Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

FY23-FY25
Implementation Strategy

Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Medical Center (BIDMC) is one of the nation's preeminent academic medical centers and is nationally recognized for its world-class clinical expertise, education and research. The medical center is also a Level 1 trauma center with a full range of medical/surgical, critical care, OB/GYN, and emergency services, and an extensive network of primary care and outpatient specialty care practices. BIDMC prides itself on its ability to combine exceptional, compassionate patient care with advanced medical knowledge, research, and technology in ways that allow it to achieve the best outcomes for its patients. BIDMC, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in their service area.

The Community Health Needs Assessment (CHNA) and planning work for this 2022 report was conducted between September 2021 and September 2022. 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 across all the assessment's individual components to include the voices of community residents who are often left out of health assessments like this one, such as those who are unstably housed or homeless, who do not speak English, who are recent immigrants, who are in substance use recovery, or who experience 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 four components, the assessment included 85 one-on-one interviews with key collaborators in the community, 22 focus groups with segments of the population facing the greatest health-related disparities, and community listening sessions that engaged 226 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. Accordingly, using an interactive, anonymous polling software, BIDMC's CBAC and community residents, through the community listening sessions, 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:

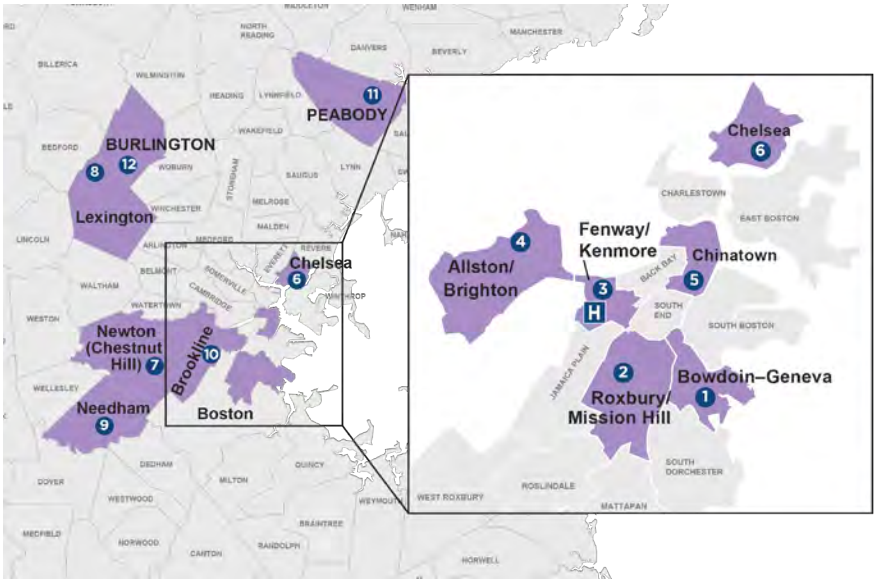
- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute 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. The activities that will be implemented as a result of this assessment will support all the people who live throughout the 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 BIDMC operates licensed facilities in Burlington, Needham and Peabody, 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) CBSA and the Town of Needham is located within Beth Israel Deaconess-Needham's (BID Needham) CBSA. As a result, the community benefits activities for these municipalities have been formally delegated to LHMC and BID Needham to ensure that activities are properly coordinated and address the identified needs.



Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Community Benefits Service Area

- H Beth Israel Deaconess Medical 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, Peabody
- 12 BIDMC Infusion Services, Burlington

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

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 the digital divide (i.e., promoting equitable access to the internet) and supporting education across the lifespan 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, small businesses, build capacity of healthcare workforce, navigation of healthcare system, linguistic access barriers, promotion/awareness of SDOH resources, cost and insurance barriers, more peer-led services, addressing mistrust in healthcare, youth mental health, stress, depression, anxiety, isolation, impacts of violence & trauma, education (for communities, and for providers on how to best reach and treat them), stigma, culturally appropriate/competent health and community services, cross sector collaboration and responses, and linguistic access/barriers to community resources/services.

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, 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.

