Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health
Beth Israel Deaconess Needham

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
BID Needham is a member of Beth Israel Lahey Health (BILH). BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery–academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care–in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

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

The mission of Beth Israel Deaconess Hospital–Needham (BID Needham) is to serve BID Needham patients compassionately and effectively and to create a healthy future for them and their families. BID Needham's mission is supported by the hospital's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining financial health. The hospital is also committed to being active in the community. Service to community is at the core of BID Needham's mission.

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

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

- **Involving BID Needham's staff**, including its leadership and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy;

- **Engaging and learning from residents** throughout BID Needham's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of BID Needham and those who are often left out of assessment, planning, and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize

those in the community who are most vulnerable and face disparities in access and outcomes;

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

- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry 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., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations
Beth Israel Deaconess Hospital–Needham's CBSA includes Dedham, Dover, Needham, and Westwood. BID Needham's FY19 Community Health Needs Assessment (CHNA) findings, on which this report is based, show that low-to moderate-income individuals and families, individuals with chronic/complex conditions, youth, and older adults face the greatest health disparities and are most at risk. Collectively, these geographic, demographic, and socio-economic population segments are BID Needham's priority populations. While BID Needham is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated Community Benefits guidelines, BID Needham's Implementation Strategy will focus on these populations.

Basis for Selection
Community health needs assessments; public health data available from government (MDPH, Boston Public Health Commission, federal agencies) and private resources (foundations, advocacy groups); BID Needham's areas of expertise.

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in BID Needham's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS). Fiscal Year 2021 was the second year of BID Needham's 2020-2022 Implementation Strategy. The Community Benefits programs focused on the three priority areas highlighted in the FY2019 Community Health Needs Assessment: Social Determinants of Health and Access to Care, Chronic and Complex Conditions and their Risk Factors, and Mental Health and Substance Use.

Response to the COVID-19 pandemic continued for the FY21 reporting year. Many of the Community Benefits programs the hospital supports were modified to address needs that were exacerbated by the pandemic. Additionally, the closure of Norwood Hospital continued

to put a significant strain on the physical and human resources at the hospital, with BID Needham seeing more mental health and substance use patients, and more patients with needs related to social determinants of health.

The following highlights programs in each of the hospital's priority areas for FY21:

Social Determinants of Health and Access to Care
The organizations BID Needham supports continue to report that food access and housing access are some of the biggest issues coming out of the pandemic. The hospital supported food access programs in all four towns in its CBSA.

In Westwood, the Council on Aging delivered shelf-stable food boxes to seniors who were unable to get out to the grocery store. In Dedham, the Dedham Food Pantry saw their largest demand for food, and was able to offer access to all Dedham residents who needed it. In Dover, "grab and go" meals were offered to seniors, as not only a source of nourishment, but also as a mental health "well check." In Needham, the hospital continued a partnership with the Needham Community Farm, Charles River Center and Needham Bank, to run a mobile market delivering free, fresh produce to residents living in public housing in Needham. BID Needham also continued to collaborate with The Town of Needham to prepare meals for the town's traveling meals program, delivering more than 9,500 meals in FY21, and provided a grant to the Needham Farmer's market.

On a regional level, BID Needham supported Mass Bay Community College's summer food access program for students in need, and continued support of food access organizations including the Needham Farmer's Market, Ripples of Hope, and Three Squares New England.

BID Needham, The Town of Needham, and The Needham Council on Aging continued the "Healthy Aging" partnership (in year three of five). This program subsidized fitness programming, including use of the fitness center, trainers and evidence-based strength and balance classes, for older adults in the community. During FY21, the funding also supported rides to medical appointments during the pandemic, and grocery delivery for homebound individuals or those with higher risk conditions.

In the area of housing, BID Needham supported Family Promise MetroWest's LIFE Initiative to prevent homelessness for families. In regards to other social needs, the hospital also provided a grant to Needham Steps Up for their mentorship program, and to Needham Housing Authority for their after-school program. They also supported WELCOMEBACK packs for the Concord Prison Outreach, and provided a grant to the Dedham Council on Aging to purchase iPads and improve technology access for homebound seniors.

In the area of Access to Care, BID Needham continued to employ financial counselors to assist with insurance enrollment and navigation and to provide options for linguistically and culturally appropriate health care. The hospital also partnered with Circle of Hope to provide essentials, such as clothing, shoes, jackets and personal care items, to emergency department patients who were in need of basic items.

Chronic and Complex Conditions and their Risk Factors
BID Needham continued to support local organizations with grants to provide programming to the community for those suffering from chronic or complex conditions. These programs included the Charles River YMCA's LiveStrong program for cancer survivors, Charles River Center's medical needs for their residents, and VNA Care's "Removing Barriers to Health" program. The hospital also continued to provide epi-pens to the Needham Public Schools.

To help patients get to medical appointments, the hospital supports The Needham Community Council's medical appointment transportation program and The Neighbor Brigade's transportation and assistance program to those suffering from chronic conditions.

Within the hospital, BID Needham works to address readmissions with a utilization review committee and partnerships with EMTs. Within the community, BID Needham works to educate on chronic disease risk factors and prevention through community talks and education, partnering with the Boston JCC and Beth Israel Deaconess Medical Center, and also supports the American Cancer Society's Annual Relay for Life.

Mental Health and Substance Use
In the area of mental health and substance use, the hospital continues to integrate behavioral health into patient care, a need that has increased exponentially this year at BID Needham and in the hospital's CBSA, between the pandemic and the closing of Norwood Hospital.

In order to address substance misuse, the hospital maintains a prescription drug kiosk and a sharps disposal kiosk in the main lobby. BID Needham's Pain Management and Opioid Taskforce continues its work on prescribing practices as well as patient and clinician education. In FY21, the hospital funded a pilot program at Needham Public Health to provide Narcan and training classes to the community.

Within the community, the hospital serves on local committees and taskforces to address the needs of residents in crisis situations, such as the Community Crisis Intervention Team, Needham's Youth Resource Network and Charles River Opioid Taskforce. BID Needham awarded grants to Walker, Plugged In, Dover Parks and Recreation, and St. Joe's Summer Theater to run youth programming for mental wellness, and to the Needham Council on Aging for their "Sunday Supper" virtual dinner program for seniors.

To educate the community and reduce stigma around mental health, BID Needham provides funding for mental health and substance use programming for youth and families. In FY21, this included bringing parent education to the community with SPAN and Needham Community Education, and continuing the partnership with Students Advocating for Life without Substance Abuse (SALSA) to provide education for middle school students. The hospital also continued to support The Riverside School.

As access to behavioral health care continues to be an issue, the Hospital has provided funding for the Interface Mental Health Hotlines in Needham and Medfield. To address care

within the community, BID Needham supports BILH's Collaborative Care program, which provides a social worker in local Primary Care Physician offices.

Plans for Next Reporting Year

In FY19, Beth Israel Deaconess Hospital–Needham conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, BID Needham will focus its FY20-22 Implementation Strategy on three priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in BID Needham's CBSA who face the greatest health disparities. These priority areas are:

- Social Determinants of Health and Access to Care
- Chronic/Complex Conditions and their Risk Factors
- Mental Health and Substance Use

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). BID Needham'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 FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine BID Needham's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, BID Needham, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BID Needham's FY20-22 Implementation Strategy should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care and service gap, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that targeted low- to moderate-income populations, youth, older adults, and those with chronic/complex conditions.

