Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Beth Israel Deaconess Needham

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SECTION I: SUMMARY AND MISSION STATEMENT

Beth Israel Deaconess Hospital–Needham (BID Needham) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BID Needham's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities. While 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 makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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

The mission of Beth Israel Deaconess 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.

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.

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

Priority Cohorts

BID Needham's CBSA includes Dedham, Needham, Norwood and Westwood. In FY 2022, BID Needham conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BID Needham's partners and community residents, and thoughtful prioritization, planning, and

reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BID Needham is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BID Needham's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BID Needham's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in the BID Needham CBSA were issues related to age, race/ ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were non-white, people of color, immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers faced systemic challenges that limited their ability to access health care services. Some segments of the population were impacted by language and cultural barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2023 – 2025 IS, BID Needham will work with its community partners, with a focus on Dedham and Norwood, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BID Needham's Community Benefits investments and resources will focus on the improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations

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

Key Accomplishments for Reporting Year
BID Needham's most recent CHNA and IS were conducted and approved by the Board during the fiscal year ended September 30, 2022. That CHNA and IS will inform the Community Benefits mission and activities of BID Needham for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025.

This report covers BID Needham's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the BID Needham Board before September 30, 2019 and informed BID Needham's Community Benefits initiatives for the fiscal years ending September 30, 2020; September 30, 2021; and September 30, 2022. As such, the

accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2019.

Program accomplishments include:

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 residents in the CBSA are facing. The hospital provided grant funding to the organizations and programs listed below.

The hospital supported food access programs, including the Westwood Council on Aging's fresh produce delivery from a local farm to homebound seniors. In Dedham, the Dedham Food Pantry continued to see increased demand for their services and received grant support from BID Needham. In Needham, the hospital continued its 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 and provided a grant to the Needham Farmer's Market.

BID Needham, the Town of Needham, and the Needham Council on Aging continued the "Healthy Aging" partnership (in year four of five), subsidizing fitness programming, including use of the fitness center, trainers and evidence-based strength, balance and arthritis classes for older adults in the community.

In the area of housing, BID Needham supported Family Promise MetroWest's LIFE Initiative to prevent homelessness for families. The hospital also supported the Needham Domestic Violence Action Committee, in their mission to assist domestic violence victims and engage in community outreach for the education and prevention of domestic violence.

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, as well as continued its partnership with Circle of Hope to provide essentials, such as clothing, shoes, jackets and personal care items, to patients who needed these items for a healthy discharge.

Chronic and Complex Conditions and their Risk Factors
BID Needham continued its ongoing partnership with the Charles River YMCA's LiveStrong program for cancer survivors, providing strength and mobility training and support.

To help patients get to medical and other essential appointments, the hospital supports the Needham Community Council's medical appointment transportation program and the Neighbor Brigade's transportation and food 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, collaborating with the Boston JCC and Beth Israel Deaconess Medical Center. The hospital continues to support the American Cancer Society's Annual Charles River 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, while also educating the community on this topic.

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. 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.

Within the community, the hospital serves on local committees and taskforces to address the needs of residents in crises. The coalitions are focused on various topics including Community Crisis Intervention, Substance Prevention, Mental Health, Community Resources, Wellbeing, Medical Error Prevention and Emergency Planning. The hospital awarded a grant to Walker to provide expanded access to community-based mental health services for individuals (primarily children and youth) with chronic mental health challenges and offer effective therapeutic support for their families. BID Needham also awarded funding to Riverside Community Care to support capacity building for the behavioral health workforce, with Solution Focused Therapy Training and the availability of hourly consultation to provide additional support after the training. In addition, a grant was awarded to the Dedham Council on Aging to provide additional hours for a social worker to offer support groups.

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 FY 2022, this included support of the Becca Schmill Foundation's educational and advocacy program and continuing the partnership with Students Advocating for Life without Substance Abuse (SALSA) to provide resiliency education for middle school students.

As access to behavioral health care continues to be an issue, the Hospital has provided funding for the Interface Mental Health Hotlines in Needham, Westwood 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 FY 2022, BID Needham conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BID Needham's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, BID Needham will focus its FY

2023 - 2025 IS on four 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 four priority areas are:

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). 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 FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BID Needham's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BID Needham, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BID Needham's FY 2023 - 2025 IS, it will work with its community partners, with a focus on Dedham and Norwood, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BID Needham's Community Benefits investments and resources will focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; and racially, ethnically and diverse populations.

BID Needham will partner with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - BID Needham will continue its partnership with the Needham Community Council to provide rides to medical appointments for residents who do not have access to transportation.

- **Social Determinants of Health**

  - BID Needham will work with Family Promise Metrowest's LIFE Program to prevent homelessness for families in the Metrowest area.

- **Mental Health and Substance Use**
  - BID Needham will work with Riverside Community Care and the Walker School to improve the capacity of mental health workers and to improve access to outpatient therapy.

- **Complex and Chronic Conditions**
  - BID Needham will continue its partnership with the Charles River YMCA to support the Livestrong Program, which helps cancer survivors regain their strength and mobility after treatment.

