

September 17, 2025
Meeting Packet

September 17, 2025
Meeting Agenda



**Community Benefits Annual Meeting
Beth Israel Deaconess Medical Center (BIDMC)
Wednesday, September 17, 2025
5:00 pm – 7:00 pm**

Location: Klarman Building, 111 Francis St. Boston, 11th Floor Conference Room

I. 5 minutes	Welcome
II. 15 minutes	BIDMC / Dana-Farber Cancer Institute Collaboration Update
III. 20 minutes	Community Benefits Program Highlights Including FY25 Community Health Needs Assessment and FY26-28 Implementation Strategy
IV. 65 minutes	Community Investments: <ul style="list-style-type: none">• Housing Affordability Grantee Panel• Lessons from the Healthy Neighborhoods Initiative
V. 15 minutes	Next Steps and Informal Networking

Meeting Slides

Beth Israel Deaconess Medical Center Community Benefits Annual Public Meeting

Nancy Kasen, Vice President, Community Benefits & Community Relations (CBCR)
BILH/BIDMC

Anna Spier, Manager, CBCR, BIDMC

Emmanuella René, Program Administrator, CBCR, BIDMC

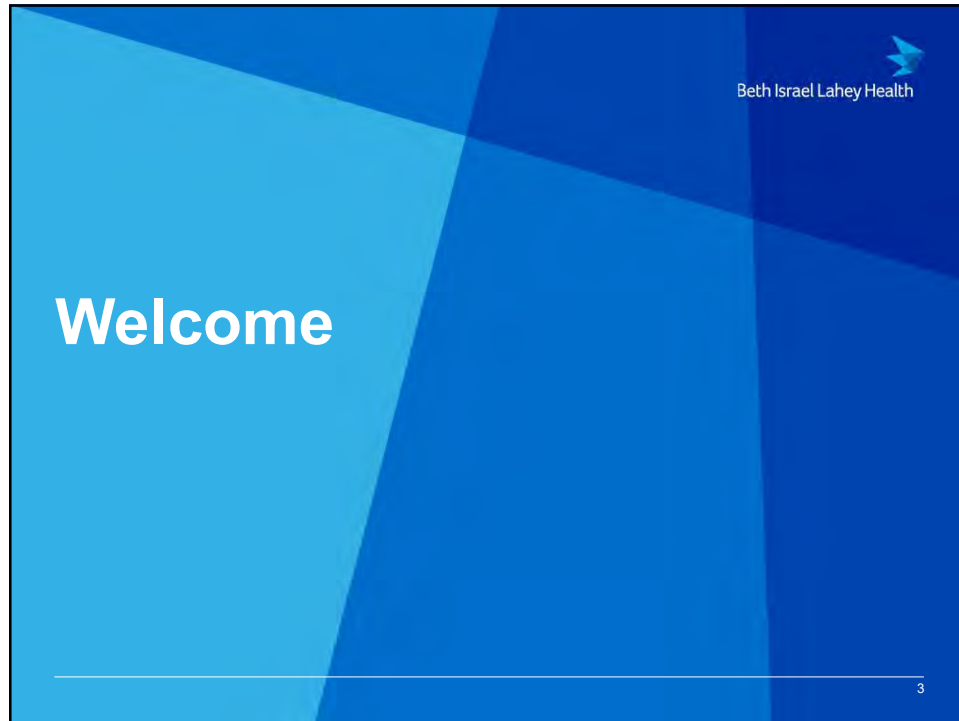
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Content



- Welcome
- Dana-Farber Cancer Institute Collaboration Update
- Community Benefits Program Highlights and FY25 CHNA and FY26-28 Implementation Strategy
- Community Investments
 - Housing Affordability Grantee Panel
 - Lessons Learned from the Healthy Neighborhoods Initiative
- Next Steps and Informal Networking



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.

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PROJECT UPDATE

Incorporated into the approved 10-year Institutional Master Plans for BIDMC and DFCI, the 300-bed **Future Cancer Hospital** also includes imaging, observation beds and a cafeteria. The project has committed to off-site mitigation in the public realm – including a full redevelopment of **Joslin Park**.



HOSPITAL CONNECTORS A Patient Care Network

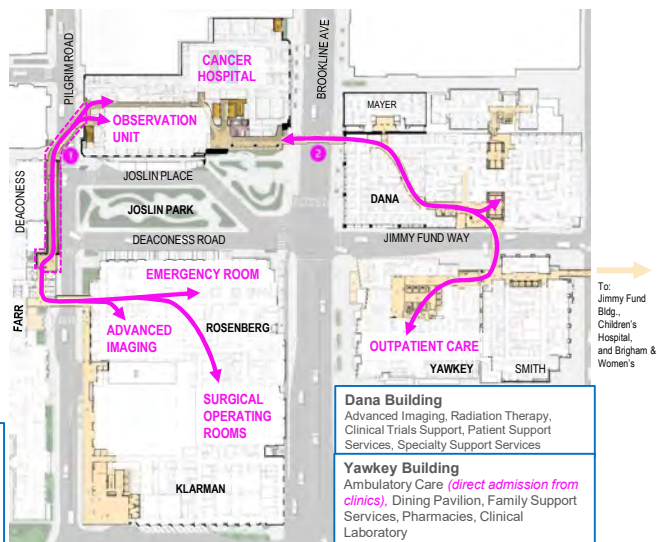
For **patient safety**, a third-floor network of hospital connectors links essential clinical services.

The **Pilgrim Connector 1** will provide a "one-elevator" transport route from the BIDMC Emergency Department, operating rooms, and other critical specialties.

The **Brookline Connector 2** will furnish an intuitive, low-stress pathway for transfers from DFCI ambulatory care clinics.

