Community Benefits Report

Fiscal Year 2024

Beth Israel Lahey Health

Beth Israel Deaconess Needham

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SECTION I: SUMMARY AND MISSION STATEMENT

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

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BID Needham's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

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

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

The mission of Beth Israel Deaconess Hospital–Needham (BID Needham) is to serve BID Needham patients compassionately and effectively and to create a healthy future for them and their families. BID Needham's mission is supported by the hospital's commitment to personalized, excellent care for patients; a workforce committed to

individual accountability, mutual respect, and collaboration; and a commitment to maintaining financial health. The hospital is also committed to being active in the community. Service to community is at the core of BID Needham's mission.

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

- **Involving BID Needham's staff**, including its leadership and dozens of community partners in the Community Health 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 social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership within and across sectors** (e.g., 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 2022, BID Needham conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to

engage BID Needham's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BID Needham is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BID Needham's FY 2023 - 2025 Implementation Strategy (IS) 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 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in the BID Needham CBSA were issues related to age, race/ethnicity, language, and disability status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were non-white, people of color, immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers faced systemic challenges that limited their ability to access health care services. Some segments of the population were impacted by language and cultural barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may lead to discrimination and disparities in access and health outcomes.

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

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

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

Key Accomplishments for Reporting Year
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in BID Needham's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

Social Determinants of Health and Access to Care

The organizations BID Needham supports continue to report that food access and housing access are some of the biggest issues residents in the CBSA are facing. The hospital provided grant funding to the organizations and programs listed below.

The hospital supported multiple food access programs, including the Westwood Council on Aging's fresh produce delivery from a local farm to homebound seniors. In Dedham, the Dedham Food Pantry continued to see increased demand for their services and received grant support from BID Needham, enabling the pantry to add two additional shopping days per month and provide snacks to families living in migrant shelters. In Needham, the hospital continued its partnership with the Needham Community Farm to run a mobile market that delivers free, fresh produce to more than 200 residents living in public housing in Needham. This year the farm was able to increase production by 10% to help meet increasing demand. BID Needham also continued to collaborate with the Town of Needham to prepare meals for the town's traveling meals program. A new program was added this year, supporting Needham Farmer's Market SNAP Match Program. Through this initiative, shoppers at the weekly Sunday market were able to double their benefits under SNAP, increasing the amount of fresh produce they could purchase.

In the area of housing, BID Needham began funding a Community Health Initiative in Dedham to address homelessness prevention. In the first year of its new partnership with Neighborworks Housing Solutions, triage support and referrals were provided to 50 families facing a housing crisis. BID Needham also continued to support Family Promise MetroWest's LIFE Initiative to prevent homelessness for 123 families who now are stably housed.

In order to improve access to medical appointments, the hospital has continued to support the Needham Community Council's medical appointment transportation program and a similar program in the Town of Norwood. Demands for rides in both programs continued to increase, particularly in Norwood where residents have been struggling since the closure of Norwood Hospital. Both programs provide rides to health-related appointments with any medical provider.

Within the hospital BID Needham continued to employ financial counselors to assist with insurance enrollment and navigation and to provide options for linguistically and culturally appropriate health care. The hospital's partnership with Circle of Hope expanded to patients beyond the Emergency Department. Through this program, patients who need items for a healthy discharge are provided essentials such as clothing, shoes, jackets and personal care items.

BID Needham also invested in developing its workforce through programs that enhance the skills of its diverse employees and provide career advancement opportunities. These efforts included education grants, leadership training, a nurse residency program, and peer coaching.

Chronic and Complex Conditions and their Risk Factors

BID Needham continued its ongoing partnership with the Charles River YMCA's LiveStrong program for cancer survivors, providing strength and mobility training and support. BID Needham also continued its support for Neighbor Brigade's transportation and food

assistance program to those suffering from chronic conditions. The number of individuals served through this program increased in FY24 as did the number of program volunteers.