Hospital Self-Assessment Form
Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BID Needham Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 50). The BID Needham Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BID Needham's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
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 CBSA and beyond. The hospital's mission is to provide safe, high-quality, community-based health care and access to tertiary care regardless of the patient's ability to pay, race, color, ethnicity, religion, gender, gender identity, sexual orientation, national origin, ancestry, age, genetics, disability, military service or any other legally protected status. 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. Hospital senior leadership is actively engaged in the development and implementation of the BID Needham's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

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 makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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

The BID Needham Community Benefits program is spearheaded by the Director of Community and Strategic Relations. The Director of Community and Strategic Relations 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 cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

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

Community Benefits Advisory Committee (CBAC)
The BID Needham Community Benefits Advisory Committee (CBAC) works in collaboration with BID Needham's hospital leadership, including the hospital's governing board and senior management to support BID Needham's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BID Needham's community. The CBAC provides input into the development and implementation of BID Needham's Community Benefits programs in furtherance of BID Needham's Community Benefits mission. The membership of BID Needham's CBAC aspires to be representative of the constituencies and priority cohorts 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.

The BID Needham CBAC met on the following dates in FY 2022: December 8, 2021; March 22, 2022; May 26, 2022; June 15, 2022; and August 30, 2022.

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

BID Needham currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BID Needham collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. BID Needham has a

particularly strong relationship with Needham Public Health. This relationship includes working together on programs related to healthy aging, substance use and mental health, and food access.

The following is a comprehensive listing of the community partners with which BID Needham collaborated on its FY 2020 – 2022 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 50).

Community Partners

American Cancer Society
Charles River Regional Chamber
Charles River YMCA
Circle of Hope
Dedham Council on Aging
Dedham Food Pantry
Dedham Public Health
Dedham Youth Commission
Dover Council on Aging
Family Promise MetroWest
Greater Boston JCC
Livable Dedham
Medfield Coalition for Suicide Prevention
Medfield Public Schools
Needham Bank
Needham Clergy Association
Needham Community Council
Needham Community Farm
Needham Council on Aging
Needham Domestic Violence Action Committee
Needham Emergency Management
Needham Farmer's Market
Needham Fire Department
Needham Sports Boosters
Needham Housing Authority
Needham Police Department
Needham Public Health
Needham Resilience Network
Needham Traveling Meals Program
Needham Youth & Family Services
Neighbor Brigade
Newton Wellesley Hospital
Norwood Fire Department
Norwood Police Department
Riverside Community Care
Sean D. Biggs Memorial Foundation
Students Advocating Life without Substance Abuse (SALSA)
Substance Prevention Alliance of Needham (SPAN)
Town of Dedham
Town of Needham
Walker School
Westwood Council on Aging
Westwood Youth & Family Services
Westwood Fire Department
William James College

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. 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 cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BID Needham's most recent CHNA was completed during FY 2022. FY 2022 Community Benefits programming was informed by the FY 2019 CHNA and aligns with BID Needham's FY 2020 – FY 2022 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed BID Needham to:

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

BID Needham's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that BID Needham serves, especially the population segments that are often

disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. BID Needham's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, BID Needham conducted 18 one-on-one interviews with key collaborators in the community, facilitated four focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 480 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers and other community partners.

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

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research

shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.

- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2022 BID Needham Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Community Farm (NCF) 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 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	Goal met: NCF served more than 200 families through the Mobile Market in 2022. At the Mobile Market, NCF distributed approximately 3,000 pounds of fresh produce, valued at approximately $18,000. The farm continued with the same distribution model in 2022, delivering to 4 Needham Housing Authority sites weekly to address the increased need for food caused by the pandemic. The Mobile Market also serves as a social-emotional check-in during the pandemic, an unplanned benefit.
Program Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Westwood Council on Aging Emerging Needs for Seniors** **Health Issue: Additional Health Needs (Food Insecurity)**		
Brief Description or Objective	The Westwood Council on Aging works to address the emerging needs for seniors in Westwood.	
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)	To ensure fresh vegetables are delivered to older adults who are homebound from a local organic farm.	
Goal Status	Goal met: In the summer of 2022 the Westwood Council on Aging ordered, picked up and delivered fresh produce from Powisset Farm in Dover MA to 32 homebound older adults on a bi-monthly basis. Everyone on the list was truly grateful for this opportunity and if there was any extra produce, it was put out free for any senior to enjoy. The Council on Aging also partnered with HESSCO, a local Aging Services Access Point (ASAP) to provide a sandwich, salad chips and water bottle with each of these deliveries, so that the homebound older adults got not only fresh veggies, but lunch as well.	
Program Year: Year 3	**Time Frame Duration: Year 3**	**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 (NFM)
Health Issue: Additional Health Needs (Access to Healthy Foods)

Brief Description or Objective	The Needham Farmers Market (NFM) is a community-operated and oriented food market that runs from June to November in Needham. The NFM was founded in 2012 with the purpose of providing fresh, local, wholesome produce and food products from farmers, bakers, and other vendors; promoting a local, sustainable food system; providing a wholesome social experience that builds community; and educating participants about healthy eating and sustainable living.
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)	Leverage the NFM social media and marketing outreach platforms to increase awareness of the Market, thereby increasing the number of shoppers per Market. Maximize the number of vendors that provide food products that are considered essential to a healthy diet.
Goal Status	Goal met: 10,325 shoppers attended Needham Farmers Market in 2022 (which was a 15% decrease over the 12,225 shoppers attending NFM in 2021.) NFM year-over-year attendance statistics were significantly and adversely impacted by extreme summer heat. Social media activity metrics indicated an increased interest in NFM, with Instagram and Facebook being the major "news outlet" for NFM. When comparing 2022 attendance to 2021, note that 2021 was 57% higher than 2020. Goal met: NFM averaged 12 vendors per market versus nine in 2021. The mix of vendors improved with the addition of cheese, kombucha and varied prepared food vendors. Toward the end of the season a replacement was found for a meat vendor. In addition, NFM "Market Bucks" SNAP-EBT became available for use at vendors with SNAP eligible products. In FY23, it is anticipated that NFM will to some extent match the "market bucks."