BIDMC West Campus Emergency Department, Operating Rooms

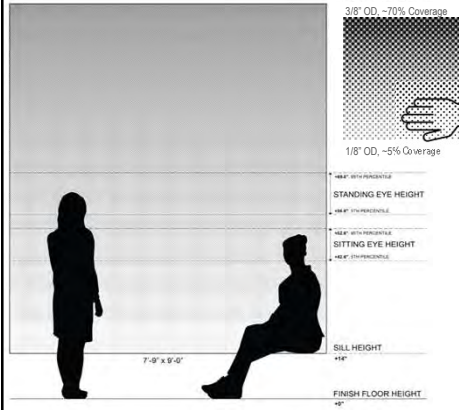
Specialty Procedures, Advanced Imaging, Surgical Specialties, Medical Consultations, (Cardiac, Renal, Neuro, etc.), Pathology Laboratory, Medical Utilities



Dana Building
Advanced Imaging, Radiation Therapy, Clinical Trials Support, Patient Support Services, Specialty Support Services

Yawkey Building
Ambulatory Care (*direct admission from clinics*), Dining Pavilion, Family Support Services, Pharmacies, Clinical Laboratory

VEIL-LIKE CURTAIN | PROPOSED FRIT DESIGN



Patient Window Frit Pattern



PROJECT VIEW:
BROOKLINE AVE





EXTERIOR VIEW FROM THE CORNER OF BROOKLINE AND DEACONESS



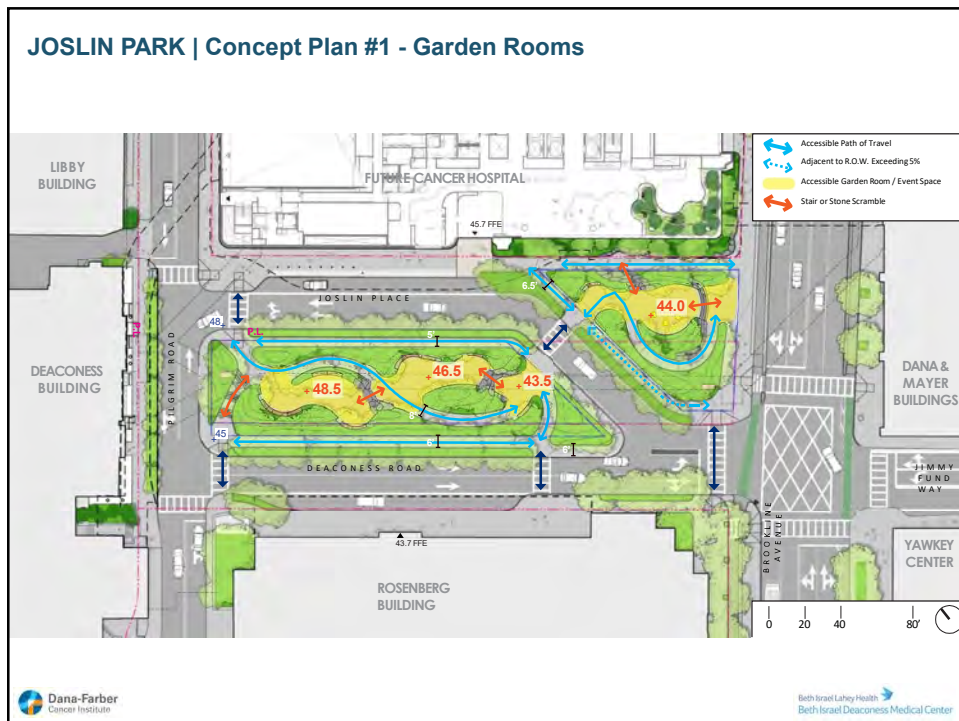
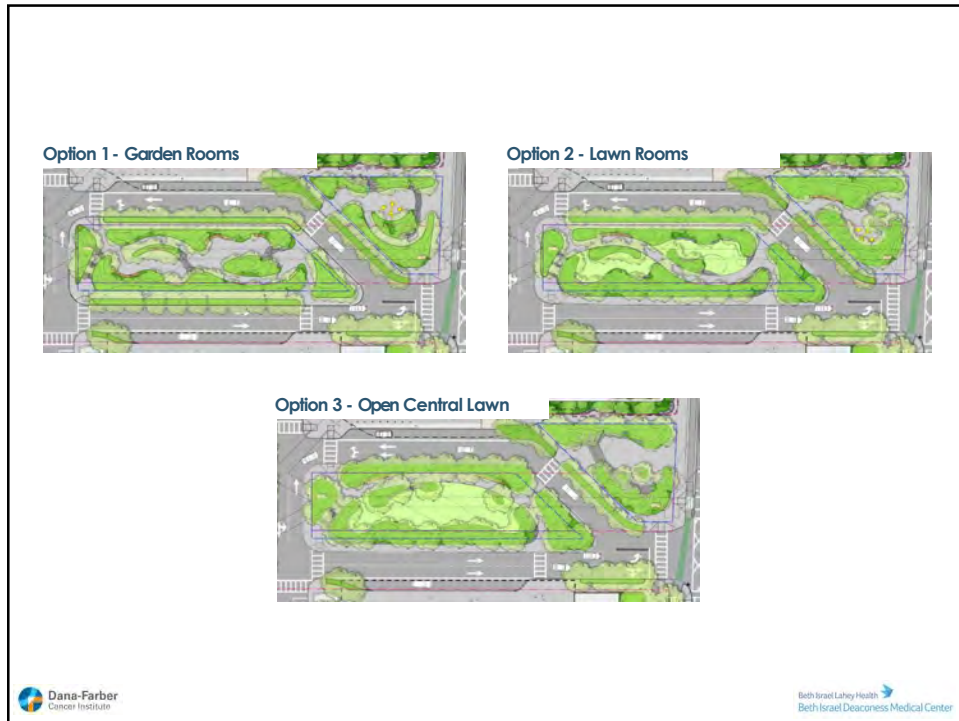
JOSLIN PARK | BEFORE AND AFTER

