March 26, 2025
Meeting Packet

Meeting Agenda

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Community Benefits Advisory Committee (CBAC) Meeting
Beth Israel Deaconess Medical Center (BIDMC)
Wednesday, March 26, 2025
5:00 pm – 7:00 pm
Klarman Building, 3rd Floor Conference Room

I.	5 minutes	**Welcome and Introductions**
II.	20 minutes	**FY23-FY25 Implementation Strategy**
III.	50 minutes	**FY25 Community Health Needs Assessment and FY26-28 Implementation Strategy Updates**
IV.	35 minutes	**Community-based Health Initiative Updates**
V.	10 minutes	**Next Steps and Adjourn**

Next Meeting: June 18, 2025 (virtual)

Meeting Slides

Beth Israel Deaconess Medical Center Community Benefits Advisory Committee Meeting

Nancy Kasen, Vice President, Community Benefits & Community Relations (CBCR), BILH/BIDMC
Anna Spier, Manager, CBCR, BIDMC
Emmanuella René, Program Administrator, CBCR, BIDMC

March 26, 2025

Beth Israel Lahey Health
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Welcome

Beth Israel Lahey Health
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Content

- Welcome
- FY23-25 Implementation Strategy
- FY25 Community Health Needs Assessment and FY26-28 Implementation Strategy Updates
- Community-based Health Initiative Updates
- Next Steps

Thank You!

Shantel Gooden

Kelina Orlando

Anna Welland

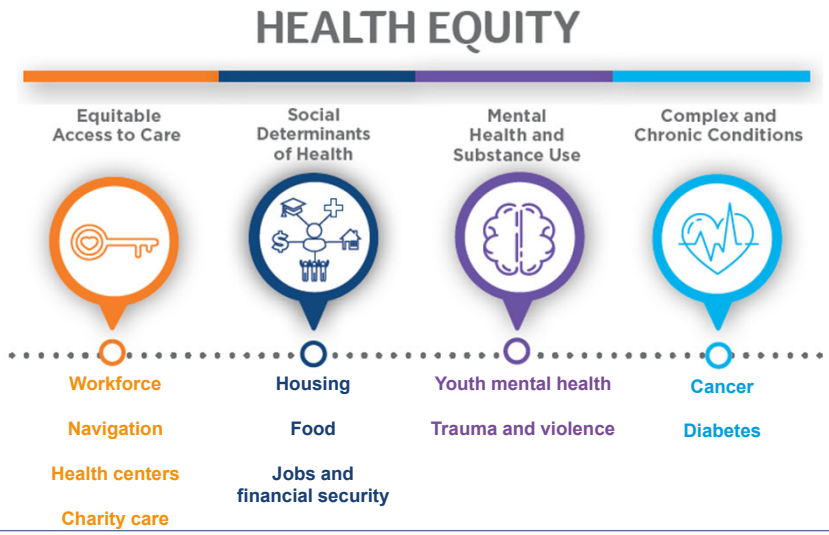
FY23-25 Implementation Strategy

Annual Regulatory Reports
Reporting Agencies

Mass Attorney General (AGO)	Internal Revenue Service (IRS)	Department of Public Health (DPH)	City of Boston
Annual Community Benefits Report	IRS 990 Tax form Schedule H Schedule I	Determination of Need (DoN) Community-based Health Initiative	Payment in Lieu of Taxes (PILOT) Report

Report on the FY23-25 Implementation Strategy

FY23-25 Implementation Strategy
BIDMC Community Health Priorities



Equitable Access To Care
FY24 Progress

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

Selected Strategies and Metric Status Updates:

Increase access to primary care and specialty care services, including OB/GYN and maternal child health services.	• 111,128 patients seen at affiliated FQHCs • 26 BIDMC specialists practiced at CCA health centers • Enrolled 9,044 patients in Health Safety Net
Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.	• Developed and implemented system-wide DEI training for bias and disability awareness for BILH staff • Provided 40,783 patients with access to interpreter services
Provide and support residents with transportation access.	• Provided 7,079 ride-sharing vouchers

Social Determinants of Health
FY24 Progress

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

Selected Strategies and Metric Status Updates:

Promote thriving neighborhoods and enhance community cohesion and resilience.	• Across four neighborhood collectives, an average of 78% of collective members reported that they have strengthened their relationships with other members
Increase mentorship, leadership, training, and employment opportunities for youth and young adults residing in the communities BIDMC serves.	• 26 students participated in the paid Youth Summer Jobs program • 35 youth participated in the youth leadership program at Bowdoin Street Health Center
Promote healthy eating and active living by increasing opportunities for physical activity and providing healthy food resources to patients and community residents.	• 958 bags of free groceries through Fair Foods were distributed and 573 grocery store vouchers were distributed to patients at Bowdoin Street Health Center, and 314 meals were donated to Food for Free by Sodexo