BID Needham partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, CHNA 18, local substance prevention and crisis prevention committees, and businesses.

The accomplishments highlighted in this report are based upon priorities identified and programs contained in BID Needham's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS).

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the BID Needham Community Benefits team completed a hospital self-assessment form (Section VII, page 59). The BID Needham Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in BID Needham's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)
The membership of BID Needham's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by BID Needham'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. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board members and senior leadership who are held accountable for fulfilling BID Needham's Community Benefits mission. Among BID Needham's core values is 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 BID Needham's structure and reflected in how it provides care at the hospital and in affiliated practices.

BID Needham is a member of BILH. While BID Needham oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

The BID Needham Community Benefits program is spearheaded by the Director of Community Benefits. The Director of Community Benefits has direct access and is accountable to the BID Needham President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

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

FY21 Community Benefits Advisory Committee Meetings

December 10, 2020	June 15, 2021
March 25, 2021	September 23, 2021

Community Partners

Beth Israel Deaconess Hospital–Needham 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. BID Needham's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BID Needham's staff, its health and social service partners, and the community at-large. BID Needham's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BID Needham's mission.

BID Needham serves and collaborates with all segments of the population. However, in recognition of its long-standing ties to the surrounding communities and the health disparities that exist in these communities, BID Needham focuses its Community Benefits efforts on improving the health status of the low-income and underserved populations living in Dedham, Dover, Needham, and Westwood.

BID Needham currently supports many educational, outreach, community health improvement, and health system strengthening initiatives within the community. In so doing, the hospital collaborates with many local leading healthcare, public health, and social service organizations. BID Needham works closely with the Public Health Departments in the area, as well as local Councils on Aging, and food pantries to address substance abuse prevention, mental health, chronic disease management, food access, and transportation. The hospital also supports local organizations that provide opportunities to prevent and manage chronic disease, such as the Boston JCC and the Charles River YMCA. The hospital provides funding to and programming with mental health organizations such as the Charles River Center, Walker, and Riverside.

BID Needham is also an active participant in several local coalitions and committees, including The Needham Community Crisis Intervention Team (CCIT), Youth Resource Network, and the Needham Local Emergency Planning Committee. Joining with such grass-roots community groups, public health and first responders, BID Needham strives to create a vision for health improvement and preparedness, and to address on-going crises for residents in the community. Also important are partnerships to address substance use and mental health, including BID Needham's involvement with the Substance Prevention Alliance of Needham (SPAN), Charles River Opioid Taskforce, and CHNA 18.

BID Needham's Board of Trustees, along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise, education, and research, along with an underlying commitment to health equity, are the primary tenets of its mission. BID Needham's Community Benefits Department, under the direct oversight of BID Needham'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.

The following is a comprehensive listing of the community partners with which BID Needham joins in assessing community need as well as planning, implementing, and overseeing its

Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 59).

Community Partners

American Cancer Society
Charles River Center
Charles River Regional Chamber
Charles River YMCA
CHNA 18
Circle of Hope
Concord Prison Outreach
Dedham Council on Aging
Dedham Food Pantry
Dover Council on Aging
Dover Parks & Recreation
Family Promise MetroWest
Greater Boston JCC
Livable Dedham
LiveStrong at the YMCA
Mass Bay Community College
Medfield Coalition for Suicide Prevention
Medfield Public Schools
Needham Bank
Needham Clergy Association
Needham Community Council
Needham Community Education
Needham Community Farm
Needham Council on Aging
Needham Emergency Management
Needham Farmer's Market
Needham Fire Department
Needham Sports Boosters
Needham Housing Authority
Needham Police Department
Needham Public Health
Needham Public Schools
Needham Steps Up
Needham Traveling Meals Program
Needham Youth & Family Services
Neighbor Brigade
Newton Wellesley Hospital
Norwood Fire Department
Plugged In Band
Riverside Community Care
Sean D. Biggs Memorial Foundation
St. Joe's Summer Theater
Students Advocating Life without Substance Abuse (SALSA)
Substance Prevention Alliance of Needham (SPAN)
Three Squares New England
Town of Dedham
Town of Needham
VNA Care Network
Walker
Westwood Council on Aging
Westwood Youth & Family Services
Westwood Fire Department
William James College

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment (CHNA) along with the associated FY20-22 Implementation Strategy was developed over a ten-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill BID Needham'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 BID Needham's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, BID Needham's most recent CHNA was completed during FY19. FY20 Community Benefits programming was informed by the FY19 CHNA and aligns with BID Needham's FY20-FY22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods

The FY19 CHNA was conducted in three phases, which allowed BID Needham to:

- Compile an extensive amount of quantitative and qualitative data,
- Engage and involve key stakeholders, BID Needham clinical and administrative staff, and the community at large,
- Develop a report and detailed strategic plan, and
- Comply with all Commonwealth Attorney General and Federal IRS community benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, focus groups, a community forum, and a survey.

The CHNA used a participatory, collaborative approach to look at health in its broadest context. The assessment process included synthesizing existing regional data on social, economic, and health indicators, as well as information from key informant interviews, focus groups with residents and social service organizations, a community forum for all residents in the service area, and online and in-person surveys. Community dialogues and key informant interviews were conducted with individuals from across the four towns that comprise the BID Needham service area, and with a range of people representing different audiences, including leaders in emergency response, education, health care, and social service organizations focusing on vulnerable populations (e.g., youth and aging). The hospital also worked collaboratively with Needham Public Health to share information from its respective needs assessment activities relative to its efforts to become an accredited health department. Ultimately, the qualitative research engaged more than 500 people.

Beth Israel Deaconess Hospital–Needham's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. BID Needham's understanding of these communities' needs is derived from discussions with and observations by healthcare and health-related workers in the community, as well as more formal assessments through available public health data, focus groups, and surveys. This data was then augmented by demographic and health status information gleaned from a variety of sources including The Massachusetts Department of Public Health, The Boston Public Health Commission, federal resources such as the Institute of Medicine and Centers for Disease Control and Prevention, and review of literature relevant to the particular community's needs.

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

Summary of FY19 CHNA Key Health-Related Findings
Beth Israel Deaconess Hospital–Needham's CHNA resulted in key findings related to social determinants of health, substance use and mental health and access to these services, chronic and acute physical health conditions, health risk factors, and challenges related to navigating the health care system and coordination of care. The following summarizes the assessment's key findings.

Social Determinants of Health Have a Substantial Impact on Many Segments of the Population
One of the dominant themes from the assessment's findings was the impact that the underlying social determinants of health are having on those living in the CBSA. The segments of the population most challenged by these issues are older adults, low-income individuals/families, racial/ethnic minorities, non-English speakers, and those with disabilities or with chronic / complex conditions. More specifically, these segments struggle with financial insecurity, safe/affordable housing, transportation, access to healthy/affordable food, lack of social support, social isolation, and language barriers. These issues affect many people's and families' ability to access or pay for the services, housing, food, or other essential items they need and/or to live a happy, fulfilling, productive life.