Program Year: Year 3	**Time Frame Duration: 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	The Dedham Food Pantry distributes essential food items, including non-perishable pantry staples; perishable items such as frozen meat, eggs, cheese and bread; and fresh seasonal produce when available, to Dedham residents in need.
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, which provides food to individuals and families experiencing food insecurity in Dedham.
Goal Status	Goal met: In FY22, the Dedham Food Pantry served 2,994 households with 324,000 pounds of food; including 1,702 seniors, 3,652 adults and 2,817 children. The pantry spends approximately $14,000 per month on food, so the hospital's grant covered about 2 weeks of food distribution.

Program Year: Year 3	**Timeframe Duration: 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	The Traveling Meals program delivers meals to homebound residents who do not have the support of family or any in-home services that would enable them to purchase or prepare their daily meals. The two-meal package is nutritionally balanced. The package includes one hot and one cold meal and is prepared at BID Needham. The packages are delivered by volunteers to the individuals that meet the criteria.
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 older adults who are homebound.
Goal Status	Goal met: The traveling meals program prepared and delivered more than 10,256 healthy meals to older adults who were homebound in 2022.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Resilience Network** **Health Issue: Additional Health Needs**	
Brief Description or Objective	The Needham Resilience Network (NRN) is a "whole of society" effort designed to establish relationships across silos, build skills in communicating across differences, explore local issues from various perspectives, and facilitate a process of co-creation in proposing solutions.
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)	Work on building communications skills for all 30 members of the NRN. Develop skills for all 30 members around the "State of Needham."
Goal Status	Goal met: The 30 NRN members have all engaged in learning communications skills, including: "flip a switch" from conversations bent on persuasion and influence to conversations of listening and understanding; creating a communications agreement that delineates support for confidentiality, full spectrum listening, respect of others' space and time, and speaking for self, versus others; prompt themselves and co-members to reframe statements that do not follow the NRN Communications Agreement; address a harm that occurs in the process of conversation. Goal met: 30 NRN members have received data and narratives from expert town leaders (NRN members) and have reflected on data summaries, gaps and ways in which to support community challenges and efforts. The NRN explored community issues with an eye towards how we can all work together to support a stronger community. Topics to date include mental and behavioral health, and food & economic insecurity. Each member is bringing information/resources/questions to their subnetwork groups and bringing lived experiences/questions/feedback back to the NRN for reflection. This process will then have the potential to impact the hundreds/thousands of Needham residents represented by the NRN members.
Program Year: Year 3	**Time Frame Duration: Year 1** / **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 facing housing insecurity by preventing evictions and shelter entry for families in the service area.
Goal Status	Goal met: 45 families were served in the LIFE program in 2022. 22 of those families graduated from the LIFE program in 2022 (the remaining 23 were carried into 2023). All 22 graduating families remained in safe, affordable housing at program graduation. No families served by the LIFE program in 2022 ended up entering shelter. All 45 retained or moved into safe housing.

Program Year: Year 3	**Timeframe Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Needham Domestic Violence Action Committee (DVAC)** **Health Issue: Additional Health Needs (Domestic Violence)**	
Brief Description or Objective	The Needham Domestic Violence Action Committee is a community-based interagency and interdisciplinary team formed to address issues of domestic violence and teen dating violence. The Committee strives to assist the community and engage in community outreach for the prevention of domestic violence.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the grant period, DVAC will have reached three new organizations in the Needham Community and provided them with an Educational Awareness Campaign presentation. By the end of the grant period, these three organizations/agencies in Needham will be able to identify DVAC's mission and the resources available for domestic violence survivors, as measured by meeting surveys. By the end of the grant period, DVAC has supported every domestic violence survivor who requests help with financial assistance as allowable, for their immediate needs in their crisis as measured by written requests from organizations and approval from the DVAC committee.
Goal Status	Goal partially met: A presentation is scheduled for 1/26/23 at the Center of the Heights for the elderly. Presentation dates are being finalized for Town Employees, Needham Housing Authority, League of Women Voters, Library, and the Needham Community Council. Goal partially met: A survey was developed and will be utilized after presentations. The data will also be shared with REACH as DVAC's program/manual is a pilot for them as well and there is an interest to see how well it serves the purpose it was created for. Goal met: There were no requests for funds during this reporting period from DVAC (other available funds might have been used to cover immediate needs).

Program Year: Year 3	**Time Frame Duration: Year 1**	**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 a 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)	Increase the number of clients served with transportation, meals and groceries through Neighbor Brigade.
Goal Status	Goal met: In 2022, with the funding from BID Needham, Neighbor Brigade served 417 clients. The clients report back positively on the literally lifesaving aspects of this program and Neighbor Brigade's free services.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Senior Volunteer Program** **Health Issue: Additional Health Needs**	
Brief Description or Objective	The volunteer program at BID Needham 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 older adults.
Goal Status	Goal met: There are 15 adult volunteers in the older adult volunteer program, which has returned in a limited capacity following COVID-19. The program currently has 6 high school student volunteers who come in after school, as well.

