Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health
Beth Israel Deaconess Needham

Beth Israel Lahey Health

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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 serve more than 100 individuals every week. In Needham, the hospital continued its partnership with the Needham Community Farm and Needham Bank to run a mobile market that delivers free, fresh produce to more than 200 residents living in public housing in Needham. BID Needham also continued to collaborate with the Town of Needham to prepare meals for the town's traveling meals program.

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

In the area of housing, BID Needham supported Family Promise MetroWest's LIFE Initiative to prevent homelessness for 84 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. In addition, BID Needham has a new partnership with the Town of Norwood to provide transportation to medical appointments via a similar program funded through the hospital's Community-based Health Initiative (CHI). 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 FY23 as did the number of program volunteers.

Within the hospital, BID Needham works to address readmissions with a utilization review committee and partnerships with EMTs.

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 established a 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 2023, 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.

As access to behavioral health care continues to be an issue, the Hospital has provided funding for the Interface Mental Health Hotline in Westwood. 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, a grant was awarded to the Dedham Council on Aging to provide additional hours for a social worker to offer support groups. Throughout the year the social worker met with 137 individuals through group and individual sessions.

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 37). The BID Needham Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BID Needham's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BID Needham's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. The hospital's mission is to provide safe, high-quality, community-based health care and access to tertiary care regardless of the patient's ability to pay, race, color, ethnicity, religion, gender, gender identity, sexual orientation, national origin, ancestry, age, genetics, disability, military service or any other legally protected status. BID Needham's Community Benefits Department, under the direct oversight of BID Needham's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BID Needham's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the BID Needham's Board of Trustee members and senior leadership who are held accountable for fulfilling BID Needham's Community Benefits mission. Among BID Needham's core values 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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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, 2022, March 29, 2023, June 8, 2023 and September 21, 2023.

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 37.

Community Partners:
American Cancer Society
Charles River Regional Chamber
Charles River YMCA
Circle of Hope
Dedham Council on Aging
Dedham Food Pantry
Dedham Public Health
Dedham Youth Commission
Family Promise MetroWest
Needham Bank
Needham Community Council
Needham Community Farm
Needham Council on Aging
Needham Emergency Management
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
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)	Decrease food insecurity in Needham by donating thousands of pounds of produce to the Needham Food Pantry and distributing through the free Mobile Market.	
Goal Status	Goal met: NCF served more than 200 families through the Mobile Market in 2023, distributing approximately 4,000 pounds of fresh produce, valued at approximately $21,000, marking a significant increase over 2022. The farm continued with the same distribution model in 2023, delivering to 3 Needham Housing Authority sites weekly to address the increased need for food caused by the pandemic.	
Time Frame Year: Year 1	**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 2023 the Westwood Council on Aging ordered, picked up and delivered fresh produce from Powisset Farm in Dover MA to 35 older adults who were homebound on a bi-monthly basis. Everyone on the list was truly grateful for this opportunity and if there was any extra produce, it was put out free for any senior to enjoy. The Council on Aging also partnered with HESSCO, a local Aging Services Access Point (ASAP) so with each of these deliveries, a sandwich, salad chips and water bottle was provided so that the recipients received not only fresh vegetables, but lunch as well.	
Time Frame Year: Year 1	**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, with a 35-30% spike in requests since Covid and more than over 100 people were served every Saturday. The number of older adult shoppers continues to grow; in 2022 there were 35-40 shoppers every two weeks and in 2023 that number grew to 50-60. There was also a 16% increase in the number of bags of food distributed in the second half of 2023 compared to the first half.	
Time Frame Year: Year 1	**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 FY23 the traveling meals program prepared and delivered more than 9,570 healthy meals to older adults who were homebound.		
Time Frame Year: Year 1	**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)	Bring 30 diverse leaders together for 9 (1.5 hour) workshops to learn about and align around the "state of Needham" — its strengths, weaknesses, and inequities in the domains of mental and behavioral health, public health and housing, community satisfaction, public safety, schools, food scarcity, and local social cohesion — by reflecting on local data and members' lived experiences.		
Goal Status	Goal met: As an output, NRN published a report featuring the Network's reflections as well as series of ideas for projects focused on: increasing local belonging; increasing awareness of mental health and access to mental health resources; and preventing and countering hate in Needham.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Family Promise LIFE Housing Program** **Health Issue: Housing Stability/Homelessness**		
Brief Description or Objective	The LIFE program (Local Initiative for Family Empowerment) is a homelessness prevention program that supports families who are at risk of eviction but not yet homeless.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Decrease the number of people facing housing insecurity in 2023 by preventing evictions or shelter entry for 70 families in the service area.	
Goal Status	Goal met: In 2023, 84 families were served in the LIFE program and all 84 families remain in safe, affordable housing. No families served by the LIFE program in 2023 ended up entering a homeless shelter.	
Time Frame Year: Year 1	**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)	1) Increase the number of clients served, as bandwidth and reach as an organization is directly related to our funding capacities. Note: 417 clients were served in FY22. 2) Increase in the number of volunteers who sign up to serve in the Dedham and Needham Chapters. 3) Clients report back positively on the literally life-saving aspects of this program and Neighbor Brigade's free services.	
Goal Status	Goal met:	

