Community Benefits Report

Fiscal Year 2019

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

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Section I: MISSION STATEMENT

Summary and Mission

Beth Israel Deaconess Medical Center (BIDMC) is a member of Beth Israel Lahey Health (BILH). BILH was established with an appreciation for the importance of caring for patients and communities in new and better ways. BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery – academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care and this belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the community. Working collaboratively with BILH, BIDMC's Community Benefits staff are committed to addressing the leading health issues and creating a healthy future for individuals, families, and communities.

The mission of BIDMC is to serve its patients compassionately and effectively, and to create a healthy future for them and their families. BIDMC's mission is supported by BIDMC's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect and collaboration; and a commitment to maintaining financial health. BIDMC is also committed to being active in its community. Service to community is at the core and an important part of BIDMC's mission. BIDMC's founders made a covenant to care for the underserved, attend to unmet need, and address disparities in access to care and health outcomes. BIDMC's commitment to this covenant and the people served remains steadfast today.

The following annual report provides specific details on how BIDMC is honoring its commitment and includes information on BIDMC's Community Benefits Service Area (CBSA), community health priorities, target populations, and community partners, as well as detailed descriptions of its Community Benefits programs and their impacts.

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

- **Involving BIDMC's staff**, including its leadership, and dozens of community partners in the community health needs assessment process as well as in the development, implementation, and oversight of the Implementation Strategy (IS);

- **Engaging and learning from residents** throughout BIDMC's CBSA in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. In this regard, special attention is given to engaging diverse perspectives; those who are not patients of BIDMC and those who are often not involved in the assessment, planning, and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes;

- **Implementing community health programs and services** in BIDMC's CBSA that is geared towards improving current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the healthcare system, and working to decrease the burden of the leading health issues;

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

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

Target Population

BIDMC's CBSA includes the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury, the City of Chelsea, and the towns of Brookline, Lexington, Needham, and Newton (Chestnut Hill). BIDMC's FY 2019 Community Health Needs Assessment (CHNA), on which this report is based, shows that low income and racially/ethnically diverse populations living in Boston's neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury as well as the adjacent City of Chelsea face the greatest health disparities and are most at-risk. As a result, these Boston neighborhoods and the City of Chelsea have been identified and prioritized as the focus for BIDMC's community health efforts. The FY 2019 CHNA also identified three smaller but high need segments of the population that are also underserved, at-risk, and face disparities: youth, older adults, and the Lesbian Gay Bisexual Transgender and Queer or Questioning (LGBTQ) community. Collectively, these geographic, demographic, and socio-economic population segments make up BIDMC's priority populations. While BIDMC is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated Community Benefits guidelines, BIDMC's IS will focus on the following most at-risk priority populations in the five Boston neighborhoods and the City of Chelsea – Low Income, Racially/Ethnically Diverse, LGBTQ, Older Adults, Youth, and Limited English Proficient.

Basis for Health Priorities Selection

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

Key Accomplishments of Reporting Year

While BIDMC's most recent CHNA was completed during FY 2019, unless otherwise noted, the accomplishments highlighted in this report are based upon priorities identified and programs contained in BIDMC's FY 2017-2019 IS:

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

Plans for Next Reporting Year

In FY 2019, BIDMC conducted a comprehensive and inclusive CHNA that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2019 CHNA, BIDMC will focus its FY 2020 – 2022 IS on the following four priority areas. These four priority areas collectively address the broad range of health and social issues facing residents living in BIDMC's CBSA who face the greatest health disparities. These four priority areas are:

1) Social Determinants of Health;
2) Chronic/Complex Conditions and Risk Factors;
3) Access to Care; and
4) Mental Health and Substance Use

It should also be noted that these priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic

Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BIDMC's priorities are also aligned with the priorities identified by the MDPH to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the social determinants of health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2019 CHNA provided new guidance and invaluable insight on quantitative trends and community perceptions that are being used to inform and refine BIDMC's efforts. In completing the FY 2019 CHNA and FY 2020-FY 2022 IS, BIDMC, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the quantitative and qualitative findings of the CHNA, including discussions with a broad range of community participants, there was an agreement that BIDMC's FY 2020-2022 IS should prioritize certain demographic, socio-economic and geographic population segments that have complex needs, face barriers to care and services, as well as other adverse social determinants of health. These factors put these populations at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY 2019 CHNA identified the importance of supporting initiatives that focus on low income populations, youth, older adults, racially/ethnically diverse populations, limited English proficient, and LGBTQ populations.

BIDMC partners with dozens of community-based organizations and service providers to execute its IS, including public agencies, social service providers, community health organizations, academic organizations, and businesses. BIDMC also partners with numerous CHCs through the Community Care Alliance (CCA, BIDMC's health center network) to implement programs that address health disparities (related to race, ethnicity, sexual orientation, gender identity, and physical attributes) and implement targeted public health programs and chronic disease management programs, including efforts to address health risk factors such as health eating and active living. BIDMC also partners with these health centers to implement, strengthen, and leverage the patient-centered medical home service delivery model to promote coordinated, cost-effective, high quality care for the community.

Example programs/strategies in the FY20-22 IS include:

- Supporting and collaborating with the community-based organizations to promote accessible/affordable healthy food
- Supporting the Fitness in the City Program at BSHC
- Holding healing services (circles) when appropriate for community residents affected by violence
- Responding to all incidents of homicide or violence within a catchment area that meet criteria established by the Boston Public Health Commission
- Implementing and expanding education and workforce development opportunities
- Supporting programs in CCA clinics that educate and screen patients for diabetes, hypertension, and persistent asthma
- Supporting and promoting the city-wide cancer navigators' program
- Providing free or subsidized pharmacy medications to eligible, low income patients
- Increasing access to care and services for Limited English Proficient individuals

- Supporting primary care and behavioral health integration at BIDMC's CCA clinic sites and BIDMC's Chelsea service site, as well as at BIDMC's Affiliated Physicians Group (APG) and Healthcare Associates (HCA) practices
- Providing services for domestic violence, sexual assault, and community violence victims through BIDMC's Center for Violence Prevention and Recovery (CVPR) program

Self-Assessment Form:

The Community Benefits Leadership team completed the self-assessment form. The completion of this form included input from the BIDMC Community Benefits Committee and the Community Advisory Committee. Additionally, the BIDMC Community Benefits team shared and requested completion of the Community Representative Feedback Form by members of its Community Benefits Committee, Community Advisory Committee and community stakeholders who participated in BIDMC's CHNA.

Section II: Community Benefits Process

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

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

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

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

Providing direction for BIDMC's collective commitment and effort are The Community Benefits Guiding Principles that follow below. Adopted by a broad-based constituency of Board, senior leadership and staff, these principles provide the framework for the execution of the plan, spearheaded by the Director of Community Benefits. The Director is accountable to the BILH Vice President of Community Benefits and Community Relations and the Chief Strategy Officer for BILH. The Vice President of Community Benefits and Community Relations also has direct access

to the BIDMC President. It is the responsibility of these four senior managers to ensure that Community Benefits is addressed by the entire organization and the needs of the underserved populations are considered every day in discussions on resource allocation, policies, and program development.

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

Guiding Principles of BIDMC's Community Benefits Program

I. Why?

Our Community Benefits program is designed to ensure that:

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

II. What and for Whom?

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

III. How?

- *We partner with community leaders and community-based organizations; they serve as links to the community and teachers of how we can better serve the populations they represent. In addition, we collaborate with a wide variety of organizations because healthcare services by themselves are not adequate to maximize improvement of health status.*

- *Improving the community's health requires more than clinical services. We look to public health, prevention, and other health-related approaches not traditionally provided by many acute care hospitals.*

- *Our commitment to the Community Benefits mission is as fundamental as our commitment to our patient care and academic missions. We will constantly seek ways to fulfill all of them in as effective and efficient a manner as possible.*

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

Community Benefits Committee Meetings

December 4, 2018
March 19, 2019
June 4, 2019
September 5, 2019

Community Partners

BIDMC recognizes its role as an academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BIDMC's CHNA and the associated IS were completed in close collaboration with BIDMC's staff, its health and social service partners, and the community at-large. BIDMC's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BIDMC's mission.

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

BIDMC serves and collaborates with all segments of the population. However, in recognition of its long-standing ties to specific Boston neighborhoods and the health disparities that exist for these

communities, BIDMC focuses its Community Benefits efforts on improving the health status of the low income, underserved populations living in the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury, and the City of Chelsea.

BIDMC currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In so doing, BIDMC collaborates with many of Boston's leading healthcare, public health, and social services organizations. BIDMC has particularly strong relationships with many of the CHCs that operate in its CBSA. The health centers that are part of the CCA are critical components of the health care safety net in the communities in which they operate. In 2019, the CCA health centers provided primary care medical, dental, behavioral health, and enabling services to approximately 123,788 patients. The CCA health centers include:

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

These health centers are ideal community partners as they are rooted in their communities and, as federally qualified health centers (with the exception of BSHC), are mandated to serve low income, underserved populations.

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

BIDMC is also an active participant in the North Suffolk Integrated Community Health Needs Assessment (iCHNA) and a founding member of the Boston CHNA- Community Health Improvement Plan (CHIP) Collaborative. Joining with such grass-roots community groups and residents, the BPHC, MDPH, and other academic medical centers, BIDMC strives to create a vision for both city-wide and neighborhood-based health improvement. Another important partnership is BIDMC's involvement with the Initiative to Eliminate Cancer Disparities (IECD) through the Dana-Farber/Harvard Cancer Center (DF/HCC), of which BIDMC is a founding member. Collectively the IECD, the DF/HCC, BIDMC and others are working to address the unequal burden of cancer within diverse communities by facilitating research in disparities and minority clinical trial education and enrollment.

Appendix A is a comprehensive listing of the community partners with which BIDMC joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits IS. The level of engagement of all community partners can be found in the Self-Assessment (Section VII).

Section III: Community Health Needs Assessment

Date Last Assessment Completed and Current Status

The FY 2019 CHNA along with the associated FY 2020 - 2022 IS was developed over an eleven-month period from October 2018 to September 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill BIDMC's need to conduct a CHNA, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an IS. However, these activities are driven primarily by BIDMC's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, BIDMC's most recent CHNA was completed during FY 2019 but its FY 2019 Community Benefits programming was informed by the FY 2016 CHNA and aligns with BIDMC's FY 2017 – FY 2019 IS. The following is a summary description of the FY 2019 CHNA approach, methods, and key findings.

Approach and Methods

The FY 2019 CHNA was conducted in three phases, which allowed BIDMC to: 1) compile an extensive amount of quantitative and qualitative data, 2) engage and involve key stakeholders, BIDMC clinical and administrative staff, and the community at-large, 3) develop a report and detailed strategic plan, and 4) comply with all Commonwealth Attorney General and Federal IRS Community Benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, surveys, focus groups, and community forums.

Rather than conducting one-single assessment, BIDMC's Community Benefits staff conducted their own assessment and participated in a series of additional, concurrent, comprehensive assessments that were then aggregated together to create the 2019 CHNA Report. These concurrent assessments were conducted by organizations or collectives of organizations, with whom BIDMC partners with on a regular basis, throughout Boston and Chelsea (Boston CHNA-CHIP Collaborative, North Suffolk Integrated CHNA, and BILH and Other Hospital CHNA). BIDMC also integrated the extensive community engagement and planning work that BIDMC is conducting as part of its Massachusetts DoN New Inpatient Building CHI. Involvement in these four efforts allowed BIDMC to leverage resources, and create a robust and inclusive CHNA and IS. Involvement in these concurrent assessments also facilitated important collaboration between BIDMC and health and social services organizations across Boston.

BIDMC's CBC oversaw all aspects of the assessment and planning process and was integral to the development of the CHNA report and the IS. The assessment was also supported by BIDMC's Advisory Committee, which was initially constituted to oversee BIDMC's New Inpatient Building CHI. Both the CBC and Advisory Committee are made up of community members, service providers, and other key stakeholders that either live in and/or work with the neighborhoods in Boston or the City of Chelsea that are part of BIDMC's CBSA. The expertise and knowledge that these committees brought to the process was invaluable.

Collectively, these efforts exemplify BIDMC's commitment to a comprehensive, inclusive, engaged, collaborative assessment and planning process. The efforts also show BIDMC's commitment to understanding unmet needs, the underlying social determinants of health, and community engagement. All of these processes emphasized engaging hard to reach populations that are often left out of these types of activities.

Summary of Key Health-Related Findings from FY 2019 CHNA

Access to Care

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

Chronic/Complex Conditions and their Risk Factors

- **High Rates of Chronic and Acute Physical Health Conditions (e.g., heart disease, hypertension, cancer, and asthma).** The assessment quantitative data clearly shows that many communities in BIDMC's CBSA have high rates for many of the leading physical health conditions (e.g., heart disease, hypertension, cancer, and asthma). In many communities these rates are statistically higher than Commonwealth rates, indicating a particularly significant problem. However, even for those communities where the rates are not statistically higher, these conditions are still the leading causes of premature death.
- **Limited Access to Cancer Screening for Racial/Ethnic Diversity and Other At-risk Populations.** Many of the communities that are a part of BIDMC's CBSA have high cancer mortality rates. This is particularly true for certain cancers in specific communities in specific Boston neighborhoods, such as Roxbury, Dorchester, and Chinatown that have a high proportion of racial/ethnic diversity. At the root of addressing high mortality is screening, early detection and access to timely treatment.
- **High Rates of the Leading Health Risk Factors (e.g., Lack of Nutritional Food and Physical Activity, Alcohol/Illicit Drug Use, and Tobacco Use).** One of the leading findings from the assessment is that many communities and/or population segments in BIDMC's CBSA have high rates of chronic physical and behavioral health conditions. In some people, these conditions have underlying genetic roots that are hard to counter. However, for most people these conditions are widely considered preventable or manageable. Addressing the leading risk factors is at the root of a sound chronic disease prevention and management strategy.

Social Determinants and Health

- **Social Determinants of Health (e.g., economic stability, education, and community/social context) Continue to Have a Massive Impact on Many Segments of the Population**: The dominant theme from the key informant interviews, survey, focus groups and community forums was the continued impact that the underlying social determinants of health are having on the CBSA's low income, underserved, diverse population cohorts. More specifically, determinants such as poverty, employment opportunities, housing, violence, transportation, racial segregation, literacy, provider linguistic/cultural competency, social support, and community integration limit many people's ability to care for their own and/or their families' health.

- **Disparities in Health Outcomes Exist in BIDMC's CBSA by Race/Ethnicity, Foreign Born Status, Income, and Language**: There are major health disparities for residents living in BIDMC's CBSA. This is particularly true for racially/ethnically diverse, foreign born, low income, and non-English speaking residents living in Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury. The impact of racism, barriers to care, and disparities in health outcomes that these populations face are widely documented in literature and confirmed by data captured across all of BIDMC's CHNA components.

  It is crucial that these disparities be addressed and, to this end, BIDMC's IS continues to include a myriad of programs, strategic interventions, and services that are carefully targeted to address these disparities. However, it is critical to note that there is a multitude of individual, community and societal factors that work together to create these inequities. The underlying issue is not only race/ethnicity, racism, income, or language but rather a broad array of interrelated social issues including economic opportunity, education, crime, transportation, and community cohesion.