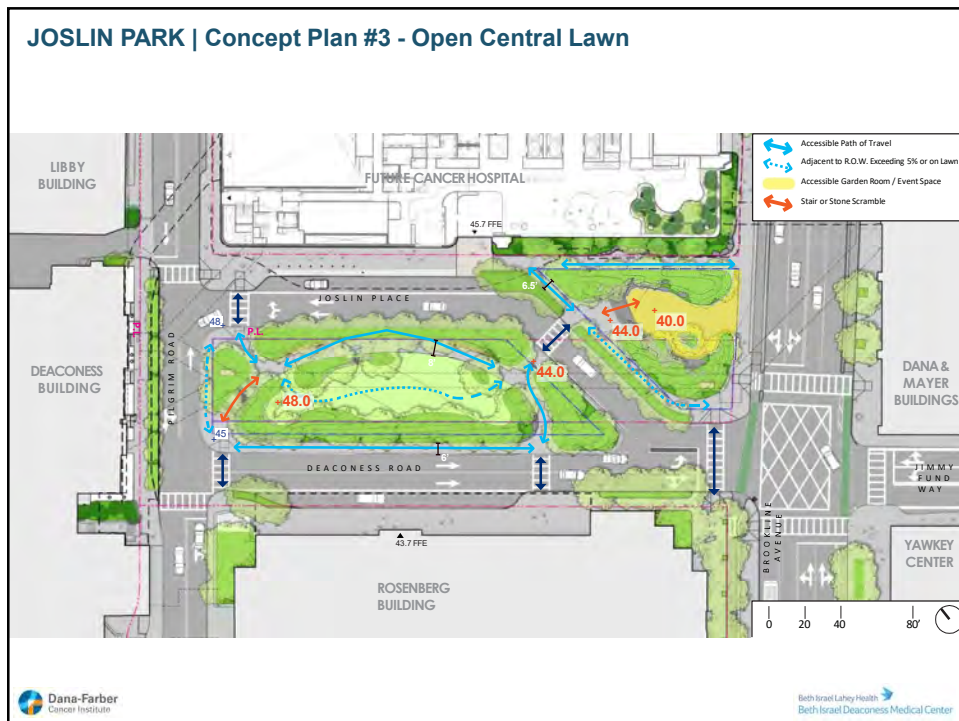
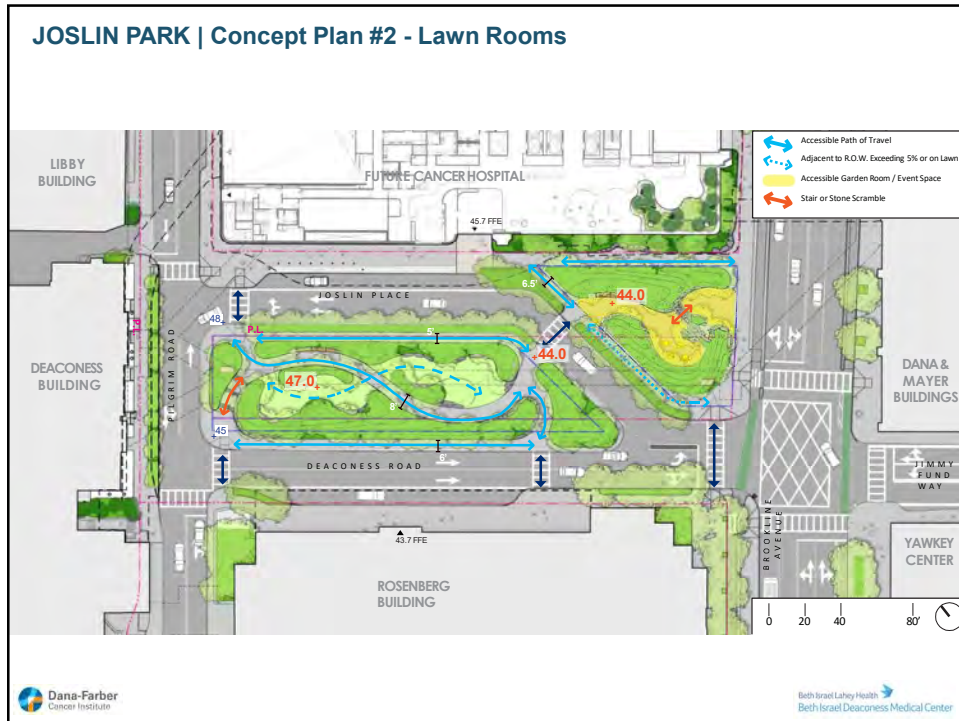


Aerial view: Current conditions at Joslin Park



Aerial view: Proposed New Park







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Community Benefits Program Highlights

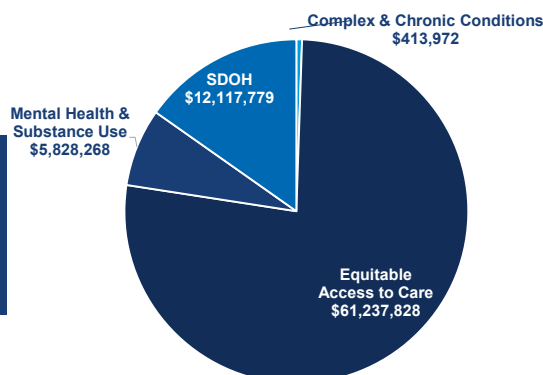
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This slide features a blue geometric background. The Beth Israel Lahey Health logo is in the top right corner. The main title "Community Benefits Program Highlights" is centered in large white font. A thin white horizontal line is positioned above the page number "20" in the bottom right corner.

