Community Benefits Report

Fiscal Year 2025

Beth Israel Lahey Health
Beth Israel Deaconess Needham

TABLE OF CONTENTS

SECTION I: SUMMARY AND MISSION STATEMENT 3
- **Priority Cohorts 5**
- **Basis for Selection 5**
- **Key Accomplishments for Reporting Year 5**
- **Plans for Next Reporting Year 6**

SECTION II: COMMUNITY BENEFITS PROCESS 9
- **Community Benefits Leadership/Team 9**
- **Community Benefits Advisory Committee (CBAC) 10**
- **Community Partners 10**

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT 13
- **Approach and Methods 13**
- **Summary of FY 2025 CHNA Key Health-Related Findings 14**

SECTION IV: COMMUNITY BENEFITS PROGRAMS 16

SECTION V: EXPENDITURES 41

SECTION VI: CONTACT INFORMATION 42

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM 43

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 southern New Hampshire and advancing the science and practice of medicine through ground-breaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 5,900 physicians and 36,000 employees.

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

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

The mission of Beth Israel Deaconess 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 Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

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

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

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

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

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

The following annual report provides specific details on how 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 2025, 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 (February 2018). 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 2026 - 2028 Implementation Strategy (IS) is focusing 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 2025 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2026 – 2028 IS, BID Needham will work with its community partners, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BID Needham's Community Benefits investments and resources will focus on improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Individuals Living with Disabilities
- 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 FY 2025 CHNA and FY 2026-FY 2028 IS were approved and adopted, respectively, by the BID Needham Board of Trustees during the fiscal year ended September 30, 2025. That CHNA and IS will inform the Community Benefits mission and activities of BID Needham for the fiscal years ending September 30, 2026; September 30, 2027; and September 30, 2028.

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

Program accomplishments include:

- Supported Needham Community Farm's Mobile Market in the delivery of over 6,600 pounds of free produce to residents of the Needham Housing Authority. This represents a 20% increase over the previous year and underscores the growing level of food insecurity among residents.
- Funded transportation programs through both Needham Community Council and the Town of Norwood to provide residents with free rides to medical appointments, ensuring they had access to the care they needed. The two programs provided over 3,400 and 1,200 rides, respectively.
- Assistance was provided to low-to-moderate income families facing homelessness or eviction in Dedham via financial skills educational sessions (18 attendees) and counseling services (15 individuals).
- Funded Teen Mental Health First Aid (MHFA) train-the-trainer sessions for Needham Public School counselors. Having more trained staff will allow the schools to continue to roll out MHFA to all 10th graders.
- Provided over 1,100 clothing items via the ED Essentials Closet to patients in need to allow for a safe and healthy discharge.
- Established a new partnership with a tele-psychiatry service provider to offer both emergency and psychiatric consultations 24/7/365.
- Provided financial assistance counseling to 431 patients in need and helped them enroll in either a Connector Plan, MassHealth, over 65 programs, and the Health Safety Net Program as appropriate.

Plans for Next Reporting Year

In FY 2025, 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. In response to the FY 2025 CHNA, BID Needham will focus its FY 2026 - 2028 IS on four priority areas. These priority areas collectively address the broad range of health

and social issues facing residents living in 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 2025 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 2025 CHNA and creating its FY 2026 - 2028 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 identity, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2025 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BID Needham's FY 2026 - 2028 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BID Needham's Community Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and linguistically diverse populations; and individuals living with disabilities.

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 2026 – 2028 IS.

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

- **Social Determinants of Health**

- BID Needham will work with Needham Community Farm to fund a mobile market to deliver free produce on a weekly basis to the Needham Housing Authority.

- **Mental Health and Substance Use**
  - BID Needham will continue its work with the Dedham Council on Aging to provide social services to those with mental health needs. The grant funds regular support groups for those who are bereaved and for those struggling with caregiver responsibilities as well as those seeking connections with their peers.

- **Complex and Chronic Conditions**
  - New in FY26, BID Needham will be partnering with Needham Community Council for its recently launched Dementia Care Partners Support program. The Council currently runs monthly Memory Cafes and with this grant will expand services to include individualized Care Partner Consultations and facilitated Care Partner Support Groups.

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 44). The BID Needham Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

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

- ***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 BID Needham Community Benefits program is spearheaded by the Community Benefits and Community Relations Manager, who has direct access to 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 Community and Health Impact Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

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

- December 18, 2024
- March 27, 2025
- June 25, 2025
- September 18, 2025 (Public Meeting)

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 the local Public Health Departments in the towns of Dedham, Needham and Norwood. These relationships include working together on programs related to healthy aging, substance use and mental health, food access, and access to care.

The following is a comprehensive listing of the community partners with which BID Needham joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 49).