Mental Health and Substance Use

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

Section IV: Community Benefits Programs

Access to Care - Community Based Primary and Specialty Care

Brief Description or Objective	Greater Boston has one of the strongest and most comprehensive healthcare systems in the world. This system is expansive and spans the full healthcare continuum including primary care and specialty care services. There are limited gaps in services across the continuum, even for low income and racially/ethnically diverse populations that often struggle with access to health care services. However, this does not mean that all segments of the population receive the culturally sensitive care they need when and where is best. Despite the success of the Affordable Care Act and the Commonwealth's heath reform efforts, data shows that segments of the population, particularly low income, racially/ethnically diverse populations, non-English speakers, undocumented immigrants, isolated rural residents, and Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) populations face significant barriers to care and struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and shortages of providers willing to serve Medicaid insured or low income, uninsured patients. BIDMC believes that Community Health Centers (CHC) are in a unique position to provide accessible, culturally sensitive, linguistically appropriate primary care and specialty care services, including outreach, preventive, and enabling services, to diverse medically underserved communities in its Community Benefits Service Area (CBSA). The health centers that BIDMC supports are rooted in their communities, understand the unique social, cultural, and health-related needs of those they serve, and are better equipped than any organization to meet these needs. BIDMC is committed to strengthening the capacity of its seven affiliated CHCs including: Bowdoin Street Health Center (BSHC), The Dimock Health Center, Fenway Health, Charles River Community Health, Sidney Borum Jr. Health Center (part of Fenway Health), South Cove Community Health Center, and Outer Cape Health Services. The partnership takes many forms: recruitment, retention, financial support and credentialing of physicians and mid-level providers, BIDMC admitting privileges and access to managed care contracts, Harvard Medical School appointments and teaching opportunities, BIDMC-sponsored educational programs, and access to Up-to-Date. The CHCs also have access to teaching and growth opportunities including the Linde Family Fellowship Program (LFFP). The LFFP provides physicians with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation. BIDMC's commitment to community-based care translates into a number of BIDMC specialties (e.g., OB/GYN, Infectious Disease, etc.) and ancillary services (e.g., radiology, lab) being provided on-site at the health centers.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Provincetown, Wellfleet, Harwich, Quincy • **Gender:** All • **Age Group:** Adult, Children

	• **Ethnic Group:** Asian, Black/African American, Hispanic/Latino, White • **Language:** Cape Verdean Creole, Chinese, Portuguese, Russian, Spanish, Other • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Uninsured/underinsured, Immunization, Injury and violence, Mental health, Alcohol and substance abuse, Asthma/allergies,

	Cancer, Diabetes, Family planning, Hypertension, Language/literacy, Lead poisoning, Nutrition, Osteoporosis/menopause, Pregnancy, Pulmonary disease/tuberculosis, Rape, Safety, Sexually Transmitted Diseases, Sickle cell disease, Smoking/tobacco, Stroke, Vision, Overweight and obesity, Responsible sexual behavior, Substance Abuse, Tobacco Use

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, BIDMC will increase the number of patients receiving primary care, OB/GYN, and specialty care at affiliated CHCs from 110,268 patients in FY18.	123,788 patients received primary care, OB/GYN, and specialty care at affiliated CHCs in FY19.	3	3	Process Goal
By the end of FY19, BIDMC will increase the number of specialists practicing at CHC sites from 30 in FY18.	23 BIDMC specialists practiced at CHC sites in FY19.	3	3	Process Goal
By the end of FY19, BIDMC will increase the number of residents with CHC preceptors from 31 residents in FY18 and 14 in the primary care residency track in FY18.	31 residents were assigned to CHCs during the 2019 Academic Year. 7 residents were in a primary care residency track in the 2019 Academic Year.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Bowdoin Street Health Center	Continuity Clinic	https://www.bidmc.org/locations/bowdoin-street-health-center
The Dimock Center	Continuity Clinic	https://www.dimock.org
Fenway Health	Continuity Clinic	https://fenwayhealth.org/
Charles River Health Center	Continuity Clinic	https://www.charlesriverhealth.org/
Outer Cape Health Services	Elective Site	https://outercape.org/
Sidney Borum Jr. Health Center	Continuity Clinic	https://fenwayhealth.org/info/locations/the-borum/
South Cove Community Health Center	Continuity Clinic	https://scchc.org

Access to Care – Community Care Alliance

Brief Description or Objective	In 1997, BIDMC was instrumental in helping its seven affiliated and/or licensed health centers form a new network called Community Care Alliance (CCA). By collaborating together on clinical and administrative issues, CCA helps its members continue to provide high-quality, cost-effective healthcare

	services by collectively contracting for services and funding, as well as sharing resources and expertise for the benefit of their patients and communities. Since 1997, BIDMC has been actively engaged on an annual basis to help manage and strengthen this network with an eye towards promoting partnership, leveraging resources, improving quality of care, coordinating care within and outside of this network, and ensuring that network providers are fully prepared to participate in value-based payment and emerging service delivery and payment reform mechanisms. In addition to partnering with CCA, BIDMC makes many administrative services available to its affiliated health centers including marketing, media services, interpreter services, risk management, compliance, access to managed care contracts, trainings, assessment, Conexion, The Partnership, as well as financial support, and other program and technical assistance. BIDMC's Mystery Shopping process ensures that ambulatory sites, as well as participating CCA health centers are adhering to quality standards related to patient safety and satisfaction. By engaging a team of "mystery shoppers" to monitor incoming patient calls, BIDMC provides prompt feedback to health center staff in order to improve responsiveness and the ability to provide efficient, patient-focused assistance at every interaction. In March 2019, with the formation of Beth Israel Lahey Health (BILH), the CCA health centers became part of the BILH health system. Participating in the BILH system will provide the health centers with the opportunity to continue their long-standing partnerships with BIDMC and further explore new relationships with hospitals and providers in Eastern Massachusetts.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Middlesex County, Suffolk County, Boston (Allston, Brighton, Bowdoin/Geneva, Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Quincy, Waltham, Malden, Harwich, Provincetown, Wellfleet • **Gender:** All • **Age Group:** Children, Adult • **Ethnic Group:** Asian, Black / African American, Hispanic/Latino, White • **Language:** Cape Verdean Creole, Chinese, English, Haitian Creole, Portuguese, Russian, Spanish, Vietnamese • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education

(Select up to 3)	• ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Cultural competency, Immunization, Injury and violence, Mental health, Uninsured/underinsured

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC's Mystery Shopping team will shop 6 CCA clinics each month, totaling 72 shops per year and reports will be disseminated to CCA health center staff to address QI issues around access and patient experience.	Due to a process change, BIDMC conducted 56 Mystery Shops in FY19. The Mystery Shopping team provides reports back to CHC Executive Directors, Medical Directors and Operations Managers and some Quality Improvement managers.	3	3	Process Goal
In FY19, BIDMC will have more than 15 specialists practicing at the Community Care Alliance health centers.	24 BIDMC specialists practiced at CCA health centers in FY19.	3	3	Process Goal
In FY19, BICMC will identify opportunities for administrative and fiscal savings.	BIDMC has continued monthly regulatory OIG reviews for all CHC personnel and vendors.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Bowdoin Street Health Center	Continuity Clinic	https://www.bidmc.org/locations/bowdoin-street-health-center
The Dimock Center	Continuity Clinic	https://www.dimock.org
Fenway Health	Continuity Clinic	https://fenwayhealth.org/
Charles River Health Center	Continuity Clinic	https://www.charlesriverhealth.org/
Outer Cape Health Services	Elective Site	https://outercape.org/
Sidney Borum Jr. Health Center	Continuity Clinic	https://fenwayhealth.org/info/locations/the-borum/
South Cove Community Health Center	Continuity Clinic	https://scchc.org

Access to Care – Trauma, Emergency Management and Public Health Surveillance	
Brief Description or Objective	BIDMC has a robust trauma and emergency management program that is integrated into the City of Boston and the Commonwealth's emergency preparedness system. BIDMC's Emergency Management department routinely plans for a range of crises, from natural disasters and terrorist scenarios to outbreaks of widespread illness. Previously, BIDMC Emergency Management developed templates for magnetic disaster simulation boards in order to drill multiple care areas simultaneously. BIDMC is a regular participant in citywide drills, taskforces, and projects, and plan development meetings including those for citywide planned mass casualty events which also includes BIDMC's health center partners in simulations. The trauma team provides numerous in-service trainings throughout the year, including the semi-annual Advanced Trauma Support classes for New England-wide hospital personnel. Annually, the emergency management team supports two planned major events in Boston, the July 4th celebration, and the Boston Marathon. BIDMC Emergency Management participates in the following city and state committees: • MASCO Emergency Preparedness Committee • Boston Healthcare Preparedness Committee • COBTH Emergency Management Committee • BPHC Training and Exercise workgroup • State Region 4C project workgroup • State Region 4 Workplace Violence workgroup • Boston LEPC Committee • BPHC Patient Tracking workgroup • Milton LEPC Committee • Needham LEPC Committee • Plymouth LEPC Committee • Region 4B MDPH Hospital Group • Region 5 MDPH Hospital Group • Region 5 Healthcare Coalition BIDMC also participates in the ASPR hospital preparedness program.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban

	• **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☒ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	First Aid/ACLS/CPR, Injury and violence, Public safety

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, the Emergency Management team will develop the role of the Floor Marshal on units, identify the training needs for a Floor Marshal program, identify appropriate stakeholders in the program, and begin training.	The Floor Marshal goal was partially completed. Trainings were developed and the Emergency Management team will post modules on-line.	3	3	Process Goal
By the end of FY19, the Emergency Management Committee will hold a Labor Pool Exercise.	In September 2019 the Emergency Management Committee held a tabletop exercise for the Labor Pool teams. The full-scale exercise was held later in September on the East Campus.	3	3	Process Goal
BIDMC will continue to collaborate with city, state and federal emergency management programs to ensure preparedness of medical center and CHCs for untoward emergencies.	BIDMC continued to participate in trainings, simulations and planning meetings. BIDMC continued to collaborate with city, state and/or federal partners on drills/exercises. BIDMC also continued to house the Emergency Medical Services Station serving Boston's Longwood, Mission Hill, and Roxbury neighborhoods.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://bphc.org/Pages/default.aspx
MA Department of Public Health	Government agency	https://www.mass.gov/orgs/department-of-public-health
Boston Fire Department	Emergency Responders	https://www.boston.gov/departments/fire-operations
Boston Emergency Medical Services	Public safety agency	https://www.boston.gov/departments/emergency-medical-services
Mayor's Office of Emergency Management	Prepares for city wide events	https://www.boston.gov/departments/emergency-management
MASCO	Supports Longwood Medical Area services	https://www.masco.org/about/about-masco
Medical Intelligence Center	Coordinates emergency management	https://www.bphc.org/whatwedo/emergency-services-preparedness/public-health-preparedness/medical-intelligence-center/Pages/Medical-Intelligence-Center.aspx
COBTH	Dedicated to supporting the missions of teaching hospitals	http://www.cobth.org/about.html

Access to Care – Culturally Responsive Care	
Brief Description or Objective	A growing body of literature emphasizes the importance of cultural factors in providing appropriate care to patients. Cultural influences determine cognitive constructs including how patients define health, illness, and well-being, even dictating when and if an individual seeks medical care. Understanding one's cultural background provides guidance for developing health promotion strategies as well as influencing the design of treatment interventions and patients' adherence to medical protocols. Providing culturally responsive care is integral to BIDMC's mission, vision, and service delivery approach. The Medical Center has focused on these issues in a highly intentional manner for more than 25 years. Over the years, BIDMC has developed a set of tools and approaches to ensure delivery of culturally responsive care that are regularly updated and enhanced. From intake assessment forms to multilingual patient satisfaction questionnaires, to health education and navigation assistance materials in multiple languages, BIDMC has tried to facilitate communication with, and understanding of the patients' orientation and experience. Data shows that there is an increasing number of residents and families in Boston who do not speak English or who have Limited-English Proficiency (LEP). With this in mind, BIDMC was one of the first hospitals with an Interpreter Services Department and has a proven track record in helping patients overcome linguistic barriers to care, expanding interpreter services capacity and resources every year. BIDMC led the way in employing an American Sign Language (ASL) interpreter full time and installed multiple Sorenson public videophones to increase communication access for the Deaf and Hard-of-Hearing. By developing and translating patient information and educational materials, BIDMC has also facilitated access to care, helped patients understand their course of treatment, and adhere to discharge instructions and other medical regimens. BIDMC continues to use a licensed online catalog of patient information (Lexicomp). The patient fact sheets in this collection are available in multiple languages, with select fact sheets available in more than a dozen translations. While BIDMC will continue to provide its clinicians with customized patient fact sheets when needed, it is increasingly directing clinicians to the online collection as a way to dramatically increase its capacity to ensure that patients who do not speak English have access to printed materials about their condition or treatment. For customized, original translations that require internal vetting, BIDMC has developed an enhanced collaboration between the BIDMC Learning Center fact sheet program and the BIDMC translation team, for the purpose of effectively and efficiently vetting newly translated materials.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Middlesex County, Norfolk County, Suffolk County, Plymouth County, Boston, Harwich, Provincetown, Quincy, Truro, Waltham, Wellfleet

	• **Gender:** All • **Age Group:** Adults • **Ethnic Group:** Asian, Black/African American, Hispanic/Latino • **Language:** Cambodian, Cape Verdean Creole, Chinese, English, Haitian Creole, Portuguese, Russian, Spanish, Vietnamese • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable

Health Issues Tags (type as many as apply from this list)	Access to health care, Cultural competency, Language/literacy

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, BIDMC will continue to increase the availability of commonly-used patient education items translated into other languages.	BIDMC did not complete the goal of increasing the number of translated materials for FY19. Efforts were geared towards distributing previously translated materials.	3	3	Process Goal
By the end of FY19, BIDMC will increase the availability of the 200 translated "welcome packets" of materials for inpatients.	In FY19, BIDMC focused on effective distribution and use of the translated "welcome packets" completed late in FY19. BIDMC delivered starter packets to each unit and provided a way for units to replenish their supplies from a central depository once completed.	3	3	Process Goal
By the end of FY19, BIDMC will launch a translated version of the Welcome Video in five languages.	In FY19, BIDMC launched five translated versions of the welcome video that is shown to all patients on admission. The five videos were added to the patient TVs.	3	3	Process Goal
By the end of FY19, BIDMC will roll out 22 interpreter iPads throughout the medical center.	BIDMC successfully rolled out 22 iPads to supplement current staffing needs to better meet LEP needs.	3	3	Process Goal
In FY19, BIDMC will increase the capacity of the Interpreter Services department interactions.	Number of interpreter services interactions (face-to-face) totaled 138,297 in 81 languages.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
South Cove Community Health Center	Continuity Clinic	https://scchc.org
Found in Translation	Interpreter services	https://found-in-translation.org
Massachusetts Commission for the Deaf and Hard of Hearing	Government agency	https://www.mass.gov/orgs/massachusetts-commission-for-the-deaf-and-hard-of-hearing
Community Care Alliance Health Centers and Affiliated Hospitals	Healthcare partnerships	https://www.bidmc.org/about-bidmc/helping-our-community/community-initiatives/community-benefits/bidmcs-community-health-centers/community-care-alliance

Access to Care – Geographically Isolated Communities	
Brief Description or Objective	Although many assume that Cape Cod is a well-resourced, wealthy community, in fact, it is one of the Commonwealth's most medically underserved areas, challenged by geography and economics. This is particularly true for those who live on the Outer Cape, near the end of the Cape Cod Peninsula. For individuals living on this portion of Cape Cod, healthcare services are extremely limited which limits access to care and is extremely dangerous for those experiencing medical emergencies. The nearest hospital could be as many as 50 miles away on a two-lane highway. To address these issues, BIDMC continues to offer on-site medical specialty care services, including infectious disease services, pulmonary services, oncology and oncology services, including digital radiology and mammography screening. BIDMC also continues to support the Med-Flight helicopter program which transports those living in isolated areas that need emergency medical services. For those patients and families who are long distances from home, BIDMC provides housing assistance through programs like Hospitality Homes or specially adapted apartments for those undergoing bone marrow transplantation (Galleria Apartments). BIDMC has a staff member who helps patients find lodging with Room Away from Home. The Medical Center also provides temporary housing to Bone Marrow Transplant (BMT) patients.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Harwich, Provincetown, Wellfleet • **Gender:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☐ All ☒ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention

	• ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Injury and violence

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
BIDMC will continue to address unmet medical needs for rural Cape Cod.	BIDMC continued to offer on-site infectious disease and pulmonary services, and collaborate with Outer Cape Health Services on digital radiology services which includes mammography screening.	3	3	Process Goal
BIDMC will continue to provide access for remote communities to quaternary care.	BIDMC continued ongoing support for Med-Flight.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Med Flight	Transportation for critically ill	https://www.bostonmedflight.org/
Galleria Apartments	Housing	http://longwoodgalleriaapartments.com
Hospitality Homes	Short term housing for patients	http://hosp.org

Access to Care – Care Connection	
Brief Description or Objective	For many years, BIDMC has dedicated resources to helping patients and/or their referring physicians connect to both primary and specialty care services. BIDMC's Care Connection department offers a number of services that benefit the Community Health Centers (CHC) and their patients, including: • The Find a Doctor call center where detailed information about CHCs, their services and availability of appointments is updated monthly to facilitate timely appointments for patients. The Find a Doctor services are specifically marketed to patients without a Primary Care Provider (PCP) who come through the Emergency Department, a BIDMC specialty department, or BIDMC Urgent Care locations (Chestnut Hill, Chelsea). • The Doctor to Doctor call center supports the CHC providers with their specialty referral needs, especially for urgent and complex care needs. Care Connection Registered Nurse (RN) staff work closely with referring CHC physicians to arrange specialty consult appointments that meet the clinically needed timeline for safe, quality patient care. • Care Connection's Inpatient Discharge Follow Up program helps CHC patients who were admitted to BIDMC arrange post discharge follow up care. Patients are always booked to see their PCP after an inpatient stay. Staff identifies all members of the patient's care team and work to preserve established specialty relationships, ensuring timely, clinically appropriate follow up care is booked prior to discharge.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training

	• ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care

Goal Description	**Goal Status**	**Current Year of Program**	**Total Years of Program**	**Goal Type**
In FY19, BIDMC's Care Connection Department will facilitate access through referrals to and from community primary care providers.	The Care Connection call center made 933 appointments/referrals to or from CHCs in FY19.	3	3	Process Goal
In the Doc-Doc Group, BIDMC's Care Connection Department will answer 80% of calls with an abandonment rate of 5% in FY19.	In the Doc-Doc group, the BIDMC Care Connection Department processed 6,498 calls with a service level of 89.4% and an abandonment rate of 1.4%.	3	3	Process Goal

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In the Find a Doc group, BIDMC's Care Connection Department will answer 80% of calls with an abandonment rate of 5% in FY19.	In the Find a Doc group, the BIDMC Care Connection Department processed 13,349 calls with a service level of 71% and an abandonment rate of 5.8%.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Not applicable		

Access to Care - Seamless Continuity of Care	
Brief Description or Objective	As patients move between community-based and hospital-based care (ambulatory specialty care, Emergency Department (ED) or inpatient hospitalization), it is imperative that providers in both settings have accurate, real-time clinical information. BIDMC has harnessed technology to ensure this communication through Health Information Exchange (HIE) enhancements and BIDMC remains an important part of the Governor's launch of the state healthcare information exchange (Mass HIWay). In 2009, the health centers and BIDMC collaborated on a HRSA-funded project to "push" ED and inpatient discharge summaries to primary care providers. This HIE project was the foundation of subsequent information technology (IT) solutions that now provide timely communication and enhance continuity of care across settings and providers. With rising concern about unnecessary ED visits and re-admissions, information technology provides data that make possible immediate follow-up care in the community while decreasing errors, unnecessary re-admissions, and duplicate tests and procedures. BIDMC implemented the interfaces for the downloading of lab and radiologic reports as well as notes from specialists directly into the electronic health records of community practitioners. In fiscal year 2019, BIDMC continued its participation in the statewide Mass HIWay initiative, providing the technical interfaces for the Community Health Centers (CHC) to share information with quality measure databases and other data sharing initiatives. BIDMC continues to work with the CHCs to provide bidirectional viewing of clinical information and care management, and provide support to Bowdoin Street Health Center (BSHC) for data exchange to immunization registries and meaningful use projects. In FY19, BIDMC continued to work with the CHCs on their connections to the HIWay.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC will continue to contribute to Mass HIWay initiative.	BIDMC continues to share Meaningful Use data, including immunizations and public health surveillance data with the state via the Mass HIWay. BIDMC continues to work with the CHCs on their connections to the HIWay.	3	3	Process Goal
In FY19, BIDMC will continue sending inpatient and ED discharge summaries with the expanded primary care network.	BIDMC continues to share patient's daily discharge information with an expanded primary care network including Affiliated Physicians Group and Atrius Health.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Not applicable		

Access to Care – Care to Uninsured and Underinsured in Underserved Communities	
Brief Description or Objective	Despite health care reform, roughly 13% of patients seen at a Massachusetts federally qualified health center is uninsured according to the CY 2018 Uniform Data System (UDS) data. For many who continue to be without coverage, they may qualify for assistance from the Health Safety Net (HSN) Program, a fund to which BIDMC makes a significant annual contribution. A team of financial benefits counselors work with uninsured and underinsured patients to facilitate access to entitlement programs, while Medication Assistance Counselors aid patients with obtaining no-cost pharmaceutical prescriptions. In 2019, BIDMC's on-site retail pharmacy and specialty pharmacy implemented a patient co-payment assistance program for patients with family income at or below 200% of the federal poverty level. Additionally, the retail pharmacy is registered as an HSN pharmacy and provides courtesy fills for low-income patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, BIDMC employs two patient assistance staff. BIDMC's Community Resource Specialists connect low income patients to resources such as transportation, housing, support groups, food assistance, financial assistance, insurance, Social Security Disability Insurance, unemployment benefits, etc. They determine what resources would optimally meet patients' and families' needs, including beds in continuing care facilities, transportation, Meals on Wheels, financial assistance, Medicaid, special housing, special funds, etc. The medical center covers the cost of handling remains of indigent patients. BIDMC also pays the transportation costs for patients discharged from inpatient units and the Emergency Department when they do not have the means to return home. For low income patients being discharged from the medical center with a newborn child, BIDMC links them to services that may provide infant car seats to these families at no cost. BIDMC also subsidizes inpatient psychiatric services for those most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others, or who are unable to care for themselves due to mental illness. Additionally, BIDMC subsidizes primary care services provided by BIDMC's Affiliated Physicians Group throughout BIDMC's Community Benefits Service Area.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status

	☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☒ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC Community Resource Specialists will continue to connect all low-income patients who need services to resources based on identified need.	In FY19, Community Resource Specialists connected low income patients to multiple services such as transportation, housing, support groups, food assistance, financial assistance, insurance, Social Security Disability Insurance, and unemployment benefits.	3	3	Process Goal
BIDMC will continue to subsidize Health Safety Net (HSN) Trust Fund.	Continue to make annual contribution to the HSN. During FY19, BIDMC served 2,385 HSN patients.	3	3	Process Goal
In FY19, BIDMC will screen and enroll eligible patients into entitlement programs.	Staff screened 10,784 patients for eligibility and enrolled 9,560 patients into entitlement programs. Continue to provide medication assistance and no-cost pharmaceutical prescriptions to needy patients.	3	3	Process Goal
After opening in January 2019, the BIDMC retail pharmacy will provide free-care pharmacy medications to patients.	BIDMC provided 253 unique patients with courtesy medication prescriptions after opening the new retail pharmacy in January 2019.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Pine Street Inn	Housing services	https://www.pinestreetinn.org
La Alianza Hispana	Culturally sensitive social services	https://laalianza.org
WilmerHale Legal Services	Social services	http://www.legalservicescenter.org
Fair Foods	Food access organization	http://www.fairfoods.org
A Room to Grow	Services for new mothers	https://www.roomtogrow.org

Access to Care- Boston Healthy Start Initiative	
Brief Description or Objective	In April of 2014, Bowdoin Street Health Center (BSHC) became an official site of the Boston Healthy Start Initiative (BHSI) with grant funding through the Boston Public Health Commission (BPHC). This initial funding was for a 5-year cycle and came to an end on 3/31/19. In April 2019, the BPHC was told their federal funding would be reduced and thus there could only be five sites instead of eight. For the new 5-year cycle with reduced sites, BSHC submitted a new application for funding and BSHC was fortunate to be chosen as a site and retain its funding. The BHSI funding allows BSHC to provide dedicated Community Health Worker (CHW) support to its prenatal patients and better support their needs through frequently high-risk pregnancies. The BHSI is a federally funded program designed to improve birth outcomes and eliminate birth outcome disparities among Boston women. BHSI works closely with clinical sites, consumers, and partners outside the traditional health sector to achieve these aims through five federally-defined approaches: 1) Improving the health of women, 2) Promoting quality of health services to women and families, 3) Strengthening the resilience of families, 4) Achieving collective impact through enhanced collaboration, and 5) Increasing mutual accountability across the BHSI system of care, through quality improvement, performance monitoring and evaluation. Specifically, BSHC and BHSI provide: a. Support and case management from a family partner with specialized skills and training around pregnancy and parenting support, including confidential support related to family social and emotional concerns; b. Collaborate with and offer connection to enhanced support from a skilled public health nurse over the short-term or for up to five years postpartum if risk assessment at any point in care indicates the presence of chronic health conditions or social needs requiring more intensive care; c. Engage and support father or significant other who plays or could play a positive role in pre and post-partum parenting; d. Personalized support around maternal and child nutrition, including but not limited to breastfeeding support; e. Ongoing implementation of Centering Pregnancy An important partner to BSHC and Boston families with young children, The Family Nurturing Center provides neighborhood-based and city-wide programs to reach parents or caregivers through home visits, playgroups, and parenting education. The Family Nurturing Center helps parents better understand the vital role they have in their child's early brain development, kindergarten readiness, and later school success.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Dorchester, Roxbury • **Gender:** Female • **Age Group:** Adults and Children • **Ethnic Group:** Black/African American and Latino • **Language:** English

	• **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Family planning

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, BSHC will enroll at least 44 newly pregnant women who identify as Black and live in Boston in the BHSI program at BSHC.	BSHC enrolled 23 pregnant patients in BHSI in FY19. The goal was not met due to a shortage of OBGYN providers on-site, changes in data collection process; and fewer women identifying as Black and living in Boston presenting for care at BSHC.	3	3	Process Goal
By the end of FY19, BSHC will provide support and case management to at least 88 prenatal or post-natal patients.	Total Family Partner Caseload was 104 prenatal or post-natal patients in FY19.	3	3	Process Goal
By the end of FY19, BSHC will complete application to remain a BHSI site in next 5-year grant cycle (FY19-FY23).	Completed application to remain a BHSI site for next grant cycle in FY19.	3	3	Process Goal
By the end of FY19, BSHC will be accepted as an applicant and will remain a site.	Accepted as an applicant and retained status as BHSI site in FY19.	3	3	Process Goal
By end of FY19, BSHC Family Partner/ CHW will obtain official CHW certification through MA DPH.	Family Partner/Community Health Worker obtained official CHW certification through newly implemented MA DPH program.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://www.bphc.org/Pages/default.aspx

Chronic Disease Management – Diabetes, Hypertension, and Asthma	
Brief Description or Objective	Cardiovascular disease (heart disease), cancer, and cerebrovascular disease (stroke) are the three leading causes of death in the United States, Massachusetts, and Boston. In addition, diabetes is ranked in the top 10 leading causes of death across all three of these geographic areas, and asthma and other respiratory diseases have a huge impact on large portions of adults and children. Data from the Boston Public Health Commission's (BPHC) 2017 Health of Boston Report reports that rates are even higher in the Boston neighborhoods of Roxbury, and North Dorchester. Boston adults have higher rates of diabetes hospitalizations, emergency department visits, and deaths compared to the Commonwealth of Massachusetts, with the highest rates in Boston being in Roxbury, North Dorchester, and South Dorchester. In 2015, 25% of Boston residents reported that they had hypertension. Boston had higher rates of hospital utilization (per 100,000 people) for hypertension and higher mortality rates for heart disease compared to the Commonwealth with the highest rates being in Roxbury, North Dorchester, and South Dorchester. With more than 50% of disease attributable to health behaviors, BIDMC and its affiliated and/or licensed Community Health Centers (CHC) providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. Bowdoin Street Health Center's (BSHC) Diabetes Initiative is a comprehensive care management program, caring for more than 1,000 adults diagnosed with diabetes. As part of the Patient Centered Medical Home model, members of a multidisciplinary team collaborate to promote improved health outcomes through disease prevention, detection, education and treatment. Individual appointments with a dietitian, nurse or physician, plus group medical visits, self-care management visits, exercise and behavioral health programs are available to patients and are responsive to their language, education and learning needs. BIDMC's affiliated federally qualified health centers screen and educate patients for diabetes, hypertension and asthma, provide evidence-based care and treatment, and work with BIDMC to ensure access to needed specialty care. These health centers collectively served 5,136 diabetic patients (of which 19% were Hispanic/Latino and 11% were Black/African American); 9,815 patients with hypertension (of which 18% were Hispanic/Latino and 13% were Black/African American); and 1,909 patients with persistent asthma in FY 19. The Bowdoin Street Wellness Center provides patients with diabetes access to a range of exercise and nutrition counseling classes conveniently located in their neighborhood. BSHC has received positive feedback from patients who report making lifestyle changes around exercise and diet. BSHC Diabetes Education Program is recognized by the American Diabetes Association. BIDMC also supports diabetes management programs at other affiliated CHCs such as the Charles River Community Health (CRCH) Live and Learn Diabetes Program. Through the Live and Learn Program, CRCH providers proactively contact diabetes patients who are overdue for care. These patients are able to attend a Diabetes Day event, during which they have multiple

	appointments (dental, vision, nutrition, nursing self-management support, podiatry, and lab work) in one day with only one co-pay. Additionally, CRCH offers provider-led group diabetes visits, including a Spanish-speaking and Portuguese-speaking group. At BSHC, the Prevent T2 program, developed by the Centers for Disease Control (CDC), is a health literacy and lifestyle modification program focused on preventing or delaying an individual's risk of developing Type 2 diabetes through dietary changes, increased physical activity and stress reduction. The evidence-based CDC curriculum consists of 26 classes offered over the course of one year to participants who are at risk for developing Type 2 diabetes. Risk is determined through blood work and/or the completion of a risk assessment survey. The aim of the program is to help participants lose 5-7% of their weight through diet and 150 minutes of moderate physical activity per week. BSHC's Prevent T2 program also includes cooking classes and group exercise classes.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston/Brighton, Bowdoin/Geneva, Dorchester, Roxbury), Chelsea, Waltham • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** English, Haitian Creole, Portuguese, Spanish, Vietnamese • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment

	• ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Asthma/allergies, Diabetes, Dental health, Hypertension, Overweight and obesity, Vision

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, 100% of CRCH medical assistants (MAs) will be trained to use EMR prompts to identify health center patients with diabetes when they come in for care for any reason.	CRCH continues to train MAs and providers on the use of their prevention and wellness template to identify care gaps. In addition, 100% of MAs are trained to use the Pre-Visit Planning (PVP) document during all visits that alert them to actions they can take during any visit.	3	3	Process Goal
By the end of FY19, MA's will utilize the diabetes registry to increase the level of patients having A1C checked within last six months, from FY18 baseline of 66% to 69%.	82.3% of patients on the diabetes registry had their A1C checked within the last six months.	3	3	Process Goal
By the end of FY19, CRCH will increase population health management of LDL measurement from FY18 baseline of 66% to 69%.	68.6% of LDL checked within the last six months. CRCH has expanded the role of MAs as population health managers by training and "turning on" more alerts in the Pre-Visits Planning document.	3	3	Process Goal
By the end of FY19, the Diabetes Nurse Educator will hold 1 session of pre-diabetes nurse clinics per month to make CRCH patients aware of the potential for diabetes and lifestyle modifications they can make to prevent it.	Provided 1 session per month for a period of 7 months. CRCH Waltham DM RN came to Brighton to provide this service due to staffing challenges at CRCH, limiting the number of sessions.	3	3	Process Goal
By the end of FY19, CRCH will increase the number of diabetes education visits for CRCH patients that already have a diabetes diagnosis to help them better understand, manage, and improve their condition by 5%.	In FY19, CRCH increased diabetes education visits by 5% from 1,044 visits in FY18 to 1,098 visits in FY19.	3	3	Process Goal
BSHC will successfully complete second required data submission to the CDC on all participants in effort to become a fully recognized site by the February 1, 2019 submission date.	BSHC successfully completed the second required data submission to the CDC.	3	3	Process Goal

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the start of FY19, BSHC will recruit a minimum of 15 participants to participate in Prevent T2 diabetes program in FY19.	Goal not reached due to staff changes.	3	3	Process Goal
By the end of FY19, BSHC will successfully submit attendance logs, weight, glucose test, demographic info, risk assessment test, data required by CDC on all participants.	BSHC successfully submitted attendance logs, weight, glucose test, demographic info, risk assessment test, data required by CDC on all participants.	3	3	Process Goal
By the end of FY19, BSHC will increase the number of completed annual eye exams to 58% from 50.2% in patients with diabetes	The percentage of patients with diabetes completing an eye exam decreased to 43.6% due to staffing changes.	3	3	Process Goal
By the end of FY19, an additional internal medicine provider will offer one group medical visit for patients with Type 2 diabetes.	Dr. Killian started a monthly group in February with 8 patients attending. This group has now merged with another provider's medical group visits.	3	3	Process Goal
In FY19, the percent of CCA FQHC adults with diabetes whose condition is controlled (HbA1c $\leq$ 9) will increase from 70%.	5,136 (78%) adults with diabetes had HbA1C < 9 in FY 2019.	3	3	Outcome Goal
In FY19, the percent of FQHC adults with hypertension whose blood pressure is < 140/90 will increase from 65.5%.	9,815 (63%) patients with hypertension had blood pressure < 140/90 in FY 2019.	3	3	Outcome Goal
In FY19, the percent of FQHC adults with persistent asthma whose condition is controlled will increase from 94.7%.	1,909 (86%) of patients with persistent asthma had their asthma under control in FY 2019.	3	3	Outcome Goal