Program Year: Year 3	**Timeframe Duration: Year 3**	**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)	Provide essential clothing and toiletries to BID Needham patients to ensure they have the personal items necessary for a healthy discharge.	
Goal Status	Goal met: Circle of Hope provided 567 items of clothing, 24 backpacks, 68 pairs of shoes, 24 rain ponchos, and 380 undergarments/socks to BID Needham patients to ensure they had the personal items necessary for a healthy discharge.	
Program Year: Year 3	**Timeframe Duration: Year 2**	**Goal Type: Process 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**		
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.	
Goal Status	Goal met: DoN funds were used to support fitness activities, including the fitness center, personal trainers, and balance/fitness programs. Classes included Fitness for Arthritis (365 participants over the year), Train the Brain (25 participants), Core Strength (130 participants) and Stretching (295 participants).	
Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process 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 the BID Needham 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	Goal met: In FY22, BID Needham's financial counselors successfully enrolled 127 patients in MassHealth. Financial assistance applications and information are available in English, Spanish, Chinese, and Russian.	
Program Year: Year 3	**Timeframe Duration: 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 organizations to provide access to care.
Goal Status	Goal met: 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 3	**Timeframe Duration: Year 3**	**Goal Type: Process 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 assisted with insurance other public program enrollment, and patient navigation by offering culturally responsive care, including interpreter services.
Goal Status	Goal met: AMN Healthcare (Stratus) video remote interpretive services were accessed 2,476 times in FY22 at BID Needham, allowing patients for whom English as a Second Language (ESL) services are needed, to access care in a culturally competent way. Telephonic interpretation sessions were used 1,332 times in FY22 at BID Needham, allowing patients for whom English as a Second Language (ESL) services are needed to access care in a culturally competent way. Face-to-face interpretations were used 0 times in FY22 at BID Needham.

Program Year: Year 3	**Timeframe Duration: 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 staff members and volunteers, with the ride-share service, Lyft. To request a ride, the individual calls the Needham Community Council and is scheduled with 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 ridership and awareness of program with presentations to local organizations and other gate keepers in the community and highlight the program in monthly newsletters and social media posts to increase riders by 10-15%, help keep older adults in their homes, and help residents get to critical as well as routine medical appointments in the next year. Within the next 6-12 months, establish a formal volunteer program dedicated to the transportation service. This includes establishing a workstation for volunteer use to administer the transportation program; recruiting 2-3 new specialized volunteers; provided targeted training efforts for new volunteers to build skills and help with rides due to increased demand for service; and dedicating specific volunteer hours to this project (enter and track in database).	
Goal Status	Goal met: Gave 6 organizational presentations highlighting the transportation program; included program information and sign-up information in each of the Council's monthly e-newsletter editions; 10 social media posts dedicated to the transportation program; and lastly increased the average rides per month from 64 in 2021 to 122 in 2022. The average unique ridership has also increased this year from 25 to 32 riders. Goal in progress: The Council has established a dedicated workstation and begun recruitment and training of 2 specific volunteers to add to the workflow of this program. This recruitment and training will extend into the next grant cycle.	
Program Year: Year 3	**Timeframe Duration: 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 worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as 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, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees. By September 30, 2022, 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 data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	Goal met: All 10 BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan. Goal met: All FY22 regulatory reporting data were entered into the Community Benefits Database.
Program Year: Year 3	**Timeframe Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Chronic & Complex Conditions and their Risk Factors **Program Name: Wrap-Around Services for Patients with Chronic Conditions** **Health Issue: Chronic Disease**	
Brief Description or Objective	The hospital subsidizes wrap-around services to support patients with chronic conditions, to ensure they are getting the care needed during and after 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)	Increase the number of people with chronic/complex conditions whose conditions are under control, by providing training to health workers to provide community health care. 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. Increase access to affordable, safe transportation options to health care by providing Uber vouchers to those who need a ride home from medical appointments at the hospital. Increase the number of people with chronic/complex conditions whose conditions are under control, by providing EMTs with medical supplies to provide community health care.

Goal Status	Goal met: BID Needham has an ongoing partnership with local EMTs to train first responders in how to identify a stroke in the field. When EMS alerts the hospital of a stroke patient coming in, the patient is met at the door by registration, a nurse, and a physician and immediately 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 FY22. Goal met: BID Needham has a Utilization Review Committee that reviews all readmissions to the hospital on a daily basis Monday through Friday. 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 identifies 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. Goal met: BID Needham employs two CHF nurses (34 hours a week and 28 hours a week). The nurses follow patients who have high-risk CHF by making frequent calls to assess for symptoms, medication changes, tests or procedures, education on prevention of CHF exacerbation, dietary teaching, referrals and coordination of care. The nurses also see inpatients to ensure they are receiving proper care and review information with inpatient nursing and provide educational in-services. Goal met: The hospital provided a total of 1,007 Uber rides for patients in FY 22, totaling $21,329.04, and offering a safe way for patients to have a ride home from an appointment or hospital stay. Goal met: BID Needham restocked ambulances with medications to ensure that access to medications and supplies were available. More than $21,000 in medications and supplies were donated to EMTs in the hospital's CBSA in FY 22.

Program Year: Year 3	**Timeframe Duration: 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	Goal met: The 12-week program had 11 participants, with participants reporting 100% improved leg strength, 100% improved upper body strength, and 100% improved their balance.