This year BID Needham supported an additional program offered by the Charles River YMCA. The Diabetes Prevention Program is designed to teach participants healthy lifestyle habits to help prevent or manage diabetes.

Mental Health and Substance Use

In the area of mental health and substance use, the hospital continues to integrate behavioral health into patient care, while also educating the community on this topic.

Within the hospital, BID Needham has several measures in place to provide mental health care. The Director of Medical Psychiatry provides consults for our providers related to both inpatient units and the Emergency Department with telephone support from Psychiatric Nurse Practioners on weekends as needed. In addition, BIDN and Gosnold Inc. have continued their collaborative clinical and operational approach to addressing the treatment, referral, and continuing care needs of patients with substance use disorders. Gosnold provides a Recovery Navigator to deliver Recovery Navigation and Management services 7 days / week, within the BID Needham Emergency Department and on other hospital floors.

Within the community, the hospital serves on local committees and taskforces to address the needs of residents in crises. The coalitions are focused on various topics including Community Crisis Intervention, Substance Prevention, Mental Health, Wellbeing, Medical Error Prevention and Emergency Planning. BID Needham also awarded funding to Riverside Community Care to support advanced psychological and behavioral training for their Home-Based service clinicians and staff.

To educate the community and reduce stigma around mental health, BID Needham provides funding for mental health and substance use programming for youth and families. In FY 2024, this included continuing the partnership with Students Advocating for Life without Substance Abuse (SALSA) to provide resiliency education for middle school students. Grant money was used to support efforts to recruit and train additional student peer educators at Needham High School. New in FY24, the BID Needham conducted two Mental Health First Aid training sessions, open to both staff and community members.

As access to behavioral health care continues to be an issue, the Hospital continues to provide funding for the Interface Mental Health Hotline in both Westwood and Needham. To address care within the community, BID Needham supports BILH's Collaborative Care program, which provides a social worker in local Primary Care Physician offices. In addition, the Dedham Council on Aging receives a grant to provide additional hours for a social worker to offer support groups, including bereavement and caregiver groups.

Lastly, BID Needham began two new partnerships in Dedham as part of its Community Health Initiative. The first is a grant to Dedham Public Schools supporting their program with Boston College's City Connects. Through this initiative, a tailored support plan will be created for every student - leveraging the prevention, intervention, and enrichment services that already exist in the schools and surrounding communities. Using proprietary software

students will be tracked and monitored to ensure they are getting the necessary support. The second partnership is with the Town of Dedham to create a transportation service that provides rides for residents attending mental health and substance use programs.

Plans for Next Reporting Year

In FY 2022, BID Needham conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BID Needham's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, BID Needham has focused its FY 2023 - 2025 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in BID Needham's CBSA who face the greatest health disparities. These four priority areas are:

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BID Needham's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BID Needham's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BID Needham, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BID Needham's FY 2023 - 2025 IS, it 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 diverse populations.

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

- **Equitable Access to Care**
  - BID Needham will continue its partnerships with the Needham Community Council and 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 and Needham Bank 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.

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

Hospital Self-Assessment Form
Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BID Needham Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 46). 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 Trustee members and senior leadership who are held accountable for fulfilling BID Needham's Community Benefits mission. Among BID Needham's core values is the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BILH and BID Needham's structure and reflected in how care is provided at the hospital and in affiliated practices.

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

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

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

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

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

The BID Needham CBAC met on the following dates: December 13, 2023, March 26, 2024, June 11, 2024 and September 26, 2024.

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 46).

Community Partners:
American Cancer Society
Charles River Regional Chamber
Charles River YMCA
Circle of Hope
Dedham Council on Aging
Dedham Food Pantry
Dedham Public Health
Dedham 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 Resilience Network
Needham Traveling Meals Program
Needham Youth & Family Services
Neighbor Brigade
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 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill 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 2022. FY 2023 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 2022 CHNA approach, methods, and key findings.

