Community Benefits Report

Fiscal Year 2020

Beth Israel Lahey Health
Beth Israel Deaconess Milton

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SECTION I: SUMMARY AND MISSION STATEMENT

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

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

The mission of Beth Israel Deaconess Hospital-Milton is to provide free or low-cost programs that address unmet health and wellness needs of racially, ethnically, and linguistically diverse communities in Milton, Randolph and Quincy, in a manner shaped by community input, aligned with hospital resources, and guided by our objective to deliver high-quality care with compassion, dignity, and respect.

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

More broadly, the Beth Israel Deaconess Hospital-Milton's Community Benefits mission is fulfilled by:

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

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

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes;

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

- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations
Beth Israel Deaconess Hospital-Milton's CBSA includes the city of Quincy and the towns of Milton and Randolph. BID Milton's FY 2019 Community Health Needs Assessment's (CHNA) quantitative and qualitative findings, on which this report is based, identified certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health that put them at greater risk. While BID Milton is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated community benefits guidelines, BID Milton's Implementation Strategy will focus on the following most at-risk priority populations in the identified service area – Youth; Older adults; Low- to moderate-income individuals and families; Individuals with chronic and complex conditions; and Racial/ethnic minorities and non-English speakers.

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

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in BID Milton's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

Social Determinants of Health and Access to Care

- Funding provided to Randolph Public Schools through the Blessings in a Backpack organization provided 50 low-income students with access to healthy food on the weekends for the school year
- Grant funding provided to Quincy Community Action Program rental assistance and eviction prevention program prevented 31 individuals from 16 households from becoming homeless. The grant provided an average of $844 to each household for rental assistance
- Assisted 115 community members enroll in and receive health insurance benefits

Chronic and Complex Conditions and Their Risk Factors

- Held evidence-based diabetes self-management workshops at the hospital in partnership with the South Shore YMCA
- Provided grant funding to Enhance Asian Services on Health to implement Chinese T2 Diabetes Prevention Program
- Held community education lectures at the hospital and local senior centers to educate community members on various chronic health conditions
- Continued to offer low-dose CT scans for lung cancer screenings
- Added an additional two primary care providers to the hospital's medical staff to support preventive health and chronic disease management

Behavioral Health (Mental Health and Substance Use)

- Continued to provide financial support to the Town of Milton's Interface behavioral health hotline
- Provided free Mental Health First Aid training workshops to community members
- Continued to partner with Milton Public Schools to implement Botvin Life Skills health education programming geared around substance use prevention and social emotional learning
- Continued to provide funding to Quincy Public Schools to support vaping education and prevention to high school students
- Implemented new Peer Recovery Coach Program in the hospital's Emergency Department

For the FY20 reporting year, Beth Israel Deaconess Hospital-Milton dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. BID Milton was intentional when assessing risk factors within our CBSA and worked closely with our local community partners. BID Milton worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (Haitian Creole, Spanish and Chinese) to the communities most impacted by COVID-19 to help slow the spread. BID Milton redeployed staff and procured tangible necessities for both the community-at-large and hospital staff such as Personal Protective Equipment (PPE), food, hand sanitizer, and other critical items.

Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were cut or significantly reduced because of the COVID-19 pandemic.

Plans for Next Reporting Year

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

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

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). Beth Israel Deaconess Hospital-Milton's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine Beth Israel Deaconess Hospital-Milton's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, BID Milton along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BID Milton's FY20-22 Implementation Strategy should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care and service gap, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY 2019 CHNA identified the importance of supporting initiatives that targeted low-income populations, youth, older adults, racially/ethnically diverse populations, and limited English proficient populations.

Beth Israel Deaconess Hospital-Milton partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses.

- **Behavioral Health-Mental Health and Substance Use**
  - Beth Israel Deaconess Hospital-Milton will continue to be an active member of the Milton Substance Abuse Prevention Coalition and work alongside the local public health department and law enforcement to provide staff and financial resources to coordinate education, community health improvement activities and referral services.
  - Will continue to enhance access to mental health and substance use screening, assessment, and treatment services with its Peer Recovery Coach programs in its Emergency Department to link those individuals with recovery, case management, and navigation support.

- **Chronic Complex Conditions and Their Risk Factors**
  - BID Milton will partner will local service agencies including the YMCA to provide evidence-based health education and self-management support programs
  - Will work with local school systems to provide resources and education to youth and adolescents geared to reducing vaping and tobacco use
  - Will continue to provide educational opportunities to the community on a variety of chronic disease issues and their risk factors
  - Continue to provide access to free health and cancer screenings

- **Social Determinants of Health and Access to Care**
  - Beth Israel Deaconess Hospital-Milton will continue to provide enrollment counseling and assistance and patient navigation support services to uninsured/underinsured residents and increase access to culturally appropriate and responsive care
  - Continue to provide grant funding for local partners and social service agencies that address social determinants of health to help low-income individuals and families maintain housing and prevent eviction
  - Partner with local agencies and schools to promote and provide access to healthy food
  - Continue partnership with the Blue Hills Regional Coordinating Council and other community partners to enhance access to affordable, safe, and accessible transportation options in the hospital's CBSA.
  - Ensure access to preventive measures, testing, screening and treatment for those at-risk or exposed to COVID-19

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the Beth Israel Deaconess Hospital-Milton Community Benefits team completed a hospital self-assessment form (Section VII, page 57). The BID Milton

Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in BID Milton's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)
The membership of Beth Israel Deaconess Hospital Milton's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by BID Milton's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation, and gender identity, as well as those from corporate and non-profit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

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

Beth Israel Deaconess Hospital Milton is a member of BILH. While BID Milton oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

The Beth Israel Deaconess Hospital Milton Community Benefits program is spearheaded by the Community Benefits & Relations Manager. The Community Benefits & Relations Manager has direct access and is accountable to the BID Milton President and the BILH Vice President of Community Benefits and Community Relations, and the latter reports directly to the BILH Chief Strategy Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

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

Community Benefits Committee Meetings
Beth Israel Deaconess Hospital-Milton's CBAC met three times during FY 20:
December 12, 2019
June 25, 2020

September 24, 2020

Community Partners

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

Beth Israel Deaconess Hospital-Milton currently supports several educational, outreach, community health improvement, and health system strengthening initiatives within the CBSA. In so doing, Beth Israel Deaconess Hospital-Milton collaborates with many public health and social service organizations.

Beth Israel Deaconess Hospital-Milton is an active participant in the Blue Hills Community Health Alliance (CHNA 20). Joining with such grass-roots community groups and residents, Beth Israel Deaconess Hospital-Milton strives to create a vision for both city-wide and neighborhood-based health improvement. In working with the CHNA 20, Beth Israel Deaconess Hospital-Milton became an active member and funder of the Blue Hills Regional Coordinating Council (BHRCC). The BHRCC supports healthy communities by addressing mobility and transportation access barriers for older adults and other vulnerable populations. Working with our regional partners and member organizations, in alignment with the MA Department of Transportation, the Governor's Council on Healthy Aging, the WHO/AARP Healthy Aging Designation criteria and the MA Gateway Cities initiative, the BHRCC conducted a deeper community needs analysis exposing the root causes of access disparities and designed a regional plan to close gaps, strengthen structural and systemic inadequacies, and increase utilization of public and private systems.

Another important partnership is Beth Israel Deaconess Hospital-Milton's involvement with the Milton Substance Abuse Prevention Coalition. BID Milton works alongside the coalition's community stakeholders, professionals, students, and town leaders to work collaboratively on reducing, preventing, and addressing substance abuse and related mental health challenges in our Town of Milton, primarily amongst youth.

Beth Israel Deaconess Hospital-Milton's Board of Directors, along with its clinical and administrative staff, is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise and education, along with an underlying commitment to health equity are the primary tenets of its mission. BID Milton's Community Benefits Department, under the direct oversight of BID Milton's Board of Directors, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations.

The following is a comprehensive listing of the community partners with which Beth Israel Deaconess Hospital-Milton 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 57).

Community Partners

- AARP
- Asian American Service Association
- Aspire Health Alliance
- Bay State Community Services
- BID Milton Patient Family Advisory Council
- Blue Hills Regional Coordinating Council
- Blue Hills Regional Health Network (CHNA 20)
- Curry College
- Enhance Asian Communities on Health
- First Baptist Church, Randolph
- Fruit Center Marketplace (Milton)
- Fuller Village
- Gosnold Recovery Services
- Interfaith Social Services
- Manet Community Health Centers
- Milton Board of Health
- Milton Council on Aging
- Milton Substance Abuse Prevention Coalition
- Milton Police Department
- Milton Public Schools
- Quincy Board of Health
- Quincy Community Action Programs
- Quincy Family Resource Center
- Quincy Public Schools
- Quincy Police Department
- Randolph Board of Health
- Randolph Intergenerational Center
- Randolph Public Schools
- South Shore Elder Services
- South Shore YMCA

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Approach and Methods

The FY19 CHNA was conducted in three phases, which allowed Beth Israel Deaconess Hospital-Milton to:

- compile an extensive amount of quantitative and qualitative data;
- engage and involve key stakeholders, Beth Israel Deaconess Hospital-Milton clinical and administrative staff, and the community at-large;
- develop a report and detailed strategic plan, and;
- comply with all Commonwealth Attorney General and Federal IRS Community Benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, and four community forums.

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

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

Summary of FY19 CHNA Key Health-Related Findings

Access to Care

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

Chronic Disease Management and Health Risk Factors

- **High Rates of Chronic and Acute Physical Health Conditions (e.g., heart disease, hypertension, diabetes, cancer, and asthma).** The assessment's quantitative data clearly shows that many communities in Beth Israel Deaconess Hospital-Milton's CBSA have high rates for many of the leading physical health conditions (e.g., heart disease, hypertension, cancer, and asthma). In many communities these rates are statistically higher than Commonwealth rates, indicating a particularly significant problem. However, even for those communities where the rates are not statistically higher, these conditions are still the leading causes of premature death.

- **High Rates of the Leading Health Risk Factors (e.g., Lack of Nutritional Food and Physical Activity, Alcohol/Illicit Drug Use, and Tobacco Use).** Based on information gathered from focus groups, interviews, community meetings, the community health survey, and quantitative sources, the assessment found that there were substantial concerns related to the leading health risk factors, such as healthy eating, physical activity, obesity, tobacco use/vaping, alcohol use, and stress. Many of those who were involved in the assessment believed that there was a need for more health education and a greater emphasis on health promotion and illness prevention

Social Determinants of Health

- **Social Determinants of Health Continue to Have a Tremendous Impact on Many Segments of the Population:** One of the dominant themes from the assessment's findings was the impact that the underlying social determinants of health are having on those living in the CBSA. The segments of the population most challenged by these

issues are older adults, low-income individuals/families, racial/ethnic minorities, non-English speakers, and those with disabilities or with chronic / complex conditions. More specifically, these segments struggle with financial insecurity, safe/affordable housing, transportation, access to healthy/affordable food, lack of social support, social isolation, and language access /cultural humility. These issues impact many people's and families' ability to access or pay for the services, housing, food, or other essential items they need and/or to live a happy, fulfilling, productive life.