Program Year: Year 3	**Timeframe Duration: 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 and substance use disorder care.
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 non-clinical settings, through an Emergency Department (ED) partnership with Riverside Community Care. 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.
Goal Status	Goal met: Patients seeking ED care for mental health conditions are referred to Riverside Community Care, BIDN's contracted Emergency Service Provider (ESP), for an evaluation. As part of this partnership, Riverside Community Care manages the bed search and placement process for all patients requiring inpatient level of care. As part of BIDN's behavioral health expansion efforts, the hospital's contract with Riverside Community Care has increased to include an embedded social worker in the ED. This full-time clinician serves as the liaison between the ED and Riverside Community Care (ESP). Goal met: The hospital has made changes to the ED environment as an effort to improve care and experience of the patient with behavioral health needs. The hospital understands that some patients with presenting behavioral health conditions may struggle with an overstimulating environment, while others may require increased observation to ensure patient safety. As such, the hospital has hired additional security to help with these efforts. In addition, in response to the volume changes BIDN experienced following the closure of Norwood Hospital, the ED was renovated in FY22, adding four patient bays, private clinical spaces used to assess and treat patients with acute conditions, and a nurses' station. The construction project enables the hospital to meet the demand while maintaining its high standards of safety, service, and care. Finally, the hospital purchased and began sending "Care Cards" as a discharge follow up to patients who present in the ED with suicidal ideation. Goal met: BID Needham has continued to expand the Behavioral Health staff at the hospital, which now includes a Chief of Psychiatry, a Director of Medical Psychiatry, Psychiatry Nurse Practitioners to provide weekend coverage via telehealth, and a

	Director of Behavioral Health. In addition, BID Needham hired a William James intern in September 2022 to assist with piloting behavioral health programs to assist patients after discharge.

Program Year: Year 3	**Timeframe Duration: 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	The National Alliance on Mental Illness (NAMI) reports that one-in-four individuals experiences a mental illness each year, underscoring a critical need for mental healthcare access across all patient populations. In the 2019 BID Needham Community Health Needs Assessment, mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified as one of the leading health issues for residents of the service area. Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety. To improve access to behavioral health, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model (CoCM) in employed primary care practices over a 5-year period (starting in March 2019). Collaborative Care is a nationally recognized integrated model that specializes in providing behavioral health services in the primary care setting. The services are provided by an embedded licensed behavioral health clinician, and they include short-term brief interventions, case review with a consulting psychiatrist, and care coordination. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of behavioral health conditions. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals. The behavioral health clinician uses therapies that are proven to work within the primary care setting. A consulting psychiatrist may advise the primary care provider on medications that may be helpful.
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	Goal met: Two sites with social workers were maintained in Needham for FY22, treating 187 patients.
Program Year: Year 3	**Timeframe Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Community Mental Health and Substance Use Prevention Programs** **Health Issue: Substance Use Disorder**	
Brief Description or Objective	The hospital works to ensure the prevention of substance misuse in the community through programming that impacts patients, their families and the 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 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. Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose of sharps. Decrease the availability of unused prescription drugs and promote collaboration across the health system to address substance use through a Pain Management & Opioid Taskforce. Support community-based health education events and programming with community partners to raise awareness, and educate on risk/protective factors, and services available in the community.
Goal Status	Goals met: 409 pounds of medication and 109 gallons of sharps were disposed of in FY22. Goal met: In FY22, 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 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 using electronic medical records to better assess patient pain and timing/delivery of medications to address patient pain. The committee also introduced a "comfort menu" in FY22 to offer non-medication alternatives to pain relief. Goal met: BID Needham provided a grant to the Becca Schmill Foundation to support their work in advocacy and community education on cyber harms and substance use. Their FY22 accomplishments included three community education events on cyber harms for youth, participation in the first International Opioid Awareness Night in Needham, and a Caring Communities campaign.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process 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, and other pertinent community issues, through participation in community taskforces.
Goal Status	Goal met: BID Needham employees participated in 13 community taskforces for a total of 194 hours. The coalitions are focused on various topics including Community Crisis Intervention, Substance Prevention, Mental Health, Community Resources, Wellbeing, Medical Error Prevention and Emergency Planning.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Needham 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 with mental health and substance use issues, through assistance with finding mental health services.
Goal Status	Goal met: Needham's Interface Helpline served 185 cases from December 2021 to November 2022. This reporting period most referrals continued to be for children, though there were many adult callers, and most (~60%) were female. There were also several repeat callers. Most callers were requesting help for anxiety and/or depression.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Westwood INTERFACE Program** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	BID Needham's partnership with Westwood Youth and Family Services and William James College provides a free mental health referral hotline to those who live and/or work in Westwood. 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 with mental health and substance use issues, through assistance with finding mental health services.
Goal Status	Goal met: Westwood's Interface Helpline served 114 cases from 12/01/2021 to 11/30/2022.
Program Year: Year 3	**Timeframe Duration: Year 1** / **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)	In FY22, Walker staff will provide 175 individuals/families with outpatient therapy, in-home therapy, and therapeutic mentoring. At least 70% of clients will show progress by meeting at least one goal in their treatment plan.
Goal Status	Goal met: During FY22, Walker Community Counseling's Needham-based team served 119 unduplicated individuals through outpatient therapy, in-home therapy, and therapeutic mentoring (approximately 10% of these clients received multiple services). Of the 119 served, approximately 71% were children and 29% were adults; 56% were male and 44% were female. In terms of racial demographics, 53% of clients were White or Caucasian, 8% were multi-racial, 7% were Hispanic/Latino, 4% were Black or African American, 3% were Asian, 3% were Other, and 22% were Unknown. Goal met: During FY22, 75% of clients who discharged from Walker Community Counseling's Needham-based outpatient therapy, in-home therapy, and therapeutic mentoring services stepped down to a less restrictive level of care and 74% met or partially met at least one goal.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Riverside Community Care Behavioral Health Programs** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The Riverside Community Care Behavioral Health Program provides advanced psychological and behavioral trainings for Riverside's Home-Based service clinicians and staff. Riverside's Home-Based services include In Home Therapy, Intensive Family services, and Therapeutic Mentoring programs that are available to residents of Needham, Dedham and Westwood. The trainings provide an opportunity for clinicians to retain their skills and acquire new knowledge around a growing body of research in addressing the surge in behavioral healthcare needs of the 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)	Provide therapy training and support for at least 22 local mental health clinicians in FY22.
Goal Status	Goal met: Riverside Community Care held a 2-day Solution Focused Therapy Training attended by 22 clinicians, distributed copies of "Crossing the Bridge: Integrating Solution Focused Therapy into Clinical Practice," and provided 10 months of hourly consultation following the training.