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

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

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

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

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

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

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

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

Social Determinants of Health

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

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

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

Mental Health and Substance Use

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

Complex and Chronic Conditions

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

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

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health **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)	1) Increase the total produce amount grown on the Farm by 5% in response to increasing food insecurity. 2) Expand educational opportunity access to priority populations to learn how to grow their own food. 3) Improve produce use and storage through knowledge sharing in priority populations through recipe and informational cards.	
Goal Status	1) Goal met: increased total produce grown by 10% year over year. 2) Goal met: Promoted scholarship fund to low-income populations through fliers at Mobile Markets and cross promotion in Community Council newsletter. Received 10% more enrollees compared to last year. 3) Partially met: Knowledge sharing was achieved through the distribution of storage informational cards during the Mobile Market season and informal discussions with staff.	
Time Frame Year: Year 2	**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 2024 the Westwood Council on Aging ordered, picked up and delivered fresh produce to 40 homebound older adults on a bi-monthly basis. This was an additional 5 adults compared to 2023. In addition to the existing relationship with Powisett Farm, the Council added Ward's Farm as a second community partner, allowing a great variety of produce to be included this year. The Council continues to partner with HESSCO, a local Aging Services Access Point (ASAP), so a sandwich, salad chips and water bottle was provided with each delivery so that the homebound older adults got not only fresh produce, but lunch as well.	
Time Frame Year: Year 2	**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 Dedham Food Pantry continued to see the growing need for food for Dedham residents. This year was even busier - there was a 23% increase in the number of bags distributed and a 21% increase in the number of households served year-over-year. Two extra shopping days were added each month to lessen the load on Saturdays and give the clients an evening shopping option. Lastly, the pantry is providing snack bags to the migrant families living in Dedham shelters.	
Time Frame Year: Year 2	**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: In FY24 the traveling meals program prepared and delivered more than 10,947 healthy meals to older adults who were homebound.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health Program Name: Needham Resilience Network Health Issue: Additional Health Needs (Violence & Safety)		
Brief Description or Objective	The Needham Resilience Network (NRN) is a "whole of society" effort designed to establish relationships across silos, build skills in communicating across differences, explore local issues from various perspectives, and facilitate a process of co-creation in proposing solutions.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Thirty diverse community leaders representing major identity and stakeholder groups in Needham will co-create a set of rapid response resources to be used by the community in the event of a hate incident, including: 3 public statement templates (tailored to 3 different types of bias/hate incidents) and 1 protocol for rapid response organizing (e.g., response decision chain, call chain, etc.).	
Goal Status	Goal partially met: Needham Resilience Network is part way through this process. NRN members have engaged in a participatory session on best practices in rapid response and are currently working through the three hate-incident scenarios.	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**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 2024 by preventing evictions or shelter entry for 70 families in the service area.	
Goal Status	Goal met: Family Promise Metrowest decreased the number of people facing housing insecurity in 2024 by preventing evictions or shelter entry for 123 families in the service area.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Neighbor Brigade** **Health Issue: Additional Health Needs (Transportation, Access to Healthy Food)**			