Partners

Partner Name	Description	Partner Web Address
Joslin Clinic	Healthcare institution	https://www.joslin.org
Mount Auburn Hospital	Healthcare institution	https://www.mountauburnhospital.org

Chronic Disease Management – Reducing Disproportionate Burden of Cancer in Diverse Communities	
Brief Description or Objective	In 2016, cancer was the second leading cause of death in the United States and the first leading cause of death in Massachusetts. Quantitative and qualitative data from the FY 2016 Community Health Needs Assessment (CHNA) corroborated these findings with data showing great disparities on the Outer Cape and in Boston neighborhoods that are part of BIDMC's Community Benefits Service Areas (CBSA). As with other health conditions, there are major disparities in outcomes and death rates across all forms of cancer, which are directly associated with race, ethnicity, income, and whether an individual has comprehensive medical health insurance coverage. As a Cancer Center of Excellence recognized by the American College of Surgeon's Commission on Cancer, BIDMC is a leader in translating research into clinical care and community practice—"bench to trench." BIDMC participates in both the Dana Farber/Harvard Cancer Center (DF/HCC) and the Faith-Based Cancer Disparities Network, facilitating the educational and outreach programs within 10 churches and the Black Ministerial Alliance. Building on the partnership with the faith-based community, beginning in FY 2013, the DF/HCC incorporated a new strategy that provided cancer survivors within the faith community an opportunity to break through the silence. Through self-portraits and testimonies, 19 survivors told their stories of hope and resilience which promoted awareness about cancer in their communities and showed that life with and beyond cancer can be glorious and fulfilling. In FY 2014, an additional 14 portraits and stories of patients from diverse backgrounds were added to the installation. BIDMC hosted the installation in FY 2017 and FY 2018 and did so again in FY 2019. When cancer specialty care or inpatient hospitalizations are necessary, BIDMC offers the services of bilingual and bicultural Cancer Patient Navigators who bridge the gulf between community providers and the medical center. One Patient Navigator specializes in serving the Chinese community, though they also serve patients from other ethnic groups. This Patient Navigator also leads support groups for cancer patients such as Tea Time (for Chinese women with breast cancer). To provide support to Patient Navigators, BIDMC hosts a city-wide Patient Navigator Network that meets quarterly for education, support, networking, and sharing of resources.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston/Brighton; Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Lexington, Quincy, Revere, Waltham, Winthrop, Hyde Park, Jamaica Plain, West Roxbury, Roslindale, Lawrence, Fall River, Newburyport, Gloucester, Rockport, Andover, Plymouth, Milton, Brockton • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** English**,** Chinese • **Environment Served:** ☒ All

	☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Breast cancer, Lung cancer, Other cancer

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC will increase the number of mammograms in CHCs from, 26 mammograms at Outer Cape Health Services, 639 mammograms at Fenway Health, and 4,657 mammograms at South Cove Community Health Center in FY18.	Offer on-site mammography services at Fenway Health, Outer Cape Health Services, and South Cove Community Health Center. In FY19, 732 patients received mammograms at Outer Cape Health Services, 545 patients received mammograms at Fenway Health, and 4,627 patients received mammograms at South Cove Community Health Center.	3	3	Process Goal
In FY19, BIDMC will coordinate and host a city-wide Patient Navigator Network.	25 patient navigators representing 10 healthcare institutions participated in four network luncheons in FY19.	3	3	Process Goal
In FY19, BIDMC patients will have access to a Cancer Patient Navigator.	The Chinese Patient Navigator saw 492 active patients of which 193 were new patients, providing a total of 2,579 encounters during FY19.	3	3	Process Goal
In FY19, BIDMC Social Work will provide Cancer Support Groups.	BIDMC hosted 8 different types of cancer support groups in FY19.	3	3	Process Goal
In FY19, BIDMC will increase the number of low- income individuals who received a mammogram.	2,308 low-income individuals received a mammogram at BIDMC in FY19 compared to 2,705 in FY18.	3	3	Process Goal
In FY19, BIDMC will increase the number of low-income individuals receiving colon cancer screening.	1,784 low-income individuals received a colon cancer screening at BIDMC in FY19 compared to 1,896 in FY18.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Dana Farber Cancer Institute	Healthcare institution	https://www.dana-farber.org

Chronic Disease Management – HIV/HCV Coinfection Screening, Prevention, and Treatment	
Brief Description or Objective	Hepatitis C (HCV) disproportionately affects non-Hispanic Black persons, with a rate almost three times that of non-Hispanic White persons. According to the 2002 National Health and Nutrition Examination Survey, the nationwide prevalence of Hepatitis C (HCV) Viral RNA among all participants was 1.3% (CI, 1.0% to 1.5%), equating to 3.2 million (CI, 2.7 million to 3.9 million) HCV RNA–positive persons. The majority of these individuals were likely infected during the 1970s and 1980s, when rates were highest. A BIDMC infectious disease consultant collaborates with The Dimock Center to provide screening, care, and education regarding Human Immunodeficiency Virus (HIV)/HCV co-infection on-site at The Dimock Center every week. This care and service includes a special focus on access to care, initiation, and completion of state-of-the-art HCV therapy. Making these services available at The Dimock Center reduces access barriers for patients who are particularly vulnerable and who otherwise might not receive the latest regimen or be able to access or complete treatment. This program also has a BIDMC infectious disease liaison from The Dimock Center to the BIDMC Liver Center for proper engagement and advocacy for vulnerable patients to promote successful treatment outcomes.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Suffolk County, Boston (Dorchester, Roxbury) Chelsea • **Gender:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention

	• ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Hepatitis, HIV/AIDS

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
Screen HIV positive patients for HCV	98% of HIV+ patients were screened for HCV.	3	3	Process Goal
By the end of FY19, the number of visits to The Dimock Center attended by an infectious disease physician will be 100 visits over 1 year.	230 visits with 115 patients were attended by an infectious disease physician.	3	3	Process Goal
By the end of FY19, the number of HIV/HCV co-infected patients who have begun HCV treatment will be at least 4.	3 HIV/HCV co-infected patients began HCV treatment. Insurance approval led to delays.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
AIDS Action Committee	Reducing risk of HIV/AIDS	https://aac.org
Boston Living Center	Resource center for HIV+ individuals	https://www.vpi.org/boston/
Community Research Initiative	Organization dedicating to ending the HIV epidemic	https://crine.org
Community Servings	Provides meals to chronically and critically ill individuals	https://www.servings.org
New England AIDS Education and Training Center	Provides AIDS education and trainings	https://www.neaetc.org
MA Department of Public Health (DPH)	Government agency	https://www.mass.gov/orgs/department-of-public-health

Chronic Disease Management – HIV Support Groups	
Brief Description or Objective	Great strides have been made with respect to treating Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS), and for most it is considered to be more of a chronic condition that can be managed with medications rather than a terminal condition. Rates of illness, death, and HIV transmission have declined dramatically over the past decade. However, HIV/AIDS still has a major impact on the lesbian, gay, bisexual and transgender (LGBT) community, certain Boston neighborhoods (Fenway/Kenmore, Roxbury, North Dorchester), and the communities on the Outer Cape (Wellfleet, Truro, and Provincetown). In Massachusetts, Black (non-Hispanic) and Hispanic/Latina females are affected by HIV/AIDS at levels 26 and 15 times that of White (non-Hispanic) females showing that HIV/AIDS disproportionately affects women of color. For 20 years, BIDMC has offered a support group called Experienced and Positive for gay men who have advanced AIDS. These long-term survivors, many of whom were first diagnosed in the 1980s, are coping with multiple stressors including the death of partners, significant complications from medications, and reoccurring hospitalizations. Recognizing that women with HIV are an underserved population who often feel socially isolated and stigmatized due to their diagnosis, BIDMC formed the Support Group for HIV+ Women eight years ago. Both of these support groups focus on helping patients cope with their diagnosis, providing a welcoming environment that fosters mutual support and encourages patients as they continue with treatment.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** All Massachusetts • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening

	• ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☒ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	HIV/AIDS

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, the BIDMC Social Work Department will provide 22 support group sessions for male HIV positive patients and 22 support group sessions for female HIV positive patients.	In FYI9, BIDMC continued offering support groups for HIV positive patients (25 sessions for men, 2 hours per session, 8 men per group and 25 sessions for women, 2 hours per session, 9 women per group).	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Not applicable		

Social Determinants and Health Risk Factors – The Walking Club	
Brief Description or Objective	Not only does BIDMC's Cardiovascular Institute have expertise in heart disease, but they are also in the vanguard with prevention programs to promote heart healthy behaviors. The Walking Club provides free kits that include workout logs and information sheets to participants. The Walking Kits have been adapted for corporate entities, patients with special needs, and Boston Public School students. While the kit is used by science/health and gym teachers, one of the primary goals of the program is to encourage students to walk during non-school hours with a parent/guardian in an effort to combat childhood obesity and inculcate healthy lifestyle behaviors. Each child in the Walking Club is given a pedometer to track their steps. Adopted by many Boston Public Schools, the Walking Club kit includes a booklet that has information sheets to promote healthy behaviors, including: workout logs, an examination of the anatomical parts utilized while walking, and basic math and science exercises, such as calculating heart rates and steps into miles. The kits also include booklets for staff at the schools. BIDMC staff collaborated with staff from Tufts University's Child Obesity 180 program. The organization provided access to grade 3-5 teachers who offered feedback on ways to rewrite and redesign the Walking Club information packet for a younger target audience. Historically, BIDMC provided the Walking Club supplies to the schools in the fall semester. This effort was a centerpiece of BIDMC's plan to refocus and concentrate its efforts on the population that has far and away made the best use of the Walking Club materials and provided the most demand: Boston Public Schools. Throughout FY 2019, 28 elementary and middle schools (including K-8 schools), and 13 after school programs, implemented the Walking Club program.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Chinatown, Dorchester, Roxbury), Chelsea • **Gender:** All • **Age Group:** Adult, Preteen, Teen • **Ethnic Group:** All • **Language:** English, Spanish • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☒ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Cancer, Cardiac disease, Diabetes, Hypertension, Mental Health, Overweight and Obesity, Physical Activity

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
The BIDMC Marketing Department will provide pedometers/walking packets to 45 BPS Schools and 15 after school programs by October 1, 2019.	The BIDMC Marketing Department provided material to 28 elementary and middle schools (including K-8 schools) and 13 after school programs to implement the walking club.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Tufts University, Child Obesity 180 Program	Community program to reduce childhood obesity	https://nutrition.tufts.edu/research/projects-initiatives/childobesity-180

Social Determinants and Health Risk Factors - Healthy Food Equity Project and Improving Healthy Foods	
Brief Description or Objective	Bowdoin Street Health Center's (BSHC) assessment of healthy, affordable food options revealed no full-service supermarkets in the neighborhood. Instead, there are small corner stores which are unequipped to store and sell fresh fruits and vegetables. BSHC's Healthy Food Equity Plan continues to increase access to healthy foods in the Bowdoin/Geneva neighborhood. The health center continues to sustain a weekly farmer's market in the summer and autumn months. The Healthy Food Equity Project continued its successful education of community members on healthy eating through the efforts of 15 youth called the Healthy Champions. The Healthy Champions program engaged a new group of teens (ages 12-16) in healthy cooking classes and nutrition education workshops led by the BSHC Nutritionist. In an effort to incorporate additional food access-based education into Healthy Champions programming, participants learned about BSHC's on-site Farmers Market, and were also able to shop at the on-site Fresh Truck (a converted school bus providing access to fresh fruits and vegetables), using healthy food vouchers from the BSHC "Food Rx" program. The Food Prescription (Food Rx) Program served as an integral component of nutrition education and food access programming at BSHC in FY 2019 providing patients with opportunities to purchase fresh and affordable produce in locations convenient to their needs. To enroll in the program, patients met with the BSHC Dietitian for an initial nutrition consult, and to receive an overview of the benefits of each of the participating healthy food resources. Upon completion of this visit, patients received Food Rx vouchers which could be redeemed at various locations convenient to the health center. In addition to these successes, staff from BIDMC continued to support BSHC's Farm to Family Program, a Community Supported Agriculture (CSA) project. Over 50% of BIDMC employees who purchased CSA shares volunteered to subsidize a weekly carton of fresh fruits and vegetables for a low-income family. Improving Healthy Foods in the Allston-Brighton Community is a program to provide hunger relief and improve nutrition for Charles River Community Health (CRCH) patients by increasing access to a variety of fruits and vegetables. The funds provided by BIDMC allow CRCH staff to connect patients and their families to high-quality healthy food, connect them with necessary health and support services and to teach the principles of a healthy lifestyle. The Mobile Market allows CRCH to round out the comprehensive, culturally competent and affordable care offered to patients, who are among the most vulnerable in the community.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Dorchester, Roxbury, Mattapan, Hyde Park), Randolph, Waltham • **Gender:** All • **Age Group:** All • **Ethnic Group:** Asian, Black/African American, Hispanic/Latino, White

	• **Language:** English • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to healthy food, Overweight and obesity, Nutrition

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, the Bowdoin Geneva Farm Stand will increase its sales by 5% by increasing outreach to customers of the Bowdoin/Geneva community.	The 2019 Bowdoin Geneva Farm Stand sales decreased by 1.6%.	3	3	Process Goal
By the end of FY19, the Bowdoin Geneva Farm Stand will increase its customer attendance by 5% by increasing outreach to customers of the Bowdoin/Geneva community.	The 2019 Bowdoin Geneva Farm Stand Customer attendance remained the same at 58 individuals.	3	3	Process Goal
In FY19, BSHC Farmers Market will provide weekly access to fresh fruits and vegetables in Boston neighborhoods.	In 2019, weekly farmers markets were held during the summer and autumn months. Vendors at the Farmers' Market accept SNAP, WIC, and Senior Farmers' Market Nutrition Program benefits. The CSA project provided 30 families with subsidized cartons of fruits and vegetables.	3	3	Process Goal
By the end of FY19, CRCH will serve at least 400 unduplicated individuals through the Mobile Market in the 1-year grant period.	CRCH assisted 488 unduplicated individuals through the Mobile Market.	3	3	Process Goal
By the end of FY19, CRCH will provide mobile market assistance to an average of 150 households each month for an overall reach of over 1,700 transactions.	CRCH provided assistance to an average of 160 households each month for an overall reach of over 1,920 transactions.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://www.bphc.org/Pages/default.aspx
Mayor's Office of Food Initiatives	City initiative to promote access to food	https://www.boston.gov/departments/food-access
Urban Farming Institutes	Develop and promote urban farming	https://urbanfarminginstitute.org
Ward's Berry Farm	Local farm	https://www.wardsberryfarm.com
Dorchester NSC	Social services	https://bostonabcd.org/location/dorchester-neighborhood-service-center/
Dorchester Head Start	Social services	https://bostonabcd.org/location/abcd-dorchester-head-start/
Brigham and Women's Faulkner Hospital	Healthcare institution	https://www.brighamandwomensfaulkner.org
Dorchester North WIC	Supplemental nutrition program	https://www.wicprograms.org/ci/ma-dorchester
Mass in Motion	Government program to promote active living and healthy eating	https://www.mass.gov/orgs/mass-in-motion
Trustees of Reservations	Preserves public land	http://www.thetrustees.org
Bowdoin Geneva Main Streets	Social services	http://bowdoingenevams.org
Greater Boston Food Bank	Food distribution and pantry	https://www.gbfb.org
New Balance	Athletic store	https://www.newbalance.com
Outdoor Rx	Improve public health through outdoor activity	https://www.outdoorrx.org
WIC	Supplemental nutrition program	https://www.fns.usda.gov/wic
Harvard Business School	Education institution	https://www.hbs.edu/Pages/default.aspx
Cradles to Crayons	Provides youth essentials	https://www.cradlestocrayons.org