Program Year: Year 3	**Timeframe Duration: 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	Goal met: 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 3	**Timeframe Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Community Mental Health & Substance Use Prevention Programs** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder**	
Brief Description or Objective	The hospital works to ensure the prevention of substance misuse in the community through programming that impacts patients, their families and the 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 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. Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose of sharps. Decrease the availability of unused prescription drugs and promote collaboration across the health system to address substance use through a Pain Management & Opioid Taskforce. Support community-based health education events and programming with community partners to raise awareness, and educate on risk/protective factors, and services available in the community.
Goal Status	Goal met: 409 pounds of medication were disposed of in FY22. Goal met: 106 gallons of sharps were disposed of in FY22. Goal met: In FY22, 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 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 using electronic medical records to better assess patient pain and timing/delivery of medications to address patient pain. The committee also introduced a "comfort menu" in FY22 to offer non-medication alternatives to pain relief. Goal met: BID Needham provided a grant to the Becca Schmill Foundation to support their work in advocacy and community education on cyber harms and substance use. Their FY22 accomplishments included three community education events on cyber harms for youth, participation in the first International Opioid Awareness Night in Needham, and a Caring Communities campaign.

Program Year: Year 3	**Timeframe Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Dedham Council on Aging Social Worker Support Groups** **Health Issue: Mental Health/ Mental Illness**	
Brief Description or Objective	The Town of Dedham has hired a social worker to provide social services for those with mental health needs. This grant will allow the social worker to extend hours to offer regularly-scheduled support groups for seniors who are bereaved, struggling with caregiving responsibilities, and those struggling with mental health 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)	Improve access to mental health services by hiring a clinical social worker and offering counseling services and support groups.
Goal Status	Goal in process: Job description developed and search conducted to hire clinical social worker.

Program Year: Year 3	**Timeframe Duration: Year 1**	**Goal Type: Outcomes Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$857,269.00	$0
Community-Clinical Linkages	$287,721.00	$92,506.00
Total Population or Community Wide Interventions	$322,476.00	$249,211.00
Access/Coverage Supports	$26,118.00	$4,028.00
Infrastructure to Support CB Collaborations	$5,919.00	$0
Total Expenditures by Program Type	**$1,499,503.00**	**$345,745.00**
CB Expenditures by Health Need		
Chronic Disease	$609,008.10	
Mental Health/Mental Illness	$530,320.18	
Substance Use Disorders	$17,747.23	
Housing Stability/Homelessness	$11,182.78	
Additional Health Needs Identified by the Community	$331,244.71	
Total by Health Need	**$1,499,503.00**	
Leveraged Resources	$263,726.00	
Total CB Programming	**$1,499,503.00**	
Net Charity Care Expenditures		
HSN Assessment	$748,337.84	
Free/Discounted Care	$0	
HSN Denied Claims	$174,487.97	
Total Net Charity Care	$922,825.81	
Total CB Expenditures	**$2,686,054.81**	

Additional Information	
Net Patient Services Revenue	**131,851,000.00**
CB Expenditure as % of Net Patient Services Revenue	**2.04%**
Approved CB Budget for FY23 (*Excluding expenditures that cannot be projected at the time of the report)	**$2,500,000.00**
Bad Debt	**$1,256,059.11**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	BID Needham also subsidized $41,185 in Behavioral Health services outside of its CBSA. In addition to the above amounts, Beth Israel Lahey Health contributed $1 millweion to The Latino Equity Fund and the New Commonwealth Racial Equity and Social Justice Fund in support of addressing health disparities related hypertension, diabetes and obesity and further integration and alignment, particularly regarding stakeholder engagement and convening with the Health Equity Compact.

SECTION VI: CONTACT INFORMATION

Alyssa Kence, Director, Community & Strategic Initiatives
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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1
Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:
   - Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
   - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not.

     Beth Israel Deaconess Hospital–Needham (BID Needham) is a member of Beth Israel Lahey Health (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/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – **We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.**

2. Community Benefits Advisory Committee (CBAC)
   - Members (and titles):
     - Lina Arena DeRosa, Director, Westwood Council on Aging
     - Janet Barrett, Advisor, BID Needham Board of Advisors
     - Diane Barry Preston, Board Member, Livable Dedham and Dedham Council on Aging Carol Burak, Trustee, Dedham Food Pantry
     - Virginia Carnahan, Trustee, BID Needham Board of Trustees; BILH Community Benefits Committee
     - Janet Claypoole, Director, Dover Council on Aging
     - Sue Crossley, Executive Director, Family Promise MetroWest
     - Kathy Davidson, Chief Nursing Officer, BID Needham
     - Lise Elcock, Membership Director, Charles River Regional Chamber
     - Frank Fleming, Associate Director of Integrated Behavioral Health Service, Fenway Health
     - Jeanne Goldberg, Regional Practice Director, Beth Israel Deaconess Healthcare
     - Alyssa Kence, Director of Community Benefits, BID Needham
     - Wanita Kennedy, Advisor, BID Needham Board of Advisors
     - Matthew Kuklentz, Assistant Principal, Thurston Middle School
     - Valerie Lin, Board Member, Dover Parks and Recreation