Brief Description or Objective	Neighbor Brigade organizes volunteers that can be mobilized to help residents who under-resourced when facing a sudden crisis, such as cancer diagnosis or other illness, as well as assist with managing day-to-day tasks such as meal preparation, rides, and basic household chores.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Increase the number of volunteers who sign up to serve in our Dedham and Needham Chapters: We intend to grow our Chapter's base of volunteers by engaging a diverse group of community members, offering various ways to contribute based on their availability and interests. We will aim to ensure that every person who needs help has access to volunteer assistance and build a pool of volunteers ready to step in when needed.		
Goal Status	Goal met: There was an increase in the number of volunteers in our Dedham and Needham Chapters, with the total of new volunteers being 33.		
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**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 Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.	
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 partner organizations and grantees to increase better understand impact.	
Goal Status	1) Goal met: BID Needham supported and implemented 22 programs and granted $540k to local organizations. 2) Goal met: BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization.	
Time Frame Year: Year 2	**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 or Objective	Circle of Hope's ED Essentials Closet supports the vital needs of BID Needham's emergency department and inpatient patients. Circle of Hope delivers new clothing, underwear, socks, shoes, seasonally appropriate outerwear, and vital hygiene supplies to BID Needham on a monthly basis, to fully stock the "Essentials Closet" for those patients who do not have the essential items they need for a safe discharge.		
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Circle of Hope will provide 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 partially met: Circle of Hope provided 1,016 items of clothing, shoes, backpacks and other necessities to the BID Essentials Closet. COH made monthly deliveries during the grant period ensuring 250 patients received the items needed for a healthy discharge.		
Time Frame Year: Year 2	**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)	Provide SNAP matches for 15 shoppers per week and increase number of transactions to 150 or more compared to 63 in 2023.		
Goal Status	Goal partially met: The program reached an average of 5 shoppers per week, up from 4 the prior year. There were 93 transactions in 2024, a 48% increase over the prior year		
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**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)	1) Provide triage and referral for 50 tenants and homeowners facing a housing crisis. 2) Avert displacement for 10 eligible homeowners experiencing housing distress by providing financial assistance and other supports. 3) "Rehouse with dignity" 40 homeowners requiring rehousing through counseling and one-on-one support.	
Goal Status	1) In progress: Identified 51 Dedham homeowners and renters who had applied to NHS for assistance with their housing crisis during this reporting period. Contacted each household by direct mail and sent a program flyer for this program. The flyer included a link to the intake form which they would complete if they wanted the opportunity for additional financial assistance and to work with a housing counselor. 2) In progress: Coordinated with the RAFT team to identify Dedham homeowners who are eligible for RAFT assistance, but needed more than $7000 in order to bring their loan current. NHS was able to assist one household with an additional $2000 from this program to avoid foreclosure during the reporting period. The client is assigned to a counselor and active with counseling. 3) In progress: As NHS works to assist clients, they make them aware of the opportunity for additional one-on-one support and assistance if they need to find new housing. There were no requests for rehousing assistance from Dedham residents during the reporting period.	
Time Frame Year: Year 1	**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 or Objective	The Needham Community Council Transportation Program provided a concierge dispatch service, operated by staff members and volunteers, with the ride-share service, Lyft. To request a ride, the individual calls the Needham Community Council and is scheduled with a Lyft ride.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Conduct more outreach and establish closer contact with the agencies in Needham who serve the clients who need transportation, including the Council on Aging (COA) and the Needham Housing Authority (NHA).		