FY24 Regulatory Report Highlights BIDMC Community Benefits Expenditures



77% Equitable Access to Care
7% Mental Health & Substance Use
1% Complex & Chronic Conditions
15% Social Determinants of Health



Note: Equitable Access to Care includes payments to the Health Safety Net, as well as Free and Discounted Care (aka Charity Care); Total FY24 CB Expenditures includes approx. \$4.5M for Community-based Health Initiative (DoN)

Total FY24 CB Expenditures:
\$79,597,847

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BIDMC FY23-25 Implementation Strategy Equitable Access to Care



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.

Key Impacts/Accomplishments:

- Approx. **120,000 patients** seen annually at affiliated community health centers
 - **Over 25 BIDMC specialists** on-site each year
- Established Medical-Legal Partnership for Immigrants
- **12,000+** transportation vouchers distributed to patients
- Partnered with Dr. John Torous (*BIDMC Digital Psychiatry*) to offer a health equity digital literacy program at Bowdoin Street Health Center
 - Over **500 patients/community residents** served in FY24-25 with **over 200** receiving free digital tablets/phones



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BIDMC FY23-25 Implementation Strategy Social Determinants of Health

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Goal: Promote healthy neighborhoods by enhancing the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

Key Impacts/Accomplishments:

Food Security/Hydroponic Freight Farm installed in Chelsea



Housing Security

377 youth contacted

24 youth gained housing



39 youth gained employment



58 youth partook in 3+ counseling sessions



Jobs Teaching Kitchen Training Program



- 100% of trainees received an earned training wage of up to \$5,300 while participating in the program
- 65 secured food service jobs at average hourly wage of \$18.71 and almost half receiving employer-paid benefits
- Partnered with 8 pipeline employers



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BIDMC FY23-25 Implementation Strategy Complex and Chronic Conditions

Beth Israel Lahey Health



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.

Key Impacts/Accomplishments:

- **Cancer:** Successfully advocated for passage of **An Act Relative to Medically Necessary Breast Screenings and Exams for Equity and Early Detection** – takes effect in 2026 and ensures patients will have access to breast cancer screenings and exams with **no or limited out-of-pocket costs**
- **Diabetes:** Average of **75%** of affiliated community health center patients had diabetes controlled

"I already had two heart attacks. But today I am undergoing treatment and already I asked the doctor what I could do to avoid that." - Workshop participant



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BIDMC FY23-25 Implementation Strategy Mental Health and Substance Use

Beth Israel Lahey Health



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



Key Impacts/Accomplishments:

- Began a new multidisciplinary hospital-based Addiction Consultation Service with recovery coaches in FY25
- Issued RFP for Behavioral Health Community-based Navigation grant(s) in Chelsea
- **340** medical professionals and trainees received trauma-informed care training
- **81** BIDMC employees completed in Mental Health First Aid trainings

Six (6) behavioral health grantees achieved collective impact including:

↑ More than three (3) out of every five (5) participants experienced **improvement in mental health symptoms**

↓ Statistically significant **decrease** in the proportion of participants with scores of **moderate to severe depression**

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BILH Community Benefits Committee System Priorities FY 23-FY25 Collective Impact

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Over **\$2.4 million** invested in food and nutrition; over **287,684 pounds** of free, nutritious food distributed to **40,773** community residents.



Over **\$4.6 million** invested in housing; over **2,792 people** permanently housed.



Over **\$60 million** spent to address mental health and substance use; community members are expressing greater understanding and reductions in stigma for anxiety of anxiety and depression

Data includes direct financial support inclusive of Determination of Need investments, in-kind and subsidized programs and services. Final data for FY23-25 outcomes will be collected in fall 2025 and reported in 2026

FY26-28 strategies will build off the FY23-FY 25 Implementation Strategy success and continue to drive impact on food and nutrition, housing, and behavioral health, with increased focus on youth mental health

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FY25 CHNA and FY26-28 Implementation Strategy

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FY25 CHNA and FY26-28 IS Purpose


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Identify and prioritize the health-related and social needs of those living in the hospital's Community Benefits Service Area with an emphasis on diverse populations and those experiencing inequities.

- A **Community Health Needs Assessment (CHNA)** identifies key health needs and issues through data collection and analysis.
- An **Implementation Strategy (IS)** is a three-year plan to address public health problems collaboratively with municipalities, organizations, and residents.

All non-profit hospitals are required to conduct a CHNA and develop an IS every three years.

SBO

FY25 Community Health Needs Assessment FY26-28 Implementation Strategy

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Thank You!



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FY25 Community Health Needs Assessment BIDMC Methods – Focused on Health Equity

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Collection of secondary data, e.g.:

- US Census Bureau
- Center for Health Information and Analytics (CHIA)
- County Health Rankings
- Behavioral Risk Factor Surveillance Survey
- Youth Risk Behavior Surveys
- CDC and National Vital Statistics
- Other local sources of data



15 Interviews



2,296 FY25 BIDMC Community Health Survey Respondents

(includes data from BCHC, CHA, Tufts, and North Suffolk Public Health Collaborative)



5 Focus Groups

- Spanish-speaking young adults (*La Colaborativa*)
- Newly arrived families from Haiti (*Association of Haitian Women in Boston*)
- Cape Verdean speakers (*Cape Verdean Association of Boston*)
- Adults with disabilities (*Boston Center for Independent Living*)
- Transgender and non-binary residents (*Transgender Emergency Fund*)

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FY25 Community Health Needs Assessment BIDMC Community Health Survey Responses

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2,296 responses
(Includes responses from BILH, CHA, Tufts, and BCHC Surveys)


19% of respondents report a language other than English as the primary language spoken in their home



72% of the respondents are women

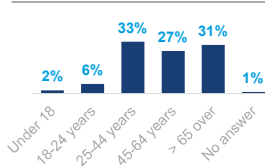


16% of the respondents identify as having a disability

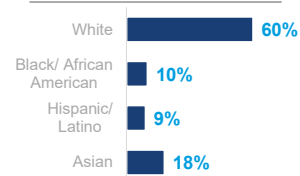


11% identified as gay, lesbian, asexual, bisexual, pansexual, queer, or questioning

