September 19, 2023
Meeting Packet

Meeting Agenda

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Community Benefits Annual Meeting
Beth Israel Deaconess Medical Center (BIDMC)
Tuesday, September 19, 2023
5:00 pm – 6:30 pm
Zoom Meeting – Email for Link

I. 10 minutes	**Welcome and Introductions**
II. 25 minutes	**Community Benefits Program Highlights**
III. 10 minutes	**BILH System Priority: Behavioral Health Access**
IV. 20 minutes	**Community-based Health Initiative Overarching Evaluation Update**
V. 20 minutes	**Community Care Alliance**
VI. 5 minutes	**Next Steps and Adjourn**

Next Meeting: December 12, 2023

Meeting Slides

Beth Israel Deaconess Medical Center Community Benefits Annual Meeting

Nancy Kasen, Vice President, Community Benefits and Community Relations, BILH
Robert Torres, Director Boston Region, Community Benefits, BILH
Anna Spier, Program Manager, Community Benefits, BIDMC

September 19, 2023

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Content

- Welcome and Introductions
- Community Benefits Program Highlights
- BILH System Priority: Behavioral Health Access
- Community-based Health Initiative Overarching Evaluation Update
- Overview of the Community Care Alliance
- Next Steps and Adjourn

Housekeeping

- Please join the meeting using video (if possible)
- If you lose your connection, please call in
  - Phone number: +1 309 205 3325
  - Meeting ID: 922 0615 2598
  - Everyone will be muted upon arrival
- Please use the chat function for requests to be unmuted, to ask questions, or to make comments
- Our Zoom moderator is Anna

Welcome and Introductions

A Shared Vision to Reshape Our Futures

BILH's merger was critical to our success; however, it did not address all that is needed to be the preeminent academic health system in New England

Dana-Farber Cancer Institute (DFCI) is looking to build on a history of world-leading cancer care and innovations in research, therapies, and technology

Our shared vision bridges and fundamentally repositions both institutions to transform the future of cancer care.

Our Shared Vision
To Redefine Cancer Care, Discovery, & Education

A bridge to transform the future of cancer care

A comprehensive collaboratio **ult cancer care**, anchored in a new dedicated cancer hospital in Boston's Longwood Medical Area that will transform the future of accessible, coordinated cancer care. This collaboration will create a forward-looking platform to deliver comprehensive advanced cancer care, research and education – infusing bench-to-bedside innovations from Dana-Farber and BIDMC research into the entire patient care journey.

We envision a newly constructed, cutting-edge adult cancer hospital—providing patients with a state-of-the-art, welcoming and nurturing care environment that is designed to flexibly integrate innovations in cancer treatment and care – as part of a fully inter-locking campus where world-renowned clinicians and researchers work shoulder-to-shoulder to provide the full spectrum of the world's best cancer care.

Our Shared Vision
Patient-Focused Benefits Advance the Future of Cancer Care

World-Class Patient Experience	*A coordinated patient experience across the spectrum of cancer care in the Longwood Medical Area*
Expanded Community Access	*Enhanced access to top-class adult oncology care and clinical trials across a broad and diverse population*
Bench-to-Bedside Innovation	*Collaboration to advance world-class cancer discovery and innovation*
Enhanced Affordability	*Positive impact to the Commonwealth by reducing the total cost of cancer care by substantial cost savings over 10 years*[1]

1. The initial economic analysis of commercially insured patients based on risk-adjusted relative price ratios that are published by the State (CHIA) and anticipated volumes from detailed financial modelling (as of July 26th, 2023)

Collaboration Agreement Overview
Executive Summary

BIDMC, DFCI, and HMFP are forming a comprehensive affiliation to provide the full continuum of cancer care

While BIDMC and DFCI will be closely collaborating, they will **remain separate and independent institutions**

