and the 1990s (South Cove). Additionally, BIDMC is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

c) Do you need assistance identifying community-based organizations doing maternal health work in your area?

BIDMC currently works with The Dimock Center, Fenway Health and South Cove Community Health Center. BIDMC's maternal health work will be guided by the MHQEC and BIDMC looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

III. Updates on Regional Collaboration

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

BIDMC Community Benefits staff continues to be involved in the Boston Community Health Collaborative (previously known as the Boston CHNA-CHIP Collaborative) and the North Suffolk Public Health Collaborative.

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

Appendix A: Partners

FY24 Partner	Level of Community Engagement	FY24 Partner	Level of Community Engagement
A Better City	Consult	HomeStart	Community Driven/Led
A Room to Grow	Involve	Hospitality Homes	Consult
About Fresh	Collaborate	International Institute of New England	Community Driven/Led
Action Inc.	Involve	Jane Doe Inc.	Involve
Action for Boston Community Development (ABCD)	Involve	Jasmine Grace Outreach	Involve
Adcare Treatment Center	Collaborate	Jewish Community Center (JCC) of Greater Boston	Collaborate
African Bridge Network	Involve	Jewish Family and Children's Service	Consult
AIDS Action Committee	Consult	Jewish Vocational Services	Involve/Collaborate
AIDS Support Group of Cape Cod	Consult	Joe Andruzzi Cancer Fund	Involve
Alzheimer's Association of MA (Waltham)	Consult	Jose Mateo Ballet Theatre	Collaborate
American Cancer Society	Collaborate	Josiah Quincy Elementary School	Community Driven/Led
American Heart Association	Collaborate	Joslin Diabetes Center	Involve
American Chinese Christian Education & Social Services, Inc.	Inform	Just a Start	Involve
Asian American Civic Association	Inform	Justice Resource Institute (JRI) in Boston	Involve
Asian Community Development Corporation	Community Driven/Led	La Alianza Hispana (Boston)	Consult
Atrius Health	Collaborate	La Colaborativa	Community Driven/Led
Audubon Circle Neighborhood	Community Driven/Led	Lahey Health Treatment Center	Consult
Bay Cove Center Club	Collaborate	Leukemia & Lymphoma Society	Collaborate
Beth Israel Lahey Health Primary Care	Community Driven/Led	Louis D. Brown Peace Institute	Collaborate
Boston Area Rape Crisis Center (BARCC)	Collaborate	Madison Park Technical High School MA Program	Collaborate
Boston Center for Independent Living	Collaborate	Massachusetts College of Art and Design	Collaborate
Boston Children's Hospital	Involve	Massachusetts Commission for the Blind	Involve
Boston Chinatown Neighborhood Center	Community Driven/Led	Massachusetts Commission for the Deaf and Hard of Hearing	Involve
Boston Comprehensive Treatment Center	Involve	Massachusetts Department of Children and Families	Involve
Boston Elder Services	Involve	Massachusetts Department of Environmental Protection (MassDEP)	Delegate
Boston Emergency Medical Services	Empower	Massachusetts Department of Public Health	Collaborate
Boston Fire Department	Collaborate	Massachusetts Department of Transitional Assistance	Inform
Boston Green Academy	Empower	Massachusetts Department of Transportation (MassDOT)	Inform
Boston Health Care for the Homeless Program	Collaborate	Massachusetts General Brigham	Collaborate

Boston Housing Authority	Community-Driven/Led	Massachusetts Health Information Highway	Involve
Boston Living Center	Involve	Massachusetts HIV Drug Assistance Program	Involve
Boston Medical Center	Collaborate	Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA)	Inform
Boston Police Department	Collaborate	Massachusetts Institute of Technology	Empower
Boston Private Industry Council (PIC)	Collaborate	Massachusetts Insurance Commission	Consult
Boston Public Health Commission	Collaborate	Massachusetts Rehabilitation Commission	Consult
Boston Public Schools	Involve	Massachusetts State Police	Collaborate
Boston University Law Clinic	Involve	Mass Hire Boston	Collaborate
Boston University School of Public Health	Collaborate	Millenium Training Institute	Involve
Bowdoin Geneva Main Streets	Collaborate	Mount Auburn Hospital	Collaborate
Bowdoin Street Health Center	Empower	New England AIDS Education and Training Center	Consult
Boys and Girls Club of Boston	Involve	New England Life Flight Inc (DBA Boston)	Involve
Brigham and Women's Hospital	Collaborate	North Shore Community College	Involve
Brigid's House of Hope	Collaborate	New England AIDS Education and Training Center	Consult
Building Pathways	Community Driven/Led	New England Life Flight Inc (DBA Boston)	Involve
Bunker Hill Community College	Involve	North Shore Community College	Involve
Brockton Area Multi Service Inc. (BAMSI)	Consult	Operation ABLE of Greater Boston	Involve
Cambridge Community Learning Center	Involve	Operation P.E.A.C.E.	Consult
Cambridge Health Alliance	Collaborate	Outer Cape Health Services	Collaborate
Cape Verdean Association of Boston	Collaborate	PAIR Project	Involve
CAPIC, Inc.	Community Driven/Led	Partners for World Health	Collaborate
Casa Myrna	Community Driven/Led	Pine Street Inn	Involve
Catholic Charities Boston	Collaborate	Pink Revolution	Collaborate
Charles River Community Health	Collaborate	Practice Green Health	Inform
Charles River Recovery	Consult	Private Industry Council	Collaborate
Chelsea Black Community	Community Driven/Led	Project Home Again	Collaborate
Chelsea Community Connections	Community Driven/Led	RIA, Inc.	Collaborate