Resources/Financial Investment: BIDMC will commit direct, community health program investments, and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of the Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

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	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote equitable care, health equity, health literacy, and cultural humility for patients across BIDMC and BILH's licensed and/or affiliated health centers, especially those who face cultural and linguistic barriers.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+	• Sexual Orientation and Gender Identity (SOGI) Data Collection • Interpreter Services	• # of patients assisted • # of services provided • # of languages provided	• Bowdoin Street Health Center • The Dimock Center • Fenway Health • Charles River Community Health • South Cove Community Health Center • The Student National Medical Association • The Latino Medical Student Association • Harvard Medical School • Found in Translation • Massachusetts Commission for the Deaf and Hard of Hearing	Chronic and Complex Conditions

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	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Increase access to primary care and specialty care services, including OB/GYN and maternal child health services.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+	• Community Care Alliance (CCA) and support for Community-based Primary and Specialty Care • Network/IT Integration and Access for CCA Health Centers • Care Connection • Residency Training Program	• # of specialists at CCA health centers • # of patients seen at affiliated Federally Qualified Health Centers (FQHCs) • # of visits provided at affiliated FQHCs • # of patients without insurance served at affiliated FQHCs • # of BIDMC specialists at affiliated FQHCs	• BILH Primary Care • Bowdoin Street Health Center • Charles River Community Health • Fenway Health • South Cove Community Health Center • The Dimock Center • Healthcare Associates (HCA)	Not Applicable
Address the health-related social needs (HRSN) of patients in order to support access to care.	Low-resourced populations	• Community Health Worker Program • BIDMC Social Work Department Services	• # of patients assisted with HRSN • # of patients provided with housing support • # of patients provided emergency food or gift cards • # of patients provided clothing	Bowdoin Street Health Center	Social Determinants of Health
Provide and promote career support services and career mobility programs to hospital employees.	BIDMC employees	• Pipeline programs • Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes	• # of employees who participated	• Bunker Hill Community College • Conexión, Inc. • Jewish Vocational Services (JVS) • The Partnership, Inc.	Social Determinants of Health - Jobs and Financial Security

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	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote access to health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured	Low-resourced Populations	• Financial Counseling • Pharmacy Programs	• # of patients screened for eligibility • # patients enrolled into entitlement programs • # patients enrolled in Masshealth • # patients enrolled in Health Safety Net (HSN)	• BILH Pharmacy	Chronic and Complex Conditions
Advocate for and support policies and programs that address healthcare access.	Community residents	To be determined	• # of policies reviewed • # of policies supported	BILH Government Relations	Not Applicable
Support research aimed at providing more equitable care for patients and community members.	BIDMC patients and community residents		Amount of funding dedicated to improving health outcomes	• The Student National Medical Association • The Latino Medical Student Association • Harvard Medical School	Not Applicable
Provide and support residents with transportation access, public safety, emergency care, public health and emergency preparedness.	BIDMC patients and Commonwealth residents	• Medical and Critical Care Transportation • Trauma, Emergency Management, and Public Health Surveillance • Public Safety	• # of patients assisted • # taxi or ride-sharing vouchers provided	• Boston Emergency Management Office • Boston Emergency Medical Services • Boston Fire Department • Boston Public Health Commission • Conference of Boston Teaching Hospitals • MA Department of Public Health • Medflight • Medical Academic and Scientific Community Organization (MASCO)	Social Determinants of Health

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 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.

Resources/Financial Investment: BIDMC will commit direct, community health program investments, and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of the Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support evidence-based programs and strategies to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+ • Families affected by violence and/or incarceration	Investments in housing programs to stabilize or create access to affordable housing	• # of participants and their demographics • Housing stability[1] • # of youth housed • # of housing policies passed	• Bridge Over Troubled Waters • Metro Housing|Boston • Asian Community Development Corporation (CDC) • BAGLY, Inc. • City Life/Vida Urbana • Chinese Progressive Association • Fenway Community Development Corporation (CDC) • Nuestra Community Development Corporation (CDC) • Opportunity Communities • Innovative Stable Housing Initiative (ISHI) • Additional grantees TBD	Not Applicable

1. Data are being collected on housing situation, agency, and affordability. Data are being collected on two aspects of individuals' housing situations: description of their housing situation and satisfaction with their housing situation. Agency is measured through control and confidence related to housing. To measure affordability, participants are asked which, if any, household expenses they have had to forgo in order to pay for their housing in the last 3 months.