The Burden of Substance Use and Mental Health Issues
Mental health and substance use issues continue to be one of the region's most relevant and challenging issues and are having a profound impact on individuals, families, and communities throughout the CBSA. These issues are also a major burden on the health and social service system. Health and social service providers, public health agencies, first responders, and community-based organizations are confronted on a daily basis with people

struggling with acute or chronic conditions and have difficulty providing or linking them to the care they need. With respect to mental health issues, depression/anxiety, stress, social isolation, and the impacts of trauma are the leading issues. With respect to substance use, the opioid crisis continues to have a tremendous impact on the region, along with alcohol use, marijuana use, and vaping in youth. The fact that physical health, mental health, and substance use issues are so intertwined compounds the impact of these issues. Of particular concern are the increasing rates of opioid use and the impacts of trauma.

Limited Access to Behavioral Health (Mental Health and Substance Use) Services
Despite the prevalence of mental health and substance use issues and the impact that these issues are having on individuals, families, and communities, the behavioral health service system in the region is extremely limited. There are major shortages of specialized providers, such as psychiatrists, therapists, addiction specialists, and case managers who are capable of providing the full breadth of preventive, screening, assessment, treatment, and recovery support services that the community needs. This is particularly true for those who have limited English skills or different cultural perspectives that require specialized care, such as immigrants, racial/ethnic minorities, and LGBTQIA+ individuals. Uninsured individuals, those covered by Medicaid, and those in low- to moderate-income brackets also struggle to access or pay for the services they need or to find providers who are able to take their coverage or insurance.

High Rates of Chronic and Acute Physical Health Conditions
Another major finding from the assessment is the high rates of chronic and complex conditions that exist for many of the leading physical health conditions (e.g., heart disease, hypertension, cancer, and asthma) in the CBSA. Overall, the rates of illness and death are not statistically higher than the rates for the Commonwealth, however, it is important to note that these chronic physical health conditions are still the leading causes of death and must be addressed to improve the region's health status.

High Rates of the Leading Health Risk Factors
Based on information gathered from focus groups, interviews, community meetings, the community health survey, and quantitative sources, the assessment found that there were substantial concerns related to the leading health risk factors, such as healthy eating, physical activity, obesity, tobacco use/vaping, alcohol use, and stress. Many of those who were involved in the assessment believed that there was a need for more health education and a greater emphasis on health promotion and prevention.

Challenges Navigating the System and Coordinating Needed Services
Another major theme from the interviews, focus groups, and community meetings conducted for the assessment was the challenges that many people in the CBSA face navigating the health and social service system. There was a general sense that there was a broad range of health and social services available in the region but that many did not know where to go for services or struggled to access the services even when they knew where to go. Once again, the population segments who struggle most to navigate the system are older adults, low-income individuals/families, racial/ethnic minorities, non-English speakers, and those with

disabilities or chronic/complex conditions. Many people said that there was a need for a resource inventory that would help residents access services along with counselors or case managers who could further assist people to obtain and access the services they need.

Priority Populations

BID Needham is committed to improving the health status and well-being of all residents living throughout its service area. All geographic, demographic, and socioeconomic segments of the population face challenges of some kind that can hinder their ability to access care or maintain good health. With this in mind, BID Needham's Implementation Strategy (IS) includes activities that will support residents throughout its service area and across all segments of the population. However, based on the assessment's quantitative and qualitative findings, there was broad agreement that BID Needham's IS should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health that put them at greater risk. The assessment identified the following priority populations to be included in the Implementation Strategy: youth, older adults, low- to moderate-income individuals and families, and individuals with chronic and complex conditions.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Community Farm Mobile Market** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	Fresh locally grown produce is delivered weekly to Needham Housing Authority sites and distributed free of charge. A guide written by nutritionists describes how to store, prep, and use of the produce. Translations for some recipes are available in English, Chinese, and Russian. The program includes education for the elderly and disabled in the Needham Housing Authority units at Linden Chambers. There are also gardening activities for families at Captain Robert Cook.
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)	Increase access to low-cost healthy foods with an emphasis on priority populations.
Goal Status	The program at Captain Robert Cook focused on making the gardens an inviting place for residents to learn about growing and eating vegetables. Harvests from the garden were distributed to families from the neighborhood. At Linden Chambers, approximately $100 of seeds and organic vegetables starts were donated to their Garden Club, an important social interaction for the residents. The Farm also loaned the residents a cold frame to increase the success of their garden. Needham Community Farm (NCF) served more than 100 families through the Mobile Market in 2021. At the Mobile Market, NCF distributed approximately 1,700 pounds of fresh produce, valued at over $14,000. In addition, the farm continued with the distribution model in 2021, delivering to each neighborhood weekly to address the increased need for food caused by the pandemic. The mobile market continues to serve as a social-emotional check-in during the pandemic, an unplanned benefit.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community Access to Healthy Food: Westwood Council on Aging** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	BID Needham is committed to providing nutrition and health information in the community and supports several local efforts to provide healthy food to seniors and families in our Community Benefits Service Area.
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)	Address food insecurity by working with local Councils on Aging (COA) to provide healthy food to homebound seniors, by providing grants to local COAs.
Goal Status	The Westwood Council on Aging provided 23 shelf stable boxes to food insecure seniors in Westwood in December 2020 and January 2021. Four different boxes were offered, based on health needs including: • no health issues • those with diabetes • vegetarian • gluten free foods

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community Access to Healthy Food: Dover Council on Aging** **Health Issue: Additional Health Needs (Food Insecurity)**		
Brief Description or Objective	BID Needham is committed to providing nutrition and health information in the community and supports several local efforts to provide healthy food to seniors and families in our Community Benefits Service Area.	
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)	Address food insecurity by working with local Councils on Aging (COA) to provide healthy food to homebound seniors, by providing grants to local COAs.	
Goal Status	The Dover COA provided healthy meals, fresh fruit and farm produce to older adults, as well as reduced isolation and provided an opportunity for socialization with COA staff and the community. Healthy food was individually packaged and distributed in a Grab & Go format with curbside pick-up behind Caryl Community Center in Dover. The COA partnered with several local farms and a bakery, holding thirteen events between February 1-September 30, 2021. 708 adults accessed these programs (175 unduplicated adults) ranging in age between 42-98, with the majority of participants aged 75 and older.	
Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community Access to Healthy Food: Needham Council on Aging** **Health Issue: Additional Health Needs (Food Insecurity)**		
Brief Description or Objective	BID Needham is committed to providing nutrition and health information in the community and supports several local efforts to provide healthy food to seniors and families in our Community Benefits Service Area.	
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)	Address food insecurity by working with local Councils on Aging (COA) to provide healthy food to homebound seniors, by providing grants to local COAs.	
Goal Status	The Needham Council on Aging delivered 560 meals to 62 individuals between January-June 2021. The program was developed to provide an opportunity for meaningful and structured social interaction, in addition to meal support to older adults in Needham. The program was successful and several of the participants continued to meet on their own after the program ended.	
Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Housing Authority After-School Program** **Health Issue: Mental Health/Mental Illness, Additional Health Needs (Other SDOH)**	
Brief Description or Objective	The After School program operates from 3:00 pm-4:30 pm Monday-Thursday out of the After School Center located at 42 Captain Robert Cook Dr. This program provides educational assistance to families with children in the Capt. Robert Cook Development. The program is led by a Northeastern University graduate with a passion for helping youth who may struggle with learning, and assisted by volunteers from Babson College and the Noble & Greenough High School. Each child is provided with a snack and the opportunity to decompress and relax. The staff also engages in science projects and some recreational activity. At least once a month the children are taken on a field trip within Needham.
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)	Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports.
Goal Status	The after-school program was funded in FY21, but was unable to operate due to COVID-19 and other factors. The funding will be used in FY22 as the program restarts in January 2022.
Program Year: Year 1	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care Program Name: Community Access to Healthy Food: Needham Farmer's Market Health Issue: Additional Health Needs (Access to Healthy Foods)	
Brief Description or Objective	BID Needham is committed to providing nutrition and health information in the community and supports several local efforts to provide healthy food to seniors and families in our Community Benefits Service Area.
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)	Increase access to healthy food by supporting the Needham Farmer's Market.
Goal Status	The hospital provided funding to the Needham Farmer's Market (NFM) in FY21, bringing fresh produce to Needham's town center every Sunday from mid-June to late November. NFM serves under-resourced individuals, families, and seniors through SNAP, EBT, HIP, WIC, Senior Coupons, and other State programs. 12,225 shoppers attended Needham Farmers Market in 2021, which was a 57% increase over shoppers attending NFM in 2020 (7,802).