Age



Race/Ethnicity



Collaboration

- Established data sharing agreements with the Boston Community Health Collaborative, North Suffolk Public Health Collaborative, Tufts Medical Center, Cambridge Health Alliance to get robust and representative survey results

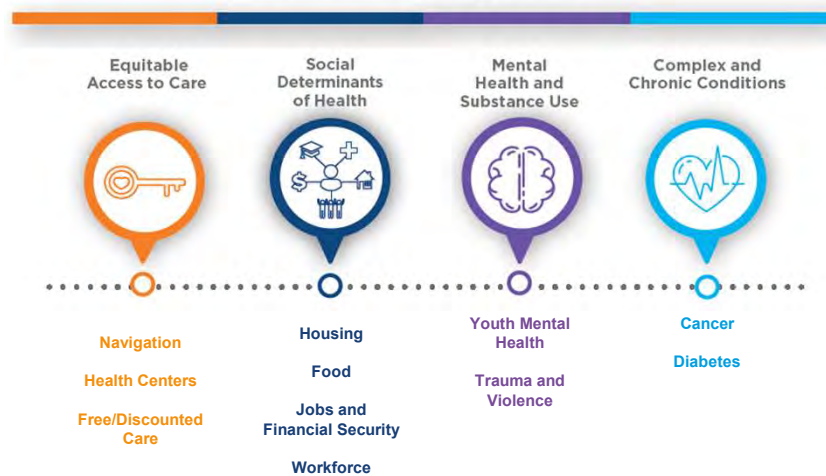
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FY26-28 Implementation Strategy BIDMC Community Health Priorities

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HEALTH EQUITY



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FY26-28 Implementation Strategy BIDMC Priority Cohorts



BIDMC has a duty to treat all patients to the best of our ability and a critical part of that goal is: (i) identifying which patients, in particular, are having difficulties accessing care, and (ii) figuring out ways to dismantle the barriers all patients in our community face in accessing care but in particular those who have been identified as encountering barriers to access. While BIDMC Implementation Strategies provide benefits to all, the following cohorts within BIDMC's patient population and larger community were identified by members of the community as being underserved and/or encountering barriers to care and services.



Low-
resourced
populations



Older adults



Youth



Racially, ethnically,
and linguistically
diverse populations



LGBTQIA+



Families affected by
violence and/or
incarceration

FY26-28 Implementation Strategy Priorities and 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.



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.



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.







Chronic and Complex 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.



Housing Affordability Grantee Panel



		
Hannah Odaa	Trevor LaFauci	Caroline Ellenbird
International Institute of New England (IINE)	Roxbury Collective for Affordable Housing / Urban Edge	Comunidades Enraizadas Community Land Trust (CE-CLT)

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Healthy Neighborhoods Initiative Funding Model



Seven collectives for **six Boston neighborhoods** and the **City of Chelsea**.

Projects are:

- Responsive to a **neighborhood priority**
- **Decided and led by the neighborhood community**

Goal: Boston neighborhoods and Chelsea have sustained grassroots, collective decision making and collaboration mechanisms to address neighborhood priorities.

Fund provides:

- **\$355,000-\$395,000** over 2 years
- Dedicated **5-month planning phase**
- Dedicated **evaluation support**



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Healthy Neighborhoods Initiative Community-based Organizations



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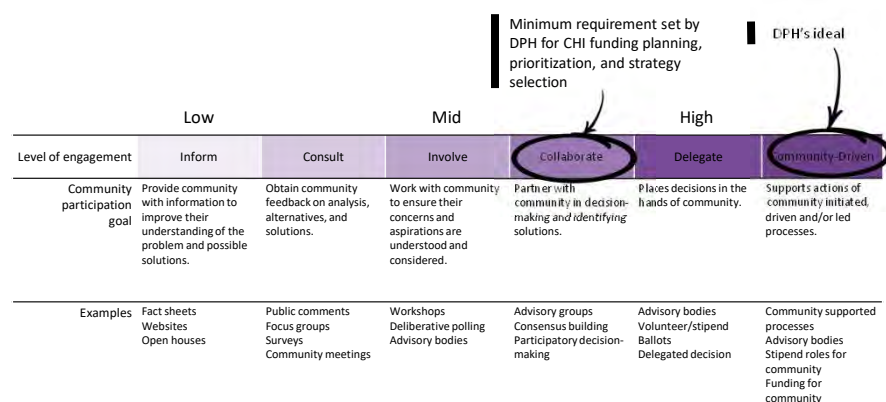
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Healthy Neighborhoods Initiative Findings from Planning Phase



- 1/ BIDMC delegated key decisions about the grant to the collectives.
- 2/ Collectives successfully utilized multiple methods across the continuum of community engagement.
- 3/ Each of the 7 collectives conducted a robust community engagement process during the planning phase.
- 4/ Two key outcomes to date:
 - new relationships and collaborations
 - increased skills and experience in community engagement.

Healthy Neighborhoods Initiative Continuum of Community Engagement



Healthy Neighborhoods Initiative Continuum of Community Engagement



Continuum of community involvement at each stage

Collectives 2 and 5 chose to collaborate with residents on earlier decisions.

Collective	1	2	3	4	5	6	7
Gather ideas							
Rank priority areas							
Decide on Project							
Refine project idea(s)							

	Low		Mid		High	
Key:	Inform	Consult	Involve	Collaborate	Delegate	Community-Driven

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Healthy Neighborhoods Initiative Continuum of Community Engagement



Continuum of community involvement at each stage

Collective 7 determined the project through a public vote, thereby **delegating** the project decision to residents.

Collective	1	2	3	4	5	6	7
Gather ideas							
Rank priority areas							
Decide on Project							
Refine project idea(s)							

	Low		Mid		High	
Key:	Inform	Consult	Involve	Collaborate	Delegate	Community-Driven

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Healthy Neighborhoods Initiative Turn + Talk



Now it's your turn! Turn to your neighbor and...