Goal: Enhance the built, social, and economic environment 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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support evidence-based programs, strategies, and partnerships to increase employment and earnings and increase financial security.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+ • Families affected by violence and/or incarceration	• Investments in jobs and financial security programs to strengthen the local workforce and address underemployment • Community hiring	• # of participants and their demographics • Adult Hope Scale[2] • Financial capabilities • # of community residents hired	• Bridge Over Troubled Waters • Community Servings • English for New Bostonians • La Colaborativa • Metro Housing|Boston • Sociedad Latina • African Bridge Network • Jewish Vocational Services • Operation ABLE • Roxbury Community College • YMCA – Training, Inc. • BILH Workforce Development • Additional grantees TBD	Not Applicable

2. The self-efficacy measure is defined as believing that you can overcome obstacles and get things done. To measure this outcome, grantees are using a version of the Adult Hope Scale (adapted by the American Psychological Association (APA)). There are six questions: three questions that measure Agency, or goal directed energy, and three questions that measure Pathways, or the planning to accomplish goals. Each question is scored on a scale of 1-8, from definitely false (1) to definitely true (8). The scores for all six questions can be summed to calculate a Hope score. Subscale scores for Agency and Pathways may also be calculated in or order to examine both dimensions of "Hope" independently. Specifically, the Agency and Pathways subscales are scored by summing the score (1-8) of three questions, out of a possible 24 each. The full Hope score is calculated by adding all 6 responses together out of 48.

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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote thriving neighborhoods and enhance community cohesion and resilience.	• Youth • Racially, Ethnically and Linguistically Diverse Populations • Older Adults • Low-resourced Populations • Families Affected by Violence and/or Incarceration	• Healthy Neighborhoods Initiative • The Wellness Center at Bowdoin Street Health Center • Village in Progress (VIP) • Neighborhood Trauma Team • Placemaking activities and neighborhood improvement	• Collective relationships and cohesion • Impact of community-driven/led investments • # of neighborhood incidents responded to • # of therapeutic sessions provided • # of new community leaders	• We're Here for You: Fenway/Kenmore • Healthy Bowdoin Geneva • Chelsea Healthy Neighborhoods Initiative • Chinatown HOPE • Allston/Brighton, Mission Hill, and Roxbury Collectives TBD • Boston Police Department • Boston Public Health Commission • Family Nurturing Center • Greater Four Corners Action Coalition • Louis D. Brown Peace Institute • Medical Academic and Scientific Community Organization (MASCO) • St. Peter's Teen Center	Mental Health and Substance Use
Increase mentorship, leadership, training, and employment opportunities for youth and young adults residing in the communities BIDMC serves.	• Youth (including youth with physical and cognitive disabilities) • Racially, ethnically and linguistically diverse populations • Low-resourced populations	• Youth summer jobs program • BIDMC Youth Advisors	• # of youth involved • Job skills • Public health skills and knowledge	• Action for Boston Community Development (ABCD) • Boston Private Industry Council • Bowdoin Street Health Center • Boys and Girls Club of Boston • Mary K. Lyon School • Massachusetts Commission for the Blind • Sociedad Latina • Steps to Success • YMCA of Greater Boston	Not Applicable

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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Advocate for and support policies and programs that address the social determinants of health.	Community residents	To be determined	• # of policies reviewed • # of policies supported	BILH Government Relations	Not Applicable
Conserve natural resources, reduce carbon emissions, and foster a culture of sustainability to create a healthy environment for residents.	• BIDMC patients and employees • Community residents	Environmental Sustainability	• Greenhouse gas emissions • % local food and beverage spend • Waste diversion[3]	• A Better City • Boston Green Academy • City of Boston's Green Ribbon Commission • Commonwealth Kitchen • Eversource • Healthcare Without Harm • Practice Green Health • MA Department of Environmental Protection • Sodexo • US Environmental Protection Agency	Not Applicable

3. Defined as non-hazardous solid waste diverted from landfill or incineration through reduction, reuse, recycling, compost, or use of future technologies.