Social Determinants and Health Risk Factors – Active Living and Healthy Eating Programs	
Brief Description or Objective	Regular physical activity combined with healthy eating are important for people of all ages. Physical activity helps prevent many diseases (e.g. heart disease, diabetes and some cancers), strengthens bones and muscles, reduces stress and depression, and makes it easier for people to maintain a healthy body weight. Results from the 2016 Community Health Needs Assessment (CHNA) indicate that in 2014, more than half (58%) of Massachusetts adults (18+) and nearly one-quarter (23%) of children and youth (0-18) were either obese or overweight. The percentage of Boston's residents who were overweight or obese was similar to the Commonwealth with more than half of all Boston adults being either overweight or obese. There is considerable variation by race/ethnicity and by neighborhood. Thirty-three percent of Black/African American adults and 27% of Hispanic/Latino adults were obese compared to only 16% of White, non-Hispanics/Latinos, and 15% of Asians. In Roxbury, 30% of adults were obese and in North and South Dorchester approximately 27% of adults were obese, compared to 22% for the South End/Chinatown and 12% for Allston/Brighton and Fenway/Kenmore. Lack of access to healthy food, nutrition education, and physical activity within these neighborhoods hinder people's abilities to be and stay healthy. This is especially true for individuals with chronic conditions. The Wellness Center at Bowdoin Street Health Center (BSHC) contains a demonstration kitchen, a large exercise room for dance and physical activity classes including Tai Chi classes for older adults, and a gym with work-out equipment, offers Bowdoin/Geneva residents the opportunity to learn and practice healthy habits in their own neighborhood. Youth enrolled in the Fitness in the City (FITC) program at BSHC are able to engage in physical activities and nutrition-based services on-site at the Wellness Center, instead of having to solely rely on community partners for these activities. BSHC has also created a Wellness Center membership process which will allow FITC participants to bring family or friends (who are non-patients) to participate in wellness activities with them.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Dorchester, Roxbury, Mattapan, Hyde Park), Randolph • **Gender:** All • **Age Group:** All • **Ethnic Group:** Asian, Black/African American, Hispanic/Latino, White • **Language:** Cape Verdean Creole, English, Haitian Creole, Portuguese, Russian, Spanish, Vietnamese • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:**

	☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☒ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to healthy food, Cancer, Cardiac disease, Hypertension, Mental health, Nutrition, Overweight and obesity, Physical activity

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, BSHC will host a total of six sessions of Fit Kids/Fit Families programming, targeting Fitness in the City parents.	In FY19, BSHC completed four sessions of Fit Kids programming and two sessions of Fit Families programming for Fitness in the City participants.	3	3	Process Goal
By the end of FY19, the percent of children seen at affiliated federally qualified health centers that were screened for BMI will increase from 65%.	69% of children seen at affiliated federally qualified health centers were screened for BMI.	3	3	Process Goal
In FY19, BSHC will provide 5-2-1 counseling recommended by the AAP during routine well-child visits at BSHC.	Nutrition, healthy eating, and exercise information shared at routine pediatric appointments. In FY 2019, pediatric providers encouraged patients and families to attend "Healthy Weight" clinical check-ins, which include direct referral to Wellness Center programming.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Children's Hospital	Healthcare institution	http://www.childrenshospital.org
UMass Extension Nutrition Education Program	Nutrition education program	https://ag.umass.edu/nutrition
Oldways	Community resource organization	https://oldwayspt.org
Sportsmen's Tennis Club	Tennis club for underserved	http://www.sportsmenstennis.org

Social Determinants and Health Risk Factors – Environmental Sustainability and Public Safety	
Brief Description or Objective	BIDMC is actively engaged in creating a vibrant, sustainable community that fosters healthy lifestyles, enhances quality of life, and improves environmental conditions—be it improved air quality, green spaces, and parks and recreational facilities. BIDMC collaborates with colleagues at both the grass-roots level and city and state government to reduce detriments to public health and address determinants that impact health status. As part of BIDMC's commitment to enhancing the physical environment, BIDMC maintains bus stops, Joslin Park, and other green spaces near its campus. Within the hospital itself, BIDMC is implementing an Environmental Strategic Plan, spearheaded by BIDMC's multi-departmental Sustainability Committee. BIDMC is committed to conserving natural resources, reducing its carbon footprint, fostering a culture of sustainability, and advancing cost-saving opportunities through: Energy & Water Conservation Waste Reduction Safer Chemicals Environmentally Preferable Purchasing Local & Sustainable Food Green Commuting BIDMC achieves environmental commitments through employee engagement, community partnerships, and innovative solutions. BIDMC pledges to continually improve environmental performance by balancing economic viability with environmental responsibility. Public safety is of concern within BIDMC's local neighborhoods as well as the Bowdoin/Geneva area. BIDMC's police and public safety presence contributes to a sense of well-being. The medical center has an excellent, cooperative working relationship with the Boston Police Department (BPD) and serves as their "eyes and ears" in the Longwood Medical Area and on Bowdoin Street. BIDMC's security technology and apparatus, including cameras and a BPD shot-spotter at Bowdoin, have been used to identify perpetrators and assist BPD investigators. In FY 2019, there were a total of 13 officers. Officers are deputized by the Suffolk County Sheriff's Department and granted special police powers by the Massachusetts State Police.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Dorchester, Roxbury, Mission Hill) • **Gender:** All • **Age Group:** Adults, Children • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☐ All ☐ Rural ☐ Suburban

	☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☒ Built Environment • ☒ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to transportation, Environmental quality, Public safety, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC Public Safety will roll out a visitor management system that issues temporary ID badges after hours between 8pm – 6am.	In FY19, BIDMC Public Safety rolled out a visitor management system that issues temporary ID badges after hours.	3	3	Process Goal
In FY19 BIDMC Public Safety will add physical security upgrades to BIDMC ambulatory clinics including BSHC (including cameras and electronic access control devices).	Physical security upgrades to BIDMC ambulatory clinics including BSHC (including cameras and electronic access control devices) are partially complete but require additional time.	3	3	Process Goal
In FY19, the Sustainability Department will establish a process for comprehensive sustainability data tracking management.	BIDMC hired a sustainability manager to work on this project. New goals have been set and metrics to track have been determined. Processes to collect the data moving forward are in various stages for each goal.	3	3	Process Goal
In FY19, the Environmental Sustainability committee will meet monthly to strategically discuss and push forward how to better meet the challenges of improving BIDMC's Sustainability Efforts and tracking of results.	The Environmental Sustainability Committee met monthly to determine strategic sustainability goals, assess the direction of the program, improve the governance structure to support the sustainability programs, and organize two annual events to celebrate, recognize outstanding employees, and promote everything that is occurring at BIDMC in terms of sustainability.	3	3	Process Goal
BIDMC will increase its recycling rate to 29% by FY19.	The recycling rate was 42.4% in FY19.	3	3	Process Goal
BIDMC will increase percentage of total food and beverage spend on local products to 12% by FY19.	Total food and beverage spend on local products was 11.2% in FY19.	3	3	Process Goal
BIDMC will increase healthy beverage spend to 50% by FY19.	Healthy beverage spend rate was 61.9% in FY19.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
City of Boston's Green Ribbon Commission	Fights climate change	https://www.greenribboncommission.org
MASCO	Supports Longwood Medical Area services	https://www.masco.org
Healthcare without Harm	Promotes the health of people and the environment	https://noharm-uscanada.org/Boston
Practice Green Health	Sustainable healthcare organization	https://practicegreenhealth.org
MassDEP	Government agency	https://www.mass.gov/orgs/massachusetts-department-of-environmental-protection
Mass DOT	Government agency	https://www.mass.gov/orgs/massachusetts-department-of-transportation
US EPA	Government agency	https://www.epa.gov
ABC A Better City	Development organization	https://www.abettercity.org
Eversource	Gas/electric company	https://www.eversource.com/content/ema-c
BSHC	Community resource organization	https://www.bidmc.org/locations/bowdoin-street-health-center
Boston Police Department	Public safety agency	https://www.boston.gov/departments/police
Brigham and Women's Hospital	Healthcare institution	https://www.brighamandwomens.org
Boston Children's Hospital	Healthcare institution	http://www.childrenshospital.org

Social Determinants and Health Risk Factors – Healthy Aging	
Brief Description or Objective	As the population ages, keeping older adults healthy and out of the hospital is increasingly important. Each year, millions of adults aged 65 and older fall. These falls can provide moderate and severe injuries, including hip fractures and head traumas. Charles River Community Health (CRCH) has a partnership with Carolina Prieto Dance, a local dance studio, to provide physical activity classes for adults and older adults. Individuals can also join the Cook Healthy on a Budget class held in collaboration with Oldways Health through Heritage, an organization that helps individuals embrace healthy eating. The people who have participated in this program have developed a sense of community, celebrating holidays, birthdays and other life events together. Originally started through a partnership with Harvard Medical School's Agents of Change program, six years later, Bowdoin Street Health Center's (BSHC) Wellness Center continues to offer its Tai Chi program to older adults through a suite of programs at the BSHC Wellness Center. The Tai Chi program helps older adults increase strength and reduce the risk of falling. Although many participants are over 65 and referred by their primary care provider because they had a history of or were at risk of falls, the program is open to any patient or community resident as Tai Chi programming provides assistance with mindfulness and stress reduction.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Dorchester, Roxbury, Mattapan, West Roxbury, Jamaica Plain), Waltham • **Gender:** All • **Age Group:** Adults and Elderly • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity

	• ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to healthy food, Elder care, Nutrition, Overweight and obesity, Physical activity, Home injuries (falls), Senior health challenges

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, CRCH will increase patient access to physical activity by providing at least 30 physical activity classes per year with an average of 8 people attending each class.	CRCH held 30 physical activity classes, with an average of 10 people attending each class.	3	3	Process Goal
By the end of FY19, CRCH will increase patient's capacity to prepare healthy foods at home through provision of 2 sessions of cooking classes, entitled Cook Healthy on a Budget.	CRCH held 2 sessions of cooking classes for 6 classes each for a total of 18 classes. An average of 8-10 individuals completed a full session.	3	3	Process Goal
In FY19 BSHC will increase access to healthy living programs for older adults.	BSHC Tai Chi classes were rolled into a suite of program at the BSHC Wellness Center. 3 Tai Chi classes were offered weekly in FY19.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Oldways Health through Heritage	Community resource organization	https://oldwayspt.org
Carolina Prieto Dance	Fitness and dance organization	https://www.carolinaprieto.work

Social Determinants and Health Risk Factors – Violence Intervention and Prevention Program in Bowdoin/Geneva Neighborhood	
Brief Description or Objective	Over the past ten years, Bowdoin Street Health Center (BSHC) has collaborated with community partners to lead the Violence Intervention and Prevention (VIP) program from the Boston Public Health Commission. Known as "Village in Progress" in many neighborhoods, VIP's mission is to prevent violence through building and sustaining strong communities where residents are knowledgeable and empowered. VIPs over-arching goals are to build, knowledge, capacity, community, provide tools, and improve access. The Bowdoin Geneva VIP outreach team includes a resident Block Captain and a VIP Coordinator who engage in a door-to-door campaign and community organizing activities. Particular focus areas of VIP are to strengthen resident and community engagement; increase access to leadership opportunities for youth; coordinate community actions in the event of homicides and shootings to promote peace and non-violence and a commitment to changing the expectation of violence in the community; ensure residents in the Bowdoin Geneva neighborhood have access to quality services, resources and support. One of FY 2019's highlights was Bowdoin Geneva Community First Aid, a workshop that provides a trauma informed community healing approach to assist individuals, families and young people affected by traumatic events. The VIP gives the population an opportunity to create stronger bonds with one another and begin the recovery and healing process. BSHC hosted eight street by street meetings to engage residents in meeting their neighbors; discussed vision and action steps to keep their community safe, healthy, and vibrant. The VIP Coordinator has provided technical assistance to help residents and management in a Housing and Urban Development (HUD) senior building in the Bowdoin Geneva area organize regular resident meetings, a resident board structure and activities for its residents. Lastly the VIP organized the Bowdoin Striders for the second year in a row. This is an eight week walking group made up of over 100 community residents, BSHC staff, and the C-11 Boston Police Department.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Bowdoin/Geneva in Dorchester) • **Gender:** All • **Age Group:** Adults, Children, Teens • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History

	☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Bereavement, Domestic Violence, Physical activity, Public safety, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, VIP will continue to sustain communities and empower residents by building knowledge, building capacity, and building community. VIP will also provide tools to improve access to resources by holding at least three community events.	In FY19 VIP continued to sustain communities and empower residents through a Community First Aid workshop, hosting 8 individual street meetings, and organizing the Bowdoin Striders walk group with over 100 residents and patients.	3	3	Process Goal
By the end of FY20 develop at least 10 new community leaders	Identifying new community leaders to increase civic engagement.	2	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Family Nurturing Center	Child development organization	https://www.familynurturing.org
College Bound Dorchester	Education organization	https://uncornered.org

Social Determinants and Health Risk Factors – Center for Violence Prevention and Recovery	
Brief Description or Objective	Domestic violence, sexual assault, community violence and homicide bereavement are addressed through BIDMC's Center for Violence Prevention and Recovery (CVPR). As one of the founders of the Domestic Violence Council of the Conference of Boston Teaching Hospitals (COBTH) and one of the oldest hospital-based rape crisis intervention programs in the country, BIDMC has led the way in developing a continuum of education, outreach, and treatment interventions to respond to victims of interpersonal, sexual, community violence, and homicide bereavement. It is also one of the leaders in developing programming to address secondary traumatic stress in service providers in the domestic violence and medical communities. In response to sexual violence, CVPR provides individual and group support and counseling – medical, legal, and personal advocacy - and develops trauma-informed policies and programs with medical providers throughout the Medical Center. In FY 2019, BIDMC provided emergency medical care to 62 sexual assault survivors in the Emergency Department. The Medical Center provided follow up care to 35 survivors in the Infectious Disease Clinic at a cost to the hospital of approximately $25,000. These services include an average of three physician visits, blood draws, and appropriate vaccinations. In response to Domestic and Interpersonal violence, CVPR provides outpatient and inpatient counseling and advocacy. For those patients with severe and acute safety concerns following interpersonal assault, BIDMC provides a Safebed – a place for a survivor to remain in the hospital overnight -- if no safe shelter option can be identified. BIDMC supported 50 Safebed patients in FY 2019. In addition, CVPR provides advocacy and follow up care to those who utilize Safebeds. CVPR's community violence initiatives include neighborhood-based support groups, individual counseling, outreach, training, and advocacy. Additionally, BIDMC provides clinical support and counseling through community-based partnerships.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Cambridge, Chelsea, Revere, Waltham, Winthrop, Brockton, Lawrence, Lynn, Lowell, Milton, Newton, Quincy, Somerville, Watertown • **Gender:** All • **Age Group:** Adults, Children • **Ethnic Group:** All • **Language:** Cape Verdean Creole, English, Spanish • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban

	• **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☒ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☒ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☒ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☒ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Domestic violence, HIV/AIDS, Sexually transmitted diseases, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, CVPR will provide support and therapeutic intervention to 700 victims of domestic violence, sexual assault and community violence in the Greater Boston Area.	CVPR provided support to 712 victims of domestic, sexual, and community violence in the Greater Boston area.	3	3	Process Goal
By the end of FY19, CVPR will provide services to survivors of sexual violence in the Emergency Department.	CVPR met with 62 victims in the ED and for 35 follow up visits to the Infectious Disease Clinic in FY19.	3	3	Process Goal
By the end of FY19, CVPR will have the capacity to provide free overnight stays for 50 domestic violence victims without safe shelter.	BIDMC provided safe beds to all domestic violence victims who needed one in FY19 (33 individuals).	3	3	Process Goal
By the end of FY19, CVPR will provide education and outreach services to 500 community members and partners around sexual assault, interpersonal violence, and Secondary Traumatic Stress.	CVPR provided training and outreach services to over 1172 community members and partners in FY19.	3	3	Process Goal
By the end of FY19, CVPR will provide 50 peace circles to 400 community members in the Greater Boston area.	CVPR provided 73 peace circles to 1096 community members in the Greater Boston area in FY19.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Louis D. Brown Peace Institute	Organization dedicated to healing from violence	http://www.ldbpeaceinstitute.org
SANE	Sexual assault nurse program	https://www.forensicnurses.org/page/aboutSANE
BARCC	Organization committed to ending sexual violence	https://barcc.org
Sexual Assault Unit of DPPC	Government agency	https://www.mass.gov/locations/disabled-persons-protection-commission-sexual-assault-response-unit-statewide-saru.gov
Casa Myrna	Shelter and support services for domestic violence survivors	https://www.casamyrna.org

Social Determinants and Health Risk Factors – Neighborhood Trauma Team (NTT)	
Brief Description or Objective	In collaboration with and funding from the City of Boston/Boston Public Health Commission (BPHC), Bowdoin Street Health Center (BSHC) plays the lead agency role for the Bowdoin Geneva Greater Four Corners Neighborhood Trauma Team (NTT). As the lead healthcare agency, Bowdoin Street partners with a community organizing agency, Greater Four Corners Action Coalition (GFCAC), and provides outreach to individuals, families, and neighborhoods impacted by community violence. The NTT functions as a "hub" team comprised of a licensed clinical social worker, a Family Partner/Community Health Worker, other staff members throughout the health center, and community organizers from GFCAC. The NTT team assesses community need related to trauma in order to support and deliver prevention, response, and short- and long-term recovery services. These services are intended to support existing neighborhood strategies. The Boston NTT Network offers the following services for individuals, families, and communities impacted by community violence: • Access to a support hotline 24/7 365 days a year • Immediate support services for any individual impacted by community violence • Support for individuals and families during community events including vigils, memorial, and funeral services • Referral to ongoing behavioral health services for individuals and families • Trauma education and support at community meetings • Community outreach to distribute basic health information on trauma • Community coping/healing groups Support is available to all residents who feel impacted by community violence and all services are free and private.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Bowdoin/Geneva, Dorchester, Roxbury) • **Gender:** All • **Age Group:** All • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status