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community Access to Healthy Food: Dedham Food Pantry** **Health Issue: Additional Health Needs (Food Insecurity)**		
Brief Description or Objective	BID Needham is committed to providing nutrition and health information in the community and supports several local efforts to provide healthy food to seniors and families in our Community Benefits Service Area.	
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)	Address food insecurity by supporting the Dedham Food Pantry.	
Goal Status	From January 1, 2021 through September 30, 2021, the food pantry served 3,300 households with 45,000 pounds of food. They estimate that the grant from BID Needham allowed them to purchase 15,000 pounds of food. The food pantry's only requirement for receiving food is that people reside in Dedham, but they never turn anyone away and will provide an 'emergency' bag with basic food items.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community Access to Healthy Food: Three Squares Ride for Food** **Health Issue: Additional Health Needs (Access to Healthy Foods)**		
Brief Description or Objective	BID Needham is committed to providing nutrition and health information in the community and supports several local efforts to provide healthy food to seniors and families in our Community Benefits Service Area.	
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)	Increase access to healthy food by supporting local hunger relief organizations.	
Goal Status	BID Needham is an ongoing supporter of The Three Squares Ride for Food. With funding from organizations such as BID Needham to cover the event costs, fundraisers are able to keep 100% of the money raised for their causes.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Traveling Meals** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	Providing healthy meals for homebound seniors, BID Needham makes the meals that are delivered Monday-Friday, year around. The culinary team prepare and package the meals and volunteers deliver them to community members.
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)	Support older adults and caregivers to age in place by providing meals to homebound seniors.
Goal Status	The traveling meals program prepared and delivered more than 9,500 healthy meals delivered to homebound seniors in 2021.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Family Promise LIFE Housing Program** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	The LIFE program (Local Initiative for Family Empowerment) is a homelessness prevention program that supports families who are at risk of eviction but not yet homeless.
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)	Decrease the number of people who struggle with financial insecurity, by retaining safe, affordable housing for families in the service area.
Goal Status	All 11 families who graduated from the LIFE program this year retained safe, affordable housing. The 22 families currently enrolled all remained in their homes or were moved to other safe affordable housing. NONE entered shelters.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Neighbor Brigade** **Health Issue: Additional Health Needs (Transportation, Food Insecurity)**	
Brief Description or Objective	Neighbor Brigade organizes volunteers that can be mobilized to help under-resourced residents when facing sudden crisis, such as cancer diagnosis or other illness, as well as assist with managing day-to-day tasks such as meal preparation, rides, and basic household chores.
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)	Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings. The goal was to close the transportation gap so under-resourced individuals could increase their access to critical medical appointments, which can increase both mental and physical health outcomes. Another desired outcome was to combat food insecurity that is directly related to COVID-19 and/or being in a health crisis of another nature.
Goal Status	In 2021, with the funding from BID Needham, Neighbor Brigade provided transportation to 39 individuals, grocery/food pantry delivery to 765 individuals, meal delivery to 530 individuals, supplies to 40 individuals, and gift cards to 42 individuals.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Concord Prison Outreach WELCOMEBACKpacks** **Health Issue: Additional Health Needs (Other SDOH)**	
Brief Description or Objective	WELCOMEBACKpacks is an ongoing, monthly program that addresses the large disparities in resources held by incarcerated men and women at the time of their release from prison. Backpacks, containing hygiene and safety supplies, socks, writing and materials, women's sanitary products, a reusable water bottle, and community resources, help men and women in their first crucial weeks back in their communities. Backpacks are delivered to the prisons where each identified person is awaiting release.
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)	Decrease the number of people who struggle with financial insecurity.
Goal Status	Approximately 60 WELCOMEBACKpacks were provided to men and women returning to Norfolk county communities in FY21.
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Senior Volunteer Program** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Provides the senior population with an opportunity to give back to the community. This experience consists of a social camaraderie with other volunteers, a positive outlet for helping others, and a chance to stay connected to the community. Free parking is offered along with a free lunch in The Trotman Family Glover Cafe.
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)	Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports, by offering a volunteer program at the hospital for aging adults.
Goal Status	There are 25 adult volunteers in the older adult volunteer program, which has returned in a limited capacity following COVID-19.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health/Access to Care **Program Name: Dedham Council on Aging Technology Access Program** **Health Issue: Additional Health Needs (Digital Divide)**		
Brief Description or Objective	The Dedham Council on Aging launched a technology access pilot program in FY21, funded partially by a grant from BID Needham. The program provided iPads and training to older adults who lacked access to technology.	
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)	Increase access to technology for seniors in order to prevent isolation and to provide access to telehealth and other essential services during the pandemic.	
Goal Status	Twenty iPads were purchased and issued to older adults in Dedham, with training provided by the Council on Aging. The iPads provided access to Council on Aging programming, food pantry services, telehealth appointments and other essential services.	
Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Mass Bay Summer Meal Scholarship Program** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	The Mass Bay Summer Meal Scholarship Program provides funds to students on a weekly basis to purchase food. Students are more likely to maintain their GPA and continue their education if they do not have to worry about food insecurity.
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)	Ensure that at least 12 MassBay Community College students receive meal scholarships during May through August 2021.
Goal Status	At least 12 students received meal scholarships in the summer of 2021.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Healthy Aging Initiative** **Health Issue: Chronic Disease, Mental Health/Mental Illness, Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	Partnering with the Town of Needham, Needham Public Health, and the Needham Council on Aging (CATH), the hospital supports fitness training, health and balance classes, and social programming.
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)	Reduce falling or fear of falls and increase activity level in older adults by providing access to fitness facilities, personal trainers, and classes for the aging population. Reduce elder health isolation by offering online or socially distanced programming.
Goal Status	DON funds were used to support fitness activities, including the fitness center, personal trainers, and balance/fitness programs. This program subsidized fitness programming, including use of the fitness center, trainers and evidence-based strength and balance classes, for older adults in the community. During FY21, the funding also supported rides to medical appointments during the pandemic, and grocery delivery for homebound or those with higher risk conditions.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Certified Application Counselors & System Navigation** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by the Executive Office of Health and Human Services and the Health Connector. The CACs assist with financial counseling, benefit enrollment assistance, and payment planning to the underserved and uninsured in our community.
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)	Increase the number of people assisted with insurance and other public program enrollment and patient navigation, by providing assistance with insurance enrollment.
Goal Status	In FY21, BID Needham's financial counselors successfully enrolled 70 patients in MassHealth. Financial assistance applications and information are available in English, Spanish, Chinese, and Russian.
Program Year: Year 2	**Of X Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Primary Care Support** **Health Issue: Chronic Disease, Additional Health Needs (Access to Care)**	
Brief Description or Objective	To ensure access to primary care and screening, the hospital supports Beth Israel Deaconess HealthCare offices in their Community Benefits Service Area (CBSA).
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)	Increase partnerships and collaboration with social service and other community-based organization to provide access to care.
Goal Status	BID Needham provided financial support to Beth Israel Deaconess HealthCare Primary Care Offices within the Community Benefits Service Area to ensure access to care for local residents.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Providing culturally responsive care, especially for those whom English is not their first language, is an essential piece of access to care and managing physical disease. The hospital offers several options for Interpreter Services for patients.	
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)	Increase the number of people receiving assistance with insurance and/or other public program enrollment, and patient navigation by offering culturally responsive care, including interpreter services.	
Goal Status	AMN Healthcare (Stratus) video remote interpretive services were accessed 1,300 times in FY21 at BID Needham, allowing patients for whom English is not their primary language to access care in a culturally competent way. Face-to-face interpretations were used 0 times (due to COVID-19) in FY21 at BID Needham. Telephonic interpretation sessions were used 710 times in FY21 at BID Needham, allowing ESL patients to access care in a culturally competent way.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health/Access to Care **Program Name: Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals** **Health Issue: Chronic Disease, Housing Stability/Homelessness, Mental Health/Mental Illness, Substance Use Disorder, Additional Health Needs Access to Care)**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with MGB, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
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)	By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies. By September 30, 2021, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits Committee data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement. All 20 BILH Community Benefits staff were trained on the Community Benefits Database and began data entry for FY20 regulatory reporting.

Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: Community Disease Prevention Education** **Health Issue: Chronic Disease, Mental Health/Illness**		
Brief Description or Objective	BID Needham staff and clinicians share their knowledge with the community to prevent chronic disease and encourage healthy lifestyles. The Greater Boston JCC, Councils on Aging, and local schools and coalitions are working together with local organizations and providing workshops to educate their residents and members about pertinent health issues.	
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)	Increase the number of people who are educated about chronic disease risk factors and protective behaviors, through a series of health talks with the Boston JCC.	
Goal Status	Collaborating with BIDMC and the Boston JCC, three education talks were held in FY21. "Strategies to Maintain and Prevent Brain Health and Prevent Memory Loss," "Reducing Anxiety with Tai Chi," and "Myths and Truths About Getting Older" were held in November, January and March as virtual programs open free-of-charge to the community. Approximately 30 people attended each talk.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: EMT Partnerships** **Health Issue: Chronic Disease**		
Brief Description or Objective	BID Needham works closely with local EMTs to provide the best possible care in the community. The hospital provides training for local EMTs and works with local fire departments to provide medications and training.	
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)	Increase the number of people with chronic/complex conditions whose conditions are under control, by providing local health departments and EMTs with medical supplies and training to provide community health care.	
Goal Status	BID Needham restocked ambulances with medications to ensure that access to medications and supplies were available. BID Needham has an ongoing partnership with local EMTs to train first responders in how to identify a stroke in the field. When the EMT alerts the hospital of a stroke patient coming in, the patient is met at the door by registration, a nurse, and a physician and taken to CT scan. This process expedites care for stroke patients, ensuring that they receive life-saving care as soon as possible. BID Needham and local EMTs continued this partnership in FY21.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: Reduce Readmissions** **Health Issue: Chronic Disease**		
Brief Description or Objective	The hospital staff meet regularly to review readmission information and make changes to protocols and follow-up care as needed to reduce the rate. Part of the care includes having the cardiology department provide a nurse dedicated to follow-up with patients with congestive heart failure (CHF).	
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)	Increase the number of people with chronic/complex conditions whose conditions are under control, by reducing readmission rates. Increase the number of people with chronic/complex conditions whose conditions are under control, by reducing readmission rates and by employing a Congestive Heart Failure (CHF) nurse to follow up with patients.	
Goal Status	BID Needham has a Utilization Review Committee that meets monthly to review all readmissions to the hospital within 30 days of discharge. The committee looks to identify specific causes for the readmission, such as discharge plans, care transitions, and previous conditions. The committee reviews individual readmissions but also looks at data trends. The Committee identified patients with CHF as a high priority area for review and has a cardiologist on the committee who is tasked with reviewing all CHF readmissions. BID Needham employs a CHF nurse for 36 hours a week. The nurse follows patients with a high-risk of developing CHF by making frequent calls to assess for symptoms, medication changes, tests, or procedures, education on prevention of CHF exacerbation, dietary teaching, and referrals. The nurse also sees inpatients to ensure they are receiving proper care and review information with inpatient nursing.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: Community Medication Partnerships** **Health Issue: Chronic Disease, Additional Health Needs (Access to Care)**		
Brief Description or Objective	BID Needham partners with local schools and public health to ensure the community has access to the medication and medical supplies needed.	
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)	Increase the number of people diagnosed with chronic/complex conditions whose conditions are under control, by providing local health departments and schools with medical supplies to provide community healthcare.	
Goal Status	In FY21, BID Needham provided the Needham Public Schools with epi-pens. BID Needham provides syringes and needles to the Needham Public Health Nurses Office for public vaccination clinics.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: LiveStrong at the YMCA** **Health Issue: Chronic Disease**		
Brief Description or Objective	The Charles River YMCA LiveStrong Program helps former and current cancer patients connect, and helps them develop and maintain cardiorespiratory fitness, muscular strength, endurance, flexibility and balance.	
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)	Increase the number of people with chronic/complex conditions whose conditions are under control.	
Goal Status	Due to COVID-19, LiveStrong was continued on a virtual platform in 2021. The 12-week program had 24 participants, with participants reporting 78.5% improved leg strength, 90% improved upper body strength, and 50% improved their balance.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors
Program Name: VNA Care Network: Removing Barriers to Health
Health Issue: Chronic Disease