American Cancer Society
Charles River Regional Chamber
Charles River YMCA
Circle of Hope
Dedham Council on Aging
Dedham Food Pantry
Dedham Public Health
Dedham Public Schools
Dedham Youth Commission
Family Promise MetroWest
Needham Community Council
Needham Community Farm
Needham Council on Aging
Needham Emergency Management
Needham Farmer's Market
Needham Fire Department
Needham Housing Authority
Needham Police Department
Needham Public Health
Needham Public Schools
Needham Traveling Meals Program
Needham Youth & Family Services
Neighborworks Housing Solutions
Newton Wellesley Hospital
Norwood Police Department
Norwood Public Health Department
Riverside Community Care
Students Advocating Life without Substance Abuse (SALSA)
Substance Prevention Alliance of Needham (SPAN)
Town of Dedham
Town of Needham
Town of Norwood
Town of Westwood
Westwood Council on Aging

Westwood Youth & Family Services
William James College

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2025 Community Health Needs Assessment (CHNA) along with the associated FY 2026-2028 Implementation Strategy was developed over a fifteen-month period from June 2024 to September 2025. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the 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 2025. FY 2025 Community Benefits programming was informed by the FY 2022 CHNA and aligns with BID Needham's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2025 CHNA approach, methods, and key findings.

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

Through the FY 2025 Community Health Needs Assessment process, BID Needham conducted 15 interviews with key collaborators in the community, facilitated 5 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 580 residents, and organized a community listening session. 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 the BID Needham's Board of Trustees.

Summary of FY 2025 CHNA Key Health-Related Findings

Equitable Access to Care

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

Social Determinants of Health

- The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These conditions

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

Mental Health and Substance Use

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

Complex and Chronic Conditions

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

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

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health **Program Name: Needham Community Farm (NCF) Mobile Market** **Health Issue: Additional Health Needs (Access to Healthy Food)**		
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 older adults and individuals with disabilities 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 food donations by 10% compared to same period last year to help combat a continued rise in food insecurity.	
Goal Status	Goal met: Increased total produce donated by over 20% (from 5,500 lbs to 6,600 lbs) during timeframe. Over the past 12 months, there was roughly a 20% increase in visitors to the Mobile Market. In addition, the amount of food requested at each Market has risen, reflecting the growing levels of food insecurity across Massachusetts. To help meet this increasing demand, the farm staff is working hard to bring the newly expanded farmland into full production.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Westwood Council on Aging Emerging Needs for Seniors** **Health Issue: Additional Health Needs (Access to Healthy Food)**	
Brief Description or Objective	The Westwood Council on Aging works to address the emerging needs for older adults in Westwood. Through this program, the Council sought to provide support to those who are homebound by providing and delivering fresh produce and meals that might otherwise be difficult to obtain.

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 from a local organic farm are delivered to older adults who are homebound.	
Goal Status	Goal met: During the spring, summer and fall of 2025 the Westwood Council on Aging ordered, picked up and delivered fresh produce to 40 homebound older adults on a bi-monthly basis. Over the past six years, the Center has developed strong partnerships with Powisset Farm, in Dover, and Ward's Farm, in Canton, allowing a greater variety of produce to be ordered every week. The Council continues to partner with HESSCO, a local Aging Services Access Point (ASAP), so with each of these Thursday morning deliveries, a sandwich, salad chips and water bottle were provided so that the homebound older adults got not only fresh produce, but lunch as well. With food prices soaring and seniors not wanting to use the local food pantry, the Council was also able to put out the extra fresh vegetables for seniors who came into the Center. This weekly opportunity was highly anticipated and enjoyed by an additional 20-25 seniors every Thursday morning.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Access to Healthy Foods: Dedham Food Pantry** **Health Issue: Additional Health Needs (Access to Healthy Food)**		
Brief Description or Objective	The Dedham Food Pantry distributes essential food items to Dedham residents experiencing food insecurity, including non-perishable pantry staples; perishable items such as frozen meat, eggs, cheese and bread; and fresh seasonal produce when available.	
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 the increased need for food access by providing food to individuals and families experiencing food insecurity in Dedham.	
Goal Status	Goal met: The need for food at the Pantry continues to grow. This year (October 2024 - September 2025), the Dedham Food Pantry served 8,400 households, an increase of 13% from the same period last year. The pantry distributed 46,750 bags of food, up 8% from the prior year. The number of bags continued to increase from last year despite no longer providing bags to immigrant families when the two shelters in	

	Dedham closed. Distribution days also increased year over year due to the offering of a weekday shopping option in addition to Saturday shopping.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Traveling Meals** **Health Issue: Additional Health Needs (Access to Healthy Food)**		
Brief Description or Objective	The Traveling Meals program delivers meals to community residents who are homebound and 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 eligibility 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 10,208 healthy meals to homebound seniors in 2025.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **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 in 2025 by preventing evictions or shelter entry for 70 families, 25 in the service area.	

Goal Status	Goal partially met: FPM decreased the number of people facing housing insecurity in 2025 by preventing evictions or shelter entry for 105 families, including over 200 children, with 17 families in the service area.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Benefits Administration and Infrastructure** **Health Issue: Chronic Disease, Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**		
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Service Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs.	
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	1) Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area. 2) Offer evaluation capacity workshops to support partner organizations and grantees to better understand and report on program outcomes and impacts.	
Goal Status	1) Goal met: BID Needham supported and implemented 18 programs and granted $456k to local organizations. 2) Goal met: BILH offered five (5) evaluation workshops in FY25 focusing on data collection, analysis, interpretation, reporting and storytelling, with 96% of attendees reporting increased knowledge.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Circle of Hope ED Essentials Closet** **Health Issue: Additional Health Needs (Other SDoH)**	
Brief Description	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

