Community Benefits Report

Fiscal Year 2025

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

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SECTION I: SUMMARY AND MISSION STATEMENT

Beth Israel Deaconess Medical Center is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and New Hampshire and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 5,900 physicians and 36,000 employees.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. 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 communities BILH serves. Beth Israel Deaconess Medical Center Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

While Beth Israel Deaconess Medical Center oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

- ***W**ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E**mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C**ollaboration - We work together to achieve extraordinary results*
- ***A**ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R**espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

The mission of Beth Israel Deaconess Medical Center (BIDMC) is to serve our patients compassionately and effectively, and to create a healthy future for them and their families. Our mission is supported by our commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining our financial health. The Medical Center is also committed to being active in the community as well. Service to the community is at the core and an important part of our mission. We have a covenant to care for the underserved and to work to change disparities in access to care. We know that to be successful we need to learn from those we serve.

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 (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout BIDMC's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in Beth Israel Deaconess's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

- **Promoting health equity** by addressing inequities and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

The following annual report provides specific details on how BIDMC is honoring its commitment and includes information on BIDMC's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

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, Burlington, Cambridge, Lexington, Needham, Newton (Chestnut Hill), Peabody and Winchester. In FY 2025, BIDMC conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BIDMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines (February 2018). While BIDMC is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BIDMC's FY 2026 - 2028 Implementation Strategy (IS) will focus its Community Benefits resources focused on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BIDMC's FY 2025 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic

security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2026 – 2028 IS, BIDMC will work with its community partners, with a focus on Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BIDMC's Community Benefits investments and resources will focus on improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+; and
- Families Affected by Violence and/or Incarceration.

Basis for Selection
Community health needs assessments; public health data available from government (public school districts, Massachusetts Department of Public Health, federal agencies) and private resources (foundations, advocacy groups); and BIDMC's areas of expertise.

Key Accomplishments for Reporting Year
Beth Israel Deaconess Medical Center's most recent FY 25 CHNA and FY 26-FY 28 IS were approved and adopted, respectively, by the Beth Israel Deaconess Medical Center Board of Trustees during the fiscal year ended September 30, 2025. That CHNA and IS will inform the Community Benefits mission and activities of Beth Israel Deaconess Medical Center for the fiscal years ending September 30, 2026; September 30, 2027; and September 30, 2028.

This report covers BIDMC's fiscal year ending September 30, 2025. The previous FY 22 CHNA and accompanying FY 23-FY 25 IS were approved by the BIDMC Board before September 30, 2022 and informed the BIDMC's Community Benefits initiatives for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2022.

Program accomplishments include:

- Continued to support increased capacity of primary care and OB/GYN practices at five licensed and/or affiliated health centers
- Continued community-based specialty care services
- Provided culturally and linguistically appropriate care for patients through cancer navigation, interpreter services, and multilingual patient education
- Addressed social determinants of health, particularly violence prevention, through the Center for Violence Prevention and Recovery (CVPR), Bowdoin Street Health Center's (BSHC) Community Healing Response Network and other initiatives
- Increased access to behavioral health services through the implementation of the Collaborative Care model and offered Mental Health First Aid trainings to community members

- Continued workforce development through summer internships for underserved youth, pipeline programs, and training programs for adults
- Addressed food insecurity through BSHC's purchase and distribution of fresh fruits and vegetables to patients and community members and donations of food
- Continued to fund four organizations to address housing affordability, four organizations to address jobs and financial security, and three organizations to address behavioral health through BIDMC's Community-based Health Initiative
- Supported four neighborhood-specific collectives in Boston and Chelsea through the Healthy Neighborhoods Initiative
- Continued a digital literacy/health equity program in partnership with BSHC to promote access to digital tools and resources
- Conducted research that supports the understanding of health disparities

Plans for Next Reporting Year

In FY 2025, BIDMC conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BIDMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines. In response to the FY 2025 CHNA, BIDMC will focus its FY 2026 - 2028 IS on four priority areas. These 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:

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

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 Massachusetts Department of Public Health (DPH) 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 2025 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BIDMC's efforts. In completing the FY 2025 CHNA and creating its FY 2026 - 2028 IS, BIDMC, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2025 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BIDMC's FY 2026 - 2028 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BIDMC's Community Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which

include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; LGBTQIA+; and families affected by violence and/or incarceration.

BIDMC will partner with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership, and other key collaborators throughout its CBSA to execute its FY 2026 – 2028 IS.

- **Equitable Access to Care**
  - BIDMC will continue to partner with CCA health centers to increase access to primary care and specialty care services, including OB/GYN and maternal and child health services
  - BIDMC will continue to provide enrollment counseling and assistance and patient navigation support services to uninsured/underinsured residents and increase access to culturally appropriate and responsive care
  - BIDMC will continue to provide effective and high-quality interpreter services for patients who request this service in order to improve access to care
  - BIDMC will continue to support the Digital Outreach for Obtaining Resources and Skills (DOORS) program, which offers free device distribution, digital literacy training, digital skills office hours, and community training in partnership with organizations such as Bay Cove Center Club and the Greater Boston Chinese Golden Age Center

- **Social Determinants of Health**
  - BIDMC will work with grantees such as Boston's Higher Ground and the International Institute of New England to invest in housing programs that stabilize or create access to affordable housing
  - BIDMC will partner with grantees such as the YMCA of Greater Boston and Building Pathways to strengthen the local workforce and address unemployment and underemployment
  - BIDMC will support programs that enhance community cohesion and resilience through partnerships with organizations including the Louis D. Brown Peace Institute and the Boston Public Health Commission
  - BIDMC's Center for Violence Prevention and Recovery will continue to partner with the Louis D. Brown Peace Institute, Jane Doe, Inc., the Boston Area Rape Crisis Center, The Network/La RED, Casa Myrna, and other organizations to build community awareness, advocate for policy change, and provide supportive care for victims of violence and trauma
  - BIDMC will promote healthy eating and active living through partnerships with community-based organizations like Fair Foods and Bikes Not Bombs, among other organizations
  - BIDMC will work to provide and promote career support services and career mobility programs in partnership with Conexión, The Partnership, Inc., and other organizations
  - BIDMC will work to increase mentorship, leadership, training, and employment opportunities for youth and young adults in the healthcare field through partnerships with organizations such as Operation ABLE, Fenway Forward, Boys and Girls Club of Boston, and JVS Boston

- **Mental Health and Substance Use**
  - BIDMC will work with grantees such as Community Action Programs Inter-City (CAPIC) to invest in community behavioral health services

- BIDMC will implement evidence-based programs such as the Collaborative Care Model and Mental Health First Aid trainings for community members
- BIDMC will continue to offer the expanded, multidisciplinary Addiction Consultation service that provides access to recovery coaches in the Emergency Department and the medical floors

- **Complex and Chronic Conditions**
  - BIDMC will provide preventive 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 through programs in partnership with the CCA health centers, Dana Farber Cancer Institute, the Joslin Diabetes Center, and other organizations and institutions

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BIDMC Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 58). The BIDMC Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team

BIDMC's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA 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 Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BIDMC's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the BIDMC's Board of Trustee members and senior leadership who are held accountable for fulfilling BIDMC's Community Benefits mission. Among BIDMC's core values are the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BILH and BIDMC's structure and reflected in how care is provided at the hospital and in affiliated practices.

While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

The BIDMC Community Benefits program is spearheaded by the Community Benefits and Community Relations Manager, who has direct access to and is accountable to the BIDMC President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Community and Health Impact Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of BILH and BIDMC's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The BIDMC Community Benefits Advisory Committee (CBAC) works in collaboration with BIDMC's hospital leadership, including the hospital's governing board and senior management to support BIDMC's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BIDMC's community. The CBAC provides input into the development and implementation of BIDMC's Community Benefits programs in furtherance of BIDMC's Community Benefits mission. The membership of BIDMC's CBAC aspires to be representative of the constituencies and priority cohorts served by BIDMC's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The BIDMC CBAC met on the following dates:
December 10, 2024
March 26, 2025
June 18, 2025
September 17, 2025

BIDMC recognizes its role as a tertiary/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 Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with BIDMC's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. BIDMC's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BIDMC's mission.

BIDMC currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BIDMC collaborates with many of its local community-based organizations, public health departments, municipalities, and clinical and social service organizations. BIDMC has a particularly strong relationship with many of the community health centers that operate in its CBSA. These health centers, part of the Community Care Alliance (CCA), are critical components of the health care safety net in the communities they operate. In 2025, the CCA health centers provided primary care medical, dental, behavioral health, and enabling services to approximately 92,022 patients. The CCA health centers include:

- Bowdoin Street Health Center[1]
- Charles River Community Health
- The Dimock Center
- Fenway Health
- South Cove Community Health Center

These health centers are ideal Community Benefits partners because they are rooted in their communities and, as they are predominantly federally qualified health centers, are mandated to serve low-income, historically underserved populations. These community partners have been a vital part of BIDMC's community health 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

[1] Bowdoin Street Health Center, a member of CCA, is owned and licensed by BIDMC and is not a federally qualified health center.