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Mental Health and Substance Use
FY24 Progress

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

Selected Strategies and Metric Status Updates:

Raise awareness about mental health and substance use issues, promote screening and assessment and encourage those in need to access services.	• 96% of MHFA training participants across all BILH hospitals completing the 3-month follow-up survey reported they felt confident they could recognize that someone may be dealing with a mental health problem or crisis and 95% reported feeling confident they could offer a person in distress with basic information and reassurance
Provide access to high-quality and culturally and linguistically appropriate mental health and/or substance use services through screening, monitoring, counseling, navigation, and treatment services.	• 96 referrals made to behavioral health CHW at Bowdoin Street Health Center • 7 primary care practices used the Collaborative Care/Integrative Care model

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Complex and Chronic Conditions
FY24 Progress

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

Selected Strategies and Metric Status Updates:

Provide preventative health information, services, and support for those at-risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.

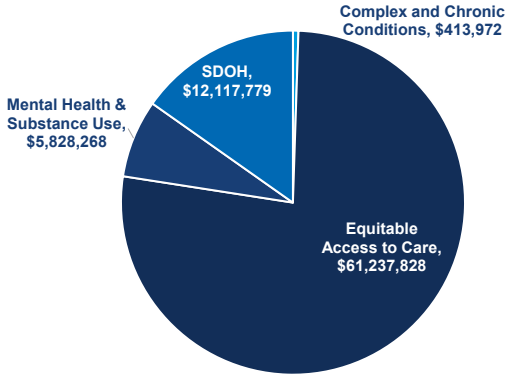
- 8 different patient support groups met regularly
- 1,364 patients received early detection lung cancer screening
- 75% of affiliated health center patients had diabetes controlled (HbA1c < 9)

FY24 Regulatory Report Highlights
BIDMC Draft Community Benefits Expenditures

FY24 Program Expenditures

- Social Determinants of Health
  - Provided funding to housing and jobs and financial security grantees
- Complex and Chronic Conditions
  - Cancer support groups and cancer patient navigators
  - Chronic disease management programs
- Equitable Access to Care
  - Support for affiliated and/or licensed community health centers
- Mental Health and Substance Use
  - Offered Mental Health First Aid trainings to the community

Pending final review by the Office of the Attorney General



Note: Access to Care includes Free and Discounted Care (aka Charity Care)

Total FY24 CB Expenditures: $79,597,847

FY25 Programs
Looking Ahead

Equitable Access to Care
- Support for CCA affiliated and/or licensed community health centers
- Digital literacy for health equity at Bowdoin Street Health Center

Social Determinants of Health
- Housing and jobs/financial security grantees continue to implement their programs
- Freight Farm™ installed at GreenRoots Teaching Kitchen

Mental Health and Substance Use
- New multidisciplinary hospital-based Addiction Consultation Service with recovery coaches
- Expansion of Mental Health First Aid trainings

Complex and Chronic Conditions
- BILH diabetes and hypertension disparities initiatives
- Ongoing partnerships with community health centers to improve chronic disease management

FY25 Community Health Needs Assessment and FY26-28 Implementation Strategy Updates

Community Benefits and Community Relations
Guiding Principles

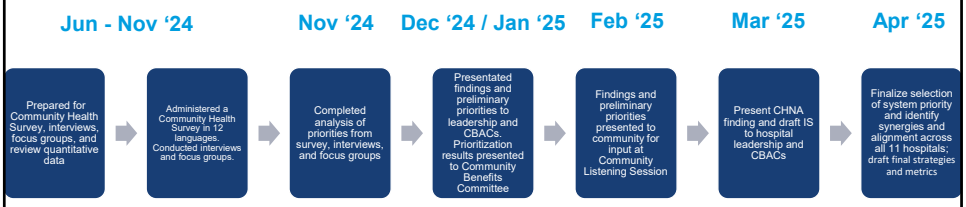
Accountability: Hold each other to efficient, effective and accurate processes to achieve our system, department and communities' collective goals.

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

Equity: Apply an equity lens to achieve fair and just treatment so that ***all*** communities and people can achieve their full health and overall potential.