or Objective	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)	Circle of Hope will provide approximately 1,200 items of clothing, shoes, backpacks and other necessities to the BID Essentials Closet through monthly deliveries ensuring approximately 3-5 patients each week receive the items needed for a healthy discharge.
Goal Status	Goal met: A total of 1,114 items, including clothing, underwear, shoes, and backpacks, were distributed, ensuring that approximately 250 patients had what they needed for a safe and healthy discharge.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Needham Farmer's Market SNAP Match Program** **Health Issue: Additional Health Needs (Access to Healthy Food)**	
Brief Description or Objective	Supplemental Nutrition Assistance Program (SNAP) is a government-funded initiative that helps reduce poverty and food insecurity by supplementing grocery budgets for low-income families. Under this grant, the Needham Farmer's Market will match SNAP funds (up to $30 per shopper per week), thereby enabling families to purchase more fresh food than otherwise would have been possible.
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)	1) Provide SNAP matches for 10 shoppers per week. 2) Increase number of transactions to 100 or more compared to 91 in 2024 and 63 in 2023. 3) Increase the actual SNAP amount customers spend - this is a true growth metric as it shows shoppers see the value of the SNAP match program.
Goal Status	1) Goal partially met: SNAP matches were provided for an average of 4 shoppers a week. 2) Goal partially met: There were 81 transactions in 2025. 3) Goal met: Customers spent $1,880 in 2025 compared to $1,680 in 2024 and $1,065 in 2023.

Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Dedham Homelessness Prevention and Rapid Re-housing** **Health Issue: Housing Stability/Homelessness**		
Brief Description or Objective	BID Needham will work with NeighborWorks Housing Solutions to address housing instability and homelessness prevention in Dedham through rental assistance and case management programs.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By December 31, 2025, program staff will conduct outreach to at least 100 households in the Dedham area at risk of homelessness with the goal of connecting them to diversion services and housing resources. By March 31, 2026, NHS will deliver a 4-session financial literacy series to at least 20 households at risk of housing instability, with 75% of participants demonstrating improved knowledge in budgeting and resource management on pre- and post-assessments. By June 30, 2026, program staff will assist 20 households in developing individualized Housing Stability Plans, with 80% of those households accessing at least one community resource or support service within 60 days of plan completion.	
Goal Status	Goal met: NHS reached out to over 500 households. Goal met: A 4-part Financial Skills Series was offered over 4 weeks in March 2025. There were 18 attendees. Goal partially met: 8 households have developed HSPs and are receiving counseling services. 7 additional households are currently developing their HSPs.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Community Council Medical Transportation Program** **Health Issue: Additional Health Needs (Transportation)**	
Brief Description	The Needham Community Council Transportation Program provides a concierge dispatch service, operated by staff members and volunteers, with the ride-share service,

or Objective	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)	Continue to provide free transportation to local residents who either don't have their own transportation or do not drive on their own.	
Goal Status	Goal met: The Council was able to provide an average of 285 roundtrips each month during FY25, to approx. 55 unique riders. Two of the riders are over 100 and use this service multiple times each month, as neither has family in the area. Due to high demand, the Council now limits rides to medical appointments and pharmacy visits only.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Norwood Transportation Program** **Health Issue: Additional Health Needs (Transportation)**		
Brief Description or Objective	In order to address the transportation issues caused by the closure of Norwood Hospital for Norwood residents, Norwood Public Health has partnered with the Town of Norwood, Norwood Council on Aging and Norwood Housing Authority to provide transportation for residents 55+ to medical appointments with any treatment provider.	
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 medical care through an expanded transportation program for those 55+ who wouldn't otherwise have access to transportation.	
Goal Status	Goal met: During Year 3 of the grant, 1,261 medical rides were provided.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that

	language and cultural barriers are major difficulties to accessing health and social services and navigating the health system. BID Needham offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.
Program Type	☐ Direct Clinical Services ☒Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	Provide access to interpretation and translation services at no cost to BID Needham patients.
Goal Status	Goal met: In FY25, BID Needham Interpreter Services supported 7,729 encounters. The top 5 languages offered were Spanish, Russian, Brazilian Portuguese, Chinese Mandarin and Haitian Creole.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs.
Program Type	☐ Direct Clinical Services ☒Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	To assist patients throughout the BILH Systems who are uninsured and underinsured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs and Hospital Charity programs.
Goal Status	Goal met: In FY2025 Needham screened 431 patients and enrolled 150 patients into a Connector Plan, 105 patients were enrolled in MassHealth and 90 patients were