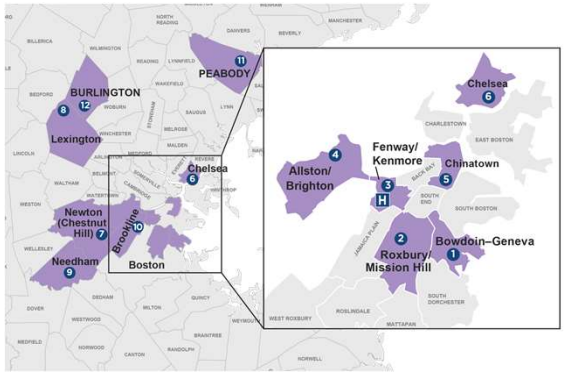
The Collaboration itself is a **three-party agreement among DFCI, BILH, and HMFP**

DFCI and BIDMC will jointly fund the construction of a new building that will house an inpatient cancer hospital under DFCI's license

The affiliation is limited to the Longwood Medical Area. While it could expand in the future, there are no plans or commitments to do so

Community Benefits Program Highlights

BIDMC Community Benefits Service Area



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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

Community Health Needs Assessment and Implementation Strategy
BIDMC Priority Populations

Low-resourced populations

Racially, ethnically, and linguistically diverse populations

Youth

LGBTQIA+

Older adults

Families affected by violence and/or incarceration

Community Benefits and Community Relations
Guiding Principles

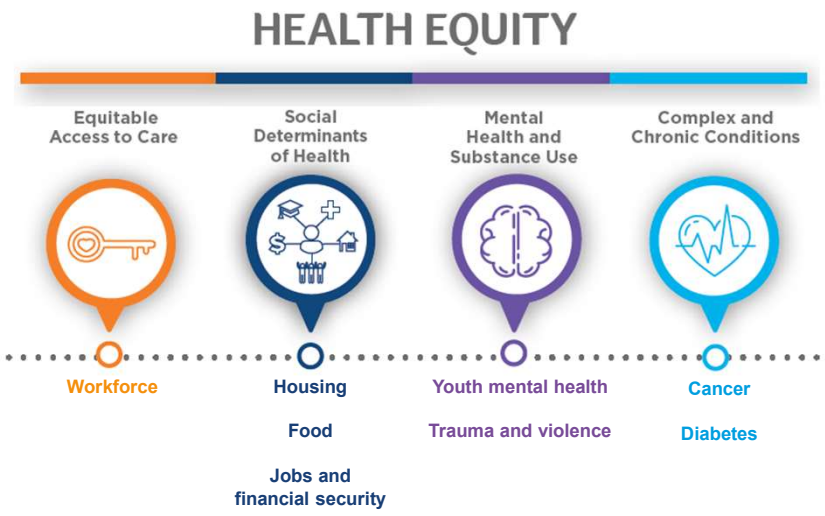
Accountability: Hold each other to efficient, effective and accurate processes to achieve our system, department and communities' collective goals.

Community Engagement: Collaborate meaningfully, intentionally and respectfully with our community partners and support community initiated, driven and/or led processes especially with and for populations experiencing the greatest inequities.

Equity: Apply an equity lens to dismantle systems of oppression and work towards the systemic, fair and just treatment of all people of any race, ethnicity, religion, gender, sexual orientation, age, immigration and/or disability status, so that all communities and people can achieve their full health and overall potential.

Impact: Employ evidence-based and evidence-informed strategies that align with system and community priorities to drive measurable change in health outcomes.

Community Health Needs Assessment and Implementation Strategy
BIDMC Final Priorities



Community Health Needs Assessment and Implementation Strategy
BIDMC FY22 Program Impact

Equitable Access to Care

- Number of patients seen at affiliated community health centers (CCA) increased to 125,946 (from 119,184 in FY21).
- 35 BIDMC specialists practiced at community health center sites (increased from 31 in FY21).
- Number of interpreter services interactions (in-person, telephone, video, and ASL) totaled 299,428 in FY22 compared to 271,357 in FY21.
- BIDMC staff screened 315,578 patients for eligibility and enrolled 31,251 patients into entitlement programs.
- FY23 metrics include: # of BIDMC staff completing SOGI training, # of DEI trainings, # of patients assisted with health-related social needs