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

FY25 CHNA and FY26-28 Implementation Strategy
Community Engagement and Prioritization



Contributors:
- Residents
- Community partners
- CBACs

Contributors:
- N/A

Contributors:
- Hospital /clinical leadership
- CBACs
- Community Benefits Committee

Contributors:
- Residents
- Community partners

Contributors:
- Community Benefits Staff
- Hospital leadership
- CBACs

Contributors:
- Community Benefits Committee
- Community Benefits Staff

Community engagement highlights: Active participant in Boston Community Health Collaborative and North Suffolk iCHNA; In-person survey distribution at community health centers, almost 2,300 surveys collected.

FY25 CHNA and FY26-28 Implementation Strategy
Balancing Requirements

BIDMC's Implementation Strategy balances community need/priority, available resources, regulatory requirements and system strategic priorities

MA Attorney General's health priorities:
- Maternal Health Equity
- Chronic Disease (cancer, heart disease, diabetes),
- Housing Stability / Homelessness,
- Mental Illness and Mental Health
- Substance Use Disorders

MA Dept of Public Health priorities:
- Built and Social Environments
- Housing
- Violence and Trauma
- Education and Employment

Federal 501r requirements:
- Serving the medically underserved
- Subsidized Services
- Consider the needs of the medically underserved
- Assess and address emerging needs

Beth Israel Lahey Health priorities
- Health Equity: Diabetes, Hypertension, Maternal Transfusion
- Board of Trustees Community Benefits Committee: Behavioral Health, Housing (DoN) and Food Security (Freight Farm™)

Community Benefits Advisory Committee (top 4 SDoH priorities)
- Affordable housing
- Childcare
- Transportation
- Economic insecurity

Community Listening Session (to 4 SDOH priorities)
- Affordable housing
- Economic insecurity
- Childcare
- Food insecurity

Beth Israel Lahey Health is committed to keeping our Implementation Strategies broad to allow for flexibility in responding to emerging community needs; showing up in and for the community; and leveraging resources and collaborating when needs exceed resources

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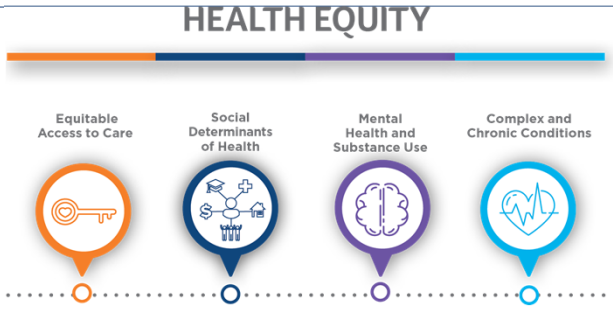
FY25 CHNA and FY26-28 Implementation Strategy
Preliminary FY26-28 Health Priorities and Cohorts



FY26-28 Priority Cohorts

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FY25 CHNA and FY26-28 Implementation Strategy
CBAC & Community Listening Session (CLS) Priorities

Social Determinants of Health
- CBAC and CLS both prioritized housing, economic insecurity, and access to affordable/healthy food

Mental Health and Substance Use
- CBAC and CLS both prioritized depression/anxiety/stress, youth mental health, and behavioral health navigation

Equitable Access to Care
- CBAC and CLS both prioritized the same four issues, with insurance and cost as the top priority

Complex and Chronic Conditions
- The CBAC prioritized care management and navigation, while CLS participants' top priority was chronic disease education/prevention

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FY25 CHNA and FY26-28 Implementation Strategy
Goals

Priority Area	Goals
Social Determinants of Health	Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.
Equitable Access to Care	Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.
Mental Health and Substance Use	Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use issues and conditions.
Complex and Chronic Conditions	Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

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FY25 CHNA and FY26-28 Implementation Strategy
Equitable Access to Care Preliminary Strategies

Strategies

- Promote access to health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured
- Increase access to primary care services for those who are uninsured, underinsured, or economically insecure, with an emphasis on those who face cultural and linguistic barriers
- Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations
- Advocate for and support policies and systems that improve access to care

Do these strategies resonate?

FY25 CHNA and FY26-28 Implementation Strategy
Social Determinants of Health

Strategies

- Support evidence-based programs that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food
- Support evidence-based programs and strategies to reduce homelessness and displacement, and increase home ownership among low-income individuals and families
- Support evidence-based programs that increase employment, earnings and financial security

Do these strategies resonate?