	1) The number of clients has increased over this past year, in addition to recurring client requests increasing. Over 450 clients were served, with 30 of them being new clients. 2) There was an increase in the number of volunteers in our Dedham and Needham Chapters, with the total of new volunteers being 28. These volunteers were instrumental in helping the organization fulfill client requests safely and expeditiously. 3) Neighbor Brigade was delighted to have received overwhelmingly positive feedback from clients as a result of their services over the year. Many shared how friendly, caring, and compassionate the volunteers and Chapter Leaders are, with several clients sharing how the services were literally lifesaving. One client shared the following, which is a testament to this program's success: "Neighbor Brigade is a wonderful program! It has been a blessing to me. All of the coordinators who set up the transportation and the drivers are such amazing people to work with and it is so greatly appreciated from all of us! Thank you so much for all you do for others!"

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Needham Healthy Aging Initiative** **Health Issue: Chronic Disease, Mental Health/Mental Illness**	
Brief Description or Objective	Partnering with the Town of Needham, Needham Public Health, and the Needham Council on Aging (CATH), the hospital supports fitness training, health and balance classes, and social programming.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Reduce falling or fear of falls and increase activity level in older adults by providing access to fitness facilities, personal trainers, and classes for the aging population.
Goal Status	Goal met: DoN funds were used to support fitness activities, including the fitness center, personal trainers, and balance/fitness programs. Classes included Yoga at the Needham Housing Authority, Fitness for Arthritis, Band Resistance, Train the Brain, Core Strength, Stretching and more. In all, 1,877 unique individuals attended one or more classes. The wellness classes were not only beneficial for older adults in the physical sense, but also were critical for those seeking to build relationships and community.

Time Frame Year: Year 5	**Time Frame Duration: Year 5**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals** **Health Issue: Chronic Disease, Housing Stability/Homelessness, Mental Health/Mental Illness, Substance Use Disorder, Additional Health Needs Access to Care**		
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Community Benefits staff continued to understand state and federal regulations, build community engagement and evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter on a quarterly basis to communicate community benefits activities to community partners, residents, and vested parties.	
Goal Status	Goal met: All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops. Goal met: All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. Goal met: BID Needham launched and sent 2 newsletters to a mailing list of 120 organizations and individuals.	
Time Frame Year: Year 1	**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)	Provide essential clothing and hygiene supplies to BID Needham patients to ensure they have the personal items necessary for a healthy discharge.	
Goal Status	Goal met: Circle of Hope provided a total of 1,204 clothing and other necessity items to the BID Emergency Room Essentials Closet, increasing from quarterly to monthly deliveries, ensuring approximately 250 patients received the items needed for a healthy discharge.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Healthcare **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Providing culturally responsive care, especially for those whom English is not their first language, is an essential piece of access to care and managing physical disease. The hospital offers several options for Interpreter Services for patients.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of people assisted with insurance, other public program enrollment, and patient navigation by offering culturally responsive care, including interpreter services.	
Goal Status	Goal met: AMN Healthcare (Stratus) video remote interpretive services were accessed 3,726 times in FY23 at BID Needham, allowing patients for whom English as a Second Language (ESL) services are needed, to access care in a culturally competent way. Telephonic interpretation sessions were used 1,201 times in FY23 at BID Needham, allowing patients for whom English as a Second Language (ESL) services	