Brief Description or Objective	Removing Barriers to Health seeks to help home health care patients, often diagnosed with chronic and complex illnesses, achieve their optimal health despite such challenges. Nurses and social workers provide vital case management services, including counseling, education, and assistance with accessing community resources and relief 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)	Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services by providing support for home health aide training.
Goal Status	Between January 1, 2021 through September 31, 2021, 437 patients were discharged from the home care program, with outcomes of needs/goals met.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: Charles River Center** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	The Charles River Center provides employment and job training, residential homes, day habilitation, and recreational programs for children and adults diagnosed with Down syndrome, autism, cerebral palsy, and other developmental disabilities. This organization is critical to the community, and BID Needham provides the organization with an annual grant to address one of their outstanding health needs. For the organization's residential programs, monitoring the health of the residents, particularly during COVID-19, was of the utmost importance in order to keep the programs running.
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)	Increase the number of adults who are engaged in evidence based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services.
Goal Status	Three AED machines were purchased and installed in July 2021 to protect the 14 residents living in the Charles River Center (CRC) group homes. Ten CRC staff were trained and certified to use this equipment and will maintain their training requirements per MA regulations. The outcome of this project increases the protection of CRC Needham group home residents from cardiac emergencies, as well as increases knowledge and prevention of cardiac incidents by training the CRC staff working in these two homes.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Transportation Assistance** **Health Issue: Additional Health Needs (Transportation)**	
Brief Description or Objective	To assist patients with getting to medical appointments, BID Needham provides rides to/from the hospital, using ride-share vouchers.
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)	Increase access to affordable, safe transportation options to health care by providing taxi and Uber vouchers to those who need a ride home from medical appointments at the hospital.
Goal Status	The hospital provided approximately 500 rides in FY21.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community Council Medical Transportation Program** **Health Issue: Additional Health Needs (Transportation)**		
Brief Description or Objective	The Needham Community Council Transportation Program provided a concierge dispatch service operated by two staff members with the ride-share service, Lyft. In order to request a ride, the individual calls the Needham Community Council and is scheduled with either a volunteer driver, if available, or a Lyft ride.	
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)	Increase access to affordable, safe transportation options to health care, through a medical appointment transportation program with the Needham Community Council.	
Goal Status	During FY21, the Community Council's Lyft Ride Program provided 577 rides to medical appointments for 132 unique low-resourced individuals.	
Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Integrated Behavioral Health Care** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	BID Needham continues to integrate behavioral healthcare into patient care. Within the hospital, BID Needham has several measures in place to provide mental health care. A Psychologist is employed to provide consultations on the inpatient units, and the Director of Clinical Liaison Psychiatry provides weekday telephone support for providers, related to Psychiatry patient care issues.
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)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing mental health services in the hospital. Increase access to screening, education, referral, and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and non-clinical settings, through an Emergency Department partnership with Riverside.
Goal Status	A Psychologist is employed to provide consultations on the inpatient units, and a Director of Clinical Liaison Psychiatry provides weekday telephone support for providers. In addition, advancements to BID Needham's behavioral health (BH) workforce includes a newly hired Director of BH, as well as a social worker embedded in the ED. BID Needham is actively recruiting a full-time Psychiatrist, a position that will serve to further enhance the hospital's BH team by assisting with diagnostic evaluations and medication initiation and stabilization. Increased supervision is provided to patients in the hospital ED that have identified BH safety concerns. Patients seeking ED care for mental health conditions are referred to Riverside, BID Needham's contracted Emergency Service Provider (ESP), for an evaluation. As part of this partnership, Riverside manages the bed search and placement process for all patients requiring inpatient level of care. As part of BID Needham's BH expansion efforts, the hospital's contract with Riverside has increased to include an embedded social worker in the ED. This full-time clinician serves as the liaison between the ED and Riverside (ESP).

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness, Social Determinants of Health – Access to Care**	
Brief Description or Objective	In order to increase access to mental health services, BID Needham 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 BILH 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.
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)	Increase access to behavioral health services.
Goal Status	Two sites with social workers were maintained in Needham for FY21, treating 452 patients.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Pain Management and Opioid Taskforce** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness**	
Brief Description or Objective	This program addresses pain management, prescribing practices, and clinician education for the hospital to reduce opioid misuse. The team is made up of surgery, pharmacy, medical staff, physical therapy, anesthesiology, quality, case management, and representatives from other clinical departments who can contribute to improving practices around opioid prescribing and education.
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)	Decrease the availability of unused prescription drugs and promote collaboration across the health system to address substance use through a Pain Management & Opioid Taskforce.
Goal Status	In FY21, the Pain Management & Opioid Taskforce continued educating clinicians and patients about prescribing practices. These initiatives included patient fact sheets and non-opioid directives, creating pain and alternative therapy resources, and distributing these to clinicians to educate on alternatives to opioids. Other initiatives included conducting an on-going prescribing query to review and modify prescribing practices within the hospital, reassessing outpatient surgical prescribing practices, and creating a new tool using our electronic medical records to better assess patient pain and timing/delivery of medications to address patient pain.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Needham Community Education Parent University** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Needham Community Education began offering free, virtual classes to parents on key topics including mental health, technology use, behaviors and other topics. BID Needham provided a grant to cover the presenter costs for one class.
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)	Provide programming for Needham Public School parents and guardians to address mental health and developmental concerns.
Goal Status	The BID Needham-supported program, "Quitting the Comparison Game" class, was well received and appreciated by community members. Ten parents attended the presentation.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Prescription Drug Disposal Kiosk** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	The hospital maintains the prescription drug disposal kiosk and sharps disposal in the lobby, as a safe way for the community to dispose of unwanted or unneeded prescription drugs and sharps.	
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)	Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose of sharps. Increase the number of opportunities that residents of the service area can give back unused prescriptions by providing a place for the public to dispose of unused and unwanted medications.	
Goal Status	The kiosk was closed for part of the year due to COVID-19; however, 74 gallons of sharps were disposed of in FY21. 376 pounds of medication were disposed of in FY21.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Community Taskforce Participation** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder, Additional Health Needs (Other SDOH)**	
Brief Description or Objective	BID Needham staff participate in local task forces directed at addressing mental health and substance use issues.
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)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, through participation in the Community Crisis Intervention Team (CCIT). Promote cross-sector partnership, collaboration, and information sharing across the broad health system by facilitating a meeting for local social service and health-focused organizations.
Goal Status	The BID Needham Chief Nursing Officer, Chief Medical Officer and Director of Behavioral Health participated in quarterly CCIT meetings. BID Needham shared emergency department data on behavioral health, substance use, violence (including domestic violence) and falls to help the team track and address these issues in the community. While some of the meetings were canceled in FY21 due to COVID-19, a hospital representative participated in Youth Resource Network roundtable discussions, serving Needham families. The goal of the meeting is to identify specific needs and identify potential resources that will help the family and change their current situation. The hospital convenes local organizations twice per year to share resources, ideas and partnership opportunities. The "Community Resource Group" meetings have been very successful. Staff from BID Needham serve on the Local Emergency Planning Committee (LEPC) in Needham. This committee has taken on a particularly important role in FY20 and FY21 with the COVID-19 pandemic. Hospital pharmacy staff participated in the Charles River Opioid Taskforce in order to identify ways to work together to address opioid misuse in the region.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Interface Mental Health Hotline** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	BID Needham's partnership with Needham Public Health and William James College provides a free mental health referral hotline to those who live and/or work in Needham. The "Interface" helpline offers callers an opportunity to work with a counselor who will provide matches to services, as well as information and resources about mental health and wellness.
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)	Increase access to clinical and non-clinical support services for those diagnosed with mental health and substance use issues, through assistance with finding mental health services.
Goal Status	Needham's Interface Helpline served 166 cases from June 2020 to May 2021. Interface reports, "During this reporting period we have experienced a tsunami of need, an overall increase in requests for referrals at approximately twice the amount we've ever had in the history of the service."

