Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

FY26-FY28
Implementation Strategy

Implementation Strategy

About the 2025 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Medical Center (BIDMC) is one of the nation's premier academic medical centers and a primary teaching hospital and research affiliate of Harvard Medical School. The medical center has 766 licensed inpatient beds, with more than 10,000 employees and over 3,000 clinicians on active medical staff. BIDMC is devoted to advancing the science and practice of medicine through groundbreaking research and education, taking particular pride in centers of excellence, including in cardiovascular, cancer, neuroscience, digestive health and obstetrics and gynecology.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. In conducting this assessment and planning process, it would be difficult to overstate BIDMC's commitment to community engagement and a comprehensive, data-driven, collaborative and transparent assessment and planning process. Altogether, this approach involved extensive data collection activities, substantial efforts to engage the medical center's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been historically underserved, such as those are are unstably housed or experiencing homelessness, individuals who speak a language other than English, persons who are in substance use recovery, and persons experiencing barriers and disparities due to their race, ethnicity, gender identity, age, or other personal characteristics.

BIDMC collects a wide range of quantitative data to characterize the communities served across its Community Benefits Service Area (CBSA). BIDMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national level to support analysis and the prioritization process. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing segments of the population most at-risk, and crafting a collaborative, evidence-informed IS. BIDMC employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Across all three components, the assessment included 35 one-on-one interviews with key collaborators in the community, 17 focus groups with segments of the population facing the greatest health-related disparities, 5 sector-based focus groups with community partners, and 1 community listening session that engaged about 40 participants.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its Implementation Strategy (IS). By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that are faced with health-related disparities. Accordingly, using an interactive, anonymous polling software, BIDMC's CBAC and community residents, through a community listening session, formally prioritized the community health issues and cohorts that they believed should be the focus of BIDMC's IS. This prioritization process helps to ensure that BIDMC maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

BIDMC's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary

prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

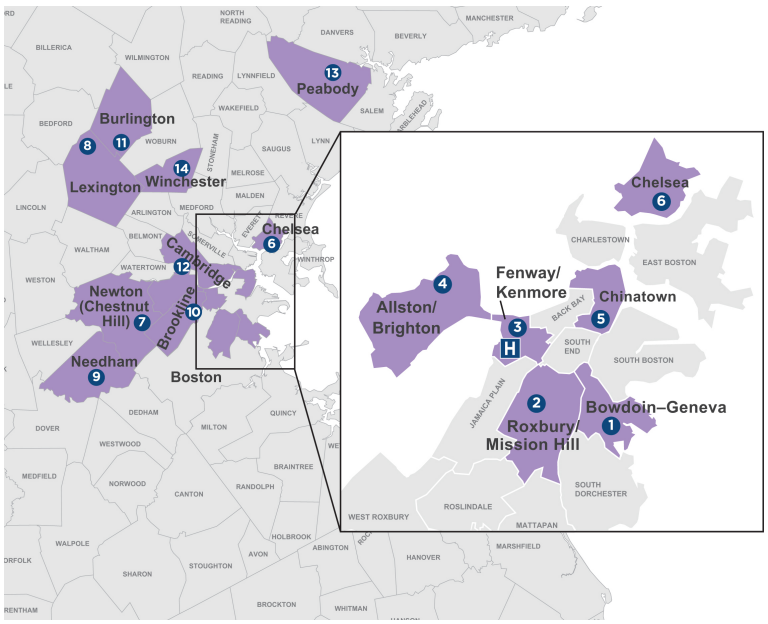
- Address the prioritized community health needs and/or populations in the hospital's CBSA
- Provide approaches across the up-, mid-, and downstream spectrum
- Are sustainable through hospital or other funding
- Leverage or enhance community partnerships
- Have potential for impact
- Contribute to the systemic, fair and just treatment of all people
- Are flexible to respond to emerging community needs

Recognizing that community benefits planning is ongoing and will change with continued community input, BIDMC's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. BIDMC is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

BIDMC's CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns that are part of the Community Care Alliance and/or where BIDMC operates licensed facilities. BIDMC's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the considerable health disparities that exist in some communities in its CBSA, BIDMC focuses the bulk of 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 the city of Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury.

While there are segments of the populations in Brookline, Burlington, Cambridge, Chestnut Hill, Lexington, Needham, Peabody and Winchester who are under-resourced and have limited access to the care they need, the greatest disparities exist for those who live in Chelsea and the Boston neighborhoods specified above. By prioritizing these cohorts, BIDMC can promote health and well-being, address health disparities, and maximize the impact of its community benefits resources. Further, while BIDMC operates licensed facilities in Burlington, Cambridge, Needham, Peabody, and Winchester. These service locations are in other BILH CBSAs. The Town of Burlington and the City of Peabody are located within Lahey Hospital and Medical Center's (LHMC's) CBSA, the Town of Needham is located within Beth Israel Deaconess Needham's (BID Needham) CBSA, the City of Cambridge is located within Mount Auburn Hospital's (MAH) CBSA, and the Town of Winchester is located within Winchester Hospital's (WH's) CBSA. As a result, the community benefits activities for these municipalities have been delegated to LHMC, BID Needham, MAH, and WH. This helps to ensure that activities are properly coordinated and address the identified needs.