	enrolled in an over 65 program. 57 uninsured patients utilized the Health Safety Net Program.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Addressing BILH Patient Health Disparities** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	A BILH Health Equity division sits within the Office of Community and Health Impact. BILH's Health Equity team's focus is on addressing health disparities to ensure equitable health outcomes across the patient populations served by BILH.
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Meet or exceed goal of 76.5% of BILH patients 18-85 years of age diagnosed with diabetes (Type 1 and Type 2) who had a hemoglobin A1c (HbA1c) level of <= 9.0% during the measurement period ending September 30, 2025. Meet or exceed goal of 74.8% of BILH patients 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period ending September 30, 2025. Meet or exceed goal of 69.6% of BILH patients 18-85 years of age with a diagnosis of both diabetes and hypertension who meet control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period ending September 30, 2025.
Goal Status	The average percentage, of the identified population above, whose hemoglobin A1c (HbA1c) level was <= 9.0% during the measurement period was 78.4% which exceeded the target average goal of 76.5%. Goal Met: 75% of the focus population had blood pressure that was adequately controlled (< 140/90 mmHg) during the measurement period. Goal Met: 70.4% of the focus population met the control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period through September 2025.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs Identified by the Community (Access to Care)**	
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate's degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1) In FY25, Workforce Development will continue to encourage community referrals and hires. 2) In FY25, Workforce Development will hire interns after internships and place in BILH hospitals. 3) In FY25, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. 4) In FY25, Workforce Development will offer internships in BILH hospitals to community members over the age of 18 5) In FY25, Workforce Development will offer paid trainings for community members across BILH. 6) In FY25, Workforce Development staff will attend events and give presentations about employment opportunities to community partners. 7) In FY25, Workforce Development will establish and maintain clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions. 8) In FY25, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. 9) In FY25, Workforce Development will offer employees career development services.

Goal Status	1) Goal met: In FY25, 306 job seekers were referred to BILH and 79 were hired across BILH hospitals. 2) Goal met: In FY25, 36 interns were hired permanently in BILH hospitals. 3) Goal met: In FY25, 126 employees across BILH were enrolled in ESOL classes. 4) Goal met: In FY25, 131 community members were placed in internships across BILH hospitals to learn valuable skills. 5) Goal met: In FY25, BILH trained total of 97 community members in pipeline programs, including Patient Care Technician/ Nursing Assistant, Pharmacy Tech, Medical Assistant, CPT, Surg Tech, Research Admin, Endoscopy Tech, and the Associate Degree Nursing Residency program. 6) Goal met: In FY25, 42 events and presentations were conducted with community partners across the BILH Community Benefits Service Area. 7) Goal met: In FY25, Workforce Development established/maintained 11 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 55 high school students in paid cooperative education placements and 20 into unpaid clinical placements. BID-Needham participated in offering these trainings. 8) Goal met: In FY25, 12 BILH employees attended citizenship classes, 102 BILH employees attended career development workshops, and 138 BILH employees attended financial literacy classes. 9) In FY25, 831 BILH employees received career development services.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BID Needham Workforce Development** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	BID Needham is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BID Needham offers incumbent employees grants to pursue educational opportunities, training sessions, peer support and peer coaching.
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 FY25, Workforce Development will provide education grants to employees to pursue educational opportunities to further their careers. In FY25, Workforce Development will conduct Leadership Training sessions for all hospital managers.

	In FY25, Workforce Development will provide hands-on training for newly hired nurses. In FY25, Workforce Development will offer support to staff who have experienced an adverse event or issue while at work. In FY25, Workforce Development will offer mentoring to staff who are interested in furthering their career.
Goal Status	Goal met: In FY25, 69 education grants were given to employees to pursue educational opportunities including degree programs, certificate programs, conferences and other ongoing education opportunities. Goal met: In FY25, 3 Leadership Training sessions were offered for hospital managers, topics included “Building an Inclusive Team Environment” (29 attendees), "The Joy of Working Together"(38 attendees) and "Resilience Beyond Earth" with NASA Astronaut Sunita Williams (80 attendees). Goal Met: In FY25 BID Needham continued the Nurse Residency program for new nurses with 39 nurses graduating from the program. In addition, BID Needham continued the nurse educator program, offering newer nurses hands-on support from an experienced nurse during their shifts. Goal met: In FY25, BID Needham continued the Peer Support program to provide support to staff who have experienced an adverse event or issue while at work. 50 outreaches were conducted in FY25. Goal met: In FY25, BID Needham continued the Peer Coaching program to provide career and professional coaching to staff who are interested in advancing their career or pursuing a new opportunity.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary Care Access** **Health Issue: Chronic Disease, Additional Health Needs (Access to Care)**	
Brief Description or Objective	Throughout BID Needham's Community Benefits Service Area, BID Needham subsidizes primary care services provided by the hospital's BILH Primary Care.
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community-Wide Interventions
Program Goal(s)	Provide access to primary care for uninsured and underinsured patients.
Goal Status	Goal met: In FY25, BID Needham provided primary and specialty care in 3 practices in CBSA.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Complex & Chronic Conditions **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 reducing readmission rates. Increase the number of people with chronic/complex conditions whose conditions are under control, 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.	
Goal Status	Goal met: BID Needham has a Utilization Review team that reviews all admissions to ensure appropriate levels of care for all patients. The UR committee reviews all readmissions to the hospital. The committee looks to identify specific causes for readmissions, such as discharge plans, care transitions, and previous conditions. The committee reviews individual readmissions as well as data trends, with special attention to high risk diagnosis such as CHF. Goal met: BID Needham continues to employ two CHF nurses. 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 1,444 Uber rides for patients in FY25, offering a safe way for patients to have a ride home from an appointment or hospital stay.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex & Chronic Conditions **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)	Charles River YMCA will offer two 12-week sessions of Livestrong at the YMCA in 2025 with the goal of enrolling 30 participants recovering from cancer. Classes will run twice a year in the Spring (beginning March 2025) and Fall (beginning September 2025). Participants will report improvement in 4 physical areas: cardio-respiratory fitness, muscular strength and endurance, flexibility, and balance. Participants will also report on their sense of belonging to the community and self-esteem. The participants will be enrolled as members of the Charles River YMCA and attend classes at Charles River Active Family Center	
Goal Status	Goal partially met: During FY25 the Charles River Y faced major staffing challenges as well as challenges scheduling classes. The Y was able to complete one session of LiveStrong that began with 6 participants, although 3 postponed their enrollment due to a need to return to active treatment. Although this session was a very small group, the program was still able to make a profound impact on the 3 participants. Two made significant improvements in their physical strength and moderate improvements in their endurance and flexibility.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs (Access to Care)**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, BID Needham participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☒ Total Population or Community-Wide Interventions
Program Goal(s)	Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA). Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.
Goal Status	Goal met: More than 146 community residents and BILH staff attended one of 11 MHFA trainings (9 Adult and 2 Youth, with 1 of the Adult trainings conducted in Spanish) provided across the BILH CBSA, of which 53% (78) completed all pre- and post-training requirements to receive Mental Health First Aid certification. Goal met: Two (2) Behavioral Health Navigation and Digital Literacy workshops were conducted in FY25 with 13 participants, including RNs, CHWs/Navigators, Social Workers and a Housing Case Manager. In the program evaluation, 82% of participants felt confident to help navigate patients to appropriate behavioral health care and 70% felt confident to guide patients to web-based apps to help them meet their behavioral health needs.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Integrated Behavioral Health Care** **Health Issue: Substance Use Disorder and 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)	1) Increase access to screening, education, referral, and peer support services for those identified with or at risk of substance use condition(s) and/or co-occurring mental health and substance use condition(s). 2) 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	1) Goal met: The Gosnold Peer Recovery Navigator Program, implemented February 2023, has continued to serve any/all patients with presenting substance use conditions. This peer support program is available to BIDN patients seven days/ week, five of which are provided by an in-person Peer Recovery Specialist. Prior to implementation of the program, approximately 1-2 patients per year were identified with hospital transfer to SUD treatment. In FY25 a total of 264 recovery navigator