Goal Status	Goal met: The Council is in frequent contact and has received many referrals from both COA and NHA which has been a factor in increasing ridership by 55% since 2023.		
Time Frame Year: Year 2	**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 2 of the grant, 1,536 medical rides were provided.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Equitable Access to Care Program Name: Interpreter Services Health Issue: Additional Health Needs (Access to Care)			
Brief Description or Objective	Providing culturally responsive care, especially for those whom English is not their first language, is an essential piece of access to care and managing physical disease. The hospital offers several options for Interpreter Services for patients.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Provide access to interpretation and translation services at no cost to BID Needham patients.		
Goal Status	Goal met: In FY24, BID Needham Interpreter Services supported 6,134 encounters. The top 5 languages offered were Spanish, Haitian Creole, Russian, Brazilian Portuguese, and Chinese Mandarin.		
Time Frame Year: Year 2	**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	Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by the Executive Office of Health and Human Services and the Health Connector. The CACs assist with financial counseling, benefit enrollment assistance, and payment planning to the underserved and uninsured in the BID Needham community.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	To assist patients throughout the BILH Systems who are uninsured and under insured 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 FY2024 Needham screened 226 patients and enrolled 96 patients into a Connector Plan, 62 patients were enrolled in a Masshealth and 39 patients were enrolled in an over 65 program. 27 uninsured patients utilized the Health Safety Net Program		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BILH Community Benefits sits within the Office of Diversity, Equity and Inclusion (DEI). BILH's Office of Diversity, Equity, and Inclusion develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent."	
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) Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation. 2) Increase spend with diverse businesses by 25% over the previous fiscal year across the system.	
Goal Status	1) Across BILH there was an 18% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires. 2) More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY24. This is a 28% increase over FY23.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs (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 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 Intervention ☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	1) In FY24, Workforce Development will continue to encourage community referrals and hires. 2) In FY24, Workforce Development will attend events and give presentations about employment opportunities to community partners 3) In FY24, Workforce Development will offer employees career development services. 4) In FY24, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. 5) In FY24, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. 6) In FY24, Workforce Development will offer internships in BILH hospitals to community members over the age of 18. 7) In FY24, Workforce Development will hire interns hired after internships and place in BILH hospitals. 8) In FY24, Workforce Development will offer paid trainings for community members across BILH. 9) In FY24, Workforce Development will establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.
Goal Status	1) Goal met: In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals. 2) Goal met: In FY24, 33 events and presentations were conducted with community partners across the BILH service area. 3) Goal met: In FY24, 1,044 BILH employees received career development services. 4) Goal met: In FY24, 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. BID Needham employees participated in these offerings. 5) Goal met: In FY24, 82 employees across BILH were enrolled in ESOL classes. BID Needham employees participated in these classes. 6) Goal met: In FY24, 107 community members placed in internships across BILH hospitals to learn valuable skills. BID Needham participated in offering these internships. 7) Goal met: In FY24, 37 interns were hired permanently in BILH hospitals. BID Needham participated in these hirings. 8) Goal met: In FY24, BILH trained total of 99 community members to Patient Care Technician or Nursing Assistant (41), Pharmacy Tech (22), Medical Assistant (29), Behavioral Health roles (3) or into the Associate Degree Nursing Residency program (4). BID Needham participated in offering these trainings.