- 1/ Introduce yourself
- 2/ What is one way you're currently involving community in your work and what is one shift you can make toward greater involvement? Remember, it's not all or nothing.
- 3/ Be curious: What would it take to make this shift successfully? What gets in the way?

Take 3 minutes each; I'll announce when to switch if you haven't already

	Low		Mid		High	
Level of engagement	Inform	Consult	Involve	Collaborate	Delegate	Community-Driven
Community participation goal	Provide community with information to improve their understanding of the problem and possible solutions.	Obtain community feedback on analysis, alternatives, and solutions.	Work with community to ensure their concerns and aspirations are understood and considered.	Partner with community in decision-making and identifying solutions.	Places decisions in the hands of community.	Supports actions of community initiated, driven and/or led processes.
Examples	Fact sheets Websites Open houses	Public comments Focus groups Surveys Community meetings	Workshops Deliberative polling Advisory bodies	Advisory groups Consensus building Participatory decision-making	Advisory bodies Volunteer/stipend Ballots Delegated decision	Community supported processes Advisory bodies Stipend roles for community Funding for community

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Healthy Neighborhoods Initiative Lessons Learned



- 1/ Trust is built, not assumed
- 2/ Collective formation and community engagement both take time and intention
- 3/ As a result, a significant level of staffing time and effort was required to implement a meaningful planning phase
- 4/ Knowing clear expectations and goals of a funder can reduce uncertainty in collective development
- 5/ Having a lead facilitator was critical for collective formation and broadening participation
- 6/ Having dedicated planning funds helped to support robust, meaningful community engagement
- 7/ Built in evaluation support eases reporting burden, weaves in learning

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Healthy Neighborhoods Initiative Onward!



Collectives in Allston Brighton, Mission Hill, and Roxbury are wrapping up implementation. Their impact, and the impact of prior cohorts, shows promise of persisting.



WHERE WE MEET:
Imagining Gardens and Futures



Photo credit: Mel Taing

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Healthy Neighborhoods Initiative Thank You!



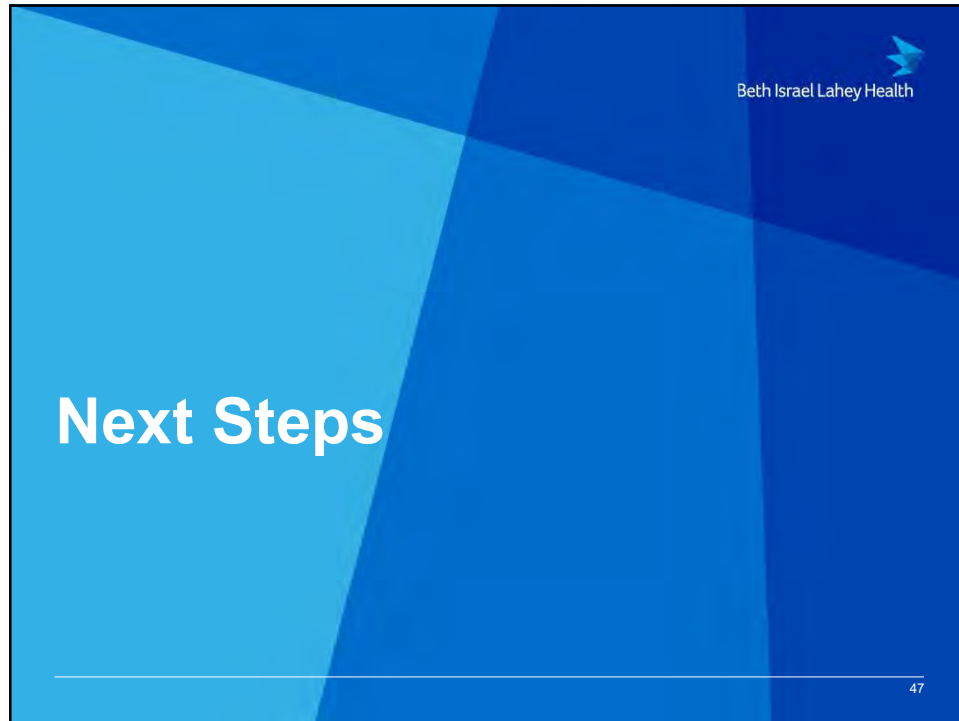
Thank you to all the Collective and community members that have contributed to the Healthy Neighborhoods Initiative and its evaluation.

Questions? Contact evan@dataplussoul.com or min@dataplussoul.com

www.dataplussoul.com

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Next Steps

CHNA and IS will be published on the Beth Israel Deaconess Medical Center website September 30, 2025 [Community Health Benefits | BIDMC of Boston](#)

More information about our funding impact can be found on our website at bidmc.org/chi