Benefits 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 Integrated North Suffolk Community Health Needs Assessment (iCHNA) and the Boston Community Health Collaborative. Joining with such grassroots community groups and residents, the Boston Public Health Commission (BPHC), Massachusetts DPH, and academic partners, BIDMC strives to create a vision for both city-wide and neighborhood-based health improvement.

See Appendix A on page 67 for a comprehensive listing of the community partners with which BIDMC joins in assessing community needs as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy.

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2025 Community Health Needs Assessment (CHNA) along with the associated FY 2026-2028 Implementation Strategy was developed over a fifteen-month period from June 2024 to September 2025. 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 the BIDMC's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by BIDMC's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BIDMC's most recent CHNA was completed during FY 2025. FY 2025 Community Benefits programming was informed by the FY 2022 CHNA and aligns with BIDMC's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2025 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2025 assessment and planning process was conducted in three phases between June 2024 and September 2025, which allowed BIDMC to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and BIDMC's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

BIDMC's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care. Throughout the CHNA process, efforts were made to understand the needs of the communities that BIDMC serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. BIDMC's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Through the FY 2025 Community Health Needs Assessment process, BIDMC (in partnership with BILH, the Boston Community Health Collaborative, and the North Suffolk Community Health Collaborative) conducted 35 interviews with key collaborators in the community, facilitated 17 focus groups with segments of the population facing the greatest health-related disparities, held 5 sector-based focus groups with community partners, and held 1 community listening session. In addition, BIDMC participated in three community health surveys that engaged residents across the CBSA. In total, the assessment process collected information from more than 3,500 community residents, clinical and social service providers and other community partners.

The articulation of each specific community's needs (done in partnership between BIDMC and community partners) is used to inform BIDMC's decision-making about priorities for its Community Benefits efforts. BIDMC works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BIDMC's Implementation Strategy that is adopted by the BIDMC Board of Trustees.

Summary of FY 2025 CHNA Key Health-Related Findings

Equitable Access to Care

- Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system-level, meaning that the issues stemmed from the ways in which the system did or did not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate. There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, access to care/navigation issues, and other important social determinants of health. There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, surveys, and the listening session reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, transportation and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults; trauma experienced by immigrants, migrants, and refugees, and social isolation among older adults.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for assistance navigating a complex behavioral health system, as it can be overwhelming for individuals experiencing mental health challenges. Providing navigation assistance ensures people can access the right services at the right time, improving continuity of care and health outcomes.
- Youth mental health was a concern in the CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Complex and Chronic Conditions

- Chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2025 BIDMC's Community Health Needs Assessment Report and Implementation Strategy on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Access to Care **Program Name: Community Based Primary and Specialty Care**		
Brief Description or Objective	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. 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. A number of BIDMC specialties (e.g., OB/GYN, Infectious Disease, etc.) and ancillary services (e.g., radiology, lab) are provided on-site at the health centers. The CHCs also have access to teaching and growth opportunities including the Linde Family Fellowship Program (LFFP). The LFFP provides early and midcareer physician leaders with an opportunity to develop expertise and skills in primary care leadership, including practice management and innovation.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, patients will receive primary care, OB/GYN, and specialty care at Community Care Alliance (CCA) health centers.	In FY25, 92,022 patients were seen at Community Care Alliance (CCA) health centers.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BIDMC specialists will practice at CCA health center sites.	In FY25, 22 BIDMC specialists practiced at CCA health center sites.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Community Care Alliance**	
Brief Description or Objective	BIDMC was instrumental in helping its affiliated and/or licensed health centers form a network called the Community Care Alliance (CCA). By collaborating on clinical and administrative issues, the 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. BIDMC is committed to strengthening the capacity of its five licensed and/or affiliated CHCs in the CBSA: Bowdoin Street Health Center (BSHC), The Dimock Center, Fenway Health, Charles River Community Health (CRCH), and South Cove Community Health Center. The partnership takes many forms: recruitment, retention, financial support and credentialing of physicians and advanced practice providers, access to managed care contracts, Harvard Medical School appointments and teaching opportunities, BIDMC-sponsored fellowships and continuing education programs, and access to clinical care resources.
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC CCA specialists will practice at health centers.	In FY25, 22 BIDMC specialists practiced at CCA health centers.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BIDMC will conduct 12 Office of the Inspector General (OIG) reviews on CCA CHC employee and vendor lists, to ensure compliance with state and federal standards.	BIDMC has continued monthly regulatory OIG reviews for all CCA CHC personnel and vendors.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Trauma, Emergency Management and Public Health Surveillance**		
Brief Description or Objective	BIDMC's robust Emergency Management program is highly involved in local, city, state, and regional emergency preparedness systems and a leader in the hospital emergency management field. BIDMC is a regular participant in citywide committees, drills, task forces, project and plan development, and meetings including those for citywide mass casualty events. This program includes BIDMCs health center partners in planning, training, and exercises.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
In FY25, Emergency Management will host or participate in exercises that enhance its readiness to mass casualty incidents.	In FY25 BIDMC Emergency Management achieved its goal by participating in three mass casualty related exercises. It held a tabletop exercise with local leadership, the ED, and Trauma. It participated in a mass casualty tabletop exercise with the Conference of Boston Teaching Hospitals. It participated in a Mass Casualty exercise with the Longwood Collective. It held a department-specific tabletop MCI exercise with Pharmacy.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Culturally and Linguistically Responsive Care**		
Brief Description or Objective	BIDMC was one of the first hospitals in New England 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. Free interpreter services are available to non-English speaking, limited-English speaking, deaf, and hard-of-hearing patients. These services are provided in person; by phone using a portable speakerphone to connect patients, their care team, and an interpreter; and through a video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	**Goal Status**	**Goal Year and Type**
Increase the number of completed video interpretations by BIDMC interpreters from FY24 to FY25.	The number of completed video interpretations by BIDMC interpreters increased by 2% from FY24 to FY25.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
By the end of FY25, BIDMC Interpreter Services will maintain average response time for major staffed languages of 4 minutes or less.	In FY25 BIDMC achieved its goal of decreasing average response time to under 4 minutes for staffed languages.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Geographically Isolated Communities**	
Brief Description or Objective	To address access to care challenges in the Outer Cape region, BIDMC continues to offer on-site medical specialty care services, including infectious disease services. BIDMC continues to support the Med-Flight helicopter program that transports those living in isolated areas that need emergency medical services. For patients and families who are a long distance from home, BIDMC provides housing assistance through programs such as Hospitality Homes or specially adapted apartments for those undergoing bone marrow transplantation.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
BIDMC will continue to address unmet medical needs for rural Cape Cod.	In FY25, BIDMC continued to address unmet needs for rural Cape Cod.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will continue to provide access for remote communities to quaternary care.	In FY25, BIDMC continued to provide access for remote communities to quaternary care.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year the BIDMC Social Work Department will provide housing support to patients in need of short or long-term housing. BIDMC will also provide short-term housing for bone marrow transplant patients.	Goal partially achieved due to lack of available emergency housing and low and moderate-income housing in the Greater Boston Area.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: 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. BIDMC also remains an important part of the Commonwealth's state healthcare information exchange (Mass HIWay). BIDMC provides ongoing reference lab services to South Cove Community Health Center and Radiology services to Fenway Health, with results being delivered directly to each site's electronic health record (EHR) via an electronic interface. BIDMC also provides community health centers with access to its instance of the Epic EHR; tools to allow Health Center staff to check the insurance eligibility for their patients accessing services at BIDMC; and network accounts that provide Health Center providers with access to various web-based tools at BIDMC.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
BIDMC will continue to contribute to the Mass HIWay initiative.	BIDMC continues to contribute to the Mass HIWay initiative.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will continue sending inpatient and ED discharge summaries with the expanded primary care network.	BIDMC continues sending inpatient and ED discharge summaries with the expanded primary care network.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Care to Uninsured and Underinsured in Underserved Communities**	
Brief Description or Objective	BIDMC utilizes BILH retail and specialty pharmacies to offer a Patient Assistance Program for patients with family income at or below 300% of the federal poverty level. The pharmacies are registered as Health Safety Net (HSN) pharmacies and provide courtesy fills for low-income BIDMC patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, BIDMC contracts with the BILH pharmacies to employ patient assistance staff. 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, throughout BIDMC's Community Benefits Service Area, BIDMC subsidizes primary care services provided by Beth Israel Lahey Health Primary Care (BILH-PC), Healthcare Associates (HCA) and Bowdoin Street Health Center. BIDMC's robust Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when family income is at or below 400% of the current Federal Poverty Level). BIDMC Financial Counseling staff screen patients and assist patients in applying for all eligible financial assistance programs.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC will screen and enroll eligible patients into entitlement programs.	In FY25 BIDMC screened 3,528 patients at 6,712 encounters. The number of MassHealth applications completed was 1,450, of which 1,221 were approved. The number of patients that applied for charity care was 1,054, of which 446 were approved. The number of uninsured patients who utilized the HSN was 9,062.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, the Retail pharmacy will aim to meet 100% of requests for adherence packaging and talking scripts and provide home delivery for patients with difficulty accessing the medical center for pick up.	The Retail pharmacy is meeting requests for adherence packaging, talking scripts and providing home delivery.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
To increase access to care by providing financial assistance for prescriptions for low income or uninsured patients.	In FY25, Beth Israel Deaconess Medical Center provided financial assistance for prescriptions to low income and/or uninsured patients.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Boston Healthy Start Initiative and Birth Center Grant**		
Brief Description or Objective	The Boston Healthy Start Initiative (BHSI) is a grant-funded program designed to improve birth outcomes and eliminate birth outcome disparities among women in Boston. BHSI allows Bowdoin Street Health Center (BSHC) to provide a dedicated Community Health Worker (CHW) to support its high-risk prenatal patients. As one of five sites funded by the Boston Public Health Commission, BSHC serves pregnant women by providing support and case management, making connections to a skilled public health nurse, engaging and supporting fathers or significant others, and providing support around maternal and child nutrition, including breastfeeding support. In September 2023, the Neighborhood Birth Center was awarded funding to create a birth center that would focus on low-resourced patients. The Neighborhood Birth Center recently received zoning approval for their building.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, the Healthy Start Family Partner will serve 100 clients total including 50 pregnant and 50 others (interconception/parenting).	In FY25, the Family Partner served 53 prenatal mothers, 112 postnatal mothers, and 110 children for a total of 276 patients.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Access to Care **Program Name: Addressing BILH Patient Health Disparities**		
Brief Description or Objective	BILH Health Equity division sits within the Office of Community and Health Impact. The BILH Health Equity team's focus is on addressing health disparities to ensure equitable health outcomes across the patient populations served by BILH.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Meet or exceed goal of 76.5% of BILH patients 18-85 years of age diagnosed with diabetes (Type 1 and Type 2) who had a hemoglobin A1c (HbA1c) level of <= 9.0% during the measurement period ending September 30, 2025.	Goal met: The average percentage, of the identified population above, whose hemoglobin A1c (HbA1c) level was <= 9.0% during the measurement period was 78.4%, which exceeded the target average goal of 76.5%.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Outcome Goal
Meet or exceed goal of 74.8% of BILH patients 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period ending September 30, 2025.	Goal met: 75% of the focus population had blood pressure that was adequately controlled (< 140/90 mmHg) during the measurement period.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Outcome Goal
Meet or exceed goal of 69.6% of BILH patients 18-85 years of age with a diagnosis of both diabetes and hypertension who meet control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period ending September 30, 2025.	Goal met: 70.4% of the focus population met the control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period through September 2025.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Outcome Goal
Meet or exceed goal of 2.65% reduction the occurrence of Severe Maternal Morbidity-Blood Transfusions during the measurement period ending September 30, 2025.	Goal not met: 2.91% of BILH patients received Severe Maternal Morbidity-Blood Transfusions.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Outcome Goal