	9) Goal met: In FY24, Workforce Development established 10 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 47 high school students in paid cooperative education placements and 11 into unpaid clinical placements. BID Needham participated in offering these trainings.	
Time Frame Year: Year 2	**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 FY24, Workforce Development will provide education grants to employees to pursue educational opportunities to further their careers. In FY24, Workforce Development will conduct Leadership Training sessions for all hospital managers. In FY24, Workforce Development will provide hands-on training for newly hired nurses. In FY24, Workforce Development will offer support to staff who have experienced an adverse event or issue while at work. In FY24, Workforce Development will offer mentoring to staff who are interested in furthering their career.	
Goal Status	Goal met: In FY24, 77 education grants were given to employees to pursue educational opportunities including degree programs, certificate programs, conferences and other ongoing education opportunities. Goal met: In FY24, 5 Leadership Training sessions were offered for all hospital managers, including the Communicating with a Purpose 3-Part Series, TypeCoach Training and Disabilities in the Media training. Goal Met: In FY24 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, to provide hands-on support from an experienced nurse during their shifts. Goal met: In FY24, BID Needham continued the Peer Support program to provide support to staff who have experienced an adverse event or issue while at work. 73 outreaches were conducted in FY24. Goal met: In FY24, 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 2	**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 ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Provide access to primary care for uninsured and underinsured patients.		
Goal Status	In FY24, BID Needham provided primary care in 3 practices in its CBSA.		
Time Frame Year: Year 2	**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 reducing readmission rates and by employing a Congestive Heart Failure (CHF) nurse to follow up with patients. Increase access to affordable, safe transportation options to health care by providing Uber vouchers to those who need a ride home from medical appointments at the hospital.	
Goal Status	Goals 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. 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. The hospital provided 1,486 Uber rides in FY24, offering a safe way for patients to have a ride home from an appointment or hospital stay.	
Time Frame Year: Year 2	**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)	The LiveStrong at the YMCA will offer two 12-week sessions in 2024 with the goal of enrolling 30 participants recovering from cancer. Classes will run twice a year in the Spring (beginning March 2024) and Fall (beginning September 2024. 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 at 380 Chestnut St., Needham, MA. 02492.	
Goal Status	Goal partially met: The Charles River YMCA has successfully run two 12-week Livestrong sessions in spring (March 2024) and Fall (September 2024) and served a total of 18 participants. Almost all of the participants saw physical improvements; some of the participants experienced unrelated health issues that hindered progress. Participants feel a sense of belonging at the YMCA and some have come in to use the facility outside of program times while others have asked about other programs the YMCA offers.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex & Chronic Conditions Program Name: YMCA Healthy Habits Diabetes Prevention Program Health Issue: Chronic Disease (Diabetes)			
Brief Description or Objective	Healthy Habits is a 10-week program that offers expert coaching and group support to help participants learn the five key health habits to achieve a healthy weight, prevent or manage Diabetes, and live their healthiest lifestyle. This class will focus on 5 core habits: fitness, nutrition, stress management, sleep, and social engagement. Over the course of the session, group leaders will use effective and sustainable techniques to help participants meet their goals and improve their quality of life.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	By the end of the 10-week Healthy Habits program, 80% of participants will a 5% reduction in body weight and report enhanced well-being through the adoption of the following five key healthy habits: regular physical activity, balanced nutrition, effective stress management, improved sleep quality, and increased social engagement. Progress will be assessed through weekly self-reports, and an evaluation at the start and end of the program.		
Goal Status	In progress: FY24 was spent planning and promoting the program. Community members have signed up for the program with an expected start date in January 2025.		
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome 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 ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1) Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA). 2) 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	1) More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification. 2) 28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26% increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**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; per most recent Gosnold report, between 10/1/2023 and 8/31/2024, 284 consults provided to BIDN patients with success rates for connecting patients to treatment at 77% in the ED and 36% on Medical Floors. 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, and a Director of Behavioral Health. The hospital also continues to invest in additional security and observers to ensure patient safety. In 2024 BID Needham established a new position, Emergency Department Behavioral Health Care Manager. This role serves to support patients and families with presenting social and emotional needs, provide real-time communication(s) and resources and collaborate with community-based teams.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome 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	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 FY24 between the months of April and September, the team provided a total of 806 screenings.		