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Community Benefits Service Area

- H Beth Israel Deaconess Medical Center and Joslin Diabetes Center
- 1 Bowdoin Street Health Center
- 2 The Dimock Center
- 3 Fenway Health
- 4 Charles River Community Health
- 5 South Cove Community Health Center
- 6 Beth Israel Deaconess Healthcare-Chelsea
- 7 Beth Israel Deaconess Healthcare-Chestnut Hill
- 8 Beth Israel Deaconess Healthcare-Lexington
- 9 BIDMC Cancer Center
- 10 BIDMC Pain Center
- 11 BIDMC Infusion Services at Lahey Hospital and Medical Center
- 12 BIDMC Infusion Services at Mount Auburn Hospital
- 13 BIDMC Infusion Services at Lahey Medical Center - Peabody
- 14 BIDMC at Winchester Center for Cancer Care

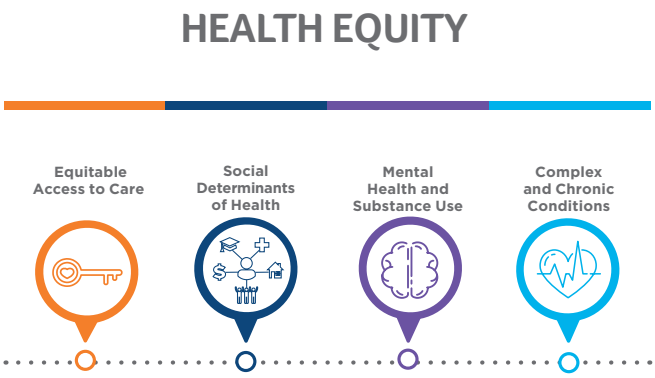
Prioritized Community Health Needs and Cohorts

BIDMC is committed to promoting health, enhancing access and delivering the best care for those in its CBSA. Over the next three years, the medical center will work with its community partners, with a focus on Chelsea and the Boston neighborhoods in its CBSA, 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, investments and resources will focus on improving the health status of the following priority cohorts and community health priority areas.

BIDMC Priority Cohorts

- Youth
- Older adults
- Low-resourced Populations
- LGBTQIA+
- Families Affected by Violence or Incarceration
- Racially, Ethnically, and Linguistically Diverse Populations

BIDMC Community Health Priority Areas



Community Health Needs Not Prioritized by BIDMC

It is important to note that there are community health needs that were identified by BIDMC's assessment that were not prioritized for investment or included in BIDMC's IS. Specifically, addressing issues related to the built environment (e.g., improving sidewalks and roads) were identified as community needs but were not included in BIDMC's IS. While these issues are important, BIDMC's CBAC and senior leadership team decided that these issues were outside of the medical center's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. As a result, BIDMC recognized that other public and private organizations in its CBSA, Boston, and the Commonwealth were better positioned to focus on these issues. BIDMC remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in BIDMC's IS

The issues that were identified in the BIDMC CHNA and are addressed in the hospital IS are housing issues, food insecurity, transportation, environmental justice/climate, economic insecurity, community safety, workforce development, language and cultural barriers to care, long wait times for care, navigating a complex health care system, health insurance and cost barriers, youth mental health, depression/anxiety/stress, support for individuals with substance use disorder, social isolation among older adults, navigating the behavioral health system, trauma, conditions associated with aging, education and prevention around chronic disease risk factors, emergency preparedness, and care navigation and management.

Implementation Strategy Details

Priority: 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, and stem from the way in which the system does or does not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was 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 forgo 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.

Resources/Financial Investment: BIDMC expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Health insurance eligibility and enrollment assistance activities • Financial counseling activities • Programs and activities to support culturally/linguistically competent care and interpreter services • Expanded access to primary care, medical specialty care, and other clinical services for Medicaid covered, uninsured, and underinsured populations • Emergency medical services training, leadership, and community preparedness activities • Intensive case management, care navigation, and referral programs • Education, wellness, navigation, and peer support programs and activities	• # of sessions conducted • # of people assisted • # of referrals made • # of interpreter services provided • # of languages • # of medical residents placed at health centers • # of specialists at health centers • # of patients seen • Financial assistance provided • # of support groups	• Colleges and universities • Community health centers • Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and systems that improve access to care.	• All priority populations	• Advocacy activities	• # of policies supported	• Local, state, and federal governmental agencies and advocacy organizations

Priority: 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 housing, food insecurity, economic insecurity, education and other important social factors.

Information gathered through interviews, focus groups, the listening session, and surveys reinforced that these issues have considerable impacts on health status and access to care in the region, especially issues related to housing, food insecurity, nutrition, transportation, and economic instability.