	are needed to access care in a culturally competent way. In person American Sign Language sessions were used 4 times in FY23, allowing patients who are hearing impaired to access care.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Healthcare **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)	Over the course of FY23, the Council will add 2-3 more specialized volunteers to support the transportation program. This includes staffing the transportation program each weekday morning with a trained volunteer to help with the increase in demand for services.
Goal Status	Goal in progress: The Council has established a dedicated workstation and recruited and trained 2 specific volunteers to add to the workflow of this program. This recruitment and training will extend into the next grant period as more help is needed to support the increase in demand for the transportation program which has doubled since October 2022. The Council provided 2,243 rides in this reporting year.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Healthcare **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 the first three months of operation (July – September 2023) 376 rides were provided to residents for medical appointments.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Healthcare **Program Name: Certified Application Counselors & System Navigation** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by the Executive Office of Health and Human Services and the Health Connector. The CACs assist with financial counseling, benefit enrollment assistance, and payment planning to the underserved and uninsured in the BID Needham community. Additionally, throughout BID Needham's Community Benefits Service Area, BID Needham subsidizes primary care services provided by BID Needham's Affiliated Physicians Group.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of people assisted with insurance and other public program enrollment and patient navigation, by providing assistance with insurance enrollment.	
Goal Status	Goal met: In FY23, BID Needham's financial counselors successfully enrolled 180 patients in MassHealth. Financial assistance applications and information are available in English, Spanish, Chinese, and Russian.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Healthcare **Program Name: BILH Office of Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office 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)	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. Increase spend with diverse businesses by 25% over the previous fiscal year across the system. Expand system-wide DEI learning, in alignment with enterprise learning management solution. Support creation or expansion of local DEI committees/resource groups. Educate BID Needham staff and providers on important DEI topics.	
Goal Status	Goal met: Across BILH there was a 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. Goal met: More than $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22. Goal met: 8 system-wide DEI trainings were conducted for all BILH staff and hospitals. Goal met: BID Needham sustained a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for our patients, our employees and our communities. Goal met: In FY23, 71 BID Needham hospital leaders, staff and providers were trained on being an Upstander/Bystander in relation to microagressions in the workplace.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Healthcare **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 ☒Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	In FY23, Workforce Development will continue to encourage community referrals and hires. In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners. In FY23, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. In FY23, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.
Goal Status	Goal met: In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. Goal met: In FY23, 67 events and presentations were conducted with community partners across the BILH service area. Goal met: In FY23, 45 employees across BILH were enrolled in ESOL classes. BID Needham employees participated in these classes. Goal met: In FY23, 20 BILH employees attended citizenship classes, 135 BILH employees attended career development workshops and 189 BILH employees attended financial literacy classes. BID Needham employees participated in these offerings.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Healthcare **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 FY23, Workforce Development will provide education grants to employees to pursue educational opportunities to further their careers. In FY23, Workforce Development will conduct Lunch & Learn Leadership Training sessions for all hospital managers. In FY23, Workforce Development will provide hands-on training for newly hired nurses with less than one year of training. In FY23, Workforce Development will offer support to staff who have experienced an adverse event or issue while at work. In FY23, Workforce Development will offer mentoring to staff who are interested in furthering their career.	
Goal Status	Goal met: In FY23, 58 education grants were given to employees to pursue educational opportunities. Goal met: In FY23, six Lunch & Learn Leadership Training sessions for all hospital managers on topics including resilience, mental health, retention strategies and LGBTQIA+ Healthcare. Goal Met: In FY23 BID Needham developed and executed a Nurse Residency program. In addition, the hospital hired an off-shift nurse educator to help with content development and administration of the program, in addition to providing hands-on support to nurses on evening and weekend shifts. Goal met: In FY23, BID Needham developed and executed a Peer Support program to provide support staff who have experienced an adverse event or issue while at work. Goal met: In FY23, BID Needham developed a 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 1	**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 providing training to health workers to provide community health care. Increase the number of people with chronic/complex conditions whose conditions are under control, by reducing readmission rates. Increase the number of people with chronic/complex conditions whose conditions are under control, by reducing readmission rates and by employing a Congestive Heart Failure (CHF) nurse to follow up with patients. Increase access to affordable, safe transportation options to health care by providing Uber vouchers to those who need a ride home from medical appointments at the hospital.
Goal Status	Goals met: BID Needham has an ongoing partnership with local EMTs to train first responders in how to identify a stroke in the field. When EMS alerts the hospital of a stroke patient coming in, the patient is met at the door by registration, a nurse, and a physician and immediately taken to CT scan. This process expedites care for stroke patients, ensuring that they receive life-saving care as soon as possible. BID Needham and local EMTs continued this partnership in FY23 and offered three training sessions this year. BID Needham has a Utilization Review Committee that reviews all readmissions to the hospital on a daily basis Monday through Friday. The committee looks to identify specific causes for the readmission, such as discharge plans, care transitions, and previous conditions. The committee reviews individual readmissions but also looks at data trends. The Committee identifies patients with CHF as a high priority area for review and has a cardiologist on the committee who is tasked with reviewing all CHF readmissions. BID Needham employs two CHF nurses (34 hours a week and 28 hours a week). The nurses follow patients who have high-risk CHF by making frequent calls to assess for symptoms, medication changes, tests or procedures, education on prevention of CHF exacerbation, dietary teaching, referrals and coordination of care. The nurses also see