- Cyndi Locke, Director of Clinical Operations, Fenway Health
- Tim McDonald, Director, Needham Public Health
- Leslie Medalie, Trustee, BID Needham Board of Trustees
- Manny Oppong, Assistant Vice President of Behavioral Health Services, Riverside Community Care
- Sheila Pransky, Director, Dedham Council on Aging
- Sandra Robinson, Director, Needham Community Council
- Susan Shaver, Director, Needham Community Farm
- Nicole Stewart, Advisor, BID Needham Board of Advisors

- Leadership:
  - John Fogarty, President
  - Nancy Hoffman, Chief Financial Officer
  - Gregory McSweeney, MD, Chief Medical Officer
  - Kathy Davidson, Chief Nursing Officer
  - Samantha Sherman, Vice President of Philanthropy

- Frequency of meetings:
  BID Needham's CBAC met quarterly during FY 2022 and also attended the hospital's annual Community Benefits public meeting. The BID Needham CBAC met on the following dates in FY 2022: December 8, 2021; March 22, 2022; May 26, 2022; June 15, 2022; and August 30, 2022.

3. Involvement of Hospital's Leadership in Community Benefits:
   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits Process.

	Review Community Health Needs Assessment	Review Implementation Strategy	Review Community Benefits Report
Senior leadership	☒	☒	☒
Hospital board	☒	☒	☐
Staff-level managers	☒	☒	☒
Community Representatives on CBAC	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

At BILH, our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our community partners, our Community Benefits Committee (CBC) and the Community Benefits team, such commitment is shared by staff at all levels within BID Needham:

Hospital Board:

- BID Needham Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy
- BID Needham Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process

Senior Leadership:

- John Fogarty, President - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBAC; participated in prioritization process
- Nancy Hoffman, Chief Financial Officer - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in prioritization process
- Kathy Davidson, Chief Nursing Officer - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBAC; participated in prioritization process
- Dr. Gregory McSweeney, Chief Medical Officer - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in prioritization process
- Samantha Sherman, VP, Philanthropy - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBAC; participated in prioritization process

Staff-level Managers:

- Nancy Kasen, BILH VP of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy
- Jennifer Pinto, Director of Behavioral Health – participated in prioritization process

BILH Community Benefits Committee (CBC):

- BILH CBC - guided the process for the system

4. <u>Hospital Approach to Assessing and Addressing Social Determinants of Health</u>

- How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)

BID Needham undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of assessments. The assessment was supported by BID Needham's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members, service providers, and other stakeholders that either live in and/or work in BID Needham's CBSA. BID Needham's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of

health: housing, transportation, economic insecurity, childcare, and food insecurity.

- How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

  BID Needham and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout BID Needham's assessment process, BID Needham worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. BID Needham's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

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

  BID Needham's IS includes a diverse range of programs and resources to addresses the prioritized needs within the BID Needham Community Benefits Service Area. The majority of BID Needham's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. BID Needham's strategies include supporting education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods; enhancing relationships and partnerships with mental health, youth-serving organizations, and other community partners to increase resiliency, coping, and prevention skills; and ensuring older adults and those with complex/chronic conditions have access to coordinated healthcare, supportive services, and resources to support overall health and age in place. Additionally, BID Needham collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions including the Dedham, Needham, and Westwood Councils on Aging, the Dedham Food Pantry and the Charles River YMCA.

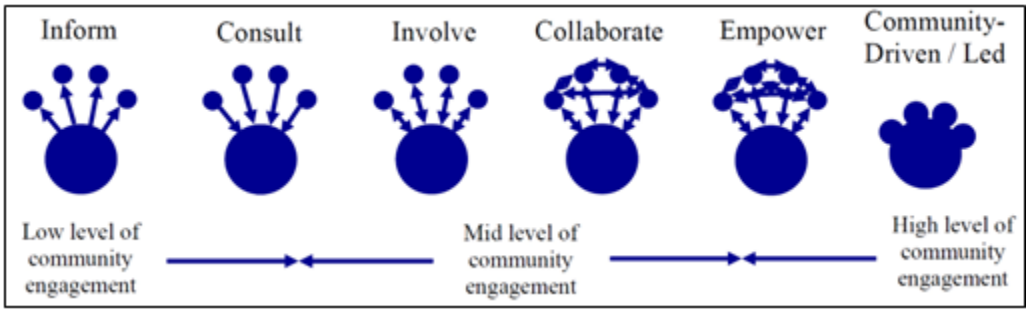
II. **Community Engagement**

1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Needham Public Health	Tim McDonald, Director of Health & Human Services	Local health department	BID Needham, Needham Public Health and the Needham Council on Aging have partnered for several years on a Healthy Aging initiative in Needham. This partnership allows seniors to participate in physical, mental and social programming focused on balance, nutrition, bone health and socialization. The program has evolved throughout COVID and has returned to pre-pandemic programming. Needham Public Health had representatives participate in the FY22 CHNA Key Informant interview, helped coordinate a focus group and shared information about the survey, focus groups and listening sessions.
Family Promise Metrowest	Danielle Conti, Executive Director	Housing organizations	BID Needham supports the LIFE (Local Initiative for Family Empowerment) Program at Family Promise Metrowest, a homelessness prevention program that supports families who are at risk of eviction but not yet homeless. In addition to paying off rent in arrears, the program requires families to attend one-on-one coaching and small group training on finances, housing, community resources, nutrition, health and safety, and childcare. Family Promise contributed to the FY22 CHNA by sharing information about the survey, focus groups and listening sessions.
Westwood Youth & Family Services	Katy Colthart, Executive Director	Behavioral health and mental health organizations	The partnership between Westwood Youth and Family Services, the Town of Westwood and BID Needham provides free access to the Interface Mental Health service to those who live or work in Westwood. The mental health hotline works to increase awareness of mental health issues impacting children, families, and adults and to facilitate access to appropriate outpatient services. Westwood Youth & Family Services contributed to the FY22 CHNA by sharing information about the survey, focus groups and listening sessions.