Priority Health Need: Access to Care **Program Name: Medical-Legal Partnership for Immigrants**	
Brief Description or Objective	A Medical-Legal Partnership (MLP) functions as a touchpoint between the medical and legal systems, providing access to critical yet typically unaffordable legal advice through patients' relationship with their healthcare provider. The Medical-Legal Partnership for Immigrants (MLPI) provides BIDMC's patients with direct access to legal services, which allows for much more effective and efficient resolution of immigration-related barriers to receiving healthcare benefits to which they are entitled. This, in turn, will increase these patients' access to care and improve their health. BIDMC has also partnered with Volunteer Lawyers Project (VLP) and Ropes & Gray to help patients of Healthcare Associates and Bowdoin Street Health Center access free legal assistance to address myriad social drivers of health. VLP provides support to BIDMC patients via direct representation, advice, referral to partners (including Ropes and Gray) for direct representation, education, resources, and other legal assistance on a range of topics, including, but not limited to, family law, consumer protection, housing, employment, wills, immigration, and public benefits.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, resolve immigrant related barriers that BIDMC patients face when accessing health care and health coverage.	Health Law Advocates has served 50 BIDMC patients to date and 24 patients have maintained benefits as a result of services provided.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal

Priority Health Need: Access to Care
Program Name: Digital Literacy for Health Equity

Brief Description or Objective	The increasing use of mobile devices in healthcare offers novel opportunities to expand treatment options and reach these underserved populations. Too often, however, the gap in digital literacy makes it difficult for low-income patients to navigate technology and benefit from it. New approaches are needed to make digital mental health accessible and equitable. Through community activation and training based on published protocols, our program empowers and teaches people in the community to use their mobile phones and computers as tools to access and advance healthcare resources, including patient portals, telehealth services, and digital health tools. The program, Digital Outreach for Obtaining Resources and Skills (DOORS), offers free services, including free device distribution, digital literacy training, digital skills office hours, and community training at sites serving older adults, individuals with psychiatric disabilities, and immigrant communities in Massachusetts. Of note, the materials for these services are available in English, Spanish, and Portuguese, and some materials are available in simplified Chinese.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By end of FY25 all materials will be translated into Portuguese and an Artificial Intelligence learning model will be developed.	Goal met: Materials were translated into Portuguese and an additional module on Artificial Intelligence was created, published, and implemented on-site.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
By the end of FY25 Digital Navigators will be established at 4 sites, with the aim of at least 50 average contacts per month.	Goal met: Digital Navigators were established at four community sites, averaging >57 contacts per month.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
By the end of FY25, the majority of program recipients will report having better access to healthcare resources and mental health services because of our services.	Goal met: In a survey of service recipients in September 2025, 94.1% responded yes to the question: “After being supported by a Digital Navigator, do you feel as if you have access to more health resources?”	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
By the end of FY25, devices (smartphone, laptop, or tablet) will be distributed to at least 300 individuals in the community.	Goal met: Devices (smartphone, laptop, or tablet) were distributed to 404 individuals in the community in FY25.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
By the end of FY25, develop updated training materials (including slides, assessments, and activities) for Digital Navigators that can be shared with external	Goal met: Slides, assessments, and activities were created for a 6-8 hour Digital Navigator training sequence that can be generalized for external	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

organizations seeking to implement digital literacy training.	organizations seeking to implement digital literacy training.	
By the end of FY25, all training and teaching materials will be disseminated.	Goal met: All materials were shared in the peer-reviewed publication New England Journal of Medicine (NEJM) Catalyst and promoted by NEJM. The program was selected as a finalist by the state for the Excellence in Community Impact award in Fall 2025	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Chronic Disease Management
Program Name: Diabetes, Hypertension, Heart Disease and Asthma

Brief Description or Objective	With more than 50% of disease attributable to health behaviors, BIDMC and its affiliated and/or licensed Community Health Center (CHC) providers collaborate on interventions to promote positive behavior change and eliminate barriers to adopting healthier lifestyles. BIDMC's affiliated federally qualified health centers (FQHC) also 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. BIDMC also supports Charles River Community Health's (CRCH) team-based care management program for patients with chronic conditions, including diabetes and hypertension. The BIDMC Cardiovascular Institute has a longstanding partnership with the American Heart Association and sponsors community education and awareness building events.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal Status	Goal Year and Type
By 9/30/25, <30% of CRCH patients ages 18-75 with a diagnosis of diabetes will have HBA1c > 9% or no test recorded.	Goal met in FY25 (21.8%).	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
By 9/30/25, 75% of CRCH patients 18-85 years of age with hypertension will have hypertension controlled (<140/90).	This goal is at 73.0% in FY25 (an improvement from 69% in FY24 and 66.5% in FY23).	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
By 9/30/25, 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.	Goal met in FY25 (part of current MA workflow).	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Hold at least one Diabetes Nurse Education session in Brighton and Waltham.	Goal met in FY25.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
By 9/30/25, the percent of CCA FQHC adults with diabetes whose condition is controlled (HbA1c < 9) will be higher than 70%.	Goal met: In FY25, the percent of CCA FQHC adults with diabetes whose condition was controlled (HbA1c < 9) was 79%.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal

By 9/30/25, the percent of CCA FQHC adults with hypertension whose blood pressure is < 140/90 will increase from the year before.	Goal met: In FY25, the percent of CCA FQHC adults with hypertension whose blood pressure was < 140/90 was 63% (compared to 61% in FY24).	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
The affiliated federally qualified health centers will continue to serve patients with diabetes, hypertension, and asthma.	The health centers collectively served 9,586 patients with diabetes, 21,922 patients with hypertension and 4,781 patients with persistent asthma in FY25.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Disease Management **Program Name: Community Health Workers**	
Brief Description or Objective	The Community Health Worker (CHW) program at Bowdoin Street Health Center (BSHC) involves integrating a CHW into the care of patients with complex medical and social needs who often struggle with adherence to care. CHWs work alongside medical home team-based nurse care managers and social workers to provide integrated care management to existing high-risk patients referred by the multidisciplinary Care Management Team (CMT) and providers.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, CHWs will respond to at least 50 on-call requests for intervention.	In FY25, CHWs responded to 160 on-call requests for intervention.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC CHWs will provide supportive intervention to at least 200 referred patients.	In FY25, CHWs provided supportive intervention to 1,882 referred patients.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, each CHW will carry a case load of at least 30 patients and provide ongoing support and intervention to those 30 patients.	In FY25, CHWs carried an average case load of 150 patients and provided ongoing support and intervention to those patients.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Disease Management **Program Name: Reducing Disproportionate Burden of Cancer in Diverse Communities**	
Brief Description or Objective	BIDMC's Social Work department supports cancer patients by helping them understand social security benefits, disability benefits, insurance coverage and other financial programs. Additionally, they provide temporary housing to individuals undergoing treatment. Patients and families are also connected to individuals who have been in similar circumstances for support.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year BIDMC patients will have access to a Cancer Patient Navigator.	In FY25, there were 1,684 encounters with Cancer Patient Navigators.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC's Social Work Department will offer cancer support groups.	In FY25, BIDMC offered 3 types of cancer support groups.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC will provide low-income individuals with mammograms.	In FY25, BIDMC provided 4,278 mammograms to low-income individuals.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year BIDMC will provide low-income individuals with colon cancer screenings.	In FY25, BIDMC provided 3,267 colon cancer screenings to low-income individuals.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Chronic Disease Management **Program Name: HIV/HCV Coinfection Screening, Prevention, and Treatment**	
Brief Description or Objective	A BIDMC infectious disease consultant is contracted with The Dimock Center to provide screening, care, and education regarding Human Immunodeficiency Virus (HIV)/Hepatitis C Virus (HCV) co-infection on-site at The Dimock Center every week. The care and service include 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 full engagement and advocacy for vulnerable patients to promote successful treatment outcomes.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, The Dimock Center will screen over 90% of HIV+ patients for HCV.	Goal met: 93% of HIV+ patients were screened for HCV.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, the number of visits to The Dimock Center attended by an infectious disease physician will be 90 visits over 12 months.	Goal met: 167 visits were attended by an infectious disease physician in the last 12 months of FY25.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, the number of HIV/HCV co-infected patients who have begun HCV treatment will be at least 2.	Goal met: The number of HIV/HCV co-infected patients who have begun HCV treatment was 2.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Active Living and Healthy Eating Programs**	
Brief Description or Objective	The Wellness Center at Bowdoin Street Health Center (BSHC) contains a demonstration kitchen, a large exercise room for dance and physical activity classes, and a gym with workout equipment. The Wellness Center offers Bowdoin/Geneva residents the opportunity to learn and practice healthy habits in their own neighborhood. The Healthy in the City program offered by BSHC is a team-based approach to weight management that actively involves a provider, nutritionist, and case manager in ongoing care planning for each participant. The intervention includes referrals to physical activities, connection to nutrition resources, and referral to mental health counseling when appropriate. To address food insecurity, BSHC partners with local organizations to increase access to healthy foods. Fair Foods is a community-based organization that works with other non-profits, community groups and religious organizations to distribute fruits and vegetables to Boston-area residents. BSHC has partnered with the Boston Public Health Commission to distribute Farmers Market coupons that can be used at any City of Boston Farmers Market during summer and fall. Information about additional food-related resources such as food distribution sites and EBT and SNAP is also made available in multiple languages.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BSHC will provide case management for youth ages 5 - 18 to address issues related to childhood obesity.	In FY25, youth met in person and participated in facilitated group discussions with topics ranging from healthy snacking to how to use a grow kit. 22 patients were enrolled in the Healthy in the City case management program. 153 patients and community members were reached through after school programs, basketball clinics, school vacation activities, and summer camps.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC will distribute farmer's market coupons for individuals to use at City of Boston Farmers Markets.	BPHC provided 75 booklets of $25 Farmers Market coupons that could be used at any City of Boston Farmers Market during the summer and fall. BSHC distributed all of the coupons between July 1, 2025 and October 31, 2025.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, the BSHC Wellness Center will hold free cooking and exercise classes for patients and community members.	In FY 2025, BSHC held 450 in-person wellness center sessions for weekly classes. The total attendance for in-person classes was 1,816. BSHC also held 50 cooking classes with 250 total attendees. BSHC also held pop up	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

	series. The Age is Just a Number program was nine sessions with an average of 10 participants each week. The chronic disease cooking class series was six sessions with an average of 5-10 attendees each week.	
Each year, BSHC will distribute healthy food to Boston-area residents.	In FY25, BSHC purchased 1,560 bags through Fair Foods and distributed them free to patients and community members. BSHC CHWs also distributed 400 grocery store vouchers to patients.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Public Safety**		
Brief Description or Objective	Public safety is of concern within BIDMC's local neighborhoods, including 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 provides support in the Longwood Medical Area and to Bowdoin Street Health Center (BSHC). BIDMC's officers are sworn Special State Police Officers by the Colonel of the Massachusetts State Police.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Add an additional Public Safety Officer to the Bowdoin Street Health Center.	That goal was met April 28th, 2025 by adding a second Public Safety Officer.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
Continue community-based interactions with staff and residents during food drives, farmers markets, and other community related events. Continue to maintain a safe and secure facility and grounds for staff and patient safety.	Goal met. Throughout the reporting period, Public Safety Officers had direct contact with staff members and residents of the neighborhood, while continuing to patrol the grounds and building.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal
Maintain a safe and secure environment for staff, patients and visitors. Keep the peace within the clinic and surrounding grounds. Attend all social neighborhood activities within the clinic.	Goal met.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Environmental Sustainability**	
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. BIDMC collaborates with grass-roots level partners and city and state government to address environmental 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, BIDMC is implementing an Environmental Strategic Plan, spearheaded by BIDMC's multi-departmental Sustainability Committee. BIDMC's operational practices will have a direct impact on its communities and BIDMC will always have the responsibility to evaluate business practices to ensure that "we do no harm" for the future of our patients and our staff. BIDMC is committed to conserving natural resources, reducing its carbon footprint, fostering a culture of sustainability, enhancing health equity, and advancing cost-saving opportunities.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
By 2030, BIDMC will reduce organizational emissions by 50% and achieve net-zero by 2050 from a baseline of 2016.	BIDMC reduced organizational emissions by 10.4% in FY25 from a baseline of 2016.	Program Year: Year 6 Of X Years: Year 9 Goal Type: Outcome Goal
By 2030, BIDMC will have achieved Zero Waste (80% diversion from landfill or incineration).	BIDMC achieved 48.7% diversion in FY25 (decrease 11% from FY24).	Program Year: Year 6 Of X Years: Year 9 Goal Type: Outcome Goal
By the end of FY25, BIDMC Food Services will increase total sustainable and local food & beverage spend to over 20%.	BIDMC purchased 15.3% sustainable and local food & beverage in FY25 (compared to 17.0% in FY24).	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal

Priority Health Need: Social Determinants of Health **Program Name: Center for Violence Prevention and Recovery**	
Brief Description or Objective	Through its Center for Violence Prevention and Recovery (CVPR), BIDMC leads 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 a leader in developing programming to address secondary traumatic stress among domestic violence and medical service providers. In response to sexual, domestic, and/or interpersonal violence, CVPR provides individual and group support and counseling (inpatient and outpatient), trauma-informed policies and programs, and advocacy. For those patients with severe safety concerns following interpersonal assault, BIDMC provides Safebeds, a place for a survivor to remain in the hospital overnight. CVPR's community violence initiatives include neighborhood-based support groups, individual counseling, outreach, training, and advocacy. CVPR's human trafficking intervention program provides training to medical professionals and offer identification and acute intervention for patients entering the medical system.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, CVPR will provide support and therapeutic intervention to victims of domestic violence, sexual assault and community violence in the Greater Boston Area.	In FY25, CVPR provided support to 589 victims of domestic, sexual, and community violence in the Greater Boston area.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, CVPR will provide services to survivors of sexual violence in the Emergency Department.	In FY25, CVPR provided direct services to 62 survivors of sexual violence who came to the BIDMC Emergency Department.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, CVPR will provide free overnight stays for domestic violence victims without safe shelter.	In FY25, CVPR provided free overnight stays for 16 clients (may have family members or children) who were without safe shelter.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, CVPR will provide free overnight stays in the hospital (Safebed) for victims of violence without safe shelter.	In FY25, CVPR provided 4 free overnight stays in the hospital (Safebed) for victims of violence without safe shelter.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, CVPR will provide education and outreach services to over 200 employees in health centers, colleges and universities, and other community groups around sexual assault, interpersonal	In FY25, CVPR hosted 29 events that provided training to 642 employees in health centers, colleges and universities, and other community groups around	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