	☒ Domestic Violence History ☒ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☒ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Bereavement, Domestic violence, Mental health, Stress management, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, NTT will respond to every incident of homicide or stabbing within BSHC's catchment area and offer outreach to victims and impacted residents.	NTT responded to 100% (11 total) of incidents and offer outreach to victims and impacted residents within BSHC's catchment area in FY19.	3	3	Process Goal
By the end of FY19, BSHC NTT will participate in at least 10 consultations around issues of trauma and community violence.	BSHC NTT consulted in 12 community meetings/events/forums over the course of FY19 to provide trauma-informed psychoeducation and supportive services.	3	3	Process Goal
By the end of FY19, BSHC will provide at least 700 direct therapeutic services to children, adults, and their families who have been impacted by violence.	BSHC NTT Clinician provided 740 direct service/therapy visits. Of that, 106 were first time clients.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Boston Public Health Commission	Health department	https://www.bphc.org/Pages/default.org
Greater Four Corners Action Coalition	Public safety and community development	https://www.gfcac.net
Grove Hall Dorchester NTT	Neighborhood Trauma Team	https://www.cityofboston.gov/images_documents/Grove%20Hall_tcm3-25314.pdf
Boston Police – C11	Police unit	https://www.boston.gov/departments/police

Social Determinants and Health Risk Factors- Education and Workforce Development	
Brief Description or Objective	As an academic medical center, BIDMC's mission includes a strong commitment to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. In FY 2019, BIDMC offered incumbent employees five "pipeline" programs to train for the following professions: Central Processing Technician, Graduate Medical Education Program Coordinator, Associate Degree Nurse Resident, Patient Care Technician, and Clinical Documentation Specialist. BIDMC's Employee Career Initiative (ECI) provides career and academic counseling, on-site academic assessment, and on-site pre-college and college-level science courses to employees at no charge. Tuition reimbursement and competitive scholarships as well as English as a Second Language (ESOL), basic computer skills, financial literacy, and citizenship classes are additional offerings. BIDMC also offers employees the opportunity to take the course "Financial Fitness Program," which helps employees build financial literacy skills and offers them three one-on-one planning sessions with a financial counselor. In FY 2019, BIDMC selected employees to participate in The Partnership, Inc.'s and Conexion's leadership programs. The Partnership program and Conexion are designed to facilitate career growth and networking for multicultural professionals in Massachusetts. The annual YMCA Black Achievers event and Latino Achievement Award event are other ways in which BIDMC celebrates the accomplishments of its diverse staff. BIDMC also encourages its staff, faculty, and community members to support community events around Boston, such as the Boston Heart Walk, and the Pride Parade, in which a group of BIDMC's lesbian, gay, bisexual, transgender, queer and questioning staff, friends and allies march. BIDMC also has an Employee Resource Group, focused on multicultural employees. BIDMC is committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies such as St. Mary's Center for Women and Children and YMCA Training, Inc. BIDMC also provides input to community organizations such as International Institute of Boston, Bottom Line, and Career Collaborative about adults applying to jobs at BIDMC. The Train4Change program at Bowdoin Street Health Center (BSHC) is a workforce and leadership development opportunity around wellness programming, offered to residents in the Bowdoin/Geneva community. Participants receive training to become group fitness instructors and are engaged in learning and developing exercise curriculum. Recognizing its commitment to the Boston area's student population, the medical center provides summer jobs and mid-year internships to introduce high school students and out-of-school youth to careers in the medical field. In partnership with the Boston Private Industry Council (PIC), BIDMC hosts students from Boston Public High Schools in an annual Job Shadow Day with additional student groups touring the skills lab throughout the year. BIDMC is

	also a presenting sponsor of the Red Sox Scholars Program that pairs BIDMC Medical Champions with 12 academically talented, economically disadvantaged 8th grade students from Boston Public Schools. The program includes opportunities for professional development such as a Job Shadow Day at BIDMC clinical sites. Finally, BIDMC hosts high school students (age 14-17) for seven weeks during the summer, where the teens can explore various careers while gaining experience in a hospital setting. BIDMC's Summer Health Corps Program is a six-week educational hands-on program for high school students. Through this program, teens can explore various careers while gaining experience in a hospital setting. In FY 2019, 40 students assisted hospital personnel in various administrative and direct patient contact positions and attended weekly tours of various departments at BIDMC. BIDMC senior leaders are active in advocating on behalf of educational and job opportunities. BIDMC President Pete Healy participated in the Massachusetts Healthcare Workforce Collaborative run by the Executive Office of Labor and Workforce Development. Joanne Pokaski, Senior Director of Workforce Development and Community Relations, is a member of the Boston PIC and chairs the PIC's Boston Health Care Careers Consortium, which brings together healthcare employers, the workforce system and educational institutions in the greater Boston area. She is a member of the Massachusetts Workforce Development Board and co-chairs its Labor Market and Workforce Information Committee. Ms. Pokaski also serves on the Executive Committee of CareerSTAT, a project of the National Fund for Workforce Solutions to encourage healthcare employers nationally to invest in the skills and careers of their front-line workers.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Chinatown, Dorchester, Fenway/Kenmore, Roxbury, Mission Hill, West Roxbury, Mattapan) Brookline, Newton Waltham • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education

(Select up to 3)	• ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☒ Employment • ☐ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Education/Learning, Income and poverty

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC will offer a series of Career Development workshops at BSHC and will market these workshops to staff and community members.	In FY19, a series of four career development workshops were held at BSHC and marketed to staff and community members, including via ads in local newspapers.	3	3	Process Goal
In FY19, BIDMC will graduate at least 25 people from pipeline programs in clinical documentation, medical coding, patient care technician, central processing technician, and medical education program coordination and move them into new roles.	29 people graduated from the pipeline programs in FY19.	3	3	Process Goal
In FY19, BIDMC will launch an associate degree nurse residency program aimed at recruiting and retaining diverse RNs.	The program launched in FY19; 69 RNs applied and 12 Associate degree nurse residents were selected and hired. These nurses will work at BIDMC for two years and also attend A.D.N. to B.S.N program at Emmanuel College, sponsored by BIDMC.	3	3	Process Goal
In FY19, BIDMC Workforce Development team will provide four job and career introductory opportunities for middle and high school students.	In FY19, BIDMC provided four job and career programs for middle and high school students. BIDMC provided 37 paid summer job opportunities; hosted 23 Boston Public School students for PIC's annual Job Shadow Day, and hosted 40 high school students in Summer Health Corps Program. Medical Champions mentored 12 academically talented, economically disadvantaged 8th graders from BPS.	3	3	Process Goal
In FY19, BIDMC will provide opportunities through Employee Career Initiative (ECI) for college-level courses as well as counseling.	In FY19 723 employees utilized ECI services.	3	3	Process Goal
In FY19, BIDMC will offer ESOL classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class.	In FY19, 31 employees were enrolled in ESOL classes; 136 employees participated in a 10-week computer skills class; 20 attended citizenship classes; and 91 attended a financial literacy workshop.	3	3	Process Goal

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC will provide job and career introductory opportunities for community residents.	In FY19, BIDMC hosted 13 adults in training internships, five of whom were subsequently hired. Enrolled 4 participants in BSHC's Train4Change Program. Hired 1 intern from Bunker Hill Community College's Learn and Earn Program.	3	3	Process Goal

Partners

Partner Name (See Appendix A for additional partners)	Description	Partner Web Address
Private Industry Council	Employment organization	https://www.bostonpic.org
Louis D. Brown Peace Institute	Organization dedicated to healing from violence	http://www.ldbpeaceinstitute.org
Conexion	Aims to develop Hispanic Latino leaders	http://conexion-all.org
The Partnership	Builds racially and ethnically diverse leadership pipelines	https://www.thepartnershipinc.org

Behavioral Health and Substance Use– Facilitating Access	
Brief Description or Objective	Mental illness and substance use have a profound impact on the health of people living in Massachusetts and the Boston area. Mental health and substance use hospitalization and death rates are higher for a number of Boston's neighborhoods, in particular Roxbury and parts of Dorchester. These two neighborhoods have a high percentage of Hispanic/Latino residents (nearly 30% of Roxbury's population is Hispanic/Latino). BIDMC formed an Opioid Care Committee in FY 2017, whose members include clinical and nonclinical staff. The newly formed addictions team includes Kevin Hill, MD, Addiction Specialist, Psychiatry; Joanne Devine, APN, Specialist in Addictions; Leslie Bosworth, LICSW, Specialist in Addictions; and Allison Borrelli, LICSW, Inpatient/Outpatient Psychotherapy. This committee is working to prevent Opioid Use Disorder and to improve the care of patients with Opioid Use Disorder. The goals of the committee include implementing a comprehensive team approach to addiction treatment; achieving best practices for opioid use in assessment, treatment, and continuity of care for acute and chronic pain management; improving management and control systems for opioid use and misuse; and complying with Federal and State regulatory requirements regarding opioid management. Bowdoin Street Health Center (BSHC) continues to integrate behavioral health services into their primary care clinic. A Behavioral Health Care Manager is on-site to provide mental health assessment, intervention, and consultation to patients and providers during primary care visits. Results of the behavioral health integration show that more high-risk patients are accessing mental health services, an increase in appointments kept by patients who receive a "warm-hand off" by their provider to therapists, and reduced wait time for mental health appointments. In continuation of BSHC's quality improvement and program evaluation work in FY17 and FY18, the health center applied for and received grant funding from the Massachusetts League of Community Health Centers/MassHealth to pilot an evidence-based treatment approach across the social work team. The Solutions-Focused Brief Therapy (SFBT) pilot sought to fulfill a number of identified needs for BSHC patients and clinicians on the Behavioral Health (BH) team. The first goal was to provide evidence-based training to all clinicians on the team to allow BSHC to more effectively meet the needs of their patients who tend to come in for BH care episodically. The second goal of the project was to then utilize the SFBT model specifically in integrated behavioral health consultations in the primary care clinic. The final goal targeted patients with mental health diagnoses who are known to be high-risk and have a historical record of low rates of engagement.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Bowdoin/Geneva, Dorchester, Roxbury), Quincy • **Gender:** All • **Age Group:** Adult • **Ethnic Group:** Hispanic/Latino

	• **Language:** English, Spanish • **Environment Served:** ☐ All ☐ Rural ☐ Suburban ☒ Urban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☒ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Access to health care, Alcohol use, Bereavement, Depression, Domestic violence, Mental health, Opioid use, Stress management, Substance use, Violence and trauma

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, BSHC will utilize secured grant funds to train all BH staff in Solution-Focused Brief Treatment (SFBT) in order to better meet patient's needs.	In FY19 all BH staff were trained in Solution-Focused Brief Treatment (SFBT) in order to better meet the needs of BSHC patients.	3	3	Process Goal
By the end of FY19, BSHC will utilize SFBT with a small cohort of patients and evaluate outcomes and satisfaction.	BSHC utilized SFBT with a small cohort of at least 10 BSHC patients and evaluated outcomes and satisfaction.	3	3	Process Goal
By the end of FY19, BSHC will develop and utilize the SFBT script for outreach to high risk patients.	Developed and utilized SFBT script to use for outreach calls to high risk patients.	3	3	Process Goal
In FY19, BSHC will continue to accept referrals for Behavioral Health services.	BSHC Behavioral Health Team as a whole received 743 patient referrals for BH services. 297 (40%) of these referrals were seen as integrated behavioral health consults in the primary care clinic. 446 (60%) of these referrals were submitted via the online medical record.	3	3	Process Goal
In FY19, BIDMC will continue to provide culturally competent mental health services to Latino patients and their families.	BSHC continued to offer the Latino Mental Health initiative providing bilingual and bi-cultural mental health services.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Not applicable		

Behavioral Health and Substance Use – Screening, Brief Intervention, and Referral to Treatment (SBIRT)	
Brief Description or Objective	Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing substance use disorders. The SBIRT screening quickly assesses severity of substance use and helps providers to identify appropriate treatments. SBIRT is recommended by the Institute of Medicine. BIDMC's Emergency Department (ED) implemented a SBIRT program. All patients are asked about alcohol use, and those with an identified issue are provided discharge instructions including contacts for alcohol use counseling. Additionally, two large primary care practices are notified by secure messaging if their patient is seen in the ED for substance use. Per the American College of Surgeons, universal screening for alcohol use must be performed for all trauma patients and must be documented. At Level I trauma centers, all patients who have screened positive must receive a SBIRT intervention by appropriately trained staff, and this intervention must be documented. It has been demonstrated that trauma centers can use the teachable moment generated by an injury to implement an effective injury prevention strategy; alcohol and/or drug use counseling for patients presenting to the hospital because of a substance use. BIDMC's Level I Trauma Center works collaboratively with Social Work, Nursing, Physicians, and all members of the care team to ensure screening, intervention, education, and referral to treatment is provided to every patient. As part of the SBIRT implementation, BIDMC developed a teaching module to educate providers about patients who may be at-risk for alcohol use, and taught residents, attending physicians and nurses the skills to assess and intervene on patients at risk for alcohol use. This additional training prepares providers to assess a patient's motivation to alter behavior and/or seek additional assistance for care. In FY 2019, BIDMC's ED continued to utilize resources available to providers in the electronic database. These include documentation, literature, and other tools available to providers for real-time interventions using SBIRT.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Bowdoin/Geneva, Charlestown, Chinatown, Dorchester, Fenway/Kenmore, Roxbury), Chelsea, Lexington, Quincy, Revere, Waltham, Winthrop, Lawrence, Brockton, New Bedford, Lowell, Haverhill, Newburyport, Amesbury, Stoughton, Malden, Lynn, Cambridge, and Somerville • **Gender:** All • **Age Group:** Adults and Elderly • **Ethnic Group:** All • **Language:** All • **Environment Served:** ☒ All ☐ Rural ☐ Suburban

	☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☒ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Alcohol use, Opioid use, Substance abuse

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, Social Work and the Trauma Care Coordinator will have screened 85% of patients for substance use and will refer them as needed to community services.	An average of 92% of trauma patients were screened for substance use and referred as needed in FY19.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
The Dimock Center	Continuity Clinic	https://dimock.org
Adcare	Addiction treatment center	https://adcare.com/locations/boston/
PAATHS	Connects people to services	https://www.bphc.org/whatwedo/Recovery-Services/paaths-connect-to-services/Pages/paaths.aspx

Equitable Care- Office of Diversity and Inclusion	
Brief Description or Objective	BIDMC recognizes the importance of provider/patient cultural concordance in providing quality care. BIDMC's on-going commitment to diversity and inclusion has evolved over the past decade. Inaugurated, in FY 2010, The Office of Multicultural Affairs worked to recruit, retain, and advance diverse residents and fellows, junior faculty, and in-house staff and faculty. In January 2015, a new Office for Diversity and Inclusion (ODI), headed by a senior faculty member was created and charged with working with Department Chairs to increase recruitment and retention of under-represented minority and women faculty, and to oversee data collection on health care disparities at BIDMC. Office for Diversity, Inclusion and Career Advancement (ODICA) actively participates in unconscious bias training. ODICA works with the Center for Education, including the directors of Undergraduate Medical Education and Graduate Medical Education, to improve recruitment and retention of medical professionals from underrepresented groups. Finally, ODICA participates in several informal activities and events aimed at increasing awareness of the relevance of professional diversity for the expert and compassionate treatment for BIDMC's diverse family of patients.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Fenway/Kenmore) • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☒ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group

DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Program Type	• ☒ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☐ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☐ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☐ Mental Illness and Mental Health • ☐ Substance Use Disorders • ☒None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Cultural competency, Racism and discrimination