Social Determinants of Health

- Housing: 18 youth have gained housing, 27 households avoided an eviction or foreclosure; 5 participants in a matched savings program purchased a home
- Food: Purchased 300 bags of food and distributed them free to patients and community members
- FY23 metrics include: housing stability, # of community residents hired, # of units of food produced and distributed, # of policies supported

Community Health Needs Assessment and Implementation Strategy
BIDMC FY22 Program Impact

Mental Health and Substance Use

- In a behavioral health program serving Asian seniors, the mean participant who took a depression screening went from a score of 8.6 at baseline (mild depression) to 4.4 (minimal depression).
- Through a bilingual clinical intensive case management program in Chelsea, participants achieved statistically significant impacts, including increased mean resilience scores, indicating an improved ability to cope with difficult situations.
- FY23 metrics include: # of participants in behavioral health programs and their demographics, mental health symptoms, # of integrated behavioral health consultations, # of policies supported

Complex and Chronic Conditions

- As of October 2022, the percentage of Black patients with A1c level > 9% decreased by 8.9%, and the percentage of Hispanic patients with A1c level > 9% decreased by 7.8%.
- FY23 metrics include: % of Federally Qualified Health Center patients whose diabetes and hypertension are controlled, # of patients receiving early detection lung cancer screening

BILH Food and Housing Investments
Goal

Food & Nutrition
Increase access to low-cost healthy foods for people in need

Housing
Increase housing stability for those at risk for eviction or homelessness

Identified common goal and priorities for all hospitals to implement

Collected consistent data across the system

2020 — 2021 — 2022

Began building infrastructure to tell the story of our impact

BILH Food and Housing Investments
FY22 Food and Nutrition

More than $1.4M ($40K) contributed to:

154,210 (3,600)
pounds of free, nutritious food food distributed to
7,878 (300)
community residents

5
Community Farmers Markets that served **3,380** people per week

25,450
nutritious meals distributed to people who were homebound

3,319
community residents participated in nutrition education

5
Food Justice & Hunger Networks to support collaboration

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BILH Food and Housing Investments
FY22 Housing

More than $2.6M ($1.2M) contributed to:

182 (30)
people housed or had positive housing outcome

12 (6)
Housing Coalitions or Tenant Associations

1,947 (819)
community residents received services to stay in their homes

555 (186)
people who were unhoused were assisted in shelters or on the street

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BILH Community Capacity Building
Evaluation Workshops and Engagement

Evaluation

- 4 training opportunities for community-based organizations and community members
  - Evaluation 101 and SMART (Specific, Measurable, Achievable, Relevant, Timely) Goals
  - Logic Models
  - Selecting Measures and Measurement Tools
  - Program Monitoring and Improvement
- Weekly office hours

BILH Community Engagement

- Louis D. Brown Peace Institute Mother's Day Walk for Peace (100+ BILH participants)
- Tu Salud Health and Wellness Fair (4,500 attendees)
- Pride for the People LGBTQIA+ Pride March (75K+ attendees)
- Embrace Juneteenth Event (inaugural event)
- Equity Compact Summit (700+ attendees)

BIDMC Community Engagement

- Community Grants Open House
- 27 sponsorships
- Healthy Neighborhoods Initiative
- CBAC meetings open to the public

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BILH System Priority: Behavioral Health Access

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BILH Behavioral Health Priority
Communication, Education, & Partnership

Community-based Health Initiative Interim Overarching Evaluation Update

Boston CHI Grantees
Evaluation Overview

Evaluation Questions:

- To what extent have the priority populations been reached?
- To what extent have outcomes improved across the participant population and/or what progress has been made towards policy change?

- **Today's update:**
  - Describes 1) service delivery and participants served to date by Boston Cohort 1 grantees and 2) key outcomes that will continue to be tracked
  - Includes data from the first 18 months of implementation (July 2021 – December 2022)
  - Focuses on baseline data to describe areas of need among participants
  - Presents preliminary findings that may change as additional participants are included in the evaluation over time

Boston Cohort Grantees
Program Implementation During First 18 Months (July'21-Dec.'22)

1,400 individuals directly engaged in first 18 months (908 individuals received services and enrolled in the evaluation, 214 received one-time services, and 284 individuals engaged in policy activities).