Neighbor Brigade	Mark Murphy, Volunteer	Social service organizations	Neighbor Brigade focuses on addressing transportation, food access and other critical social determinants of health for residents in sudden crisis. The organization relies on community-specific networks of volunteers to help residents manage day-to-day tasks such as meal preparation, rides, and basic household chores. Neighbor Brigade had representatives participate in the FY22 CHNA Key Informant interview and shared information about the survey, focus groups and listening sessions.

2. Level of Engagement Across CHNA and Implementation Strategy
Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community.



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

A. **Community Health Needs Assessment**
Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	**Level of Engagement**	**Did Engagement Meet Hospital's Goals?**	**Goal(s) for Engagement in Upcoming Year(s)**
Overall engagement in assessing community health needs	Empower	Goal was met.	Collaborate
Collecting data	Empower	Goal was met – BID Needham built capacity for community residents to co-facilitate/facilitate focus groups and breakout sessions during listening sessions.	Collaborate

Defining the community to be served	Collaborate	Starting several months before launching the CHNA, BID Needham worked with its CBAC to identify the community, those to be engaged and ways to engage them.	Collaborate
Establishing priorities	Empower	Working with BILH, BID Needham actively engaged with the CBAC and the community to identify and select priorities.	Collaborate

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

  BILH and BID Needham are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

B. **Implementation Strategy**
Please assess the hospital's level of engagement in developing and implementing its plan to address the significant needs documented in its CHNA and the effectiveness of its community engagement process.

Category	**Level of Engagement**	**Did Engagement Meet Hospital's Goals?**	**Goal(s) for Engagement in Upcoming Year(s)**
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal met – community listening sessions with breakout sessions facilitated by community members, with active CBAC engagement in prioritization discussions and decisions.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of BID Needham's FY 2020 – 2022 Implementation Strategy (IS). A grant review committee, consisting of members of the CBAC, was formed to review the allocation of resources, specifically the grant program. BID Needham will collaborate with its CBAC to select programs to invest its resources in for the FY 2023 – 2025 IS.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of BID Needham's FY 2020-2022 Implementation Strategy (IS). BID Needham will be collaborating with the community on new and existing programs for its FY 2023-2025 IS.	Collaborate

Evaluating progress in executing Implementation Strategy	Involve	Goal met - BILH and BID Needham held multiple evaluation workshops to build evaluation and data capacity of community organizations, CBAC members and community residents.	Collaborate
Updating Implementation Strategy annually	Inform	Goal met – FY 2022 was the last year of the current FY2020-2022 IS. BILH and BID Needham are working to develop, track and share data on a routine basis with the CBAC.	Collaborate

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:
  Click or tap here to enter text.

3. Opportunity for Public Feedback
   Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

   BID Needham has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. BID Needham engaged with the leadership team and the community to identify and select priorities for the new (FY2023-2025) IS. The IS was shared with the CBAC, the leadership team, adopted by the Board of Trustees and widely distributed.

4. Best Practices/Lessons Learned
   The AGO seeks to continually improve the quality of community engagement.

   - What community engagement practices are you most proud of? (150-word limit)

     BID Needham is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health departments, and other government partners. BID Needham is proud of their collaboration with these and other organizations that allowed BID Needham to engage with hard-to-reach cohorts. BID Needham is particularly proud of how it was able to reach community members who had not previously been engaged.

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

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

III. Regional Collaboration

1. Is the hospital part of a larger community health improvement planning process?
   ☒Yes ☐No

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

  For its FY 2022 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals, including BID Needham, encompassing 49 municipalities and six Boston neighborhoods. While BID Needham focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing the significant health disparities and barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.

- Collaboration:
  BID Needham worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals. Results of BID Needham's CHNA were shared with on the hospital's website and with a few key community partners who were also conducting needs assessments, such as Needham Public Health and the Needham Resilience Network.

- Institutions involved:
  - Anna Jaques Hospital
  - Beth Israel Deaconess Hospital - Milton
  - Beth Israel Deaconess Hospital - Needham
  - Beth Israel Deaconess Hospital - Plymouth
  - Beth Israel Deaconess Medical Center
  - Beverly and Addison Gilbert Hospitals
  - Lahey Hospital and Medical Center
  - Mount Auburn Hospital
  - New England Baptist Hospital
  - Winchester Hospital

- Brief description of goals of the collaboration:

  BID Needham collaborated with the other 9 hospitals in the BILH system to add rigor to the hospitals' assessments and planning processes, promoting alignment across hospital efforts and strengthening relationships between and among BILH hospitals, community partners and the community-at-large.

- Key communities engaged through collaboration:

  BID Needham collaborated with the other 9 hospitals in the BILH system to engage the 49 municipalities and six Boston neighborhoods who were part of the individual Community Benefits Service Areas from each of the licensed hospitals.