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
By the end of FY19, the number of underrepresented residents will increase by at least one in 50% of the residency programs.	Goal was met after adjustment of the students' experience during their interview visit. BIDMC added 5 underrepresented residents to the resident corps in FY19.	3	3	Process Goal
By the end of FY19, BIDMC ODI will invite two distinguished speakers from underrepresented groups to speak about health care disparities.	One speaker gave a lecture on healthcare disparities in FY19.	3	3	Process Goal
By the end of FY19, BIDMC ODI will invite 4 students from historically Black medical schools to do a clinical rotation during the 4th year.	Three students have done a rotation with BIDMC from historically Black medical schools. A fourth student withdrew.	3	3	Process Goal
By the end of FY19, BIDMC ODI will invite 3 medical students underrepresented in medicine to do a summer research rotation between first and second years.	Three students between the first and second year of medical school completed a 10-week summer research experience, 2 in cardiology and 1 in neurology in FY19.	3	3	Process Goal
BIDMC will award one two-year research career development grant to run 2018 -2020 that will ultimately result in a medical journal publication.	BIDMC will receive a report of the findings after the fellowship ends on June 30, 2020	3	3	Process Goal
By the end of FY19, BIDMC ODI will give 4 lectures on unconscious bias and healthcare disparities to members of the medical, nursing, and social work staff	In FY19 BIDMC ODI gave 6 lectures on unconscious bias and healthcare disparities to members of the medical and social work staff.	3	3	Process Goal
By the end of FY19, BIDMC ODI will develop a lecture on the biological basis of racism and how to combat it.	BIDMC ODI developed a lecture on the biological basis of racism and gave the lecture to several groups in the medical center and at the university.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
The Student National Medical Association, National and NE Chapter	Supports underrepresented medical students	https://snma.org
The Latino Medical Student Association	Represents Latino medical students	https://lmsa.site-ym.com
CHADD Mentoring Course, Harvard Medical School	Education organization Leadership and Faculty Development Conference	https://dicp.hms.harvard.edu/mentoring/chadd/planning_committee
Harvard Medical School	Prepares leaders and scientists	https://dicp.hms.harvard.edu/leadership-and-faculty-development
BSCS Science Learning Conference and New England Science Symposium	Harvard Medical School	https://dicp.hms.harvard.edu/dcp-programs/medicalgraduate/new-england-science-symposium
Diversity Affiliates	Supports diversity efforts	https://dicp.hms.harvard.edu

Equitable Care - Evidence-Based Strategies and Research	
Brief Description or Objective	The Institute of Medicine's report, *Unequal Treatment,* focused the nation's attention on disparate care and health outcomes among the U.S. populace. BIDMC's clinical and research community embraced the challenges of advancing knowledge about the root-causes of racial and ethnic health disparities, and developing evidence-based strategies to improve health status of affected groups. For example, Charles Safran, M.D. is conducting a study of real-life situations of elders and the challenges for families of communicating, coordinating, and collaborating with complex and costly care environments. Robert Gerszten, M.D. studies the risk of diabetes in the Asian community. James Whitney, Ph.D. leads a study to define the impact of early antiretroviral therapy (ART) on achieving Human Immunodeficiency Virus (HIV) remission and viral control after stopping ART. This research enterprise frequently extends beyond BIDMC's campus, involving collaboration with other Harvard Medical School (HMS) affiliates. The Dana Farber/Harvard Cancer Center (DF/HCC)'s Initiative to Eliminate Cancer Disparities is one example where seven institutions are working together on community education and outreach campaigns as well as efforts to make state-of-the-art cancer care accessible to communities of color through clinical trial enrollment and enhanced culturally competent care in hospitals. The Harvard Catalyst is the latest collaboration, bringing together the expertise of Harvard University's 10 schools and 18 academic healthcare centers and other partners to aid the translation of scientific advances into clinical practice and public health policy. BIDMC is also part of the Boston Breast Cancer Equity Coalition (BBCEC), which is made up of Boston hospitals, MA Department of Public Health, Boston Public Health Commission and various other organizations that serve racially/ethnically diverse populations in Boston. The vision of the BBCEC is to eliminate the differences in breast cancer care and outcomes by promoting equity and excellence in care among all women of different racial/ethnic groups in the City of Boston.
Target Population (indicate/select as many as apply for all fields)	• **Regions Served:** Boston (Allston, Brighton, Charlestown, Chinatown, Dorchester, Fenway/Kenmore, Hyde Park, Jamaica Plain, Mattapan, Roxbury, West Roxbury), Revere, Brookline, Chelsea, Harwich, Provincetown, Quincy, Truro, Wellfleet • **Gender:** All • **Age Group:** Adults • **Ethnic Group:** All • **Language:** English • **Environment Served:** ☒ All ☐ Rural ☐ Suburban ☐ Urban • **Additional Target Population Status:** ☐ Disability Status

	☐ Domestic Violence History ☐ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags (Select up to 3)	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☒ Research • ☐ Support Group
DoN Health Priorities (Select up to 3)	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Program Type	• ☐ Access/Coverage Supports • ☐ Community-Clinical Linkages • ☐ Direct Clinical Services • ☐ Infrastructure to Support Community Benefits • ☒ Total Population or Community-Wide Interventions
EOHHS Focus Issues	• ☒ Chronic Disease with focus on Cancer, Heart Disease, and Diabetes • ☐ Housing Stability/Homelessness • ☒ Mental Illness and Mental Health • ☒ Substance Use Disorders • ☐None/Not Applicable
Health Issues Tags (type as many as apply from this list)	Breast cancer, Cardiac disease, Diabetes, HIV/AIDS, Hypertension, Senior health challenges, Substance use

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC will advance knowledge about causes and remedies of health disparities.	Researchers/clinicians engaged in health disparities research efforts through 30 research studies.	3	3	Process Goal

Goal Description	Goal Status	Current Year of Program	Total Years of Program	Goal Type
In FY19, BIDMC will participate in multi-institutional collaborations to reap synergies and share knowledge.	BIDMC faculty and staff participated in DF/HCC, Harvard Catalyst, Harvard School of Public Health, BBCEC, and other multi-institutional collaborations.	3	3	Process Goal

Partners

Partner Name	Description	Partner Web Address
Dana Farber Cancer Institute	Healthcare institution	https://www.dana-farber.org
Boston Medical Center	Healthcare institution	https://www.bmc.org
Massachusetts General Hospital	Healthcare institution	https://www.massgeneral.org
Tufts Medical Center	Healthcare institution	https://www.tuftsmedicalcenter.org
Brigham and Women's Hospital	Healthcare institution	https://www.brighamandwomens.org

Section V: Expenditures

CB Expenditures by Program Type	Amount	Subtotal Provided to Outside Organizations (Grants/Other Funding)
Direct Clinical Services	$11,850,955	$245,000
Community-Clinical Linkages	$1,958,418	$873,919
Total Population or Community-Wide Interventions	$3,269,082	$1,003,309
Access/Coverage Supports	$10,024,424	$2,191,153
Infrastructure to Support CB Collaborations Across Institutions	$700,843	$82,636

CB Expenditures by Health Need	Amount
Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes	$12,763,167
Mental Health/Mental Illness	$5,095,697
Housing/Homelessness	$322,227
Substance Use	$2,261,995
Additional Health Needs Identified by the Community	$7,360,636
Other Leveraged Resources	$4,237,958
Net Charity Care	
Expenditures	**Amount**
HSN Assessment	$7,644,351
HSN Denied Claims	$6,694,627
Free/Discount Care	N/A
Total Net Charity Care	$14,338,978
Total CB Expenditures	**$46,380,658**

Additional Information	Amount
Net Patient Service Revenue:	$1,435,657,000
CB Expenditure as Percentage of Net Patient Services Revenue:	3.23%
Approved CB Program Budget for FY2020: **(*Excluding expenditures that cannot be projected at the time of the report)**	$27,803,722
Bad Debt:	$9,648,174
Optional Supplement:	
PILOT:	$3,418,226
Unreimbursed Medicaid:	$48,233,281
Unreimbursed Medicare:	$61,277,841

Comments:

Total Charity Care is $133,498,274 and includes BIDMC's payment of $14,338,978 to the Health Safety Net; $61,277,841 in unreimbursed Medicare Services; $48,233,281 in unreimbursed MassHealth Services; $9,648,174 in bad debt. In addition, BIDMC made contributions of $183,241 to the City of Boston's Neighborhood Jobs Trust which funds jobs, job training, and related services throughout the City of Boston and $3,418,226 representing BIDMC's voluntary PILOT payment to the City of Boston, which contributes to the health and well-being of individuals residing in its Community Benefits Service Area. Additionally, BIDMC paid $738,524 to the Center for Health Information and Analysis (CHIA) and $244,512 to the Health Policy Commission (HPC).

Section VI: Contact Information

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Section VII: Self-Assessment Form

Hospital Self-Assessment Form – Year 1

Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment.

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:
   - Are Community Benefits planning and investments part of your hospital's strategic plan?
     ☒ YES ☐ No
     - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not.

Beth Israel Deaconess Medical Center (BIDMC) is a member of Beth Israel Lahey Health (BILH). While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities.

2. Community Benefits Committee (CBC):
   - Members (and titles):
     BIDMC Community Benefits Committee Members: Phyllis Barajas, Committee Co-Chair, Founder and Executive Director of Conexion; Pamela Scott, Committee Co-Chair, President and CEO, LVCC; Carol F. Anderson, Chair, Board of Directors; Arese Carrington, MD, Vice President, Africana Consultants; Elizabeth Cheng, General Manager for Television, WGBH; Helen Chin Schlichte, Founder and Past President, South Cove Manor Nursing Home; Jose de la Rosa, President and CEO, Guardian Healthcare; Stephen Denny, Director of Diversity and Inclusion, Putnam Investments; Thomas DeSimone, Executive Vice President, WS Development Associates; Matthew E. Epstein, Attorney, Goulston and Storrs; Lee Ann Fatalo, Senior Financial Planner, Baystate Financial; Joan Feinberg Berns, PhD, Director of Donor Relations, Hebrew Senior Life; Peter J. Healy, President, BIDMC; Paula Ivey Henry, PhD, Research Associate, Harvard School of Public Health; Nancy Kasen, VP, Community Benefits and Community Relations, BILH; Jamie Katz, General Counsel, BILH; Edward (Ted) Ladd, Chair Emeritus, Standish Mellon Asset; Vivien Li, Former President and CEO, Riverlife; Femi Obi, Managing Director, KPMG; April Tang, Board President, South Cove Community Health Center; Fred Wang, Executive Director, The Wang Foundation; Tracey West, Associate Dean for External Relations and Diversity and Inclusion, Boston College Law School

- Leadership:
  Peter J. Healy, BIDMC President; Jamie Katz, BILH General Counsel, Kevin Tabb, BILH President and Chief Executive Officer; Nancy Kasen, BILH Vice President of Community Benefits and Community Relations

- Frequency of meetings:
  The BIDMC Community Benefits Committee (CBC) met quarterly during FY 2019.

3. Involvement of Hospital's Leadership in Community Benefits:
   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

	Review Community Health Needs Assessment	*Review Implementation Strategy*	*Review Community Benefits Report*
Senior Leadership	☒	☒	☒
Hospital Board	☒	☒	☐
Staff-level managers	☒	☒	☒
Community Representatives on CBAC	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

At BILH, our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our community partners, our CBC and the Community Benefits team, such commitment is shared by staff at all levels within BIDMC:

Hospital Board:
Carol Anderson, Chair - provided input on CHNA
BIDMC Board of Directors – reviewed and approved CHNA and adopted Implementation Strategy
BIDMC Community Benefits Committee - oversaw CHNA and Implementation Strategy process

Senior Leadership:
Peter Healy, BIDMC President - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBC; participated in prioritization process; participated in Key Informant Interview
Marsha Maurer, BIDMC Chief Nursing Officer - participated in prioritization process
Rich Wolff, BIDMC Chief of Emergency Medicine - participated in prioritization process
Dr. Anthony Weiss, BIDMC Chief Medical Officer - participated in Key Informant Interview

Staff-level managers:
Nancy Kasen, BILH VP of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy
Shari Gold-Gomez, BIDMC Director of Interpreter Services - assisted with language translation, interpretation, and prioritization process

Joanne Devine, BIDMC Psychiatry Clinical Nurse Specialist - participated in prioritization process
Barbara Sarnoff Lee, BIDMC Senior Director of Social Work and Patient/Family Engagement - participated in Key Informant Interview

Community Benefits Committee:
BIDMC CBC - guided community engagement process and selected/recommended priorities

4. Hospital Approach to Assessing and Addressing Social Determinants of Health
    - How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)
      BIDMC undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of assessments. The CBC oversaw the assessment, vetted findings and prioritized leading health issues and the communities and cohorts most in need. The assessment was also supported by BIDMC's Advisory Committee, initially constituted to oversee BIDMC's New Inpatient Building CHI. Both the CBC and Advisory Committee are comprised of community members, service providers, and other stakeholders that either live in and/or work in BIDMC's CBSA.

      BIDMC's Implementation Strategy (IS) reflects the hospital and the CBC's prioritization of the following social determinants of health: healthy neighborhoods, healthy eating and active living opportunities, violence prevention, housing affordability and home ownership, workforce development and the creation of employment opportunities, and environmental sustainability.
    - How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)
      BIDMC and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout BIDMC's assessment process, BIDMC worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. BIDMC's IS was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

    - How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)
      The BIDMC IS includes a diverse range of programs and resources to addresses the prioritized needs within the BIDMC community benefits service area. The majority of BIDMC's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. BIDMC's strategies include increasing access to care through support of the Community Care Alliance, participating in the Dana Farber/Harvard Cancer Center and the Faith-Based Cancer Disparities Network, and supporting the Violence Intervention and Prevention Program in the Bowdoin/Geneva neighborhood. Additionally, BIDMC collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions including Sociedad Latina, The Louis D. Brown Peace Institute, Family Nurturing Center, and YMCA Training, Inc.

II. Community Engagement:

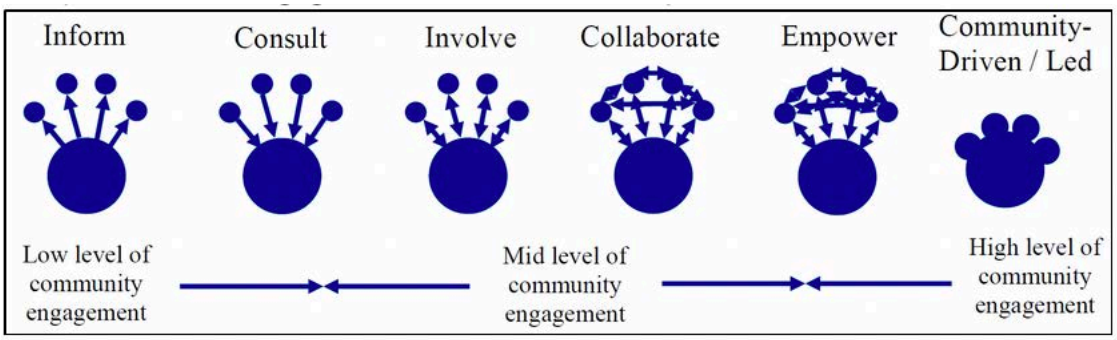
1. Organizations Engaged in CHNA and/or Implementation Strategy

   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Boston Public Health Commission	Margaret Reid, Director, Office of Health Equity	Local Health Department	BIDMC engages with BPHC on a number of programs, including the Cancer Ride Program, Safe Routes to Schools, emergency preparedness efforts, and the Boston Healthy Start Initiative. Additionally, BIDMC collaborated with the BPHC to assess the health needs of the community by leveraging existing data, and capturing further data to inform the CHNA and IS.
Community Care Alliance	Holly Oh, MD, Chief Medical Officer, The Dimock Center; Phillomin, Laptiste Executive Director, Bowdoin Street Health Center; Elizabeth Browne, Executive Director, Charles River Community Health; Jane Powers, Chief of Staff, Executive VP of Strategic Initiatives, Fenway Health; Eugene Welch, Executive Director, South Cove Community Health Center	Community Health Centers	The Community Care Alliance (CCA)is a partnership among the community health centers affiliated with BIDMC. BIDMC supports CCA affiliated health centers through technical assistance, resource sharing, and direct financial support. CCA affiliated community health centers assisted in expanding BIDMC's community engagement efforts in high need and historically underserved communities during the CHNA and IS process. CCA leadership hold positions on the committee overseeing the CHNA process.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Fenway Community Development Corporation	Richard Giordano, Director of Policy and Community Planning	Housing organizations	The Fenway Community Development (CDC) serves over 1,000 neighborhood residents each year to help improve access to jobs, education, healthcare, housing, open space, public transit, and the arts. The Fenway CDC is an important participant and collaborator in BIDMC's CHNA and IS. Their long-history in the neighborhood helps to reach Fenway/Kenmore residents who have experienced some of the harshest effects of gentrification.
Jewish Vocational Services (JVS)	Jerry Rubin, President and CEO	Social service organizations	BIDMC actively accepts candidate referrals from JVS and provides feedback on candidates. JVS is also a vendor for BIDMC's ESOL program and its pharmacy technician program. Additionally, JVS has been an active participant providing input into the formation of BIDMC's CHNA and IS, especially in how to best address the social determinants of health.

