

September 19, 2023  
Meeting Packet

# Meeting Agenda



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

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

**Next Meeting: December 12, 2023**

# Meeting Slides

# Beth Israel Deaconess Medical Center Community Benefits Annual Meeting

Nancy Kasen, Vice President, Community Benefits and Community Relations, BILH

Robert Torres, Director Boston Region, Community Benefits, BILH

Anna Spier, Program Manager, Community Benefits, BIDMC

September 19, 2023

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## Content

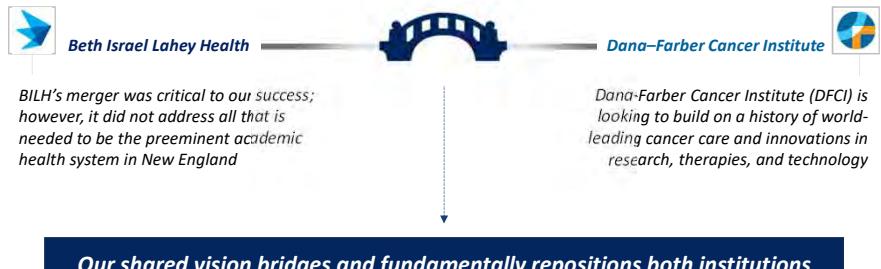
- Welcome and Introductions
- Community Benefits Program Highlights
- BILH System Priority: Behavioral Health Access
- Community-based Health Initiative Overarching Evaluation Update
- Overview of the Community Care Alliance
- Next Steps and Adjourn

## Housekeeping

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

## Welcome and Introductions

**A Shared Vision to Reshape Our Futures**



**Beth Israel Lahey Health**

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

**Dana-Farber Cancer Institute**

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

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

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**Our Shared Vision**

*To Redefine Cancer Care, Discovery, & Education*



**Beth Israel Lahey Health**

**Dana-Farber Cancer Institute**

**A bridge to transform the future of cancer care**

**A comprehensive collaboration**

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

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

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## Our Shared Vision

### *Patient-Focused Benefits Advance the Future of Cancer Care*

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

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

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## Collaboration Agreement Overview

### *Executive Summary*

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

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

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

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

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

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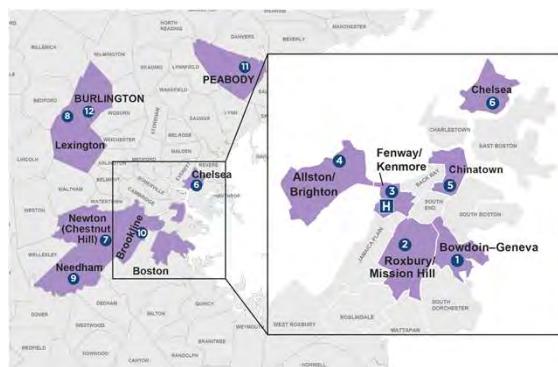
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# Community Benefits Program Highlights

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## BIDMC Community Benefits Service Area



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### Community Benefits Service Area

- 1 Beth Israel Deaconess Medical Center
- 2 Bowdoin Street Health Center
- 3 The Dimock Center
- 4 Fenway Health
- 5 Charles River Community Health
- 6 South Cove Community Health Center
- 7 Beth Israel Deaconess Healthcare-Chelsea
- 8 Beth Israel Deaconess Healthcare-Chestnut Hill
- 9 Beth Israel Deaconess Healthcare-Lexington
- 10 BIDMC Cancer Center
- 11 BIDMC Pain Center
- 12 BIDMC Infusion Services, Peabody
- 13 BIDMC Infusion Services, Burlington

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## Community Health Needs Assessment and Implementation Strategy

### BIDMC Priority Populations



Low-resourced populations



Racially, ethnically, and linguistically diverse populations



Youth



LGBTQIA+



Older adults



Families affected by violence and/or incarceration

## Community Benefits and Community Relations Guiding Principles



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



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



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



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

**Community Health Needs Assessment and Implementation Strategy**  
**BIDMC Final Priorities**

## HEALTH EQUITY

Equitable Access to Care      Social Determinants of Health      Mental Health and Substance Use      Complex and Chronic Conditions

Workforce      Housing      Youth mental health      Cancer

Food      Trauma and violence      Diabetes

Jobs and financial security

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**Community Health Needs Assessment and Implementation Strategy**  
**BIDMC FY22 Program Impact**

### Equitable Access to Care

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

### Social Determinants of Health

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

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## Community Health Needs Assessment and Implementation Strategy

### BIDMC FY22 Program Impact



#### Mental Health and Substance Use

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



#### Complex and Chronic Conditions

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

## BILH Food and Housing Investments Goal

### Food & Nutrition

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

### Housing

Increase housing stability for those at risk for eviction or homelessness

Identified common goal and priorities for all hospitals to implement



Collected consistent data across the system

2020

2021

2022

Began building infrastructure to tell the story of our impact

## BILH Food and Housing Investments FY22 Food and Nutrition

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

**154,210** (3,600)  
pounds of free, nutritious food  
food distributed to

**7,878** (300)  
community residents

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



**25,450**  
nutritious meals  
distributed to people  
who were homebound

**3,319**  
community residents  
participated in  
nutrition education

**5**  
Food Justice &  
Hunger Networks to  
support collaboration

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## BILH Food and Housing Investments FY22 Housing