Of the 908 programmatic participants served by Boston-based CHI grantees and enrolled in the evaluation in the first 18 months:

Priority Neighborhood

77.4%
associated with a BIDMC priority neighborhood

Low Resourced Individuals

74.0%
considered low resourced

- Half (51.0%) of participants identified as Black or African American, almost a third (30.8%) identified as Asian, and a quarter (25.1%) identified as Hispanic, Latino, or Spanish ethnicity
- More than a third (35.0%) of participants indicted a primary language other than English

45 staff hired + 345 staff and/or volunteers trained in first 18 months.

Behavioral Health (8 Boston Grantees)
Implementation and Baseline Evaluation Data

During the first 18 months of grant implementation (July 2021-December 2022), behavioral health grantee programs and initiatives:

Engaged 443 Individuals

to receive behavioral health services and enrolled in evaluation

Delivered 1,004 Sessions

of behavioral health counseling

The **evaluation** included measuring **stigma** and **mental health symptoms** at a baseline time point, when participants begin receiving services, and at an endpoint time point, upon completion of services. **Baseline** data from 443 participants in behavioral health programs describe areas of need.

Personal or Emotional Challenges

37.3% of participants indicated they **'often' or 'almost always' experience personal or emotional problems**

Mental Health Symptoms

27.7% of participants with a PHQ score **fell above the clinical cutoff for depression**

Help Seeking Behavior

24.8% of participants were **'likely' or 'extremely likely' to not seek help from anyone**

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Housing Affordability (7 Boston Grantees)
Implementation and Baseline Evaluation Data

During the first 18 months of grant implementation (July 2021-December 2022), housing grantee programs and initiatives:

Engaged 380 Individuals

to receive housing services and enrolled in evaluation

Delivered 341 Services

of housing support

Conducted 1,613 Policy Activities

on local and state policies

The **evaluation** included measuring **housing situation, agency and affordability** at a baseline time point, when participants begin receiving services, and at an endpoint time point, upon completion of services. **Baseline** data from 380 participants in housing programs describe areas of need.

Housing Satisfaction

47.3% of participants were **not satisfied** with their current housing situation

Control of Housing

45.9% of participants indicated **feeling low levels of control** in their housing situation

Housing Affordability

39.5% indicated in the past 3 months they had to **choose between paying for housing and paying for at least one other expense**

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Jobs & Financial Security (6 Boston Grantees)
Implementation and Baseline Evaluation Data

During the first 18 months of grant implementation (July 2021-December 2022), jobs & financial security grantee programs and initiatives:

Engaged 300 Individuals
to receive jobs & financial security services and enrolled in evaluation

Delivered 17,504
hours of workshops/courses

The **evaluation** included measuring **self-efficacy** and **financial capability** at a baseline time point, when participants begin receiving services, and at an endpoint time point, upon completion of services. **Baseline** data from 300 participants in jobs & financial security programs describe areas of need.

Hope
The mean Hope Scale score was **35.4 out of a possible 48**

Financial Capability
The mean Financial Capability Scale score was **3.7 out of a possible 8**

Saving Money
51.4% of participants report they are **not regularly putting money aside** for future use

Boston Grantees (Cohort 1)
Evaluation Next Steps and Discussion

- Upon completion of the grant evaluation period, baseline and endpoint datasets will be finalized and the outcome measures will be analyzed
  - Analysis will include comparisons of the outcome measures between baseline and endpoint time points to demonstrate change after participation in grantee programs
  - Analysis will include significance testing and stratifications dependent on final sample size
- Final results from the overarching evaluation will be available in Winter 2024 and will describe:
  - Characteristics of enrolled participants
  - Collective impact of the Boston Cohort 1 CHI grantee initiatives on behavioral health, housing affordability, and jobs and financial security outcomes
- Questions and Discussion

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Overview of the Community Care Alliance