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health to assess the hospital's level of engagement with the community.



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

A. **Community Health Needs Assessment**
   Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	**Level of Engagement**	**Did Engagement Meet Hospital's Goals?**	**Goal(s) for Engagement in Upcoming Year(s)**

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Empower	The goal was met.	Not applicable
Collecting data	Empower	In certain communities and with specific cohorts, BIDMC was able to have community members/residents and organizations field the survey. This was not consistent across communities.	Not applicable
Defining the community to be served	Involve	BIDMC worked with Senior Leadership and the CBC to review the CBSA. CBC members and community partners identified hard-to-reach cohorts and those facing disparities.	Not applicable
Establishing priorities	Collaborate	The CBC worked with CB staff and BIDMC Senior Leadership to prioritize health needs and recommend health priorities and priority cohorts.	Consult

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

  BIDMC remains committed to community engagement. During FY 19, BIDMC undertook its triennial community health needs assessment and prioritization process. Guided by BIDMC's CBC and conducted in collaboration with community partners and the Advisory Committee, this initiative employed a comprehensive community engagement process.

  To better align with the BILH governance structure, BIDMC has created a Community Benefits Advisory Committee (CBAC). The CBAC is comprised of the Advisory Committee and includes additional sector and resident representation. The CBAC will assume the functions and responsibilities previously owned by the CBC , which was sunset at the end of September 2019. Additionally members of In FY 20, BIDMC will continue to work with the CBAC and community partners to engage the community, including continuing to hold CBAC meetings that are open to the public and distributing a quarterly Community Benefits newsletter to community stakeholders.

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	Community forums, community meetings and the CBC worked with the CBLT to identify priorities and sub priorities.	Involve
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Inform	BIDMC will work to better inform and consult with its newly formed CBAC on the proportion of CB resources allocated to different priorities.	Consult
Implementing Community Benefits programs	Consult	2019 was the last year of BIDMC's FY 2017-2019 Implementation Strategy (IS). BIDMC will be collaborating with the community on new and existing programs for its FY 20-22 IS.	Collaborate
Evaluating progress in executing Implementation Strategy	Consult	2019 was the last year of BIDMC's FY 2017-2019 Implementation Strategy (IS). BILH will continue to refine data and metrics to better evaluate programming.	Consult
Updating Implementation Strategy annually	Inform	2019 was the last year of BIDMC's FY 2017-2019 Implementation Strategy (IS). BIDMC will work with its CBAC and its community partners to review its IS and update, as appropriate at the end of FY 20.	Consult

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

BIDMC has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. BIDMC engaged with the CBLT and the community to identify and select priorities for the new (FY 20-22) IS. While the IS was shared with the CBC, the CBLT, and adopted by the Board of Directors and widely distributed, delays in obtaining secondary data and the significant commitment to the comprehensive community engagement for the CHNA and the prioritization process, led to less community engagement on the drafting of the IS. Going forward, BIDMC will review the workplan and timeline of our triennial CHNA to allow more time for engagement and vetting of the IS.

In FY 20, the BIDMC CBAC meetings will continue to be open to the public. BIDMC is committed to sharing the IS and holding an annual public meeting once it is safe to do so.

3. Opportunity for Public Feedback

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

The Advisory Committee meetings are open to the public; BIDMC's priorities and strategies have been shared. BIDMC will continue to keep its CBAC meetings open to the public in FY 20.

BIDMC held five public forums in June, 2019 at five different locations within the BIDMC CBSA. The five community forums were held to inform the Community-based Health Initiative on the following days and locations: Allston/Brighton, June 11, 2019; Chinatown, June 2, 2019; Bowdoin/Geneva, June 10, 2019; Fenway/Kenmore, June 12, 2019; Roxbury/Mission Hill, June 17, 2019.

In addition, ~15 community meetings were open to the public in neighborhoods across Boston and Chelsea as part of the CHNA process (through collaborations with the Boston CHNA-CHIP Collaborative, the North Suffolk Integrated Community Health Needs Assessment, and BILH and other hospital CHNAs).

4. Best Practices/Lessons Learned
   The AGO seeks to continually improve the quality of community engagement.

   - What community engagement practices are you most proud of? (150-word limit)
     BIDMC is most proud of their committed CBC (and now the CBAC) and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. BIDMC is proud of their collaboration with these and other organizations that allowed BIDMC to engage with hard-to-reach cohorts. BIDMC is particularly proud of how it was able to reach community members who had not previously been engaged. Survey results from the five community forums held as part of the community engagement process for the Community-based Health Initiative showed that 42.3% of people in attendance had either not been to a community meeting in the past year, or had gone to a community meeting once in the past year.

   - What lessons have you learned from your community engagement experience? (150-word limit)
     Working collaboratively with other hospitals, community-based organizations, public health agencies, and area coalitions enhances the level and quality of BIDMC's community engagement efforts.

III. Regional Collaboration:

1. Is the hospital part of a larger community health improvement planning process?
   ☒ Yes ☐ No
   - If so, briefly describe it. If not, why?
     BIDMC is involved with the Boston CHNA-CHIP Collaborative, North Suffolk Integrated CHNA, and BILH-wide processes.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.
   - Collaboration:

Boston CHNA-CHIP collaborative: Nancy Kasen, then BIDMC's Director of Community Benefits, is a founding member and a current Co-Chair of the 19-member Steering Committee that was formed to oversee the Collaborative and provide strategic direction. Ms. Kasen and other BIDMC staff members also participated in both of the workgroups that were formed.
North Suffolk Integrated Community Health Needs Assessment: A BIDMC representative served on the Steering Committee for the North Suffolk iCHNA and another BIDMC representative served on one of the subcommittees.

- Institutions Involved:
  Boston CHNA-CHIP Collaborative: Beth Israel Deaconess Medical Center, Boston Children's Hospital, Boston Healthcare for the Homeless Program, Boston Medical Center, Boston Public Health Commission, Brigham and Women's Hospital, Brigham and Women's Faulkner Hospital, Community Labor United, Dana-Farber Cancer Institute, Fenway Health, Madison Park Development Corporation, Massachusetts Eye and Ear, Massachusetts General Hospital, Massachusetts League of Community Health Centers, Tufts Medical Center, Uphams Corner Health Center, Urban Edge.

  North Suffolk Integrated Community Health Needs Assessment: City of Chelsea, City of Revere, Town of Winthrop, BIDMC, Cambridge Health Alliance, Community Action Programs Inter-City, Chelsea Health and Human Services, Chelsea Board of Health, City of Revere SUDI Office, East Boston Neighborhood Health Center, Healthy Chelsea, Massachusetts General Hospital, MGH Revere, Melrose-Wakefield HealthCare, Mystic Valley Elder Services, North Suffolk Mental Health Association, The Neighborhood Developers, Revere Board of Health, Revere Cares, Revere Healthy Communities Initiative, Winthrop Board of Health, Winthrop Department of Public Health, Winthrop CASA.

- Brief description of goals of the collaboration:
  Boston CHNA-CHIP Collaborative Mission: To achieve sustainable positive change in the health of Boston by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities.
  North Suffolk Integrated Community Health Needs Assessment Mission: The communities of Revere, Chelsea, and Winthrop will use the upcoming iCHNA and CHIP to work towards a North Suffolk region where individuals from all backgrounds and circumstances will have every opportunity to live a healthy life; and where local governments, health care providers, social service and community-based organizations, and community residents work in continuous partnership to improve health outcomes for all people in the region. Key findings developed from the iCHNA and CHIP will be provided to iCHNA Collaborative Organizations to aid implementation of subsequent iCHNA and CHIP initiatives.

- Key communities engaged through collaboration:
  Revere, Winthrop, Chelsea, Boston. Specific focus on youth and adolescents, older adults, low resource individuals and families, LGBTQ, racially and ethnically diverse populations, including non-English speakers, residents who are housing insecure, survivors of violence, people affected by incarceration, and residents in active substance use recovery.

- If you did not participate in a collaboration, please explain why not: N/A

Section VIII: Appendix A

FY19 Partner	Level of Community Engagement
2Life Communities (formerly Jewish Community Housing for the Elderly (JCHE))	Collaborate
A Better City (ABC)	Consult
A Room to Grow	Involve
ABCD Parker Hill	Collaborate
Adcare	Collaborate
Aerobics and Fitness Association of America	Inform
Africa Bridge Network	Collaborate
AIDS Action Committee	Collaborate
AIDS Support Group of Cape Cod	Collaborate
Alzheimer's Association of MA (Waltham)	Consult
American Chinese Christian Education & Social Services, Inc.	Inform
American Red Cross	Inform
APG - Jamaica Plain	Consult
Asian American Civic Association	Inform
Atrius Health	Collaborate
BAMSI (Brockton Area Multi Service Inc.)	Collaborate
BIDHC-Chelsea	Community Driven / Led
BIDMC Healthcare Associates	Consult
Biomedical Science Careers Program	Collaborate
Boston Area Rape Crisis Center (BARCC)	Collaborate
Boston Career Link/ Mass Hire Career Center Boston	Collaborate
Boston Center for Independent Living	Community Driven / Led
Boston Children's Hospital	Collaborate
Boston Elder Services	Involve
Boston Emergency Medical Services	Collaborate
Boston Fire Department	Collaborate
Boston Health Care for the Homeless Program	Consult
Boston Healthcare Careers Consortium	Consult
Boston Living Center	Collaborate
Boston MedFlight	Community Driven / Led
Boston Medical Center	Collaborate
Boston Police Department	Collaborate
Boston Private Industry Council	Community Driven / Led
Boston Public Health Commission	Collaborate
Boston Public Schools	Collaborate
Boston Regional Domestic Violence Providers	Involve
Bowdoin Street Health Center	Community Driven / Led
Brigham & Women's Hospital	Collaborate
Brigham and Women's Faulkner Hospital	Collaborate
Brookline Community Mental Health Center	Collaborate
Brookline High School Work Connections for Youth	Collaborate
Brookline Senior Center	Collaborate
Buckle Up Boston	Collaborate
Bunker Hill Community College	Collaborate
Cambridge Health Alliance	Collaborate
Cancer Care	Inform
Career Collaborative	Collaborate
Carolina Prieto Dance	Collaborate
Casa Myrna	Involve
Catholic Charities	Inform
Charles River Health Center	Community Driven / Led
Children's Hospital Boston	Collaborate
City of Boston Office of Workforce Development	Collaborate
City of Boston's Green Ribbon Commission	Inform
City of Newton Mayor's Summer Jobs Program	Collaborate
CJP (Combined Jewish Philanthropies)	Collaborate
COBTH	Collaborate
COBTH Domestic Violence Advisory Council	Collaborate
College Bound Dorchester	Collaborate
Community Care Alliance	Collaborate
Community Research Initiative	Consult
Community Servings	Collaborate
Conexion	Community Driven / Led
Cradles to Crayons	Collaborate
Dana Farber Cancer Institute	Collaborate
The Dimock Center	Community Driven / Led
Diversity Affiliates	Collaborate
Dorchester Head Start	Collaborate
Dorchester North WIC	Collaborate
Dorchester NSC	Collaborate
DPPC, Sexual Assault Unit	Collaborate
Ellie Fund	Inform
Endo Collective	Consult
ESAC Taste of Jamaica Plain	Inform
Eversource	Consult
Fair Food (Boston)	Inform
Family Nurturing Center	Collaborate
Father Bill's	Collaborate
Fenway CDC	Collaborate
Fenway Health	Community Driven / Led
Found in Translation	Collaborate

FY19 Partner	Level of Community Engagement
Hyde Square Task Force	Involve
International Institute of New England	Collaborate
Jane Doe, Inc.	Collaborate
JCRC (Jewish Community Relations Council)	Collaborate
Jewish Community Center of Greater Boston (JCC)	Collaborate
Jewish Community Housing for the Elderly	Involve
Jewish Domestic Violence Coalition	Collaborate
Jewish Family and Children's Services	Consult
Jewish Vocational Services	Collaborate
Joe Andruzzi Cancer Fund	Involve
Joslin Clinic	Collaborate
La Alianza Hispana (Boston)	Consult
Leukemia & Lymphoma Society	Collaborate
Leventhal Jewish Community Center	Involve
Louis D. Brown Peace Institute	Community Driven / Led
Lungevity	Collaborate
Massachusetts Breast Cancer Coalition	Community Driven / Led
Massachusetts Communities Action Network	Collaborate
Massachusetts Department of Environmental Protection	Involve
Massachusetts Department of Public Health	Collaborate
Massachusetts Department of Transportation	Inform
Massachusetts Immigrant & Refugee Advocacy Coalition	Collaborate
Massachusetts Prostate Cancer Coalition	Collaborate
Mainspring	Inform
Mary Lyon Pilot High School	Collaborate
MASCO	Collaborate
Massachusetts College of Art and Design	Collaborate
Massachusetts Commission for the Blind	Collaborate
Massachusetts General Hospital	Collaborate
Massachusetts in Motion	Inform
Massachusetts Insurance Commission	Consult
Massachusetts Rehab Commission (State-wide)	Consult
Massachusetts Commission for the Deaf and Hard of Hearing	Collaborate
Massachusetts Department of Children and Families	Involve
Massachusetts Department of Transitional Assistance	Inform
Massachusetts Healthcare Collaborative	Community Driven / Led
Massachusetts Office for Victim Assistance	Community Driven / Led
Massachusetts Rehabilitation Commission	Collaborate
MassHire Workforce Investment Board	Community Driven / Led
Match Beyond/Duet	Collaborate
Mayor's Office of Emergency Management	Collaborate
Medical Intelligence Center	Collaborate
Mission Hill Neighborhood Housing Services	Community Driven / Led
Mount Auburn Hospital	Collaborate
My Life My Choice- A program of JRI	Community Driven / Led
National Alliance on Mental Illness (NAMI)	Collaborate
New Balance	Involve
New England AIDS Education and Training Center	Collaborate
Oldways Health Through Heritage	Collaborate
Operation A.B.L.E of Greater Boston Inc.	Collaborate
Outdoor Rx	Collaborate
Outer Cape Health Services	Community Driven / Led
PAATHS	Collaborate
Padre Pio Gottin Charities Inc.	Collaborate
Partnership, Inc.	Empower
Pine Street Inn	Involve
Practice GreenHealth	Inform
Provider Network Breakfast	Collaborate
Red Sox Foundation	Collaborate
Renewal House a Program of the Unitarian Universalist Urban Ministry	Involve
Roxbury Tenants of Harvard (RTH)	Collaborate
Ryan White Dental Program	Collaborate
Samaritans Inc.	Collaborate
Schwartz Center for Compassionate Healthcare	Collaborate
Sexual Assault Nurse Examiner Program (SANE)	Collaborate
Sidney Borum Jr. Health Center	Community Driven / Led
Silent Spring Institute	Collaborate
Sloane Family/Century Bank Primary & Specialty Care Clinic, Center Communities of Brookline	Collaborate
Sociedad Latina	Community Driven / Led
South Cove Community Health Center	Collaborate
Sportsmen's Tennis Club	Collaborate
St. Mary's Center for Women and Children	Collaborate
Suffolk County District Attorney's office (Victim Witness Advocates)	Inform
The Latino Medical Student Association	Inform
The Letters Foundation	Involve
The Network/La Red	Collaborate
The Student National Medical Association, National and NE Chapter	Inform
Tufts (MassHealth)	Collaborate
Tufts Medical Center	Collaborate
Tufts University	Collaborate
U.S. Environmental Protection Agency	Collaborate

FY19 Partner	Level of Community Engagement		FY19 Partner	Level of Community Engagement
Friendship Works	Collaborate		UMASS Extension Nutrition Education Program	Collaborate
GLAAD	Inform		United Cerebral Palsy (Watertown)	Involve
Greater Boston Chamber of Commerce	Involve		Urban Farming Institute	Collaborate
Greater Boston Food Bank	Collaborate		VFW	Involve
Greater Four Corners Action Coalition	Collaborate		Victim Rights Law Center	Collaborate
Grove Hall Dorchester Neighborhood Trauma Team	Collaborate		Victory Programs	Collaborate
Hack Diversity	Collaborate		Violence Intervention & Prevention Initiative	Collaborate
Harvard Business School	Collaborate		Volunteer Lawyer Project	Collaborate
Harvard Medical School	Consult		WalkBoston	Collaborate
Health Care for All	Collaborate		Ward's Berry Farm	Collaborate
Health Law Advocates	Involve		WIC	Collaborate
Healthcare Without Harm	Inform		WilmerHale Legal Services (also known has the Legal Service Center)	Collaborate
Horizon Learning Connection	Involve		YMCA Achievers Program	Community Driven / Led
Hospitality Homes	Consult		YMCA Training, Inc.	Collaborate