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Walker Behavioral Health Program** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Each year, BID Needham supports a behavioral health program at Walker, a non-profit providing support for youth who are facing complex emotional, behavioral, and learning challenges.
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)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, for those experiencing significant behavioral, emotional and learning challenges.
Goal Status	Walker Therapeutic Summer Camp for Day and Residential Students at The Walker School features a half-day of academic reinforcement focusing on literacy and math, 24/7 therapeutic living environment for residential students, swimming and beach trips, trips to local parks and a zoo, Battleship Cove, and Friday fun activities. In summer 2021, 99 students participated. Walker Group Home's "Camp Awesome" activities included a 24/7 therapeutic living environment, swimming and beach trips, trips to local parks and zoos, pirate ship adventure, mini golf and jumping pillow, nature hikes, waterslide fun, blueberry picking followed by baking blueberry pies. 19 students attended. Walker's Sandy Island Camping Trip included two groups (of 6 children and 4 staff each) from Walker's residential program.
Program Year: Year 2	**Of X Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Riverside Behavioral Health Programs** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	BID Needham supports behavioral health community programs at Riverside Community Care, such as The Riverside School. The school, in Needham, specializes in children with significant emotional difficulties and/or a psychiatric diagnosis. The goal is to help students navigate a challenging phase of their life and then return to a more traditional school setting.
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)	Increase access to screening, education, referral and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and nonclinical settings, with an emphasis on BID Needham's priority populations.
Goal Status	Five students were served with this grant and were able to successfully earn their school credits and pass classes based on report cards and work samples. One of the students met the requirements for graduation and the other four advanced to the next grade.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Plugged In Band Scholarship Program** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Plugged In serves musicians of all skills and abilities, allowing them to channel their creativity, learn to work in a group, and improve their music skills. Plugged In's scholarship program allows youth to participate who cannot afford to pay the enrollment fees.
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)	For the spring 2021 band class session, the program's goal is that all students are welcome, with no student turned away for the inability to pay tuition. Scholarships are provided for those unable to pay full tuition. Students with special needs are mentored by traditional students who volunteer as mentors. The volunteer mentors do not pay tuition to be a mentor. All students benefit from the mentor/mentee relationship.
Goal Status	14 students received a full scholarship to the spring 2021 and 17 students with special needs participated in band classes. There were three inclusion bands where students with more significant special needs were grouped with volunteer students to make it possible for the students with special needs to have the opportunity to be in a band.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Community Substance Prevention (SALSA)** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder**		
Brief Description or Objective	BID Needham supports the efforts of Students Advocating Life without Substance Abuse (SALSA) to introduce community programming around substance prevention and mental and emotional well-being.	
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)	Increase community education and awareness of substance use/misuse and mental, emotional, and social health, by providing funding and support for the SALSA program to teach middle school students resilience and refusal skills.	
Goal Status	BID Needham provided funding for Students Advocating Life without Substance Abuse (SALSA) and their 8th grade resilience and refusal training in Needham Public Schools. This program, which has become part of the 8th grade curriculum, trains high school students to go into 8th grade classrooms and talk about the pressures of using substances, and how to say no. Students are taught refusal skills and have the opportunity to practice them in role-play exercises with the high school students. 100 high school students teach approximately 500 8th graders each year.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Needham Narcan Training Program** **Health Issue: Substance Use Disorder**	
Brief Description or Objective	The Town of Needham, Public Health Division will address opioid overdoses in the town by providing Narcan™ and training to community members, via a take-home naloxone 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)	Enhance access to mental health and substance use screening, assessment, and treatment services.
Goal Status	The program was started in FY21 as a pilot program. In FY21 the contract negotiations to purchase Narcan were underway. The rollout of the program will occur in FY22.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Dover Parks & Recreation Hike & Craft** **Health Issue: Mental Health/Mental Illness, Additional Health Needs (Healthy Eating & Active Living)**	
Brief Description or Objective	The Hikes and Crafts program allows youth participants to register with Dover Parks and Recreation and participate in a guided hike at various Dover locations including Caryl Park, Bartlett Pines, Snow Hill, etc..., and end with a craft project.
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)	Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health.
Goal Status	The Hikes and Crafts program had 11 registered in the Winter 2020 – 2021 session, 22 registered in the Spring 2021 session, 16 in the Summer 2021 session and 27 in the Fall 2021 session. The program helps youth improve mental health, be active, increase social interaction with peers and lower the risk of obesity with exercise.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Community Mental Health Programs** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder**	
Brief Description or Objective	BID Needham works with organizations in the community to provide mental health programming and education.
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)	Educate about and reduce stigma associated with mental health and substance use issues. Support community-based organizations that provide social engagement activities to prevent mental health issues.
Goal Status	BID Needham partnered with the Substance Prevention Alliance of Needham (SPAN) to bring a talk to the community, focused on middle school youth, about "Navigating Screen Time, Digital Socializing and Parenting During COVID-19." Featuring Dr. Jill Walsh, the virtual program was attended by 177 people, with 98% reporting that the information was useful.
Program Year: Year 1	**Of X Years: Year 1** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Steps Up** **Health Issue: Additional Health Needs (Education)**		
Brief Description or Objective	Needham Steps Up empowers eligible, underserved students in the Needham Public Schools through trusted mentoring relationships that help develop the capabilities, and provide access to the resources necessary to successfully navigate high school and achieve post-secondary goals.	
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)	Increase access to peer support and one-on-one mentorship program for income-eligible high school students.	
Goal Status	BID Needham supported the summer enrichment program at Needham Steps Up. This program allows Metropolitan Council for Educational Opportunity (METCO) students to get mentorship support throughout the summer months.	
Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: St. Joe's Summer Theater Program** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder**	
Brief Description or Objective	BID Needham works with organizations in the community to provide mental health programming and education.
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)	Support community-based organizations that provide social engagement activities to prevent mental health issues.
Goal Status	The program was cancelled in 2020 due to COVID-19, so was unable to generate revenue to fund the 2021 program. BID Needham provided an emergency grant to cover the program, as teens were suffering from isolation and needed a program such as this. More than 30 students participated in the program in FY21.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Circle of Hope ED Essentials Closet** **Health Issue: Additional Health Needs (Other SDOH)**	
Brief Description or Objective	Circle of Hope's ED Essentials Closet supports the vital needs of BID Needham's emergency department and inpatient patients. Circle of Hope delivers new clothing, underwear, socks, shoes, seasonally appropriate outerwear, and vital hygiene supplies to BID Needham on a monthly basis, to fully stock the "Essentials Closet" for those patients who do not have the essential items they need for a safe discharge.
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)	Decrease the number of people who struggle with financial insecurity.
Goal Status	Circle of Hope provided 294 items of clothing, 168 personal hygiene items, 43 pairs of sneakers and 324 undergarments/socks to BID Needham patients to ensure they had the personal items necessary for a healthy discharge.
Program Year: Year 1	**Of X Years: Year 2** / **Goal Type: Outcomes Goal**

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$853,714	$604,405
Community-Clinical Linkages	$102,545	$86,045
Total Population or Community Wide Interventions	$118,402	$82,598
Access/Coverage Supports	$221,673	$0
Infrastructure to Support CB Collaborations	$54,331	$50,762
Total Expenditures by Program Type	$1,350,665	$823,810
CB Expenditures by Health Need		
Chronic Disease	$747,728	
Mental Health/Mental Illness	$421,887	
Substance Use Disorders	$9,007	
Housing Stability/Homelessness	$8,792	
Additional Health Needs Identified by the Community	$163,251	
Total Expenditures by Health Need	$1,350,665	
Total Community Benefits Program Expenditures	$1,350,665	
Leveraged Resources		
Total Leveraged Resources	$33,794	
Net Charity Care Expenditures		
HSN Assessment	$600,091	
Free/Discounted Care	$0	
HSN Denied Claims	$119,758	
Total Net Charity Care	$719,849	
Total CB Expenditures	$2,104,308	

Additional Information	
Net Patient Services Revenue	**$118,433,000**
CB Expenditure as % of Net Patient Services Revenue	**1.78%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$1,350,000**
Bad Debt	**$1,144,957**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	In FY 21, Beth Israel Lahey Health and its member hospitals, in collaboration with Mass General Brigham, designed, built, and launched a new Community Benefits Reporting Tool (CBRT). The CBRT allows our teams and community partners to more accurately capture, track, and report data related to community benefits programs and initiatives. As part of our design and launch of the CBRT, the BILH and MGB teams undertook a multi-faceted quality improvement project to improve the alignment of definitions and categories for program expenditure reporting across our member hospitals; this may be a contributing driver for differences in trend with AGO reporting categories.