FY25 CHNA and FY26-28 Implementation Strategy
Social Determinants of Health

Strategies

- Support evidence-based programs that foster social connections, strengthen community cohesion and resilience and address causes and impacts of violence
- Conserve natural resources, reduce carbon emissions, and foster a culture of sustainability to create a healthy environment for residents
- Advocate for and support policies and systems that address social determinants of health

Do these strategies resonate?

FY25 CHNA and FY26-28 Implementation Strategy
Mental Health and Substance Use

Strategies

- Support mental health and substance use education, awareness, and stigma reduction initiatives
- Support programs that increase access and enhance engagement in high-quality, culturally and linguistically appropriate behavioral health services
- Advocate for and support policies and programs that address mental health and substance use

Do these strategies resonate?

FY25 CHNA and FY26-28 Implementation Strategy
Complex and Chronic Conditions

Strategies

- Support education, prevention, and evidence-based chronic disease treatment and self-management programs for individuals at risk for or living with complex and chronic conditions
- Support programs and partnerships that advance maternal health equity by expanding access to culturally responsive care, addressing social determinants of health, and reducing disparities in maternal and infant outcomes
- Advocate for and support policies and systems that support those with complex and chronic conditions

Do these strategies resonate?

Community-based Health Initiative Updates

Community-based Health Initiative
Housing Investment Opportunity

- The Massachusetts Department of Public Health has authorized BIDMC to invest the unspent evaluation budget (approx. $400,000) into the community
- At the December meeting, the CBAC agreed to move ahead with selecting Community Development Corporation(s) with available Community Investment Tax Credits to fund housing project(s):
  - Approved by the City's Planning/Zoning Board…
  - Located within BIDMC's Community Benefits Service Area communities…
  - Giving preference to deeply affordably housing with units set aside for older adults and/or individuals living with disabilities.

Community-based Health Initiative
Housing Investment Selection: Proposed Process

1) **March 27 - April 24**: BIDMC will invite entities that meet the below criteria to complete a questionnaire(s):
   - Participates in the Community Investment Tax Credit (CITC) program and has credits available
   - Has housing project(s) currently in development that are approved by Planning/Zoning Board and are located in BIDMC's Community Benefits Service Area communities
2) **April 25 - May 14**: Completed questionnaires will be sent to voting CBAC members (who do not have an identified conflict) to review and score.
3) **May 19**: Top 4 highest scoring applicants will be invited to provide a 10-minute presentation and 5 minutes of Q&A at the June CBAC meeting.
4) **June 18**: Applicants attend and present at the CBAC meeting with final vote held at the meeting. Only voting members without identified conflicts are eligible to vote.

Community-based Health Initiative
Housing Investment Selection Criteria and Weighting

1. Available CY 2025 CITC credits
2. Quantity of affordable units
   - Should this be defined as a proportion or a total #?
3. Affordability of units
   - How should “deeply affordable” be defined? At or below 60% AMI?
4. Housing units for older adults and/or those who are living with disabilities
5. Housing units for families (i.e. more than 1-bedroom)

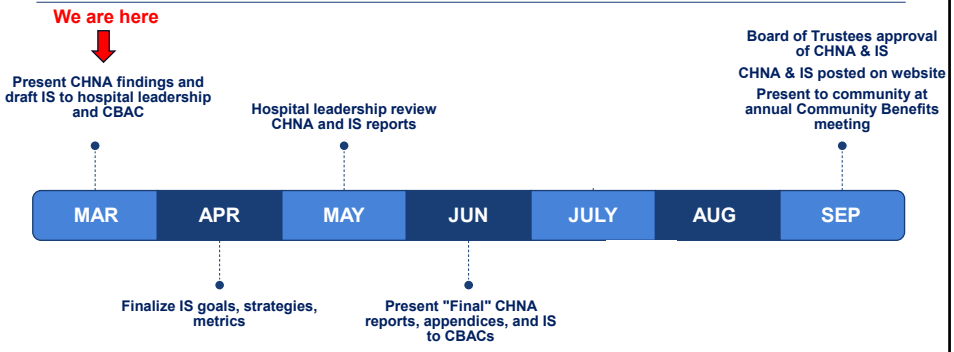
For discussion: Other considerations/potential criteria and weighting

- Preference for projects that also have homeownership opportunities?
- Preference for projects that have a community space and/or retail space?
- Other criteria?
- Rank the criteria in order of importance to determine the weighting to use for scoring