	consults were completed at BIDN, yielding a 49% treatment-connection success rate. - In the emergency department, 67 of the 264 consults were completed, with a treatment-connection success rate of 56%. - On the medical floors (inpatient units), 144 of the 264 consults were completed, with a treatment-connection success rate of 42%. 2) 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, a Director of Behavioral Health and an ED Behavioral Health Care Manager. The hospital also continues to invest in additional security and observers to ensure patient safety. New in FY25, BID Needham began providing 24/7/365 Tele-Psychiatry Services through an external contracted group, delivering both emergency and routine psychiatric consultations.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Substance Use Disorder and Mental Health/Mental Illness**	
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.
Goal Status	Goal met: A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. In FY25, the team provided a total of 1,687 screenings.

Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	In an effort 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). 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: Three sites with social workers were maintained in Needham for FY25 serving 379 patients.	
Time Frame Year: Year 3	**Time Frame 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)	1) Goal: 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. 2) Goal: Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose of sharps. 3) Goal: Continue to offer medication alternatives for pain relief.
Goal Status	1) Goal met: 270 gallons of unused and unwanted medication were disposed of in FY25. 2) Goal met: A sharps bin was available in the hospital lobby for the public to use for disposal. 3) Goal met: Purchased additional items for the "comfort menu" for patients who need pain relief.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Senior Volunteer Program** **Health Issue: Additional Health Needs (Older Adult Health)**	
Brief Description or Objective	The Senior Volunteer Program at BID Needham provides the older adult 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: In FY25 there were 25 adult volunteers in the volunteer program.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & 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 12 community taskforces for a total of 128 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.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Needham INTERFACE Program** **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 128 cases from June 2024 to June 2025, the reporting period that Interface uses. This reporting period there were actually more referrals for adults than for children, a variance from prior years. As in the past most callers were requesting help for anxiety and/or depression.	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & 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 provided by the William James College INTERFACE Referral Service to 100 residents of Westwood in 2025.	
Goal Status	Goal partially met: 59 Westwood residents were served by the WJC INTERFACE Referral Service in 2025.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & 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 intensive intervention skills that are family centered to support high quality service delivery for 22 mental health clinicians through training.	
Goal Status	Goal met: Three training sessions were offered with a total of 77 attendees. Training sessions included Understanding and Supporting Caregivers of Children with Mental Illness, Understanding and Responding to School Avoidance, and Collaborative Assessment and Management of Suicidality (CAMS) Training.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & 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)	Recruit 100 new SALSA Youth Prevention Advocates in Needham by 10/30/25 Provide new member leadership training for NHS SALSA members by 12/31/25. Conduct refusal skills training sessions for all 8th graders at Pollard Middle School during the 2024-25 school year.	
Goal Status	Goal met: 150 new members joined between 9/1/24- 5/20/25 Training partner, Prevention Solutions /Hazelden Betty Ford, trained new SALSA members at NHS during half day training event. SALSA youth prevention advocates provided refusal skills training to all 450 Pollard Middle School 8th graders in 24 individual health classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & 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 older adults 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)	1) Continue with current bereavement group which will run through January 2025 and then launch new group the following month. 2) Continue with the Caregiver group weekly.	