Behavioral Health and Substance Use

- **The Burden of Substance Use and Mental Health Issues.** Mental health and substance use issues continue to be one of the region's most prevalent and challenging issues and are having a profound impact on individuals, families, and communities throughout the Beth Israel Deaconess Hospital Milton's CBSA. These issues are also a major burden on the health and social service system. Health and social service providers, public health agencies, first-responders, and community-based organizations are confronted on a daily basis with people struggling with acute or chronic conditions and struggle to provide or link them to the care they need. With respect to mental health issues, depression/anxiety, stress, social isolation, and the impacts of trauma are the leading issues. With respect to substance use, the opioid crisis continues to have a tremendous impact on the region, along with alcohol use, marijuana use, and vaping in youth. The fact that physical, mental health, and substance issues are so intertwined compounds the impact of these issues. Of particular concern are the increasing rates of opioid use and the impacts of trauma.

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

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Access to Care - Health Insurance Enrollment and System Navigation	
Brief Description or Objective	Beth Israel Deaconess Hospital-Milton's Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by the Executive Office of Health and Human Services and the Health Connector. The CACs assist with financial counseling, benefit enrollment assistance, and payment planning to the underserved and uninsured in our community.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status ☐ Not Specified
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase the number of people assisted with insurance and other public program enrollment, and patient navigation	In FY20, BID-Milton's CACs assisted 262 community members, filed 220 applications, and successfully enrolled 70 individuals in Mass Health, 22 individuals in Commonwealth Care, and assisted 23 people in acquiring free care.	On-going	On-going	Process Goal
Make financial counseling staff available for training to become Certified Application Counselors in accordance with state regulations in order to continue to serve unmet needs of the community.	All financial counseling staff attended ongoing training in order to maintain state certifications as Certified Application Counselors.	On-going	On-going	Process Goal

Contact Information: Gail Schroth, Director, Patient Business Services, Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186, 617-313-1214

Access to Care – Culturally Responsive Care	
Brief Description or Objective	Beth Israel Deaconess Hospital- Milton is committed to providing linguistically and culturally appropriate services to our patients and families. We have an experienced team of trained medical interpreters on staff. In the medical setting, it is essential that patients actively participate in a dialogue with their health care providers. The need to understand information, diagnoses, and directions accurately is crucial before making medical decisions that affect one's own treatment or that of a loved one. While many of our Limited English Proficiency (LEP) patients and their families use English in other settings, it may not be the language they prefer to utilize for medical care. In addition, feelings of anxiousness or fear about a diagnosis or illness can affect communication. This often happens in emergency situations when a person may be too nervous to communicate clearly in anything other than his/her primary language. Interpreter services bridges linguistic and cultural gaps that may exist between a patient and the medical provider while maintaining strict patient confidentiality. At Beth Israel Deaconess Hospital-Milton, we are committed to serving the community. Our staff is dedicated to helping doctors, nurses, and healthcare providers establish a direct relationship with their non-English or limited English speaking patients through accurate and complete interpretation services. Interpreters for our non-English or limited English speaking patients are available at no charge. We offer multi-lingual services both in person and by telephone. These services are available for 140 different languages and can be used 24-hours a day. Interpreter Services collaborate with multiple departments within the hospital to ensure outreach to inform non-English speaking clients of the availability of Interpreter Services. These community outreach programs include Community Health Network Alliance (CHNA) 20, Community Benefits Advisory Committee, and Cultural Diversity Committee and Patient Family Advisory Committee, which we utilized to obtain community input for program and policy development. During the peak of COVID in the spring, feedback from CHNA 20 members indicated a need for translated material and additional community outreach to help combat the spread of the virus especially in Randolph for the Haitian population. BID Milton addressed this need by funding to support the Academic Public Health Volunteer Corps' Health Equity Initiatives in Randolph. The project concentrated on making sure that messaging around COVID-19 reached target populations through accessible guidelines and media such as community radio and internet-based social media in the Haitian language.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening

☐ Mentorship/Career Training/Internship
☐ Physician/Provider Diversity
☐ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Obtain and roll out Video Remote Interpreting (VRI) devices to each unit throughout the facility to enhance access to culturally appropriate care and language interpretation for when an in-person interpreter is not available.	Goal met: Rolled out total of 10 VRIs. Successful implementation to supplement current staffing needs to better meet LEP needs.	3	3	Process Goal
Increase the capacity of the Interpreter Services department interactions	Total face to face plus phone encounters: 4905 in FY 20 in 42 languages	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Massachusetts Commission for the Deaf and Hard of Hearing	https://www.mass.gov/orgs/massachusetts-commission-f the-deaf-and-hard-of-hearing

Contact Information: Maggie Luu, Director of Interpreter Services, Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1326, Maggie_Luu@bidmilton.org