	inpatients to ensure they are receiving proper care and review information with inpatient nursing and provide educational in-services. The hospital provided 1,046 Uber rides in FY23, offering a safe way for patients to have a ride home from an appointment or hospital stay.

Time Frame Year: Year 1	**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 2023 with the goal of enrolling 30 participants recovering from cancer. 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.
Goal Status	Goal partially met: The YMCA ran two successful sessions of LiveStrong, serving a total of 15 participants. With continued marketing and promotion of the program, they expect to meet the goal of 30 participants in the upcoming reporting period. Almost all of the participants improved physically during the program, besides the few who faced unexpected progression of their condition. Each participant expressed a feeling of belonging, and a desire to stay connected to the YMCA.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome 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 ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	Increase access to screening, assessment, referral, and patient education and engagement services for those identified with or at risk of mental health and substance use condition(s), through a partnership between BID Needham's Emergency Department and Riverside Community Care. 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). Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing mental health services in the hospital.
Goal Status	Goal met: Patients identified with or at risk of mental health and substance use condition(s) were referred to Riverside Community Care, BIDN's contracted Emergency Services' Provider (ESP), for a behavioral health crisis evaluation. As part of this partnership, Riverside Community Care provided level of care recommendations to hospital care team and managed the bed search process for those requiring inpatient level of care. As part of BIDN's behavioral health care expansion efforts, the hospital's contract with Riverside Community Care expanded to include a Behavioral Health Mare manager. This full-time social worker supports behavioral health care by strengthening communication, after care planning, education, and family support. This program was subsidized from October 2022 to January 2023. Goal met: BID Needham patients identified with or at risk of substance use condition(s) and co-occurring substance use and mental health condition(s) were referred to Gosnold, Inc. Beginning in February 2023, BID Needham contracted with Gosnold, a Massachusetts' corporation, to provide a Recovery Navigator to deliver Recovery Navigation and Management services 7 days / week, within the BID Needham Emergency Department, and on other hospital floors, to patients diagnosed with substance use disorders and co-occurring substance use and mental health disorders. BIDN and Gosnold have established a collaborative clinical and operational approach to addressing the treatment, referral, and continuing care needs of patients with substance use disorders. By the end of FY23, 50% of consults conducted by a Recovery Specialist resulted in a transfer to treatment. 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 addition, BID Needham hired a William James intern in September 2022 to assist with piloting behavioral health programs to assist patients after discharge.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	In an effort to improve access to behavioral health, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model (CoCM) in employed primary care practices). Collaborative Care is a nationally recognized integrated model that specializes in providing behavioral health services in the primary care setting. The services are provided by an embedded licensed behavioral health clinician and they include short-term brief interventions, case review with a consulting psychiatrist, and care coordination. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of behavioral health conditions. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals. The behavioral health clinician uses therapies that are proven to work within the primary care setting. A consulting psychiatrist may advise the primary care provider on medications that may be helpful.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to behavioral health services.	
Goal Status	Goal met: Three sites with social workers were maintained in Needham for FY23, serving 170 patients.	
Time Frame Year: Year 1	**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)	Increase the number of opportunities that residents of the service area can give back unused prescriptions by providing a place for the public to dispose of unused and unwanted medications. Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose of sharps. Decrease the availability of unused prescription drugs and promote collaboration across the health system to address substance use through a Pain Management & Opioid Taskforce.