Resources/Financial Investment: BIDMC expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Food access, nutrition support, and education programs and activities • Fitness and education programs and activities	• # of people served • Units distributed • # of community education events	• Private, non-profit, health-related agencies • Hospital-based activities • Community health centers
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	• All priority populations	• Community investment and affordable housing initiatives • Housing assistance, navigation, and resident support activities	• Metrics pertaining to housing stability	• Housing support and community development agencies

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.	• All priority populations	• Career advancement and mobility programs • Youth employment and internship programs	• # of youth participating • # hired by hospital • # of programs • # of participants • # of employees served	• Local primary and secondary schools • Cultural, linguistic, and community advocacy programs • Hospital-based activities
Support programs and activities that increase employment, earnings, and financial security.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • Families affected by violence and/or incarceration	• Career advancement and mobility programs	• Awareness/ utilization of skills and resources • Financial well-being • Amount invested	• Private, non-profit, and health-related agencies
Support programs and activities that foster social connections, strengthen community cohesion and resilience, and address public safety and causes and impacts of violence.	• All priority populations	• Community connection, social engagement, and beautification activities • Community healing, violence prevention, and community safety activities	• # of people served • # of classes, activities, sessions, or units of service organized • # of safe bed overnight stays • # of incidents responded to	• Private, non-profit, and health-related agencies • Hospital-based activities
Advance environmental sustainability and climate resilience by reducing carbon emissions, conserving natural resources, strengthening community and infrastructure preparedness for climate-related disruptions, and addressing the health impacts of climate change, with a focus on support for those most affected.	• All priority populations	• Sustainability and environmental health activities	• % reductions in greenhouse gas emissions • % local food and beverage spend • % waste diversion	• Hospital-based activities

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Advocate for and support policies and systems that address social determinants of health.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults, and social isolation among older adults.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options. Those who participated in the assessment also reflected on the difficulties individuals face when navigating the behavioral health system.

Substance use continued to have a major impact on the CBSA; the opioid epidemic and alcohol use 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 and economic insecurity.

Resources/Financial Investment: BIDMC expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations • Older adults • Youth • LGBTQIA+ • Families affected by violence and/or incarceration	• Health education, awareness, and wellness activities for all age groups	• # of classes • # of attendees • Changes in knowledge	• Hospital-based activities
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations • Older adults • Youth • LGBTQIA+ • Families affected by violence and/or incarceration	• Substance use and mental health screening, monitoring, counseling, and referral programs • Expand access to mental health and substance use services for individuals and families • Patient care navigator programs • Primary care and behavioral health integration and collaborative care programs • Crisis intervention and early response programs and activities • Workforce development activities	• # of people served • # of people screened • # of patients referred • # of counseling sessions • Improvement in mental health literacy • Stigma reduction • # of locations/practices • # of professionals receiving training	• Community health centers • Children and family services agencies • Cultural, linguistic, and community advocacy programs • Local primary and secondary schools • Hospital-based activities

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Advocate for and support policies and programs that address mental health and substance use.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital -based activities

Priority: Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.[1]

Resources/Financial Investment: BIDMC expends substantial resources to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BIDMC and/or its partners to improve the health of those living in its CBSA. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	• All priority populations	• Fitness, nutrition, and healthy living programs and activities • Chronic disease management, treatment, and self-care support programs • Cancer education, wellness, navigation, and survivorship support programs • Support groups (peer- and professional-led) • HIV/AIDS care, education, and support programs • Research to foster health equity	• # of people served • # of federally qualified health center (FQHC) patients whose diabetes is is controlled • % of FQHC patients whose hypertension is controlled • % HIV+ patients screened for HCV • # of visits by infectious disease physicians	• Community health centers • Private, non-profit, health-related agencies • Hospital-based activities
Advocate for and support policies and systems that address those with chronic and complex conditions.	• All priority populations	• Advocacy activities	• # of policies supported	• Hospital-based activities

[1] Massachusetts Executive Office of Health and Human Services. State Health Improvement Plan – Chronic Disease. Retrieved from https://www.mass.gov/info-details/ship-chronic-disease

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Promote maternal health equity by addressing the complex needs that arise during the prenatal and postnatal periods, supporting access to culturally responsive care, meeting social needs, and reducing disparities in maternal and infant outcomes.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations • Youth	• Culturally responsive prenatal/postnatal case management and care coordination programs	• # of patients served	• Community health centers

General Regulatory Information

Contact Person:	Anna Spier, Community Benefits/Community Relations Manager
Date of written report:	June 30, 2025
Date written report was approved by authorized governing body:	September 3, 2025
Date of written plan:	June 30, 2025
Date written plan was adopted by authorized governing body:	September 3, 2025
Date written plan was required to be adopted	February 15, 2026
Authorized governing body that adopted the written plan:	Beth Israel Deaconess Medical Center Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 21, 2022
Name and EIN of hospital organization operating hospital facility:	Beth Israel Deaconess Medical Center: 04-2103881
Address of hospital organization:	330 Brookline Ave. Boston, MA 02215

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