Social Determinants of Health – Rental Assistance/Eviction Prevention Grant	
Brief Description or Objective	Beth Israel Deaconess Hospital-Milton issued a three-year grant to Quincy Community Action Programs (QCAP) to help prevent homelessness for local at-risk families and individuals. The second year installment of $15,000 was issued in summer FY20. The grant helps support QCAP's Housing Program which works to secure and stabilize housing for renters and homeowners, thereby reducing the number of homeless individuals and families. The program, through the agency's Strategic Prevention Initiative, utilizes Homeless Prevention Specialists to help provide landlord negotiation/mediation, fair housing counseling, emergency rent payments or resolution of lease compliance issues.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☒ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☒ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
By end of FY20, decrease the number of people who struggle with financial insecurity/rent insecurity to prevent at a minimum 12 families/households from eviction	Goal met: Direct rental assistance was provided to 16 at-risk households preventing eviction/homelessness for 31 individuals.	2	3	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Quincy Community Action Programs	www.qcap.org

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Social Determinants of Health – Access to Healthy Food (Blessings in a Backpack)	
Brief Description or Objective	To address food insecurity, BID Milton formed a new partnership with the national organization of Blessings in a Backpack and the Randolph Public Schools to ensure that students most in need would have access to food on the weekends. Blessings in a Backpack is a non-profit organization that feeds school children in the United States who currently are fed during the week on the federally funded Free and Reduced Meal Program and are at risk of going hungry on the weekends. Its mission is to mobilize communities, individuals, and resources to provide food on the weekends for elementary school children across America who might otherwise go hungry. The program works with elementary school-aged children whose families cannot afford enough food. Data from BID Milton's Community Health Needs Assessment identified Randolph as the community in its community benefits service area with the most need. Working with the Blessings organization and national food school supplier Sysco, BID Milton provided funding to allow Randolph schools to distribute pre-packaged meal kits, containing enough food for three meals for two days for 50 elementary school kids. Second year funding was given in FY20.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Randolph** • **Gender: All** • **Age Group: Kids, Teenagers** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to healthy food	Weekend food packs were provided to 50 children from December 2019 to June 2020. Food continued to be provided to students during COVID.	2	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Randolph Public Schools	https://www.randolph.k12.ma.us/
Blessings in a Backpack	https://www.blessingsinabackpack.org/

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Social Determinants of Health – Transportation Initiatives

Brief Description or Objective	Lack of access to reliable transportation was identified as a pressing health challenge to many in BID Milton's community. Although, the hospital knows it cannot address all issues related to transportation itself, BID Milton continues to be an active member of the Blue Hills Regional Coordinating Council (BHRCC). Regional coordinating councils bring together stakeholders to share information, identify unmet needs, develop local and regional transportation priorities, and raise awareness of the importance of transportation in the lives of residents. Since January 2019 a group of over 20 stakeholders, including state transportation experts, regional planners, municipal officials, leaders of community-based organizations, transportation advocacy representatives, and residents, along with BID Milton, have met regularly to discuss transportation, accessibility, and mobility challenges in the area. With funding provided by BID Milton, the council has been met many milestones which include conducting a regional needs assessment focused on transportation access and developing an action plan to centralize and address the needs identified. BID Milton also pays the transportation costs for patients discharged from inpatient units and the Emergency Department when they do not have the means to return home.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Promote collaboration with community partners that enhance access to affordable, safe, accessible transportation options	Grant funding from BID Milton supported three primary outcomes associated with the BHRCC initiative: multi-agency collaboration; community engagement; and knowledge change. Funding supported engagement efforts with community members including focus groups and community conversations, primary and secondary data analysis and action plan prioritization process.	2	3	Process Goal
Provide patients with access to transportation	Free taxi vouchers were provided to patients without access to transportation	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Blue Hills Regional Coordinating Council	**https://www.bluehillsrcc.org/**

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Mental Health and Substance Use: Interface Hotline	
Brief Description or Objective	Behavioral health and substance misuse continues to be a major concern across the Commonwealth. BID Milton continued its partnership with the Milton Board of Health and Milton Substance Abuse Prevention Coalition to provide Interface, a behavioral health telephone referral service, for Milton residents seeking help for themselves or others who may be struggling with mental health or substance misuse issues. The referral service is staffed by trained clinicians who conduct an assessment over the phone. Based on the caller's specific needs, Interface clinicians will search their database of screened mental health and/or substance misuse outpatient counselors for a suitable match and provide a referral to a local provider.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to clinical and non-clinical support services for those with mental health and substance use issues	Support and collaborate with town agencies to facilitate access to behavioral care. Number of cases from December 2019 to November 2020: 44 Primary presenting concerns were anxiety and depression.	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Milton Substance Abuse Prevention Coalition **INTERFACE Referral Service**	**https://www.milton-coalition.org/** **https://interface.williamjames.edu/sites/default/files/co unity-docs/interface-milton-021218-v1.pdf**

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Mental Health and Substance Use: Mental Health First Aid	
Brief Description or Objective	BID Milton provided access to free Mental Health First Aid Trainings taught by clinicians from Aspire Health Alliance. The course focuses on identifying risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness

	☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use	A total of 20 community members were trained how to recognize the signs of someone struggling with mental illness, assist someone who might be in distress, and recognize and correct misconceptions about mental illness	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Aspire Health Alliance	**https://www.aspirehealthalliance.org/**