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      Beth Israel Deaconess Hospital–Needham (BID Needham) has worked to align its Community Benefits Advisory Committee membership to reflect the demographics included in BID Needham Community Benefits Service Area (CBSA). Additionally BID Needham has worked to have the Community Benefits Advisory Committee membership from the education and community health center sectors. Sarah Baroud from Westwood Youth and Family Services (WY&FS) left her position at WY&FS and was replaced on the CBAC by Matthew Kuklentz, Assistant Principal at Westwood's Thurston Middle School (education sector). Marsha Medalie from Riverside Community Care took another role at the organization and was unable to fulfill her role on the CBAC. She was replaced by Manny Oppong from Riverside Community Care. We added two representatives from Fenway Health (community health center sector): Frank Fleming, LICSW, LADC and Cyndi Locke. Current members include: Lina Arena DeRosa, Westwood Council on Aging. Diane Barry Preston, Livable Dedham and CBSA Resident. Carol Burak, Dedham Food Pantry and CBSA Resident. Janet Claypoole, Dover Council on Aging. Sue Crossley, Family Promise MetroWest and CBSA Resident. Lise Elcock, Newton Needham Regional Chamber and CBSA Resident. Frank Fleming, LICSW, LADC, Fenway Health. Jeanne Goldberg, Beth Israel Deaconess HealthCare and CBSA Resident. Matthew Kuklentz, Westwood's Thurston Middle School. Valerie Lin, Dover Parks & Recreation and CBSA Resident. Cyndi Locke, Fenway Health. Tim McDonald, Needham Division of Public Health. Manny Opping, Riverside Community Care and CBSA Resident. Sheila Pransky, Dedham Council on Aging. Sandy Robinson, Needham Community Council and CBSA Resident. Susan Shaver, Needham Community Farm and CBSA Resident. Deb Tambeau, Needham Housing Authority. The BID Needham Executive representatives are Kathy Davidson, Chief Nursing Officer and Samantha Sherman, VP Philanthropy. Members from the BID Needham Board of Trustees include Leslie Medalie (Chair) and Virginia Carnahan. Members from the BID Needham Board of Advisors include Janet Barrett and Wanita Kennedy. Alyssa Kence, BID Needham, Director of Community Benefits, oversees the committee.

II. Community Engagement:

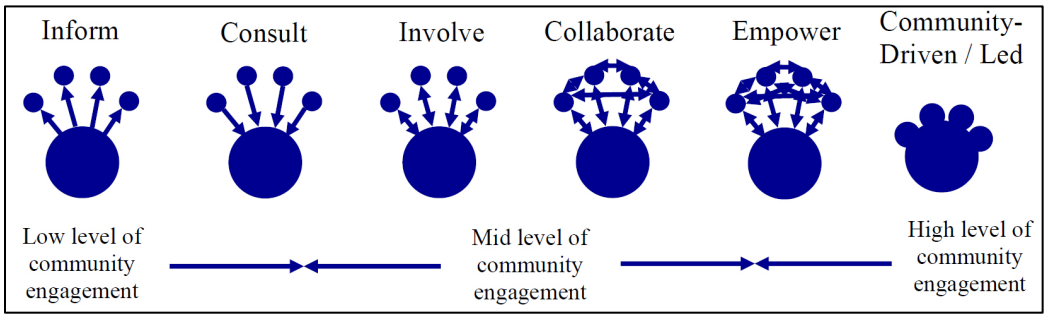
- If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Needham Department of Public Health/ Council on Aging	Tim McDonald	Public Health	The hospital continued to work with public health to address needs of the elderly, which were exacerbated by COVID-19. This partnership, created through a DON agreement and funding, provides meals, exercise and social activities for the elderly.
Family Promise Metrowest	Sue Crossley	Housing	BID Needham supported the LIFE homelessness prevention program through Family Promise. The housing needs for families in the Metrowest area have grown substantially during the pandemic.
Interface	Sara Shine	Mental Health	Interface is a free mental health hotline to assist with mental health navigation. The hospital continued to support this service as demand for mental health providers continues to soar, as a result of COVID-19.
Concord Prison Outreach	Jennifer Albanese	Social service organizations	The organization provided backpacks of essential items to incarcerated men and women at the time of release from prison to address disparities in resources.
Needham Housing Authority	Deb Tambeau	Housing organizations	After school programming for children living in Needham Housing Authority.
St. Joe's Summer Theater Program	Ronan Keane	Social service organizations	St. Joe's was in an urgent situation to find funding for their summer theater program, which many kids & parents rely on for summer activities/child care.
Town of Dover, Parks & Recreation	Mark Ghiloni	Other	The Parks & Recreation department runs summer programming for youth in Dover.

- Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community in implementing its plan to

[1] "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

address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	The CBAC was involved in developing and implementing the plan. The goal was met.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Involve	BID Needham will continue to work on involving its CBAC in the allocation of resources.	Involve
Implementing Community Benefits programs	Collaborate	BID Needham provided grants to community organizations, collaborating to address unmet health needs.	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	BID Needham collaborated with the CBAC and Community Partners to evaluate progress and measurement of programs.	Collaborate
Updating Implementation Strategy annually	Involve	The CBAC was involved in updating the Implementation Strategy through conversation about	Involve

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

		COVID-19 and other contributing factors.	

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

  BID Needham remains committed to community engagement. During FY22, BID Needham will undertake its triennial community health needs assessment and prioritization process. Guided by BID Needham's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative's guiding principles include community engagement, equity, collaboration and capacity building. In FY22, BID Needham will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, BID Needham will engage with our community through involvement on community committees, through partnerships with Public Health, Schools and through other civic and social organizations, and through our Community Resource Group.

- COVID Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits programming.

  BID Needham dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. BID Needham was intentional when assessing risk factors within our CBSA and worked closely with our local health department(s). Clinical staff provided infection control expertise to local health departments during their reopening plans, and our administration met regularly with town and state officials. BID Needham worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread.

- 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.

  BID Needham held CBAC meetings on December 10, 2020; March 2021; and June 15, 2021; and held a CBAC/Public Annual Community Benefits Meeting on September 23, 2021.

III. Updates on Regional Collaboration:

1. If the hospital reported on a collaboration in its **Year 1 Hospital Self-Assessment**, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

BID Needham continues to work as part of the Beth Israel Lahey Health (BILH) system community health improvement planning process. BILH's system-wide Community Benefits Committee (CBC) provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government payer patient populations in the communities. Guided by the CBC, hospitals' Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form.**
   Click or tap here to enter text.