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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Build community awareness, advocate for policy change, and provide supportive care for victims of violence and trauma.	Families Affected by Violence and/or Incarceration	The Center for Violence Prevention and Recovery (CVPR)	• # sexual assault victims receiving services • # of services provided to sexual assault victims in the Emergency Department (ED) • # education and outreach services • # of safe bed overnight stays • # of healing circles	• Boston Area Rape Crisis Center • Boston Medical Center • Brigham and Women's Hospital • Cambridge Health Alliance • Casa Myrna • Conference of Boston Teaching Hospitals (COBTH) Domestic Violence Council • Jane Doe, Inc. • Louis D. Brown Peace Institute • Mass General Hospital • RIA, Inc. • SANE • Sexual Assault Unit of Disabled Persons Protection Commission (DPPC) • The Network/La Red • Victim Rights Law Center	Mental Health and Substance Use
Promote healthy eating and active living by increasing opportunities for physical activity and providing healthy food resources to patients and community residents.	• Youth • Racially, ethnically and linguistically diverse populations • Low-resourced populations • Older adults	• The Wellness Center at Bowdoin Street Health Center • Grocery store gift card distribution program • Fitness in the City • Explore installation of Freight Farms™	• # of participants • # of units of food produced and distributed • # of gift cards distributed • $ amount of gift cards distributed • # of families receiving gift cards • Food insecurity status	• About Fresh • Boston Children's Hospital • Bowdoin Street Health Center • Champion Tae Kwan Do Center • Fair Foods • Sportsmen's Tennis Club • The Dimock Center • Trustees of Reservations	Not Applicable

Priority: 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, 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).

Resources/Financial Investment: BIDMC will commit direct, community health program investments and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

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 issues and conditions.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support and implement evidence-based programs that increase access to high-quality and culturally and linguistically appropriate mental health and substance use services.	• Youth • Racially, ethnically and linguistically diverse populations • Low-resourced populations • Older adults • LGBTQIA+ • Families affected by violence and/or incarceration	• Investments in community behavioral health services through screening, monitoring, counseling, navigation, and treatment • Community-based Primary and Specialty Care (Support for licensed and/or affiliated community health centers) • Screening, Brief Intervention, and Referral to Treatment • Integrative Care Model • Collaborative Care Model • Opioid Care Committee • The Dimock Center substance use clinical stabilization services	• # of participants and their demographics • Mental health symptoms (PHQ-8; PHQ-9; PSYCHLOPS) • Stigma (Recovery Assessment Scale (RAS-DS) and General Help-Seeking Questionnaire (GHSQ) • # of patients assisted • # of therapy sessions • # of integrated BH consultations • # of practices	• Boston Chinatown Neighborhood Center • Fathers' Uplift • Greater Boston Chinese Golden Age Center • The Family Van • Additional grantees TBD • Bowdoin Street Health Center • Charles River Community Health • Fenway Health • South Cove Community Health Center • The Dimock Center • Health Care Associates (HCA) • BILH Behavioral Services • BILH Primary Care	Equitable Access to Care

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 issues and conditions.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Advocate for and support policies and programs that address mental health and substance use.	Community residents	To be determined	• # of policies reviewed • # of policies supported	BILH Government Relations	Not Applicable
Implement trauma-informed care (TIC) principles and other prevention strategies to improve care for all, especially those with a history of adversity.	• Racially, ethnically and linguistically diverse populations • LGBTQIA+ • Families affected by violence and/or incarceration	Expansion of Trauma-informed care (TIC)-training across hospital	• # of hospital departments that have received TIC training • Staff knowledge and skills	• Louis D. Brown Peace Institute • BIDMC Social Work Department	Equitable Access to Care

Priority: Chronic and Complex 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.

Resources/Financial Investment: BIDMC will commit direct, community health program investments, and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

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	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
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.	• Racially, ethnically and linguistically diverse populations • Low-resourced populations • Older adults • LGBTQIA+	• The Wellness Center at Bowdoin Street Health Center • BILH Pharmacy Assistance Programs • Community-based Diabetes Prevention and Treatment Programs • Cancer Patient Navigators • Support Groups • Lung Cancer Early Detection Screening • Implement BILH Diabetes Disparities initiative strategies, as appropriate	• # of patients • # of encounters • % of Federally Qualified Health Center (FQHC) patients whose diabetes is controlled (HBA1C <9%) • % of FQHC patients whose hypertension is controlled • # of support groups • # of patients attending support groups • # of patients receiving early detection lung cancer screening	• AIDS Action Committee • BILH Primary Care • BILH Pharmacy • Boston Public Health Commission • Community Servings • Dana Farber Cancer Institute • Bowdoin Street Health Center • Charles River Community Health • Fenway Health • South Cove Community Health Center • The Dimock Center • Joslin Diabetes Center • Mount Auburn Hospital • Massachusetts Department of Public Health • New England AIDS Education and Training Center	Equitable Access to Care

General Regulatory Information

Contact Person:	Robert Torres, Director of Community Benefits
Date of written plan:	June 30, 2022
Date written plan was adopted by authorized governing body:	September 21, 2022
Date written plan was required to be adopted	February 15, 2023
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 18, 2019
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 02115