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Mental Health and Substance Use: Botvin Life Skills with Milton Public Schools	
Brief Description or Objective	A youth risk behavior survey by the Milton Public Schools highlighted the number of students struggling with anxiety, depression, underage drinking, and substance misuse. BID Milton continued to provide funding to the Milton Public Schools to implement Botvin Life Skills health curriculum for fifth-grade students across all of the town's four elementary schools. This evidence-based curriculum has been proven effective through years of research. Part of the curriculum is supplemented with vaping prevention strategies from the Stanford University School of Medicine - Anti-Vaping Toolkit. The curriculum addresses all of the most important factors leading adolescents to use one or more drugs by teaching a combination of health content, general life skills and drug resistance skills. The curriculum has been proven to help increase self-esteem, develop healthy attitudes, and improve student knowledge of essential life skills – all of which promote healthy and positive personal development. The lessons include the following topics: • Self-Esteem • Responsible Decision-Making • Tobacco/Vaping Prevention (supplemented with Stanford's Anti-Vape Toolkit) • Media Influences and Advertising • Coping with Stress • Communication Skills • Social Skills/Peer Pressure • Assertiveness
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton** • **Gender: All** • **Age Group: Children** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Provide community education and awareness of substance use/misuse and healthy mental, emotional, and social health	In year two of the grant, 204 students participated in the Botvin Life Skills Program.	2	3	Process Goal
Increase students' knowledge on substance use and mental health	In FY20, 92.2% of students reported learning something new in regards to tobacco/vaping to deter use. 82.8% of students indicated learning a new coping skill to manage stress and anxiety	2	3	Outcome

Partners

Partner Name, Description	Partner Web Address
Milton Public Schools	**https://www.miltonps.org/**

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Mental Health and Substance Use: Support for Milton Substance Abuse Prevention Coalition

Brief Description or Objective	BID Milton continues to be an active member and supporter of the Milton Substance Abuse Prevention Coalition (MSAPC), providing financial support, in-kind meeting space, and filling a stakeholder role in the committee. During FY20, MSAPC hosted 'Milton Learns Together: WEBINAR WEDNESDAYS' a series of educational and skills-building webinars in May and June to support and reach Milton families during the COVID-19 pandemic. The series focused on a variety of different topics and hosted speakers with various expertise – all concerning mental health and substance use prevention. The audience was primarily parents and guardians of teens. Each webinar was followed by a short survey to determine whether the presentation was worthwhile and inspired changes in beliefs and/or behaviors.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship

☐ Physician/Provider Diversity
☒ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health	A total of 8 webinars were conducted, reaching 132 live participants.	2	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Milton Substance Abuse Prevention Coalition	**https://www.milton-coalition.org/**

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Mental Health and Substance Use: Recovery Coach Program

Brief Description or Objective

In November of 2019, BID Milton formally began a Peer Recovery Coach Program with Gosnold. A Gosnold Recovery Specialist works in the emergency department to assist and intervene with individuals brought to the hospital following a non-fatal overdose event. BID Milton clinicians and peer recovery specialists work cooperatively to improve the screening, identification, intervention, and referral of substance dependent patients admitted to the Emergency Department. The primary objective of this collaboration is to motivate the patient to accept treatment and facilitate referral to the appropriate level of care. Treatment modalities include inpatient detox, hospital transfer, intensive outpatient programs, and Medication Assisted Treatment.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship

☐ Physician/Provider Diversity
☒ Prevention
☐ Research
☒ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Enhance access to mental health and substance use screening, assessment, and treatment services	A peer recovery specialist is now embedded in the Emergency Department five days a week, eight hours each day	1	5	Process Goal
Increase # of Recovery Specialist consults resulting in transfer to treatment	From November 2019-September 2020, 133 patients were screened, resulting in 89 patients being transferred to treatment.	1	5	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Gosnold	**https://www.gosnold.org**

Contact Information: Marlene Lemieux, Director of Case Management & Social Work, Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1618, Marlene_Lemieux@bidmilton.org

Mental Health and Substance Use: Reducing the Burden of Behavioral Health

Brief Description or Objective

BID Milton continued its partnership with Aspire Health Alliance (formerly South Shore Mental Health) to care for behavioral health patients in its Emergency Department, aimed at reducing length of stay. An Aspire behavioral health clinician is embedded in BID Milton's Emergency Department to perform emergency psychiatric evaluations to prescreen patients for placement in an inpatient psychiatric unit and/or crisis stabilization unit. Interventions of the program include patient services focused on reducing risk of symptom escalation, including: More timely crisis evaluation, insurance verification and care transition management; and therapeutic interventions (i.e., cognitive behavioral therapy), medication management, music therapy, faith counseling, peer services, and familial counseling and support.