	3) Continue with the Coffee and Conversation group weekly. 4) Continue with one-on-one sessions for those who need support, both in office and in homes for those who are homebound.
Goal Status	1) Goal met: Launched a new bereavement group in November and continued to run 8 week sessions throughout the year. 2) Goal met: The Caregiver group continued to meet weekly. 3) Goal met: Continued with the Coffee and Conversation group weekly, with a new added weekly time so the group now meets twice per week. With the additional day the group has grown from approximately 12 people per week to approximately 20 people per week. Also added a new monthly Rainbow Coffee Hour with LGBTQ+ members. 4) Goal met: Continued with one-on-one sessions for those who need support, both in office and in homes for those who are homebound. 5) Goal met: Continue with monthly Aging Well support group where each session we discuss different struggles that come with aging (ex. cognitive decline, physical decline, financial struggles, living alone, loneliness and isolation, etc.). 6) Goal met: Expanded the program to include a new initiative- a pen pal program between seniors who attend the senior center and homebound seniors who are lonely and isolated. So far there is one successful pairing and the Council is compiling a list of others who are interested in participating.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Building Equity and Access in the Dedham Public Schools** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Beth Israel Deaconess Hospital-Needham's (BID Needham) Community-based Health Initiative (CHI) funds will be invested in Dedham Public Schools to fund a district-wide City Connects intervention project to develop and enhance the mental, behavioral, and substance use support for school-aged youth. The major goals of the project include providing proper access and equity in mental health and substance use care, particularly among the district's new international population and the growing ethnic, linguistic, and cultural diversity represented in the community while enhancing services for every student.
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)	1) Mental Health: By participating in individualized action plans developed through an integrated care model, Dedham students will show a significant reduction in

	acuity of MH symptoms as evaluated by annual City Connects acuity mapping procedures by June 2027. 2) Mental Health/Substance Use: By using individualized action plans and an integrated system of care, Dedham students will show a reduction in drug use endorsements on the SBIRT and MWAHS by June 2027. 3) Social Determinants of Health: By using community mapping software and reporting to stakeholders, the district and community will increase understanding and leveraging of community buffers that can mitigate social determinants of health.
Goal Status	1) In progress: Dedham Schools will be conducting a re-tiering process in the spring of 2026 to determine whether they have seen a decrease in the acuity of MH and related social symptoms. The MyConnects software will aggregate all of the plans and show changes from FY25 as well as changes over the course of this year. 2) In progress; Over the last three years, the student services department has built a universal MH screening program. Over time, they have reduced hospitalizations by over 50% by providing immediate follow-up and MATCH-ADTC programming for at risk students. In November 2025, they administered the Metro-West Adolescent Health Survey. The data will be available in the spring of 2026. They hope to find a steady, statistically significant, decline in the number of adolescents reporting they do not feel a sense of belonging. 3) In progress: This year, Dedham Schools have added a number of reports to stakeholders, including a weekly newsletter, participation in the Boston College community partners convening, holding a community partners event during our November 4, 2025 professional development day, providing MyConnects training for principals, reporting to school committee, participating in the BILH stakeholders meeting, and updating teachers on the progress of the CityConnects team through a winter 2025 report.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use
Program Name: Dedham Transportation Program: Providing Residents with Rides to Mental Health and Substance Use Programs and Appointments
Health Issue: Substance Use Disorders

Brief Description or Objective	Beth Israel Deaconess Hospital-Needham's (BID Needham) Community-based Health Initiative (CHI) funds will be investing in the Town of Dedham to fund a transportation program for residents who need assistance with rides to and from mental health and substance use programs, support groups, and other related appointments. Many individuals experiencing mental health and substance use challenges citetransportation as a barrier to accessing and maintaining services. Through the creation and funding of the Dedham Transportation Program, residents will be able to access frequent and reliable transportation to important meetings and appointments and will ultimately be better positioned to receive the care they 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)	1) By September 2025, 2,000 Dedham residents will have received and opened email notices educating the public about the Dedham Transportation Program. 2)By January 2026, the Dedham Transportation Program will transport 50 residents to mental health and substance use programs and appointments weekly, increasing the social and community support for these residents.
Goal Status	1) Goal met: To increase community awareness and engagement, the Dedham Transportation program has utilized multiple outreach channels. A total of five program-specific email blasts have been distributed, reaching an average of 2,600 subscribers per message. Program information was also included in the Town of Dedham's August utility bill, which was mailed to over 11,000 households. These broad distributions helped to significantly expand the program's visibility within the community. 2) Goal in progress with 21 unique riders. This goal is being revised to ensure it is both realistic and measurable. By February 2026, the Dedham Transportation Program aims to achieve a 10% month-over-month increase in ridership to mental health and substance use treatment programs and appointments.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Needham Teen MHFA Facilitator Training** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	As part of an effort to teach students about mental health, Needham Public Schools will be training staff members so they are certified to teach Youth MHFA to high school students.