violence, community violence, secondary traumatic stress, and human trafficking.	sexual assault, interpersonal violence, community violence, secondary traumatic stress, and human trafficking.	
Each year, CVPR will provide 50 peace circles to community members in the Greater Boston area.	In FY25, CVPR provided 7 peace circles attended by 132 community members in the Greater Boston area.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community Healing Response Network (fka Neighborhood Trauma Team)**	
Brief Description or Objective	Bowdoin Street Health Center (BSHC) is the lead agency for the Bowdoin Geneva Greater Four Corners Community Healing Response Network. As the lead healthcare agency, BSHC partners with Greater Four Corners Action Coalition (GFCAC) and provides outreach to individuals, families, and neighborhoods impacted by community violence. The Community Healing Response Network 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 Community Healing Response Network assesses trauma-related community needs to support and deliver prevention, response, and short- and long-term recovery services. These services are intended to support existing neighborhood strategies and all services are free and private to residents impacted by community violence.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, Community Healing Response Network will respond to every incident of homicide, shooting, or stabbing within BSHC's catchment area and offer outreach to victims and impacted residents.	Bowdoin Street Health Center staff responded to 6 instances of violence that were level 4 and 5 in FY25. (Note: Levels 4 and 5 include gun related homicide, any shooting or stabbing incident that impacts more than one victim and/or someone under the age of 18, any traumatic event that impacts a broader community).	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC will provide direct therapeutic sessions to children, adults, and their families who have been impacted by violence.	Bowdoin Street Health Center staff supported 10 new clients in FY25. There were a total of 20 client visits to the Case Manager. Staff reached 524 people through events and outreach, including a backpack drive during which 400 backpacks were given out.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Youth Leadership**	
Brief Description or Objective	The Youth Leadership Program (YLP) at Bowdoin Street Health Center (BSHC) serves youth ages 14-17 and is focused on helping teens in the Bowdoin/Geneva neighborhood develop strong personal leadership skills, contribute to positive community change and violence prevention, while earning a stipend in the process.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, YLP will recruit youth leaders to participate in a 12-week session to learn about creating peaceful communities, financial literacy, civics, healthy eating and nutrition and health education for teens. YLP will run two programs in the fiscal year.	The two 12-week sessions graduated 10 participants in the fall, 2024 session and 13 in the spring, 2025 session for a total of 23 youth served through YLP in FY25.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: BILH Workforce Development**	
Brief Description or Objective	BILH and BIDMC are strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BIDMC offers incumbent employees pipeline programs to train for professions such as a Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BIDMC's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BIDMC is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs. Lastly, BIDMC provides paid summer jobs to introduce high school students to careers in the medical field.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, Workforce Development will continue to encourage community referrals and hires.	In FY25, 306 job seekers were referred to BILH and 79 were hired across BILH hospitals.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, Workforce Development will continue to hire young people from the community for summer jobs, returning to an in-person format.	In FY25 Workforce Development hired 27 high school aged young people referred by our community partners for paid summer jobs.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
Each year, Workforce Development will attend events and give presentations about employment opportunities to community partners.	In FY25, 42 events and presentations were conducted with community partners across the BILH service area.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
In FY25, Workforce Development will offer employees career development services.	In FY25, 831 BILH employees received career development services.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will offer internships in BILH hospitals to community members over the age of 18.	In FY25, 131 community members were placed in internships across BILH hospitals to learn valuable skills. BIDMC participated in offering these internships.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will hire interns after internships and place in BILH hospitals	In FY24, 36 interns were hired permanently in BILH hospitals. BIDMC participated in these hirings.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal

Each year, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.	In FY25, 126 employees across BILH were enrolled in ESOL classes. BIDMC employees participated in these classes.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.	In FY25, 12 BILH employees attended citizenship classes, 102 BILH employees attended career development workshops and 138 BILH employees attended financial literacy classes. BIDMC employees participated in these offerings.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, Workforce Development will offer paid trainings for community members across BILH.	In FY25, BILH trained a total of 97 community members to pipeline programs, including Patient Care Technician/ Nursing Assistant, Pharmacy Tech, Medical Assistant, CPT, Surg Tech, Research Admin, Endoscopy Tech and the Associate Decree Nursing Residency program. BIDMC participated in offering these trainings.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
In FY25, Workforce Development will offer pipeline programs to community members.	In FY25, Workforce Development recruited 73 community members into pipeline programs and hired 92% of them.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Outcome Goal
In FY25, Workforce Development will establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.	In FY25, Workforce Development established 11 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 55 high school students in paid cooperative education placements and 20 into unpaid clinical placements. BIDMC participated in offering these trainings.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Outcome Goal
Each year, BIDMC will host at least 20 students in the Summer Health Corps program which provides teenagers with education about healthcare careers through service, career panels, mentoring and tours. 25% of participants will be from the Community Benefits Service Area.	BIDMC hosted 22 high school students in summer 2025. At the time of the program, 50% of these students resided in the CBSA. The students participated in service assignments, career panels, and tours, gaining experience and exposure to a variety of healthcare careers.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community-based Health Initiative: Housing Affordability Grants**	
Brief Description or Objective	BIDMC, through its Community-based Health Initiative (CHI), is investing in local organizations to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families. To date, BIDMC has awarded funds to four organizations for a three-year grant period, which began January 2024. The funded organizations are: • Boston's Higher Ground: The Family-Led Stability Initiative links education and affordable housing delivery systems to achieve the dual goals of reducing family homelessness and improving health and educational outcomes for families served by the target schools. • Boston Housing Authority (BHA): BHA will expand the First Home Program to provide increase down payment assistance to BIDMC high priority neighborhood residents, increase homeownership education for BHA residents through outreach events and materials, and expand the number of lenders who understand the process of working with subsidized low and moderate income applicants. • HomeStart: Growing the eviction prevention program in Eastern Housing Court to prevent nonpayment evictions. • International Institute of New England (IINE): The Families First Initiative will allow IINE to help immigrants in Greater Boston over the next three years obtain shelter, create greater housing stability, and avoid housing court. BIDMC provided funding to two Community Development Corporations to create and preserve affordable housing units in Chinatown and Fenway. Asian Community Development Corporation acquired a naturally occurring affordable housing development in 2023 to protect Chinatown's limited affordable housing. Funds will be used to help preserve 14 existing affordable housing units and a local small business. Fenway Forward's first affordable homeownership project will convert a 6-unit market-rate rental building into six affordable homes for households earning 80-100% of the Area Median Income (AMI). Once complete, the project will increase income-restricted homeownership in the Fenway neighborhood by 33%.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Over the grant period, CHI grantees will make progress toward reducing homelessness, reducing displacement, increasing homeownership, and implementing advocacy/policy change to address housing affordability for residents	CHI grantees are implementing their programs and collecting data to measure progress against this goal. As of the end of FY25, the housing grantees had enrolled 700 participants, hired 9	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal

who live, work, and play in Boston.	staff, and trained 77 staff/volunteers.	
Over the grant period, CHI grantees will improve participants' level of housing stability, housing instability, and housing control.	In progress; endpoint data not yet analyzed.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by attending 1 Evaluation Learning Collaborative session and participating in quarterly individual technical assistance meetings with CHI independent evaluator.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community-based Health Initiative: Jobs and Financial Security Grants**	
Brief Description or Objective	BIDMC, through its Community-based Health Initiative, is investing in local organizations to increase employment and earnings and increase financial security. In 2024, BIDMC awarded funds to four organizations for a three-year grant period which began January 2024. The funded organizations are: • Building Pathways: The Pre-Apprenticeship Program (PAP) provides a pathway for low-income Boston area residents to enter the construction trades while creating a pipeline of new talent to replace an aging construction workforce and meet labor demands for the Boston area's construction market. • Casa Myrna Vasquez: Expand the Savings and Employment Incentive Program (SEIP) to support youth and adults fleeing domestic and sexual violence (SDV) in obtaining and maintaining permanent housing through progressive engagement, housing search, and rental assistance for up to two years. • Tech Goes Home (TGH): TGH partners with organizations in the identified neighborhoods across the City of Boston to offer a comprehensive digital inclusion program to residents who have been systematically excluded from the digital world and the economic opportunities it offers. • YMCA of Greater Boston: Through the ECE Apprenticeship program, participants complete 150 learning and development hours, and 2,000 hours of paid on-the-job training work experience at a YMCA Early Education center. In addition, BIDMC awarded a three-year grant beginning January 2022 to La Colaborativa's year-round youth employment program.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Over the grant period, CHI grantees will make progress toward increasing employment and earnings and increasing financial security for residents who live, work, and play in Boston.	CHI grantees are implementing their programs and collecting data to measure progress against this goal. As of the end of FY25, the jobs and financial security grantees had enrolled 369 participants, hired 10 staff, and trained 135 staff/volunteers.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will increase utilization of skills and resources, goal orientation, financial well-being and program successes.	In progress; endpoint data not yet analyzed.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal

Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by attending 1 Evaluation Learning Collaborative session and participating in quarterly individual technical assistance meetings with CHI independent evaluator.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community-based Health Initiative: Healthy Neighborhoods**	
Brief Description or Objective	BIDMC, through its Community-based Health Initiative, launched its Healthy Neighborhoods Initiative (HNI) to build neighborhood and resident capacity and facilitate collective action to address neighborhood-specific concerns that may vary depending on geography, demographics, resource availability, and other factors. Selected collectives will use funds awarded through HNI to address specific opportunities in their community, drawing on the strengths found in each neighborhood.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
In FY25, five community collectives will implement projects informed by community engagement efforts.	In FY25, the Chelsea HNI, Chinatown HOPE, Allston Brighton Connectors, Mission Hill Healthy Neighborhoods Collective and Roxbury Collective for Housing Affordability collectives continued implementation of their neighborhood-specific projects.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Boston Community Health Collaborative**	
Brief Description or Objective	The Boston Community Health Collaborative (previously known as the Boston CHNA-CHIP Collaborative), of which BIDMC is a founding member, brings together institutions and organizations contributing to the health and well-being of residents in Boston to build a shared understanding of the most important health needs, strengths, and priorities through a coordinated city-wide Community Health Needs Assessment (CHNA) and by developing and implementing a Community Health Improvement Plan (CHIP). This Collaborative aims to achieve the benefits of broad partnership around a Boston-based CHNA and CHIP, including deeper engagement of key community and organizational stakeholders; enhanced alignment of defined priorities and strategies; maximal allocation of resources; coordination of implementation strategies for collective impact and a healthier Boston.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, maximize resources from all entities and encourage collaborative initiatives.	Collaboration is taking place across the Boston Community Health Collaborative.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
BIDMC will participate in a city-wide CHNA-CHIP process that is transparent, inclusive and comprehensive.	BIDMC continues to actively participate in the steering committee and workgroups to implement the City of Boston CHNA and CHIP.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name: Community Benefits Administration and Infrastructure**	
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.	BILH offered five (5) evaluation workshops in FY25 focusing on data collection, analysis, interpretation, reporting and storytelling, with 96% of attendees reporting increased knowledge.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Community-Based Health Initiative: Behavioral Health Grants**	
Brief Description or Objective	BIDMC, through its Community-based Health Initiative, is investing in local organizations to increase access to high-quality and culturally and linguistically appropriate mental health and substance use services. In 2024, BIDMC awarded funds to three organizations: • Children's Services of Roxbury: The Front Porch program recruits, trains, coaches and expands a team of multilingual, multicultural Family Partners (community health workers) to increase access to mental health care for parents with complex trauma, increase awareness of peer-to-peer programs, and advocate to expand the use of Family Partners. • Greater Boston Chinese Golden Age Center (GBCGAC): Elevating the Healthy Ideas program to create a dedicated behavioral health division. The initiative comprises three core components: educating about mental health awareness, offering individual counseling sessions for Chinese-speaking adults, and facilitating support groups to foster ongoing peer assistance and enhance mental wellness. • Simmons University: Using a train-the-trainer model to educate high school students about evidence-based strategies, including Mindfulness, Yoga, Health and Wellness Behaviors, that they can utilize to prevent and manage behavioral health problems.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Over the grant period, CHI grantees will make progress toward improving mental health and substance use outcomes for residents who live, work, and play in Boston.	CHI grantees are implementing their programs and collecting data to measure progress against this goal. As of the end of FY25, the behavioral health grantees had reached 293 participants, hired 2 staff, and trained 40 staff/volunteers.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will report an improvement in mental health literacy, stigma, and mental health symptoms for a majority of participants.	In progress; endpoint data not yet analyzed.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Outcome Goal
Over the grant period, CHI grantees will increase their evaluation capacity.	CHI grantees increased their evaluation capacity by attending 1 Evaluation Learning Collaborative session and participating in quarterly individual technical assistance meetings with CHI independent evaluator.	Program Year: Year 2 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Facilitating Access**	
Brief Description or Objective	To increase access to mental health services, BIDMC has implemented the Collaborative Care model, a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a Beth Israel Lahey Health licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions. At Bowdoin Street Health Center, psychiatrists, the nursing team, and the Community Health Worker collaborate as an integrated team to address the complex behavioral health needs of our patients. The Community Health Worker, a State-Certified professional trained in mental health first aid, bridges the gap between health and social services, ensuring patients have access not only to mental health and emotional support but also to substance use services and essential community resources. Together, this multidisciplinary team addresses both the immediate and long-term needs of patients, providing comprehensive care that goes beyond traditional mental health treatment to support overall well-being and stability. BIDMC's Social Work department provides support groups to individuals to help establish a community of support. The hospital provides different support groups to provide a network for individuals experiencing medical difficulties ranging from cancer to pregnancy loss to COVID-19 survivors.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC will increase access to behavioral health services through the Collaborative Care model.	BIDMC provided behavioral health services to 1,054 patients at 6 practices in FY25 through the Collaborative Care model, compared to 978 patients in FY24.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BSHC's behavioral health Community Health Worker will accept referrals.	In FY25, 120 referrals were made to the behavioral health Community Health Worker and there were approximately 1,000 patient encounters.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Process Goal
Every year the BIDMC Social Work Department will provide a total of 8 support groups	In FY25, the Social Work team ran 12 support groups.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: Substance Use Services**	
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 youth and people with substance use disorders and those at risk of developing substance use disorders. SBIRT screening quickly assesses severity of substance use and helps providers identify appropriate treatments. SBIRT is recommended by the Institute of Medicine. Patients are asked about alcohol use, and those with an identified issue are provided discharge instructions including contacts for alcohol use counseling. BIDMC also has an Opioid Care Committee that works to prevent Opioid Use Disorder and to improve the care of patients with an 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. BILH is supporting The Dimock Center's Restoring Hope Campaign through a grant that will allow for the renovation and expansion of the historic Dr. Marie E. Zakrzewska Building, a focal point of The Dimock Center's campus, to house Boston's first post-detox clinical stabilization program for men. The building will also be renovated to accommodate The Dimock Center's existing women's clinical stabilization program. Together the 16-bed men's and 16-bed women's programs will reach more than 1,000 people annually. In FY25 BIDMC received multi-year grant funding to expand the Addiction Consultation service to include the BIDMC Emergency Department. The expanded, multidisciplinary service will enable patients with substance use disorders to be seen by clinicians in-person 7 days per week. The expansion also involves a partnership with The Gavin Foundation, a nonprofit substance use disorder education, prevention and treatment agency that provides access to recovery coaches in the Emergency Department and the medical floors. Addiction Consultation clinicians also continue to offer education opportunities for other healthcare professionals and local coalitions. Bowdoin Street Health Center also received multi-year grant funding to implement substance use disorder (SUD) treatment and services, including community education and engagement, organizational policy change, diverse staff hiring, and low threshold clinical SUD service expansion.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**

Each year, Social Work will collaborate with the trauma care department to assure the ongoing management of SBIRT data and clinical assessment of patients with substance use disorders.	In FY25 the program exceeded the American College of Surgeons mandated screening rate of 80% with a 98% outcome. Qualified health care professionals, including Social Workers provide motivational counseling, assess/ support readiness for change and provide referrals to support patients moving along the continuum of change to help optimize health outcomes.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
In FY25, BIDMC will operate a multidisciplinary hospital-based Addiction Consultation service with recovery coaches.	Goal met.	Program Year: Year 1 Of X Years: Year 1 Goal Type: Process Goal

Priority Health Need: Behavioral Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, Beth Israel Deaconess Medical Center (BIDMC) participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	**Goal Status**	**Goal Year and Type**
Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA)	More than 146 community residents and BILH staff attended one of 11 MHFA trainings (9 Adult and 2 Youth, with 1 of the Adult trainings conducted in Spanish) provided across the BILH CBSA, of which 53% (78) completed all pre- and post-training requirements to receive Mental Health First Aid certification.	Program Year: Year 2 Of X Years: Year 2 Goal Type: Process Goal
Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	Two (2) Behavioral Health Navigation and Digital Literacy workshops were conducted in FY25 with 13 participants, including RNs, CHWs/Navigators, Social Workers and a Housing Case Manager. In the program evaluation, 82% of participants felt confident to help navigate patients to appropriate behavioral health care and 70% felt confident to guide patients to web-based apps to help them meet their behavioral health needs.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

Priority Health Need: Equitable Care **Program Name: 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 health disparities and developing evidence-based strategies to improve health status of affected groups. 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	**Goal Status**	**Goal Year and Type**
Each year, BIDMC will advance knowledge about causes and remedies of health disparities.	Researchers/clinicians engaged in health disparities research efforts through 41 unique research studies.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal
Each year, BIDMC will participate in multi-institutional collaborations to reap synergies and share knowledge.	In FY25, BIDMC faculty and staff participated in DF/HCC, Harvard Catalyst, Harvard School of Public Health, BBCEC, and other multi-institutional collaborations.	Program Year: Year 3 Of X Years: Year 3 Goal Type: Process Goal

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$8,755,308
Community-Clinical Linkages	$4,421,312
Total Population or Community Wide Interventions	$11,843,705
Access/Coverage Supports	$30,248,169
Infrastructure to Support CB Collaborations	$227,725
Total Expenditures by Program Type	$55,496,219
CB Expenditures by Health Need	
Chronic Disease	$26,898,518
Mental Health/Mental Illness	$5,425,539
Substance Use Disorders	$4,952,355
Housing Stability/Homelessness	$2,893,731
Additional Health Needs Identified by the Community	$15,326,076
Total Expenditures by Health Need	$55,496,219
Leveraged Resources	
Total Leveraged Resources	$9,819,073
Net Charity Care Expenditures	
HSN Assessment	$20,254,039
Free/Discounted Care	N/A
HSN Denied Claims	$9,449,034
Total Net Charity Care	$29,703,074
Total CB Expenditures	$95,018,366

Additional Information	
Net Patient Services Revenue	$2,359,619,242
CB Expenditure as % of Net Patient Services Revenue	4.03%
Approved CB Budget for FY26 (*Excluding expenditures that cannot be projected at the time of the report)	$63,233,584

Bad Debt	**$12,242,290**
Bad Debt Certification	**Yes**
Optional Supplement	Total Charity Care is $198,574,751 and includes BIDMC's payment of $20,254,039 to the Health Safety Net; $103,480,891 in unreimbursed Medicare Services; $62,597,531 in unreimbursed MassHealth Services; and $12,242,290 in bad debt. In addition, BIDMC made a contribution of $3,882,718 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 $1,003,012 to the Center for Health Information and Analysis (CHIA) and $267,925.39 to the Health Policy Commission (HPC).
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update 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:

While BIDMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity and values, encompassed by the acronym WE CARE:

Wellbeing - We provide a health-focused workplace and support a healthy work-life balance
Empathy - We do our best to understand others' feelings, needs and perspectives
Collaboration - We work together to achieve extraordinary results
Accountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals
Respect - We value diversity and treat all members of our community with dignity and inclusiveness
Equity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.