BID Milton also subsidizes inpatient psychiatric services for those

	most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others or who are unable to care for themselves due to mental illness. The hospital also hosts numerous ongoing support groups including a New Mom's Support Group, ADHD Parents Support Group, and 12-step based recovery groups such as Alcoholics Anonymous, Overeaters Anonymous and Ala-Teen. In most cases, the hospital assists in promoting these programs through its Community Education Calendar listing, at no cost to the program organizers. However, with the onset of COVID-19, some support groups have not been able to meet, while others have transitioned to a virtual setting.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Enhance access to mental health and substance use screening, assessment, and treatment services	Clinician is on call 7 days/week-24hrs/day. However, clinician is onsite 5 days/week	3	3	Process Goal
Respond to community needs by providing in-kind space and resources.	In FY20, 159 hours of support and space needs were provided for Al-Anon, Alateen, CHADD, Overeaters' Anonymous, Alcoholics Anonymous, and New Moms.	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Aspire Health Alliance	https://www.aspirehealthalliance.org/

Contact Information: Marlene Lemieux, Director of Case Management & Social Work, Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1618, Marlene_Lemieux@bidmilton.org

Mental Health and Substance Use: Collaborative of Care

Brief Description or Objective	The National Alliance on Mental Illness (NAMI) reports that one-in-four individuals experiences a mental illness each year, underscoring a critical need for mental healthcare access across all patient populations. In the 2019 LHMC Community Health Needs Assessment, mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified as one of the leading health issues for residents of the service area. Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety. In an effort to meet this need, the Collaborative Care Model (CoCM) was adopted. The model will be expanded to additional communities throughout the Beth Israel Lahey Health service area. Collaborative Care is a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services are provided by a licensed behavioral health clinician and they include counseling sessions, phone consultations with a psychiatrist, and coordination and follow up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of medical and mental 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 in primary care. A consulting psychiatrist may advise the primary care provider on medications that may be helpful.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served: All** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship

☐ Physician/Provider Diversity
☐ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
To increase access to behavioral health services	In FY 20, behavioral health clinicians were provided at two BID Milton primary care practices, reaching 94 patients.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Chronic Disease: CPR Training	
Brief Description or Objective	BID Milton offered cardiopulmonary resuscitation (CPR) training to the general community as well as healthcare providers on average twice a month. The program is provided through an American Heart Association (AHA) approved curriculum. According to the AHA, failure to act in a cardiac emergency can lead to unnecessary deaths. Effective bystander CPR provided immediately after sudden cardiac arrest can double or triple a victim's chance of survival, but only 32 percent of cardiac arrest victims get CPR from a bystander. Sadly, less than eight percent of people who suffer cardiac arrest outside the hospital survive. Due to COVID-19, the hospital was only offer classes from October 2019 to February 2020.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Enhance access to health education and Increase number of community members who are CPR-certified.	In FY20, 24 people were certified in CPR	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
American Heart Association	https://cpr.heart.org/en

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Chronic Disease: Community Education Lectures & Workshops	
Brief Description or Objective	Held each spring and fall, the Community Education Lecture Series provides the community access to free health education and wellness opportunities led by members of Beth Israel Deaconess Hospital-Milton's Medical Staff. Topics are selected based on physician and community feedback and disease prevalence, In the fall of 2019 lectures on colitis, joint pain, hernias, safe babysitting classes, and senior driver safety classes were offered. Sadly, due to the onset of the COVID-19 pandemic, community education classes did not take place in the spring of 2020. To increase physical activity and promote wellness, BID Milton began to offer free yoga classes to the community. To address healthy eating, the hospital continued its grocery shop with a dietitian program. Community members were guided through the Fruit Center Marketplace in Milton by a registered dietitian who explained how to shop and select healthy food options and read nutrition labels. Participants were also provided with healthy recipes and each participant received a gift card to the Fruit Center courtesy of BID Milton, to purchase healthy groceries. In addition to lectures conducted at the hospital, BID Milton also ventured out to the community senior centers. BID Milton partnered with the Milton Council on Aging to present a series of free, lunchtime educational lectures to seniors at the Milton Senior Center. Programs were presented by the hospital's employees and/or medical staff. Topics presented before the start of COVID in the 20120 Report Year included programs on heart health including blood thinner medications and stroke, influenza and healthy eating and grocery shopping tips. Seniors are also provided with a free lunch, courtesy of BID Milton.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase the number of people who are educated about chronic disease risk factors and protective behaviors by providing a minimum of 10 health education opportunities	In FY20 members of BID Milton's Medical Staff and employees conducted 8 lectures to 167 community members. Due to COVID, lectures did not take place in the spring at the hospital or Council on Aging.	3	3	Process Goal
Increase access to healthy food	8 community members were provided with gift cards to Fruit Center Marketplace to purchase healthy groceries. 119 seniors were provided with healthy lunches during the Council on Aging Lunch and Learn lectures	3	3	Process Goal
Increase number of adults with access to opportunities for physical activity	10 community members partook in 7 yoga classes before cancelling due to COVID.	3	3	Process Goal
Support health and wellness programming to promote independence and aging in place	12 Seniors completed the AARP Driver Safety Course in fall of FY20. Spring class could not be offered due to COVID.	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Milton Council on Aging	https://www.townofmilton.org/council-aging
Fruit Center Marketplace	https://www.fruitcentermarketplace.com/
AARP	https://www.aarp.org/

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Chronic Disease: Blood Screening

Brief Description or Objective	BID Milton hosted a low-cost Blood Screening Fair, on November 7, 2019. This two-hour screening is staffed by two BID Milton phlebotomists, and blood processing is completed in the hospital laboratory by the hospital's chemistry staff. Blood is tested for glucose, calcium, protein, and indicators of kidney and liver function. These types of tests provide screening for many community health issues such as diabetes. In addition, a complete

	lipid profile tests blood for cholesterol, triglycerides, HDL and LDL ("good" and "bad" cholesterol), and these tests can be direct indicators of heart disease risk. These bi-annual blood screening events provide access to valuable health care diagnostics at a low cost. The screenings attract many regular attendees who take advantage of the opportunity to regularly track test results over time or those individuals who do not have a primary care doctor or health insurance. Traditionally, two screenings are offered each year, but with the onset of COVID-19, the spring screening fair was not able to take place.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable

EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase amount of adults screened for chronic disease risk factors.	In FY20 36 individuals were screened for cholesterol and blood chemistry indicators. Due to COVID, there were no patients screened for skin cancer or oral, head, neck cancer screenings	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Chronic Disease: Diabetes Education & Self-Management

Brief Description or Objective	To assist community members with how to better manage their diagnosis of type 2 diabetes or pre-diabetes, BID Milton continued its partnership with the South Shore YMCA to implement The *My Life, My Health: Diabetes Self-Management Education* workshop at the hospital. This free 6-week workshop, developed by Stanford

	University Medical Center, is an evidence based self-management program for those living with or caring for someone with diabetes or pre-diabetes to learn skills to prevent, manage, and cope with the disease. BID Milton continued to provide grant funding to EACH, Inc. (Enhance Asian Community on Health) for prediabetes and type 2 diabetes prevention. The grant helped to fund health education programs and fairs in Chinese, to increase awareness of diabetes and pre-diabetes, and provided the Centers for Disease Control's "Prevent T-2: A Proven Program to Prevent or Delay Type 2 Diabetes" workshops. With the onset of COVID, many of these workshops transitioned to virtual events. Due to the COVID-19 pandemic, the hospital's 11th Annual Diabetes Fair scheduled for April 4, 2020, was cancelled.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: English, Chinese** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase the number of adults who are engaged in evidence- based self-management support, chronic disease management, for diabetes	Two 6-week workshops were held and 19 individuals successfully completed the My Life, My Health: Diabetes Self-Management course, with participants indicating an increase in knowledge in better managing their diabetes 8 participants successfully completed the Prevent T2 course	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address

South Shore YMCA
Enhance Asian Community on Health

https://ssymca.org/
https://sites.google.com/site/each4asian/home

Contact Information: Laureane Marquez, Community Benefits/Relations Manager Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Chronic Disease: Cancer Screenings	
Brief Description or Objective	BID Milton believes that prevention is the best medicine to combat chronic and complex conditions such as cancer. Each year the hospital and its local physicians provide much needed free skin and oral, head and neck cancer screening services to the community. However, with the onset of the COVID-19 pandemic free public screenings were cancelled in the spring of 2020. However, the hospital was able to continue its low-dose computerized tomography screening program to identify early-stage lung cancers.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Continue to offer screenings to increase number of adults screened for cancer	Lung cancer: In FY20, BID Milton exceeded its goal of 181 and performed 307 scans for lung cancer.	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information: Laureane Marquez, Community Benefits/Relations Manager, Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

Chronic Disease: Reducing the Prevalence of Vaping/Tobacco Use	
Brief Description or Objective	To address the growing concerns of vaping in the community, especially in youth, Beth Israel Deaconess Hospital-Milton partnered with Quincy Public Schools to help educate high school students on the dangers of vaping. Through a three-year grant, the school department implemented a comprehensive vaping education curriculum and prevention program in the City's two high schools in all 10th grade classrooms. Vaping and Nicotine Prevention and Intervention Program is overseen by a licensed mental health clinician and covers the following: 1. Impact on health 2. Media influence 3. Activity - Student self-assessment a. Identify reasons for use - peer pressure vs peer influence b. Identify losses associated with use - money, friendships, trust, goals c. Criteria for diagnosis of nicotine addiction d. Habits becoming dependence: understanding cravings, urges and triggers e. Link between vaping and other symptoms (anxiety, depression) 4. Information about how to quit a. Withdrawal symptoms b. How to help yourself and a peer to say no and/or stop use 5. Resources available In addition, a "Healthy Decisions" intervention 6-week workshop is offered to students who were caught vaping on school grounds or identified as high risk. To address tobacco use in adults, BID Milton continues to offer weekly Nicotine Anonymous support group.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Milton, Quincy, Randolph** • **Gender: All** • **Age Group: Adults, Teenagers** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs ☐ None/Not Applicable
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship

☐ Physician/Provider Diversity
☒ Prevention
☐ Research
☒ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to tobacco, vaping/e-cigarette cessation programs and prevention education	-Vaping and Nicotine Prevention and Intervention Program was taught to all 10th grade students in Quincy School District. -14 students from both of the district's high schools completed intervention workshops. -Two parent education presentations, which occurred on October 8, 2019 at North Quincy School and at Quincy High School on October 22, 2019	2	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Quincy Public Schools	**https://quincypublicschools.com/**
Nicotine Anonymous	**https://nicotine-anonymous.org/**

Contact Information: Laureane Marquez, Community Benefits/Relations Manager, Beth Israel Deaconess Hospital-Milton, 199 Reedsdale Road, Milton, MA 02186 617-313-1126, Laureane_Marquez@bidmilton.org