Licensed/Affiliated Community Health Centers

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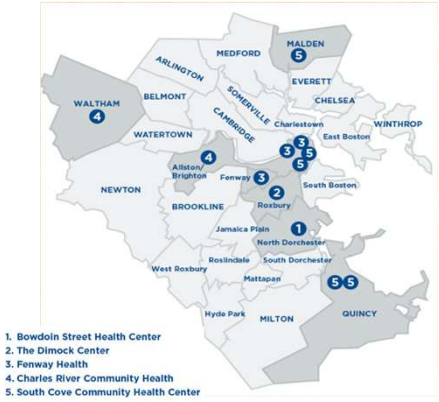
Community Care Alliance
Overview

The Community Care Alliance (CCA) consists of five health centers serving 121,000+ patients annually at 12 locations throughout greater Boston.

- Limited Liability Corporation (LLC) established in 1997 as partnership between BIDMC and affiliated community health centers.
  - Opportunities for collaboration and synergies in clinical and administrative efforts
- One BIDMC-licensed health center
- Four independently licensed Federally Qualified Health Centers (FQHCs) that identify BILH as their primary health system affiliate
- CCA Management Structure
  - Nancy Kasen, Managing Director, reports to the Board of Managers comprised of the five health center CEOs
  - Kelly McCarthy, Program Manager



BIDMC also has a secondary clinical affiliation with Outer Cape Health Services, which has sites in Harwich Port, Wellfleet and Provincetown.

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Community Care Alliance
Licensed/Affiliated Community Health Centers

Bowdoin Street Health Center
- 7,200 patients
- Bowdoin-Geneva neighborhood in Dorchester
- Licensed by BIDMC
- Majority of patients identify as African-American and Caribbean Islanders, Cape Verdean, Latinx
- BIDMC on-site pharmacy
- BIDMC Orthopedics & Nephrology on-site
- Wellness Center - exercise and healthy eating programming

Charles River Community Health)
- 13,800 patients
- Brighton & Waltham
- 73% of patients are best served in language other than English
- 26% of patients are uninsured
- 62% of patients have Medicaid/other public insurance
- OB, Lab Services and Financial Counseling through MAH

Fenway Health
- 30,400 patients
- Fenway/Kenmore and South End
- National leader in LGBTQIA+ health services
- Sidney Borum Jr. & AIDS Action Committee
- Fenway Institute conducts research studies with BIDMC
- BIDMC Dermatology & Pulmonary on-site
- OB through BIDMC

The Dimock Center
- 19,000 patients
- Roxbury neighborhood in Boston
- Health Services, Child & Family Services and Behavioral Health
- 39-bed ATS detox unit supported by BIDMC grant ($1M)
- Post-detox Women's Clinical Stabilization Services (CSS)
- BILH committed $1.2M to establish Men's CSS Program
- BIDMC/HMFP ID and Lab on-site
- Employee Occupational Health Services through BIDMC
- OB through BIDMC

South Cove Community Health Center
- 36,000 patients
- Boston, Malden & Quincy
- 98% of patients identify as Asian
- 90% of patients best served in language other than English – Mandarin and Cantonese
- Bi and tri-lingual providers
- Bone Density & Mammography on-site
- SCCHC staff BIDMC Interpreter Services Dept.
- OB and Lab Services through BIDMC

Community Care Alliance
Operational & Clinical Activities

CCA connects health centers to the BILH system and supports their business operations and collaborative care efforts to improve patient access and experience.

- **Operational Support**
  - Shared quality improvement initiatives
  - Collaboration between CHC leadership and BILH clinical and administrative teams
  - Opportunities for grants, residency rotations & provider fellowships
- **Clinical Support**
  - Support patient access to specialty care
  - Shared Respect & Dignity reporting
  - Support for provider recruitment
  - Community-based lab services
  - Community-based specialty care

Questions/Comments

- How can we better promote the work of Community Care Alliance and the collaborative efforts between BILH and community health centers?
- What are some ways in which we could foster relationships between community-based organizations and BILH's licensed/affiliated health centers?