The mission of BIDMC is to provide high-quality, compassionate medical care in partnership with its medical staff to improve the health of its communities

2. Community Benefits Advisory Committee (CBAC):

- Members (and titles): Flor Amaya, Director of Public Health, Department of Human Services and Public Health, City of Chelsea; Alexandra Chéry Dorrelus, Co-Director, Louis D. Brown Peace Institute; Lynne Courtney, Program Administrator, Workforce Planning and Development, Beth Israel Lahey Health (BILH); Shondell Davis, Community Trauma Healing Specialist, Cory Johnson Center for Post-Traumatic Healing; Pamela Everhart, Senior Vice President, Head of Regional Public Affairs, Inclusion and Impact, Fidelity Investments; Pat Folcarelli, Chief Nursing Officer and Senior Vice President for Patient Care Services, BIDMC; Lauren Gabovitch, Case

Manager, BIDMC; Nancy Kasen, Vice President, Community Benefits and Community Relations, BILH; Barry Keppard, Public Health Director, Metropolitan Area Planning Council; Angie Liou, Executive Director, Asian Community Development Corporation; Jean McClurken, Director of Behavioral Health, Fenway Health; Amy Nishman, Senior Vice President of Strategy, JVS Boston; Sandy Novack, Social Worker, Patient Family Advisor; Alex Oliver-Davila, Executive Director, Sociedad Latina; Triniese Polk, Director of Racial Equity and Community Engagement, Boston Public Health Commission; Richard Rouse, Advisory Board Member and former Executive Director, Mission Hill Main Streets; Leonardo Ruiz Sanchez, Lead Community Organizer, Fenway Community Development Corporation; Anna Spier, Manager of Community Benefits and Community Relations, BIDMC; Samantha Taylor, Executive Director, Bowdoin Street Health Center; LaShonda Walker-Robinson, Community Resource Specialist, BIDMC; Fred Wang, Executive Director, The Wang Foundation

- Leadership: Peter Healy, BIDMC President and Divisional President, Metro Boston for BILH; Jarrod Dore, Vice President, Capital Facilities and Engineering; Jo Ayoub, Divisional Vice President, Human Resources Business Partner, Metro Boston; Satish Bhogadi, Interim Chief Financial Officer; Nancy Kasen, Vice President, Community Benefits and Community Relations and Managing Director, Community Care Alliance; Pat Folcarelli, RN, MA, PhD, Senior Vice President for Patient Care Services and Chief Nursing Officer; Matthew Larkin, Chief Operating Officer; Anthony Weiss, MD, Chief Medical Officer
- Frequency of meetings: Quarterly

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:

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:

Hospital Board:
BIDMC's Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy.

Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process.

Senior Leadership:
• Peter Healy, President: Designated a member of the senior leadership team to the CBAC and participated in the approval process.
• Pat Folcarelli, RN, MA, PhD, Senior Vice President for Patient Care Services and Chief Nursing Officer: Senior leadership liaison to the Community Benefits Advisory Committee
• Nancy Kasen, Vice President of Community Benefits and Community Relations, and Community Benefits team: designed, directed and oversaw the CHNA and IS, managed prioritization process, drafted Implementation Strategy
•Anna Spier, Manager of Community Benefits and Community Relations: led BIDMC community engagement efforts
• BILH Community Benefits Committee (CBC): guided the process for the system

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 similar efforts. The assessment was supported by BIDMC's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members, service providers, and other stakeholders who live in and/or work in BIDMC's CBSA. BIDMC's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: economic stability, food insecurity and nutrition, housing, environmental sustainability, and community cohesion and resilience.

- 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. Throughout the assessment process, BIDMC worked to understand the needs of all populations in the Community Benefits Service Area, including those that have been historically underserved. The content of the Implementation Strategy is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity.

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)

BIDMC's Implementation Strategy includes a range of programs and resources to address the prioritized needs within the hospital's Community Benefits Service Area. The majority of BIDMC's community benefits initiatives are focused on cohorts and geographies due to identified needs. Additionally, BIDMC collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions.

5. Maternal Health Focus

- How does your organization assess maternal health status in the Community Needs Assessment Process? (150-word limit)

BIDMC's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include the Center for Health Information Analysis (CHIA), Community Health Equity Survey (CHES), County Health Rankings, MA DPH, National Center for Health Statistics and U.S. Census Bureau. The hospital's data table has a section for Maternal and Child Health/Reproductive Health which includes infant mortality rate (%) and low birth weight (%). In addition to secondary data capture and review, throughout the CHNA BIDMC engages with the community to collect primary data via a survey, focus groups and listening sessions to directly enable community residents to identify priorities.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement?

BIDMC partners with Bowdoin Street Health Center, The Dimock Center, South Cove Community Health Center, Fenway Health, and the Neighborhood Birth Center on maternal health initiative(s). Additionally, BIDMC is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Vice President of Health Equity serves as the Executive Sponsor. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?

BIDMC currently works with Bowdoin Street Health Center, The Dimock Center, South Cove Community Health Center, Fenway Health, and the Neighborhood Birth Center. No additional assistance is needed, BIDMC's maternal health work will continue to be guided by the BILH MHQEC and BIDMC looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

II. Community Engagement

1. Organizations Engaged in CHNA and/or Implementation Strategy

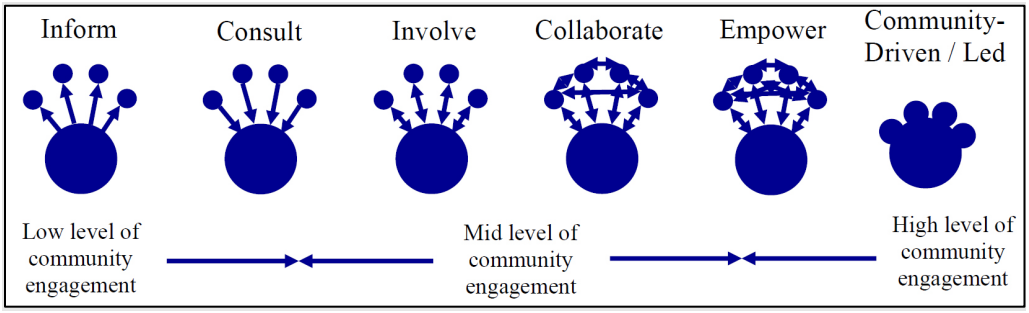
Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs

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)
Community Care Alliance	Dr. Charles Anderson, President and Chief Executive Officer, Dimock Center; Samantha Taylor, Executive Director, Bowdoin Street Health Center; Matt Mullaney, Chief Executive Officer, Charles River Community Health; Jordina Shanks, Chief Executive Officer, Fenway Health; Eric Tiberi, Chief Executive Officer, 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. Representatives from CCA health centers serve on the Community Benefits Advisory Committee.
Asian Community Development Corporation	Angie Liou, Executive Director	Housing organizations	BIDMC provided funding for one of Asian CDC's affordable housing developments. Angie Liou also serves on the BIDMC Community Benefits Advisory Committee, and Asian CDC participated in Chinatown HOPE, a community-led project funded by BIDMC's Community-based Health Initiative.
The Louis D. Brown Peace Institute	Clementina Chéry, Founder, President and CEO; Alexandra Chéry Dorrelus, Co-Executive Director	Social service organizations	BIDMC's Center for Violence Prevention and Recovery collaborates closely with the Peace Institute. Alexandra Chéry Dorrelus serves on the BIDMC Community Benefits Advisory Committee. Pat Folcarelli is co-chair of their annual Mother's Day Walk for Peace; BIDMC sends a large team every year.
Boston Public Health Commission	Triniese Polk, Director of Racial Equity and Community Engagement and Tibrine da	Local health department	BIDMC engages with BPHC on a number of initiatives, including the Farmer's Market Coupon program, emergency preparedness efforts, Boston

	Fonseca, Project Director, Boston Community Health Collaborative		Healthy Start Initiative and the Boston Community Health Collaborative.

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health2 to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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)
Overall engagement in assessing community health needs	Collaborate	Goal was met	Collaborate
Collecting data	Consult	Goal was met	Consult
Defining the community to be served	Collaborate	Goal was met	Collaborate
Establishing priorities	Collaborate	Goal was met	Collaborate

[2] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, available at: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

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

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	Collaborate	Goal was met	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	Goal was met	Consult
Implementing Community Benefits programs	Collaborate	Goal was met	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met	Consult

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

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.

In FY25, BIDMC held four CBAC meetings, a community listening session and an annual meeting that were broadly advertised to the public. Additionally, four newsletters were distributed to inform the community about the Community Health Needs Assessment and Implementation Strategy process, including opportunities for input, and other Community Benefits updates.