Children's Services of Roxbury	Community Driven/Led	Riverside Community Care	Involve
Chinatown Main Street	Community Driven/Led	Room to Grow	Involve
Children's Services of Roxbury	Community Driven/Led	Rose Kennedy Greenway Conservancy	Community Driven/Led
Chinatown Main Street	Community Driven/Led	Roxbury Community College	Involve
Chinatown Progressive Association	Community Driven/Led	Roxbury Tenants of Harvard	Involve
Chinese Resident Association	Community Driven/Led	Ryan White Dental Program	Involve
Circle of Hope	Consult	SCALE (Somerville Public Schools)	Involve
City of Boston Emergency Management Office	Collaborate	Sexual Assault Nurse Examiner (SANE) Program	Involve
City of Boston's Green Ribbon Commission	Inform	Sexual Assault Unit of Disabled Persons Protection Commission	Involve
Community Research Initiative	Involve	Simmons University	Community Driven/Led
Community Servings	Collaborate	Sociedad Latina	Community Driven/Led
Community Work Services	Involve	South Cove Community Health Center	Collaborate
Conference of Boston Teaching Hospitals (COBTH)	Empower	Spectrum Westborough	Consult
Cradles to Crayons	Involve	St. Peter's Teen Center	Community Driven/ Led
Dana Farber Cancer Institute	Collaborate	Steps to Success	Involve
Dimock Community Health Center	Community Driven/Led	Tech Goes Home	Community Driven/Led
Dorchester Catholic Parishes	Community Driven/Led	The Dimock Center	Collaborate
Dorchester Bay Economic Development Corporation	Empower	The Latino Medical Student Association	Community Driven/Led
Dorchester Food Co-Op	Community Driven/Led	The Longwood Collective	Collaborate
Ellie Fund	Inform	The Gavin Foundation	Collaborate
English for New Bostonians	Involve	The Neighborhood Developers	Community Driven/Led
Eversource	Consult	The Network/La Red	Involve
Fair Foods (Boston)	Collaborate	The One By One Project	Collaborate
Family Nurturing Center	Collaborate	The Partnership, Inc.	Empower
Father Bill's and Mainspring	Inform	The Student National Medical Association, National and NE Chapter	Community Driven/Led
Fenway Alliance	Community Driven/Led	Training, Inc.	Collaborate
Fenway Civic Association	Community Driven/Led	Trustees of Reservations	Collaborate

Fenway Community Center	Community Driven/Led	Tufts Medical Center	Collaborate
Fenway Community Development Corporation	Community Driven/Led	United Cerebral Palsy of Metro Boston	Involve
Fenway Health	Community Driven/Led	UP Academy Dorchester School	Community Driven/Led
First Source	Involve	U S. Environmental Protection Agency (EPA)	Collaborate
Food for Free	Involve	Victim Rights Law Center	Collaborate
Found in Translation	Consult	Victory Programs	Involve
GLAAD	Inform	Vinfen Corporation	Collaborate
Greater Boston Chinese Golden Age Center	Community Driven/Led	Viridian Apartments	Involve
Greater Boston Employment Collaborative	Involve	Wentworth Institute of Technology	Community Led/Driven
Greater Boston Food Bank	Inform	WilmerHale Legal Services (also known as the Legal Service Center)	Collaborate
Greater Boston YMCA	Collaborate	Work Opportunities Unlimited	Involve
Greater Bowdoin Geneva Neighborhood Association	Community Driven/Led	Wonderfund Massachusetts	Empower
Greater Four Corners Action Coalition	Empower	YMCA of Greater Boston	Collaborate
GreenRoots	Community Driven/Led		
Hack Diversity	Collaborate		
Harvard Medical School	Community Driven/Led		
Health Care for All	Collaborate		
Health Imperatives	Collaborate		
Health Law Advocates	Collaborate		
Healthcare Without Harm	Inform		