Time Frame Year: Year 1	**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: Four sites with social workers were maintained in Needham for FY24, serving 407 patients.		
Time Frame Year: Year 2	**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: 225 gallons of unused and unwanted medication were disposed of in FY24. 2) Goal met: A sharps bin was available in the BID Needham 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 2	**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 FY24 there were 25 Adult volunteers in the older adult volunteer program, an increase of 5 additional volunteers since the prior year.	
Time Frame Year: Year 2	**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: In FY24, BID Needham employees participated in 11 community taskforces for a total of 122 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 2	**Time Frame Duration: Year 3**	**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 2024.		
Goal Status	Goal partially met: 84 Westwood residents were served by the WJC INTERFACE Referral Service in 2024.		
Time Frame Year: Year 2	**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 162 cases from June 2023 to June 2024, the reporting period that Interface uses. This reporting period most referrals continued to be for children, though there were many adult callers, and most (~60%) were female. There were also several repeat callers. Most callers were requesting help for anxiety and/or depression.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**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 separate training modules were offered between January and May 2024 with 115 total attendees. Sessions include a Motivational Interviewing Workshop, Engaging Families to do the Work Training and Shifting Families Connections Towards Acceptance & Connection Training.	
Time Frame Year: Year 2	**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 10/30/24 Provide new member leadership training for NHS SALSA students by 12/31/24. Conduct refusal skills training sessions for all 8th graders at Pollard Middle School during the 2024-25 school year.	
Goal Status	Goal met: Recruited 120 new SALSA Youth Prevention Advocates by 10/30/24. Provided new member training to NHS SALSA members by 10/30/24. Conducted refusal skills training sessions for over 400 8th graders at Pollard Middle School during the school year.	
Time Frame Year: Year 2	**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) Launch a new bereavement group in early February 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.	
Goal Status	1) Goal met: Two full cycles of the bereavement group ran with 6 participants in the first group and 4 participants in the second group. 2) Goal met: The caregiver group continued to run weekly with an average of 5 people per group. 3) Goal met: Coffee and Conversation continued to run weekly with about 15 people per week. 4) Goal met: The social worker continued to meet one on one for those who need support and that varied from week to week, depending on the need. One on one sessions increased over the course of the year for various needs, as more people became aware of the support available to them.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome 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) 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) 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) 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 by November 2024.	
Goal Status	1) In progress: To date, the team has conducted extensive training for the District coordinator and 7 school project coordinators for the 5 participating schools, collaborated with school administrators/superintendent's office, and reported to the school committee. In addition, the team has begun planning how CityConnects will interface with existing Student Assistance Team model. The District will adopt the CityConnects referral plan for SAT and incorporate CityConnects in the District MTSS plan. 2) In process: This is a long term goal. The Boston College team will work with the Dedham Public Schools team to collect and analyze data from the MyConnects system at the end of each year. From that data, the team will be able to predict whether our students will report better connectedness on the VOCAL and the MWAHS by the time they complete 6th grade. 3) In process: The District has an extensive community map started. Once the team has access to the MyConnects software, they will load the data and then run reports to identify any gaps. Then, they will enlist the support of the community to continue to build out the map.	
Time Frame Year: Year 1	**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 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) By September 2024, 800 Dedham residents will have received and opened email notices educating the public about the Dedham Transportation Program. 2) By January 2025, the Dedham Transportation Program will transport 30 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: Publicity efforts included email blasts (1,088 recipients/620 opens), social media outreach (total reach - 2,290) CareCab Program Engagement Data as of September 18, 2024, 213 CareCab website views, and 22 outreaches to local service providers. 2) In progress: Appointment Request Form: 31 short link clicks and 8 QR Code scans.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$3,031,070
Community-Clinical Linkages	$424,921
Total Population or Community Wide Interventions	$206,183
Access/Coverage Supports	$177,584
Infrastructure to Support CB Collaborations	$87,443
Total Expenditures by Program Type	$3,927,201
CB Expenditures by Health Need	
Chronic Disease	$2,234,791
Mental Health/Mental Illness	$616,845
Substance Use Disorders	$70,072
Housing Stability/Homelessness	$10,714
Additional Health Needs Identified by the Community	$994,779
Total by Health Need	$3,927,201
Leveraged Resources	
Total Leveraged Resources	$1,056,060
Net Charity Care Expenditures	
HSN Assessment	$1,023,603
Free/Discounted Care	
HSN Denied Claims	$476,670
Total Net Charity Care	$1,500,273
Total CB Expenditures	$6,483,534