Goal Status	Goal met: 380 gallons of unused and unwanted medication were disposed of in FY23 Goal met: A sharps bin was available in the hospital lobby for the public to use for disposal. Goal met: In FY23, the Pain Management & Opioid Taskforce continued educating clinicians and patients about prescribing practices. These initiatives included patient fact sheets and non-opioid directives, creating pain and alternative therapy resources, and distributing to clinicians to educate on alternatives to opioids. Other initiatives included conducting an on-going prescribing query to review and modify prescribing practices within the hospital, reassessing outpatient surgical prescribing practices, and using electronic medical records to better assess patient pain and timing/delivery of medications to address patient pain. The committee also continued to offer a "comfort menu" in FY23 to offer non-medication alternatives to pain relief.
Time Frame Year: Year 1	**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: There were 20 adult volunteers in the older adult volunteer program, which has returned in a limited capacity following COVID-19.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Community Taskforce Participation** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder, Additional Health Needs (Other SDOH)**		
Brief Description or Objective	BID Needham staff participate in local task forces directed at addressing mental health and substance use issues.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, and other pertinent community issues, through participation in community taskforces.	
Goal Status	Goal met: BID Needham employees participated in 12 community taskforces for a total of 154 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 1	**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.	
Goal Status	Goal in progress: 87 individuals utilized the services between 12/01/2022 and 11/30/2023 (the timeframe INTERFACE uses for their reporting).	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Riverside Community Care Behavioral Health Programs** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	The Riverside Community Care Behavioral Health Program provides advanced psychological and behavioral trainings for Riverside's Home-Based service clinicians and staff. Riverside's Home-Based services include In Home Therapy, Intensive Family services, and Therapeutic Mentoring programs that are available to residents of Needham, Dedham and Westwood. The trainings provide an opportunity for clinicians to retain their skills and acquire new knowledge around a growing body of research in addressing the surge in behavioral healthcare needs of the community.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Provide therapy training and support for at least 22 local mental health clinicians in FY23.	
Goal Status	Goal met: In 2023, Riverside held a 2-hour Substance Use Training - Vaping Workshop for 19 people on May 4 and a 6-hour Psychosis Training for 16 on June 7.	
Time Frame Year: Year 1	**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 10/30/23 and provide new member training by 12/31/23. Conduct training sessions for all 8th graders at Pollard Middle School.	
Goal Status	Goal met: Recruited 121 new members to SALSA by 10/30/23 and provided new member training at a September event at Needham High School. During the 2022-23 school year, the entire 8th grade class (374 students) at Needham's Pollard Middle School attended training sessions led by SALSA members. These training sessions were conducted in small groups and classes during the school day.	
Time Frame Year: Year 1	**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)	The goal is to offer three bereavement groups, that run for eight weeks. In addition, the social worker will continue to run on-going weekly caregiver support groups and coffee and conversation groups with the goal of increasing participation. The hope is to double individual appointments with older adults and the social worker.	
Goal Status	Goal met: Throughout the year, a total of 137 individuals participated in the Social Worker's group and attended one-on-one appointments. Three programs were offered - a bereavement group (17 participants), coffee and conversation (68 participants), and a caregiver support group (25 participants). In addition, 28 individuals received individual sessions.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	**$1,890,216**	**$62,000**
Community-Clinical Linkages	**$443,055**	**$62,368**
Total Population or Community Wide Interventions	**$299,377**	**$251,909**
Access/Coverage Supports	**$183,972**	**$97,208**
Infrastructure to Support CB Collaborations	**$7,351**	**$0**
Total Expenditures by Program Type	**$2,823,971**	**$473,485**
CB Expenditures by Health Need		
Chronic Disease	**$1,538,227**	
Mental Health/Mental Illness	**$535,280**	
Substance Use Disorders	**$20,043**	
Housing Stability/Homelessness	**$10,572**	
Additional Health Needs Identified by the Community	**$719,849**	
Total by Health Need	**$2,823,971**	
Leveraged Resources		
Total Leveraged Resources	**$436,980**	
Net Charity Care Expenditures		
HSN Assessment	**$984,037**	
Free/Discounted Care		
HSN Denied Claims	**-$459**	
Total Net Charity Care	**$983,578**	
Total CB Expenditures	**$3,260,951**	