Decisions: Final Criteria and Final Weighting

Next Steps

FY25 CHNA and FY26-28 Implementation Strategy
Timeline



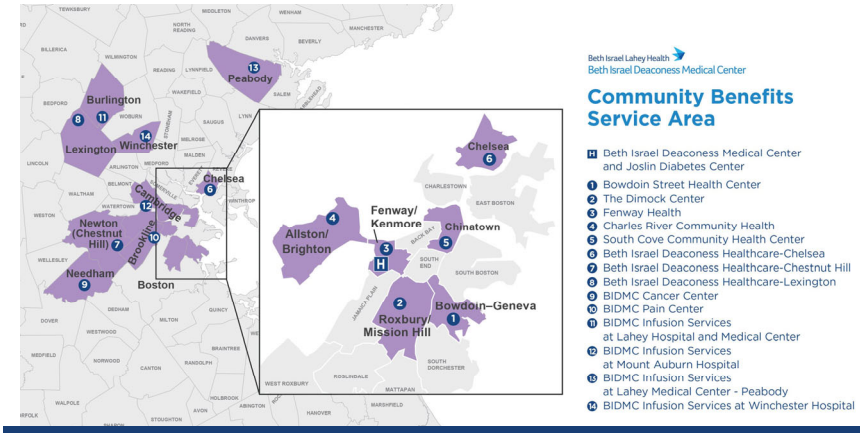
Next steps

Future meetings:

- June 18, 2025 (virtual)
- September 17, 2025 (Annual Meeting, in-person)

Appendix

FY25 CHNA and FY26-28 Implementation Strategy
Community Benefits Service Area



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Community Benefits Service Area

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

Community investments must be in BIDMC's CBSA, address a health priority in the Implementation Strategy, and be focused on more or more of the hospital's priority populations to be considered a Community Benefit that is reportable to the Internal Revenue Service, or Office of the Attorney General.

FY25 CHNA and FY26-28 Implementation Strategy
Community Engagement

2,296 Community Health Survey Respondents

15 Interviews with local leaders and community-based organizations

5 Focus groups with historically underserved populations

1 Prioritization meeting with BIDMC Community Benefits Advisory Committee

40+ Community Listening Session Participants

Collaborations and Outreach:

- ✓ Active participant of the North Suffolk Integrated Community Health Needs Assessment
- ✓ Founding member and current collaborator of the Boston Community Health Collaborative
- ✓ Partnered with community champions
- ✓ Utilized in-person survey distribution and focus groups when possible
- ✓ Direct outreach to community residents through community-based organizations

FY25 CHNA and FY26-28 Implementation Strategy
December CBAC Prioritization

SDOH

1. Affordable housing
2. Economic insecurity/high cost of living
3. Access to fresh/healthy foods
4. Transportation

Notes: Community Listening Session participants voted community safety as the 4th highest priority (transportation was ranked 7th)

Equitable Access to Care

1. Cost/insurance barriers
2. Language and cultural barriers to care
3. Navigating complex health sys.
4. Long wait times

Notes: Community Listening Session participants prioritized the same top four issues although navigating the health care system was ranked at 2 instead of 3.

FY25 CHNA and FY26-28 Implementation Strategy
December CBAC Prioritization

Mental Health and Substance Use

1. Youth mental health
2. Depression, anxiety, stress
3. Language/cultural barriers to care
4. Navigating the behavioral health system

Notes: Community Listening Session participants voted on depression, anxiety and stress as the top priority and youth mental health at #2. Navigating the behavioral health system was ranked at #3 followed by trauma among immigrants and refugees.

Complex and Chronic Conditions

1. Care navigation
2. Chronic disease education/ prevention/screening
3. Conditions associated with aging

Notes: Community Listening session participants voted on chronic disease education prevention as the highest priority followed by care navigation.

Community-based Health Initiative
Grantee Updates

- **Chelsea Jobs and Financial Security Grant (La Colaborativa)**
  - Youth employment program has completed their three-year grant period
  - **67 participants** were supported (Median age was 16, all were Chelsea residents, 100% were at or below 80% AMI and 87% were Latino(a))
  - Youth participated in **137 internships** (Arts and STEAM most popular)
  - Participants gained substantial internship and training experience, improved or maintained their professional skills, and improved financial behaviors related to budgeting.
- **Boston Cohort 2 Grantees**
  - In year 2 of implementing their 3-year grants
  - Three quarters of data have been shared with external evaluator
  - Evaluation webinar is in the planning stages for early summer
- **Healthy Neighborhoods Initiative**
  - Chinatown HOPE and Chelsea Healthy Neighborhoods Initiative – final evaluations completed and shared
  - Cohort 3 Collectives continue implementation of their neighborhood-specific programs

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