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

**182** (30)  
people housed or had  
positive housing  
outcome



**12** (6)  
Housing Coalitions or  
Tenant Associations

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

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

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## BILH Community Capacity Building Evaluation Workshops and Engagement

### Evaluation

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



### BILH Community Engagement

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

### BIDMC Community Engagement

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



## BILH System Priority: Behavioral Health Access

**BILH Behavioral Health Priority**  
**Communication, Education, & Partnership**

1  
Community-Based Communication Strategy

2  
Focused Awareness Campaign with Community Partners

3  
Development of Strategic Partnerships to Promote Screening, Assessment, and Engagement in Care

Engagement with Behavioral Health Patients and Families

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# Community-based Health Initiative Interim Overarching Evaluation Update

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## Boston CHI Grantees

### Evaluation Overview

#### Evaluation Questions:

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

#### ▪ Today's update:

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

## Boston Cohort Grantees

### Program Implementation During First 18 Months (July'21-Dec.'22)

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

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

#### Priority Neighborhood



77.4%  
associated with a BIDMC priority neighborhood

#### Low Resourced Individuals



74.0%  
considered low resourced

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

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

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

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

### Engaged 443 Individuals

 to receive behavioral health services and enrolled in evaluation

### Delivered 1,004 Sessions

 of behavioral health counseling

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

#### Personal or Emotional Challenges



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

#### Mental Health Symptoms



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

#### Help Seeking Behavior



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

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

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

 to receive housing services and enrolled in evaluation

### Engaged 380 Individuals



Delivered 341 Services of housing support



Conducted 1,613 Policy Activities on local and state policies

The **evaluation** included measuring **housing situation, agency and affordability** at a baseline time point, when participants begin receiving services, and at an endpoint time point, upon completion of services.

**Baseline** data from 380 participants in housing programs describe areas of need.

#### Housing Satisfaction



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

#### Control of Housing



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

#### Housing Affordability



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

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

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



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



**Delivered 17,504**  
hours of workshops/courses

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



### Hope

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



### Financial Capability

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



### Saving Money

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

## Boston Grantees (Cohort 1) Evaluation Next Steps and Discussion

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

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# Overview of the Community Care Alliance

## Licensed/Affiliated Community Health Centers

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### Community Care Alliance Overview

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

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

1. Bowdoin Street Health Center  
2. The Dimock Center  
3. Fenway Health  
4. Charles River Community Health  
5. South Cove Community Health Center

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

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## Community Care Alliance Licensed/Affiliated Community Health Centers

### Bowdoin Street Health Center

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

### Charles River Community Health )

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

### Fenway Health

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

### The Dimock Center

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

### South Cove Community Health Center

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

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## Community Care Alliance Operational & Clinical Activities

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

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



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## Questions/Comments

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

## Next Steps

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

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

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

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



What makes a community healthy & strong?  
**Your voice.**

When you take the MA Community Health Equity Survey, you're sharing valuable experience that can help build a healthier community. The survey is available in 11 languages, easy to take, and anonymous.

Take the survey now at [Mass.gov/Healthsurvey](https://Mass.gov/Healthsurvey)



[Start the Survey](#)

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

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

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

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

Visit [mahealthfunds.org](https://mahealthfunds.org) for more information.



MAHealthFunds.org

ABOUT THE FUNDS • WHAT WE FUND • APPLY • RESOURCES • BLOG •

Massachusetts Community Health & Healthy Aging Funds

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

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## Next Steps

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### Future CBAC meetings:

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

**Thank you!**

## Appendix

## Boston Cohort 1 Grantees

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

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

## Boston Grantees (Cohort 1) Overarching Evaluation Purpose and Methods

### To Learn:

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

### Methods:

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

## Boston Grantees (Cohort 1) Overarching Evaluation Timeline

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

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## Community Care Alliance History

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

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

BI program is “family doctor” for 6000 Roxbury children

more than 400 hours a week on cell 14 hours a

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Advisory Committee Members	2023			
	March 28	June 27	September 19	December 12
Flor Amaya	Ph	A	Ph	
Elizabeth Browne	A	Ph	Ph	
Alexandra Chery Dorrelus	A	A	Ph	
Shondell Davis	Ph	Ph	Ph	
Pamela Everhart	Ph	Ph	Ph	
Richard Giordano	Ph	Ph	Ph	
Shantel Gooden	Ph	Ph	Ph	
Barry Keppard	Ph	Ph	A	
Amy Nishman	Ph	A	Ph	
Angie Liou	Ph	A	Ph	
Sandy Novack	Ph	Ph	A	
Alex Oliver-Davila	A	Ph	A	
Triniese Polk	Ph	Ph	Ph	
Jane Powers	Ph	Ph	Ph	
Richard Rouse	Ph	Ph	Ph	
Samantha Taylor	Ph	Ph	Ph	
Fred Wang	Ph	Ph	Ph	
<b>BIDMC Staff - Ex Officio</b>				
Lynne Courtney	Ph	Ph	Ph	
Jane Foley	Ph	A	A	
Lauren Gabovitch	Ph	Ph	Ph	
Nancy Kasen	Ph	Ph	Ph	
Kelina (Kelly) Orlando	Ph	Ph	Ph	
Robert Torres	Ph	Ph	Ph	
LaShonda Walker-Robinson	Ph	Ph	A	

Key	
X	Participated in person
A	Absent
Ph	Participated by Phone or Video