Additional Information

Net Patient Services Revenue	**$143,455,129**
CB Expenditure as % of Net Patient Services Revenue	**2.96%**
Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	**$3,260,951**
Bad Debt	**$1,273,466**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	**PILOT payment = $102,420** **Statewide CHI fund for Dedham NEBH/BIDN Tier 2 ASC JV = $318,571** **BIDN provided $263,100 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:
      Geoffrey Baguma, Norwood Police/Norwood Public Schools
      MaryAnne Carty Resident, Westwood Disability Commission Volunteer
      Katy Colthart Director, Westwood Youth & Family Services
      Courtney Daly, Dedham Council on Aging
      Mani Iyer Resident, Needham
      Angela O'sei Mensah Dedham Youth Commission

      Departing Members:
      Sue Crossley, Family Promise Metrowest
      Matthew Kuklentz, Assistant Principal, Thurston Middle School
      Valerie Lin, Board Member, Dover Parks and Recreation
      Sheila Pransky, Dedham Council on Aging

II. Community Engagement

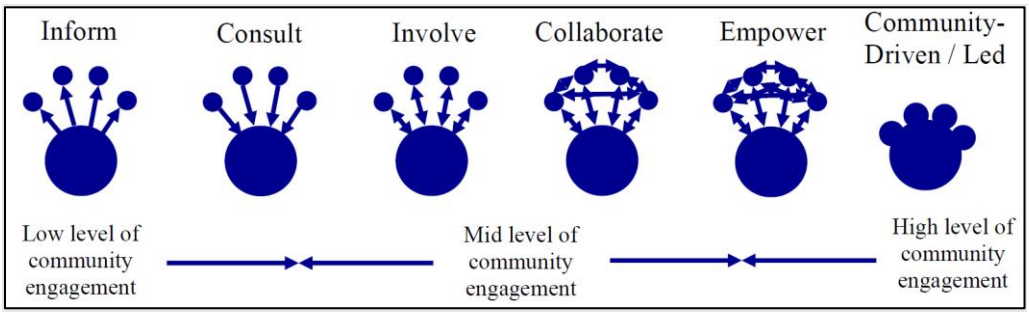
- Organizations Engaged in CHNA and/or Implementation Strategy
  If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Norwood Department of Public Health	Stacy Lane, Director of Public Health	Local Health Department	After evaluating the unmet health needs in Norwood and meeting with several constituents representing the underserved populations in Norwood, it was determined that transportation to medical appointments was a large and growing need in Norwood, due to the temporary closure of Norwood

			Hospital. BID Needham's CBAC voted to provide DoN Community Health Initiative (CHI) Funding to the Town of Norwood to address this need for underserved residents, particularly the aging population. The Town of Norwood and The Norwood Council on Aging partnered to purchase an additional vehicle this year to better meet the needs of residents, with BID Needham's multiyear CHI funding to cover a portion of the operating costs of the expanded transportation service.
Educational Partnerships with Mass Bay Community College and Merrimack College	Adam Munroe, Program Director & Chair, Associate Degree Nursing Department at MassBay Community College Jillian Costa, Clinical Placement Coordinator, Merrimack College	Workforce Development	BID Needham partners with Merrimack College and Mass Bay Community College to host and train nursing and phlebotomy students. In FY23, 24 students trained at BID Needham, furthering their education while also providing valuable services to patients.

- <u>Level of Engagement Across CHNA and Implementation Strategy</u>
  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 Norwood transportation program.	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 a provides	Collaborate

		template for tracking and 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:

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

  BID Needham held an open forum meeting on September 21, 2023 at the Dedham Council on Aging.

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.