Additional Information	
Net Patient Services Revenue	$149,537,651
CB Expenditure as % of Net Patient Services Revenue	4.34%
Approved CB Budget for FY25 (*Excluding expenditures that cannot be projected at the time of the report)	$4,515,907
Bad Debt	$1,253,016

Bad Debt Certification	**Yes**
Optional Supplement	
Comments	**BID Needham made a contribution of $119,217 representing BID Needham's PILOT payment to Needham, which contributes to the health and well-being of individuals residing in Needham.** **BIDN provided $158,053 to subsidize Behavioral Health services outside of its CBSA.**

SECTION VI: CONTACT INFORMATION

Jill Carter, Manager, Community Benefits and Community Relations
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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3
Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? **Yes**
    - If so, please list updates:

      New Members:
      Amber Carroll, Dedham Youth Commission
      Danielle Conti, Family Promise Metrowest
      Kim Fisher, Riverside Community Care

      Departing Members:
      Mani Opong, Riverside Community Care
      Angela O'sei Mensah, Dedham Youth Commission

II. Community Engagement

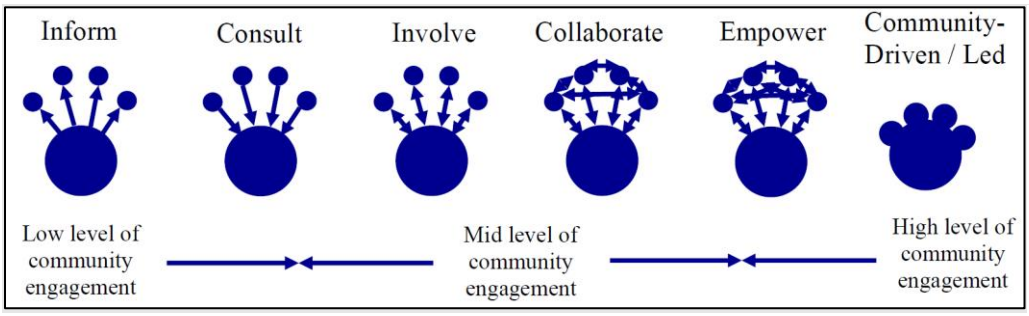
- Organizations Engaged in CHNA and/or Implementation Strategy
  If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Neighborworks Housing Solutions	Rob Corley, CEO	Housing organizations	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 housing. Neighborworks will support homelessness prevention and housing stabilization in the Dedham community.

Dedham Public Schools	Mark Carney, Director of Health & Wellness	Schools	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 is using their grant to partner with Boston College's City Connects to support the student body via navigation support.
Dedham Public Health	Kylee Foley, Director	Local health department	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. The Town of Dedham is using their grant to create a transportation program, providing free rides to mental health and substance use programs to those who otherwise would not be able to attend the program, overcoming a significant barrier to treatment.

- Level of Engagement Across CHNA and Implementation Strategy
  Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.

[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.



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. 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. BID Needham collaborated with the community and CBAC to develop and implement the Implementation Strategy.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met. BID Needham continued to award grants to organizations in the community, as part of a three-year grant commitment from FY22-FY24. In addition, BID Needham's CBAC allocated CHI funds to the Town of Dedham and Neighborworks Housing Solutions.	Consult
Implementing Community Benefits programs	Collaborate	Goal was met. BID Needham provides grants and the grantees implement programs to address the needs outlined in the CHNA.	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met. BILH conducts evaluation workshops for grantees and provides a template for tracking and	Collaborate

		evaluating progress. This allows grantees to evaluate their programs with meaningful metrics, better positioning them for additional funding opportunities (both through BID Needham and through other means).	
Updating Implementation Strategy annually	Consult	Goal was met. BID Needham and its CBAC revisit the Implementation Strategy (IS) throughout the year, using it to guide the investment of available funds. The IS is updated annually to account for any changes in programs or needs.	Consult

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

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

  BID Needham held an open forum meeting on September 26, 2024 at the Dedham Council on Aging.

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

    BID Needham's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under "Reproductive Health" and include Low birth weight (7.4%), Mothers with late or no prenatal care (3.9%), Births to adolescent mothers (8.5%), and Mothers receiving publicly funded pre-natal care (38.6%) as well as data on screening for post-partum depression. In addition to secondary data

capture and review, throughout the CHNA BID Needham engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)

  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 Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. 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?

  BID Needham's maternal health work will be guided by the 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.

III. Updates on Regional Collaboration

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

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the Year 1 Hospital Self-Assessment Form.