The BIDMC CBAC met on the following dates:

December 10, 2024
March 26, 2025
June 18, 2025
September 17, 2025

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 its committed 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 its collaboration with these and other organizations that allow for meaningful community engagement.

   What lessons have you learned from your community engagement experience? (150-word limit)

   Working collaboratively with other hospitals, community-based organizations, public health agencies, residents, and area coalitions enhances the level and quality of BIDMC's community engagement efforts.

III. Regional Collaboration

1. Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No

   a. If so, briefly describe it. If not, why?

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
   - Institutions Involved
   - Brief description of goals of collaboration
   - Key communities engaged through collaboration. If you did not participate in a collaboration, please explain why not:

For its FY 2025 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 11 licensed hospitals, including BIDMC. While BIDMC focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing significant barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect

to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

BIDMC's Community Benefits staff also gathered and included information from two other assessments conducted by organizations or collectives of organizations in Boston and/or Chelsea: 1) The Boston Community Health Collaborative, and 2) The North Suffolk Public Health Collaborative Community Health Assessment. Nancy Kasen, Beth Israel Lahey Health's Vice President of Community Benefits and Community Relations, served as the founding Co-Chair of the Boston Community Health Collaborative Steering Committee and continues to serve on its Steering Committee and workgroups. Anna Spier, Manager of Community Benefits and Community Relations at BIDMC, served on the North Suffolk Public Health Collaborative Steering Committee.

Appendix A: Partners

FY25 Partner	Level of Community Engagement	FY25 Partner	Level of Community Engagement
2nd Act	Collaborate	HomeStart	Community Driven/Led
A Better City	Consult	Hospitality Homes	Consult
About Fresh	Collaborate	International Institute of New England	Community Driven/Led
Action for Boston Community Development (ABCD)	Involve	Jane Doe Inc.	Involve
Adcare Treatment Center	Collaborate	Jasmine Grace Outreach	Involve
African Bridge Network	Involve	Jewish Community Center (JCC) of Greater Boston	Collaborate
AIDS Action Committee	Consult	Jewish Family and Children's Service	Consult
AIDS Support Group of Cape Cod	Consult	Jewish Vocational Services	Involve/Collaborate
Alzheimer's Association of MA (Waltham)	Consult	Joe Andruzzi Cancer Fund	Involve
American Cancer Society	Collaborate	Jose Mateo Ballet Theatre	Collaborate
American Heart Association	Collaborate	Joslin Diabetes Center	Involve
American Chinese Christian Education & Social Services, Inc.	Inform	Just a Start	Involve
Asian American Civic Association	Inform	Justice Resource Institute (JRI) in Boston	Involve
Asian Community Development Corporation	Community Driven/Led	La Alianza Hispana (Boston)	Consult
Atrius Health	Collaborate	La Colaborativa	Community Driven/Led
Bay Cove Center Club	Collaborate	Lahey Health Treatment Center	Consult
Beth Israel Lahey Health Primary Care	Community Driven/Led	Leukemia & Lymphoma Society	Collaborate
Bikes Not Bombs	Collaborate	Louis D. Brown Peace Institute	Collaborate
Boston Area Rape Crisis Center (BARCC)	Collaborate	Madison Park Technical High School MA Program	Collaborate
Boston Center for Independent Living	Collaborate	Massachusetts College of Art and Design	Collaborate
Boston Children's Hospital	Involve	Massachusetts Commission for the Blind	Involve
Boston Chinatown Neighborhood Center	Community Driven/Led	Massachusetts Commission for the Deaf and Hard of Hearing	Involve
Boston Comprehensive Treatment Center	Involve	Massachusetts Department of Children and Families	Involve
Boston Elder Services	Involve	Massachusetts Department of Environmental Protection (MassDEP)	Involve
Boston Emergency Medical Services	Empower	Massachusetts Department of Public Health	Collaborate
Boston Fire Department	Collaborate	Massachusetts Department of Transitional Assistance	Inform
Boston Green Academy	Empower	Massachusetts Department of Transportation (MassDOT)	Inform
Boston Health Care for the Homeless Program	Collaborate	Massachusetts General Brigham	Collaborate

Boston's Higher Ground	Community-Driven/Led	Massachusetts Health Information Highway	Involve
Boston Housing Authority	Community-Driven/Led	Massachusetts HIV Drug Assistance Program	Involve
Boston Living Center	Involve	Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA)	Inform
Boston Medical Center	Collaborate	Massachusetts Institute of Technology	Empower
Boston Police Department	Collaborate	Massachusetts Insurance Commission	Consult
Boston Public Health Commission	Collaborate	Massachusetts Rehabilitation Commission	Consult
Boston Public Schools	Involve	Massachusetts State Police	Collaborate
Boston University Law Clinic	Involve	Mass Hire Boston	Collaborate
Boston University School of Public Health	Collaborate	Millenium Training Institute	Involve
Bowdoin Geneva Main Streets	Collaborate	Mount Auburn Hospital	Collaborate
Bowdoin Street Health Center	Empower	New England AIDS Education and Training Center	Consult
Boys and Girls Club of Boston	Involve	New England Life Flight Inc (DBA Boston Medflight)	Involve
Brigham and Women's Hospital	Collaborate	North Shore Community College	Involve
Brigid's House of Hope	Collaborate	Operation ABLE of Greater Boston	Involve
Brookline Center for Community Mental Health	Involve	Outer Cape Health Services	Collaborate
Building Pathways	Community Driven/Led	PAIR Project	Involve
Bunker Hill Community College	Involve	Partners for World Health	Collaborate
Brockton Area Multi Service Inc. (BAMSI)	Consult	Pine Street Inn	Involve
Cambridge Community Learning Center	Involve	Pink Revolution	Collaborate
Cambridge Health Alliance	Collaborate	Practice Green Health	Inform
Cape Verdean Association of Boston	Collaborate	Private Industry Council	Collaborate
CAPIC, Inc.	Community Driven/Led	Project Home Again	Collaborate
Casa Myrna	Community Driven/Led	RIA, Inc.	Collaborate
Catholic Charities Boston	Collaborate	Riverside Community Care	Involve
Charles River Community Health	Collaborate	Room to Grow	Involve
Chelsea Community Connections	Community Driven/Led	Roxbury Community College	Involve
Children's Services of Roxbury	Community Driven/Led	Roxbury Tenants of Harvard	Involve
Chinatown Progressive Association	Community Driven/Led	Ryan White Dental Program	Involve

Circle of Hope	Consult	SCALE (Somerville Public Schools)	Involve
City of Boston Emergency Management Office	Collaborate	Sexual Assault Nurse Examiner (SANE) Program	Involve
City of Boston's Green Ribbon Commission	Inform	Sexual Assault Unit of Disabled Persons Protection Commission	Involve
Community Research Initiative	Involve	Simmons University	Community Driven/Led
Community Servings	Collaborate	Sociedad Latina	Community Driven/Led
Community Work Services	Involve	South Cove Community Health Center	Collaborate
Conference of Boston Teaching Hospitals (COBTH)	Empower	Spectrum Westborough	Consult
Cradles to Crayons	Involve	St. Peter's Teen Center	Community Driven/ Led
Dana Farber Cancer Institute	Collaborate	Steps to Success	Involve
Dorchester Catholic Parishes	Community Driven/Led	Tech Goes Home	Community Driven/Led
Dorchester Bay Economic Development Corporation	Empower	The Dimock Center	Collaborate
Dorchester Food Co-Op	Community Driven/Led	The Longwood Collective	Collaborate
Ellie Fund	Inform	The Gavin Foundation	Collaborate
English for New Bostonians	Involve	The Network/La Red	Involve
Eversource	Consult	The One By One Project	Collaborate
Fair Foods (Boston)	Collaborate	The Partnership, Inc.	Empower
Family Nurturing Center	Collaborate	The Student National Medical Association, National and NE Chapter	Community Driven/Led
Father Bill's and Mainspring	Inform	Tobin Community Center	Collaborate
Fenway Community Development Corporation	Community Driven/Led	Training, Inc.	Collaborate
Fenway Health	Collaborate	Trustees of Reservations	Collaborate
First Source	Involve	Tufts Medical Center	Collaborate
Food for Free	Involve	United Cerebral Palsy of Metro Boston	Involve
Found in Translation	Consult	Urban Edge	Community Driven/Led
GLAAD	Inform	U S. Environmental Protection Agency (EPA)	Collaborate
Greater Boston Chinese Golden Age Center	Community Driven/Led	Victim Rights Law Center	Collaborate
Greater Boston Employment Collaborative	Involve	Victory Programs	Involve
Greater Boston Food Bank	Inform	Vinfen Corporation	Collaborate
Greater Boston YMCA	Collaborate	Viridian Apartments	Involve

Greater Four Corners Action Coalition	Empower	WilmerHale Legal Services (also known as the Legal Service Center)	Collaborate
GreenRoots	Community Driven/Led	Work Opportunities Unlimited	Involve
Hack Diversity	Collaborate	Wonderfund Massachusetts	Empower
Harvard Medical School	Community Driven/Led	YMCA of Greater Boston	Collaborate
Health Care for All	Collaborate		
Health Imperatives	Collaborate		
Health Law Advocates	Collaborate		
Healthcare Without Harm	Inform		