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)	The Teen Mental Health First Aid program aims to equip students with the skills to recognize and respond to mental health challenges among their peers, providing them with essential tools for emotional resilience and support. Currently, there are only about five certified facilitators in Needham. To address this need and ensure the program's continued success, the school plans to certify additional teachers this summer.	
Goal Status	Goal met: Four staff members completed Mental Health First Aid training over the summer. This grant made a meaningful difference in staff participation and willingness to engage in a full-day summer training. Feedback from the group has been very positive. Staff shared that the scenarios and role-plays felt authentic to what they experience with students, and that the course gave them a stronger sense of clarity and confidence using the ALGEE action plan. They also appreciated having a shared language for recognizing early warning signs and supporting students in the moment, along with better understanding of referral pathways across our buildings. The schools are able to continue delivering MHFA to all 10th graders at the high school and they are exploring the possibility of expanding elements of the program into grades 6 through 9 over the next two years. Increasing the number of trained educators has allowed the school system to run more sessions without relying exclusively on external trainers, ensuring greater sustainability and responsiveness.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$3,287,639
Community-Clinical Linkages	$508,532
Total Population or Community Wide Interventions	$222,064
Access/Coverage Supports	$341,792
Infrastructure to Support CB Collaborations	$91,164
Total Expenditures by Program Type	$4,451,191
CB Expenditures by Health Need	
Chronic Disease	$2,119,761
Mental Health/Mental Illness	$910,882
Substance Use Disorders	$305,897
Housing Stability/Homelessness	$11,106
Additional Health Needs Identified by the Community	$1,103,545
Total Expenditures by Health Need	$4,451,191
Leveraged Resources	
Total Leveraged Resources	$1,040,879
Net Charity Care Expenditures	
HSN Assessment	$872,976
Free/Discounted Care	N/A
HSN Denied Claims	$505,836
Total Net Charity Care	$1,378,812
Total CB Expenditures	$6,870,882

Additional Information	
Net Patient Services Revenue	$167,637,980

CB Expenditure as % of Net Patient Services Revenue	**4.10%**
Approved CB Budget for FY26 (*Excluding expenditures that cannot be projected at the time of the report)	**$5,039,897**
Bad Debt	**$351,905**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	**BID Needham made a contribution of $113,419 representing BID Needham's PILOT payment to Needham, which contributes to the health and well-being of individuals residing in Needham.** **BIDN provided $195.023 to subsidize Behavioral Health services outside of its CBSA.**

SECTION VI: CONTACT INFORMATION

LeighAnne Taylor
Beth Israel Deaconess Hospital -Needham
148 Chestnut Street
Needham, MA 02492
781-691-3334
leighanne.taylor@bilh.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Year 1

Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:

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

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

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

The mission of 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.

2. <u>Community Benefits Advisory Committee (CBAC):</u>

- Members (and titles):

Lina Arena DeRosa, Director, Westwood Council on Aging
Janet Barrett, Trustee, BID Needham Board of Trustees
Carol Burak, Trustee, Dedham Food Pantry
Marena Burnett, Executive Director, Three Squares New England
Virginia Carnahan, Advisor Emeritus, BID Needham Board of Trustees
Amber Carroll, Youth Services Counselor, Dedham Youth Commission
MaryAnne Carty, Westwood Disability Commission Volunteer
Janet Claypoole, Director, Dover Council on Aging
Katy Colthart, Director, Westwood Youth & Family Services
Danielle Conti, Executive Director, Family Promise Metrowest
Courtney Daly, Director, Dedham Council on Aging
Kathy Davidson, Chief Nursing Officer, BID Needham
Lise Elcock, VP, Membership & Development, Charles River Regional Chamber
Kim Fisher. Chief Behavioral Strategy Officer, Riverside Community Care
Jeanne Goldberg, Regional Practice Director, Beth Isreal Deaconess Healthcare
Stacey Lane, Director, Norwood Public Health
Cyndi Locke, Risk Management and Patient Experience Manager, Fenway Health
Sandra Robinson, Executive Director, Needham Community Council
Courtney Sodano, Development Director, Needham Community Farm
Nicole Stewart, Advisor, BID Needham Board of Advisors
Mary Supple, Advisor, BID Needham Board of Advisors

- Leadership:

John Fogarty, President
Heidi Alpert, Senior Clinical Director
Kathy Davidson, Chief Nursing Officer
Dr. Peter J. Dempsey, Interim Chief Medical Officer
Randy Howard, Chief Operating Officer
Rita Morin, Senior Director, Healthcare Quality and Patient Safety
Sheilah Rangaviz, Chief Financial Officer
Samantha Sherman, Division Vice President, Philanthropy
Julie Welch, Vice President, Human Resources Business Partner

- Frequency of meetings: Quarterly

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

Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

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

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

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

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

Senior Leadership:
• John Fogarty, President: Designated a member of the senior leadership team to the CBAC and participated in the approval process.
• Kathy Davidson, Chief Nursing Officer
• Nancy Kasen, Vice President of Community Benefits and Community Relations, and Community Benefits team: designed, directed and oversaw the CHNA and IS, managed prioritization process, drafted Implementation Strategy
• Jill Carter, Manager of Community Benefits and Community Relations: led BID Needham's community engagement efforts
• BILH Board of Trustees Community Benefits Committee (CBC): guided the process for the system

4. Hospital Approach to Assessing and Addressing Social Determinants of Health

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

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 similar efforts. The assessment was supported by BID Needham's Community Benefits Advisory Committee (CBAC). The CBAC is comprised of community members, service providers, and other stakeholders who live 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: economic stability, education, food security and nutrition, housing, and transportation.