Next Steps

Massachusetts Department of Public Health (MA-DPH)
Community Health Equity Survey

Please take the MA-DPH Community Health Equity Survey, and:

- Send a link to family, friends and colleagues in Massachusetts
- Promote the survey on organizational mailing lists
- Post about the survey on social media
- Use staff or volunteers to identify and support survey takers

Survey data will be used by MA-DPH, hospitals, and collaborators to allocate funding, improve programming, and develop policies that address health inequities.

Massachusetts Department of Public Health (MA-DPH)
Community Health and Aging Funds

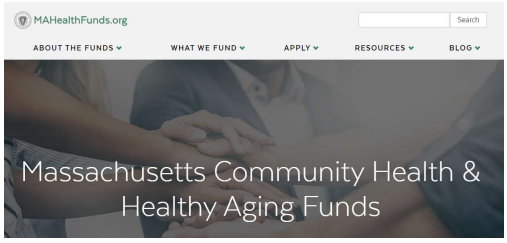
Three funding opportunities make up the Massachusetts Community Health and Healthy Aging Funds:

- Policy, Systems, and Environmental Change Approaches
- Community Health Improvement Planning (CHIP) Processes
- Healthy Aging

Applications will open this winter, and awards will be made by Summer 2024.

Visit mahealthfunds.org for more information.

Health Resources in Action is asking potential applicants to complete their Interest Survey to help them better understand who is interested in applying for this funding opportunity, and how they can best support and communicate with applicants throughout this process.



Next Steps

Future CBAC meetings:

- December 12, 2023
- March 26, 2024
- June 25, 2024
- September 24, 2024
- December 10, 2024

Thank you!

Appendix

Boston Cohort 1
Grantees

- **Across the 16 funded grantees in this cohort (2021-2023), approximately $6.55 million from the CHI will be distributed.**
  - The funding opportunity had three tracks:
  - Track 1: Cross-sector partnerships for systems change - $1 million (2 grantees)
  - Track 2: Focused investment - $500,000 (8 grantees)
  - Track 3: Capacity building for change - $100,000 (6 grantees)

Priority Area	Approximate Amount Invested	Primary Focus	Secondary Focus
Behavioral Health	$2.9 million	6 grantees	2 grantees
Housing	$2.6 million	7 grantees	--
Jobs and Financial Security	$1.1 million	3 grantees	3 grantees

Boston Grantees (Cohort 1)
Overarching Evaluation Purpose and Methods

To Learn:

- To what extent have the priority populations been reached?
- To what extent have outcomes improved across the participant population and/or what progress has been made towards policy change?

Methods:

- All 16 grantees are collecting shared process and outcome measures and program specific implementation measures
  - Shared outcome measures are intended to capture change over time and are collected at a baseline time point, when participants begin receiving services, and at an endpoint time point, upon completion of services
- Qualitative data is being collected annually through staff interviews and/or focus groups with each grantee

Boston Grantees (Cohort 1)
Overarching Evaluation Timeline

- **Grantees are funded for 3 years**: January 2021 – December 2023
  - First 6 months of funding: Planning Period
- **Grantee data collection is ongoing**; grantees transfer data to HRiA quarterly

Community Care Alliance
History

BIDMC has a rich history of supporting the community health center movement.

- **1968** - Beth Israel Hospital and The Dimock Center first partnered to address maternal and pediatric health improvement for low-income, underserved populations in Roxbury.
  - Dimock's ongoing expansion of substance use services and facilities has been supported by two capital campaign commitments in 2016 (BIDMC) and 2022 (BILH) totaling $2.2M.
- **1974** - Fenway Health received its first funding from Boston's Matching Grant Program in conjunction with New England Deaconess Hospital.
- **1981** - Beth Israel Hospital and Fenway Health collaborated to treat HIV/AIDS patients referred to the hospital, including granting admitting privileges to Fenway providers.

BI program is "family doctor" for 6000 Roxbury children

Staff Spotlight

Just like a father, but he never says 'no'

- **1995** - Transferred Bowdoin Street Health Center's license to BIDMC from Carney Hospital. Built a new building for the health center (1998), added a Wellness Center in 2015, and opened an on-site pharmacy in 2022.
- **1997** - Community Care Alliance, LLC was established as a partnership between BIDMC and licensed/affiliated community health centers.