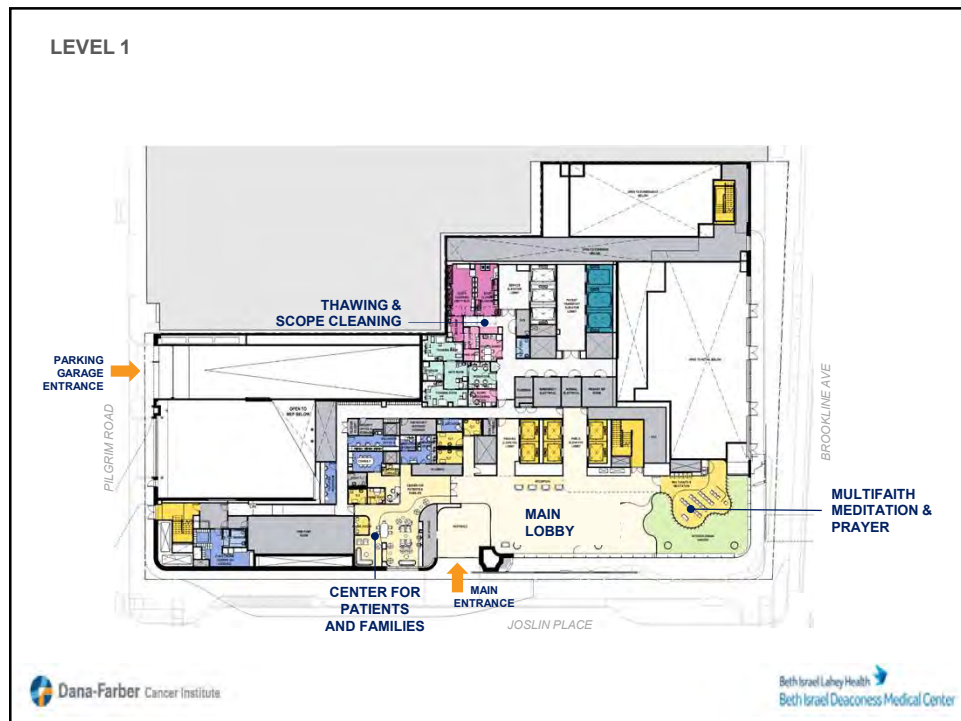
For more information or questions, please reach out to:

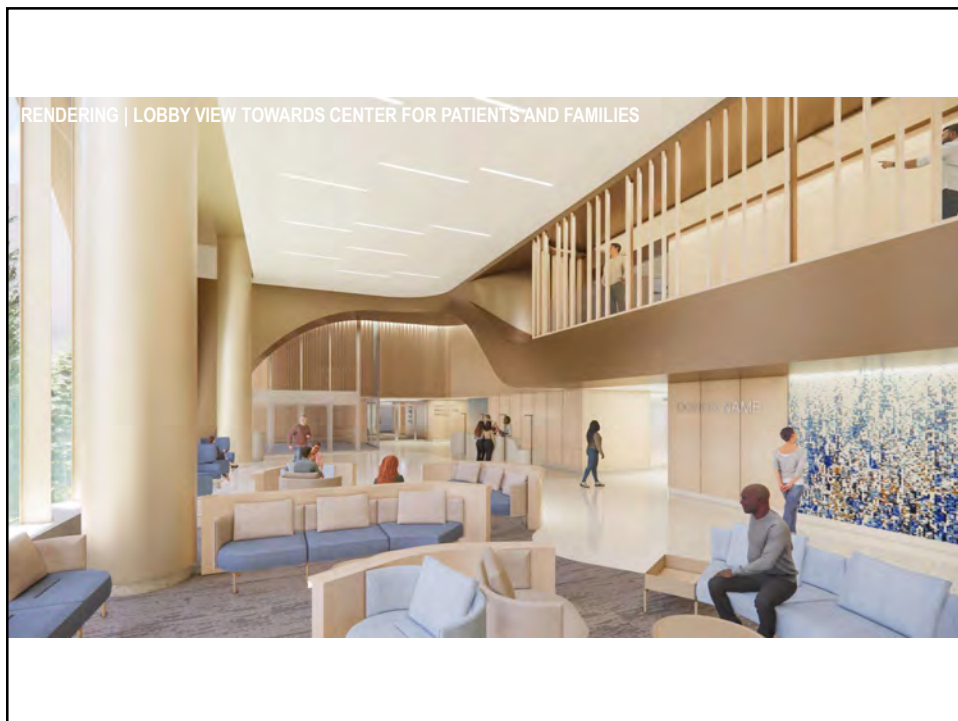
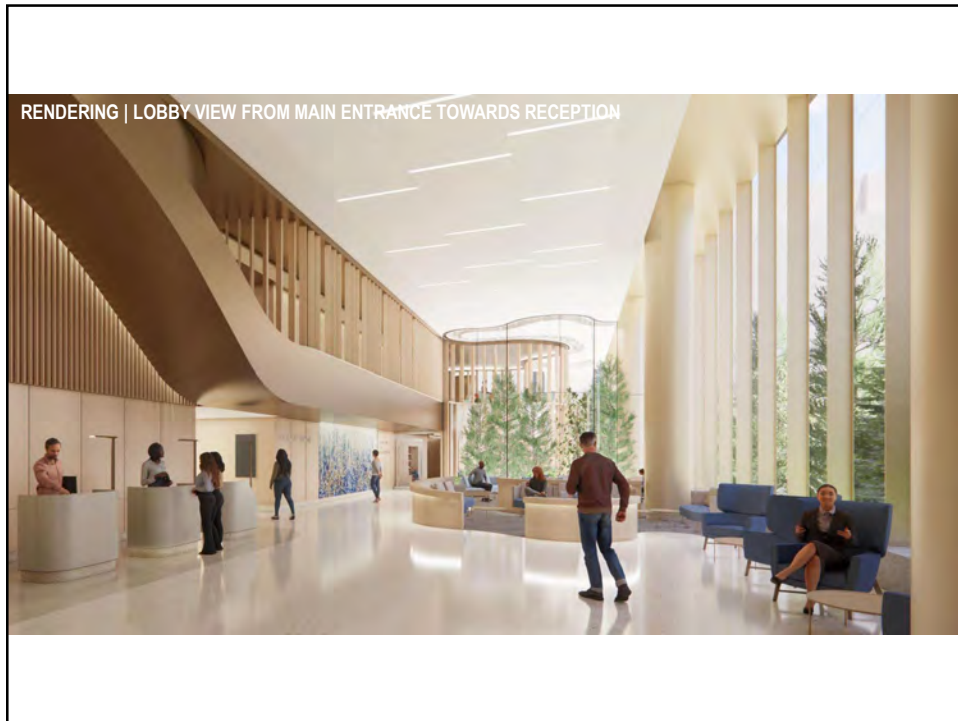
Anna Spier
 Manager, Community Benefits & Community Relations
 Beth Israel Deaconess Medical Center
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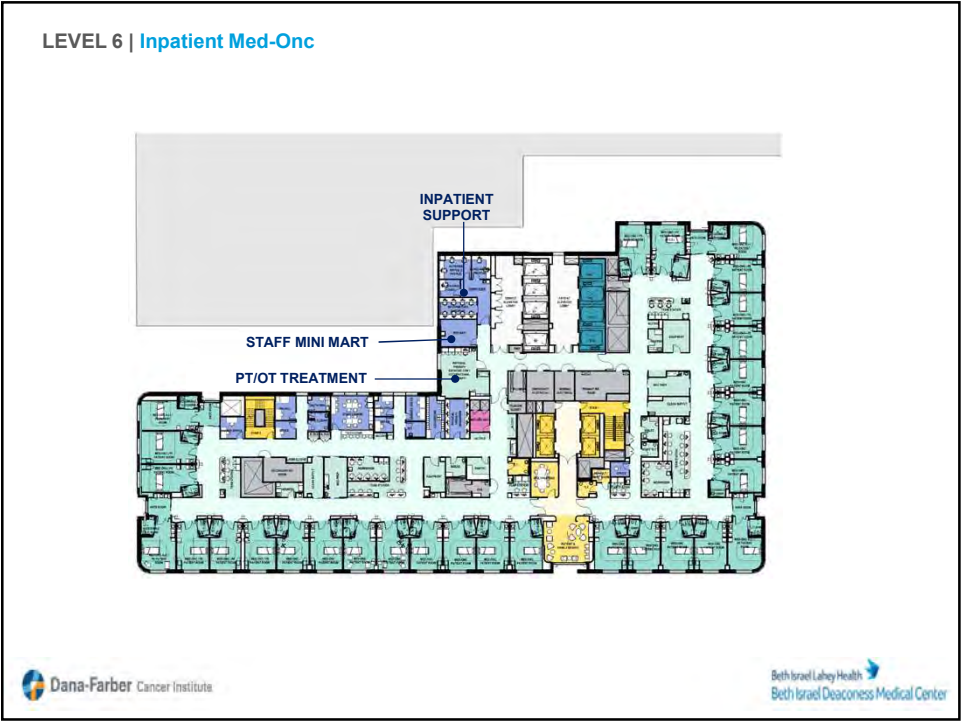
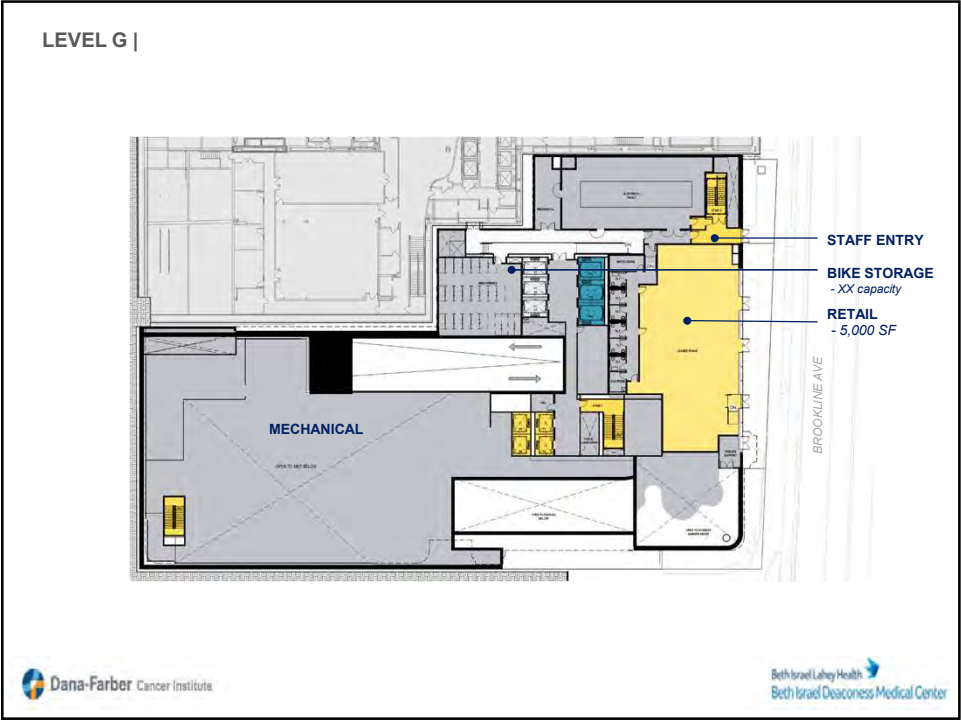
Scan the code to
 register to receive
 the *Community
 Connections*
 newsletter

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ICU PATIENT ROOM



Advisory Committee Members	2025			
	March 26	June 18	September 17	December 10
Flor Amaya	A	X	X	
Alexandra Chery Dorrelus	X	A	A	
Shondell Davis	X	X	X	
Pamela Everhart	A	X	X	
Barry Keppard	A			
Angie Liou	X	X	X	
Jean McClurken	A	A	A	
Amy Nishman	X	X	X	
Sandy Novack	X	X	X	
Abby Oliveira			X	
Alex Oliver-Davila	A	X	X	
Triniese Polk	A	X	A	
Cristina Rodrigues			X	
Richard Rouse	X			
Leo Ruiz Sanchez	X	X	X	
Samantha Taylor	X	X	A	
Fred Wang	A	X	A	
BIDMC Staff - Ex Officio				
Lynne Courtney	X	X	X	
Pat Folcarelli	X	X	X	
Lauren Gabovitch	A	X	X	
Nancy Kasen	X	X	X	
Anna Spier	X	X	X	
LaShonda Walker-Robinson	A	A	A	

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