- 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. Throughout the assessment process, BID Needham worked to understand the needs of all populations in the Community Benefits Service Area, including those who have been historically underserved. Health equity is an overarching lens applied to all four pillars within the BID Needham's Implementation Strategy. The Implementation Strategy is designed to address the underlying social determinants of health and barriers to accessing care

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

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

5. Maternal Health Focus

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

BID Needham's Community Health Needs Assessment (CHNA) process includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include the Center for Health Information Analysis (CHIA), Community Health Equity Survey (CHES), County Health Rankings, MA DPH, National Center for Health Statistics and U.S. Census Bureau. The hospital's data table has a section for Maternal and Child Health/Reproductive Health which includes infant mortality rate (%) and low birth weight (%). In addition to secondary data capture and review, throughout the CHNA BID Needham engages with the

community to collect primary data via a survey, focus groups and listening sessions to directly enable community residents to identify priorities.

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

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

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

No additional assistance is needed, BID Needham's maternal health work will continue to be guided by the BILH MHQEC and BID Needham looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

II. Community Engagement

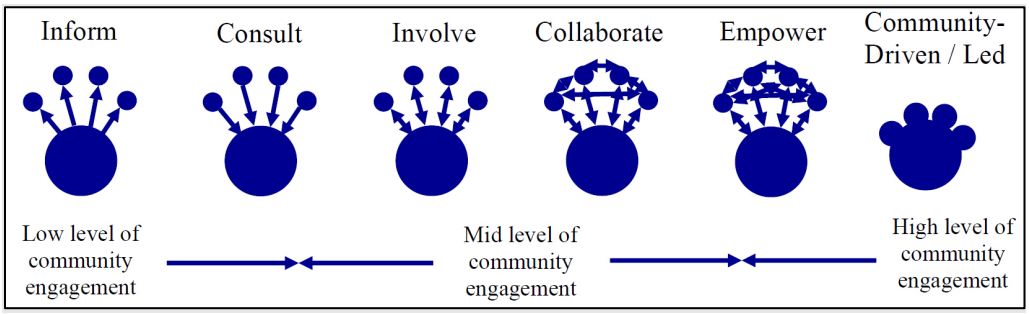
1. Organizations Engaged in CHNA and/or Implementation Strategy

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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Needham Community Farm	Susan Shaver, President	Food security	Access to healthy foods is an important social determinant of health yet fresh produce is expensive. BID Needham supports Needham Community Farm's Mobile Market, a food delivery program that delivers to the Needham Housing Authority each week and offers free fruits and vegetables. Residents can count on fresh food, ensuring a healthy meal and providing much needed food security.
Dedham Public Schools	Dr. Sara Stetson, Assistant Superintendent, Student Services	Education	New England Baptist Hospital, part of BILH, entered into a partnership to create a new ambulatory surgery center in Dedham. As part of the resulting Determination of Need, BID Needham and its Allocation Committee voted to invest part of the Community Health Initiative into mental health and substance use programs. Dedham Public Schools has used their grant to partner with Boston College's City Connects to support the student body via navigation support. Through this program, the school staff has created a resource inventory, evaluated student needs, and matched students and families to appropriate resources.
Norwood Public Health Department & Norwood Council on Aging	Stacey Lane, Director of Public Health Kerri McCarthy, Director, Council on Aging	Local health department	The town of Norwood is still feeling the lasting impact of the closure of Norwood Hospital. Transportation to medical appointments continues to be a pressing need among residents, particularly those with limited resources and those who no longer drive, many of whom are older adults. Through BID Needham's partnership with the Town of

			Norwood and the Council on Aging, van and shuttle service is available to those who require assistance, ensuring residents can get to the care and treatment needed.

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health1 to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Involve	Goal was met	Involve
Collecting data	Involve	Goal was met	Involve

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

Defining the community to be served	Collaborate	Goal was met	Collaborate
Establishing priorities	Collaborate	Goal was met	Collaborate

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

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal was met	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	Goal was met	Consult
Implementing Community Benefits programs	Collaborate	Goal was met	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met	Consult

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

3. Opportunity for Public Feedback

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

In FY25, BID Needham held four CBAC meetings, a community listening session and an annual meeting that were broadly advertised to the public. Additionally, four

newsletters were distributed to inform the community about the Community Health Needs Assessment and Implementation Strategy process, including opportunities for input, and other Community Benefits updates.

- December 18, 2024
- March 27, 2025
- June 25, 2025
- September 18, 2025 (Public Meeting)

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 department, and other government partners. BID Needham is proud of its collaboration with these and other organizations that allow for meaningful community engagement. Increased focus was placed on reaching communities typically not engaged in assessments, as such, BID Needham saw a significant increase in community surveys from the following populations: Black/African American, Hispanic/Latino, Asian and Non-English speakers.

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

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

III. Regional Collaboration

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

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

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.
   - Collaboration
   - Institutions Involved
   - Brief description of goals of collaboration
   - Key communities engaged through collaboration. If you did not participate in a collaboration, please explain why not:

For its FY 2025 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 11 licensed hospitals, including BID Needham. While BID Needham focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing significant barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.