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$465,526	$27,000
Community-Clinical Linkages	$14,540	$80,333
Total Population or Community Wide Interventions	$92,628	$73,115
Access/Coverage Supports	$258,662	$5,000
Infrastructure to Support CB Collaborations	$89,112	
Total Expenditures by Program Type	$920,469	$185,448
CB Expenditures by Health Need		
Chronic Disease	$263,564	
Mental Health/Mental Illness	$163,683	
Substance Use Disorders	$105,559	
Housing Stability/Homelessness	$16,500	
Additional Health Needs Identified by the Community	$371,164	
Total by Health Need	$920,469	
Leveraged Resources	$167,679	
Total CB Programming	$1,088,419	
Net Charity Care Expenditures		
HSN Assessment	$718,316.27	
Free/Discounted Care	-	
HSN Denied Claims	$326,301.41	
Total Net Charity Care	$1,044,618	
Total CB Expenditures	$2,132,766	

Additional Information	
Total Revenue	**$247,445,417**
Net Patient Services Revenue	**$119,321,000**
CB Expenditure as % of Net Patient Services Revenue	**1.79%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$2,000,000**
Bad Debt	**$2,087,903**
Bad Debt Certification	yes
Optional Supplement	In FY 20, BID Milton incurred $ 8,575,464 in unreimbursed Medicaid expenses and $38,753,335 in unreimbursed Medicare expenses. Additionally, BID Milton contributed $23,076.72 to the Health Policy Commission and $69,172 to the Center for Health Information and Analysis (CHIA).
Comments	

SECTION VI: CONTACT INFORMATION

Laureane Marquez
Beth Israel Deaconess Hospital-Milton
Manager, Community Benefits & Community Relations
199 Reedsdale Road
Milton, MA 02186
617-313-1126
Laureane_Marquez@bidmilton.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

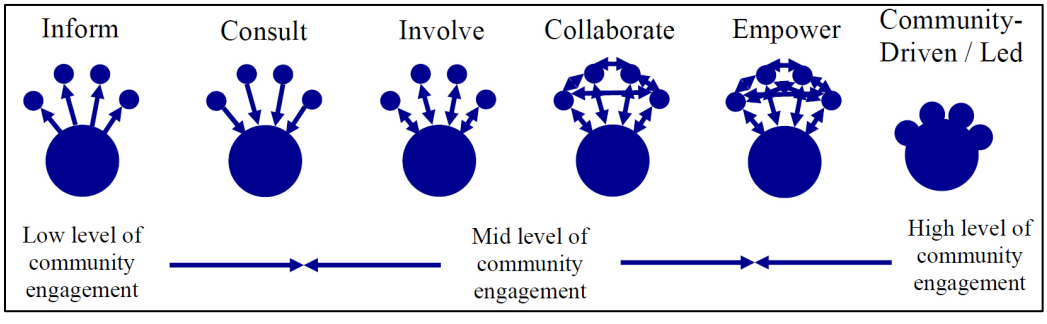
- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      Rita Bailey, Health Services Coordinator, Quincy Public Schools
      Tim Carey, Director of Program Development, South Shore Elder Services
      Daurice Cox, CEO, Baystate Community Services
      Richard Doane, Director, Interfaith Social Services
      Melissa Drohan, Social Worker, BID Milton
      Marian Girouard-Spino, Chief System Integration and Quality Officer, Aspire Health Alliance
      Ruth Jones, RN, BSN, Commissioner of Health, Quincy Health Department
      Caroline Kinsella, RN, BSN, Health Director and Public Health Nurse, Town of Milton
      Vicki McCarthy, Milton Resident
      Rev. Baffour Nkrumah-Appiah, Pastor, First Baptist Church, Randolph
      Melissa Pond, Principal Planner, City of Quincy
      Kristin Schlapp, Chief Operating Officer, Quincy Community Action Programs
      Cynthia Sierra, Executive Director, Manet Community Health Centers
      Christine Stanton, Director, Milton Council on Aging
      Katelyn Szafir, Director of Medical Wellness, South Shore YMCA
      Sara Tan, Director, Enhance Asian Community on Health
      Christine Tangishaka, Randolph Resident
      Jeanette Travaline, Executive Director, Randolph Chamber of Commerce

II. Community Engagement:

1. 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
Enhanced Asian Communities on Health	Sara Tan, Director	Social service organizations	Received grant funding from hospital to implement Chinese chronic disease self-management programs. Provided feedback on CHNA/IS. Reviewed translation of community survey and distributed survey to Asian neighborhoods. Facilitated focus group for th hospital's CHNA in Chinese.
Milton Department of Public Health	Caroline Kinsella, Health Director and Public Health Nurse	Local Health Department	Key Informant Interview. Provided feedback on CHNA, quantitative date and IS. Distributed community surveys to Milton residents.
Randolph Public Schools	Christine Tangishaka, Family and Community Engagement Coordinator	Schools	Key informant interview. Provided feedback on CHNA/IS. Worked with hospital to develop food access program at Randolph Public Schools.
Aspire Health Alliance	Marian Girouard-Spino, RN, MSN, Chief System Integration and Quality Officer	Behavioral health and mental health organizations	Key Informant Interview. Provided feedback on CHNA/IS. Reviewed community grant applications for distribution of hospital funds.

2. 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.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	Community forums, community meetings and the CBAC worked with the CBLT to identify priorities and sub priorities.	Involve
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	With the onset of COVID in the spring, BID Milton consulted with its CBAC to identify and gauge needs brought on by as a result of COVID. BID Milton will work to better consult and involve its CBAC on the proportion of CB resources allocated to different priorities.	Involve
Implementing Community Benefits programs	Collaborate	Beth Israel Deaconess Hospital-Milton worked with community partners from its CBAC to develop and implement programs surrounding housing, food insecurity, and chronic disease. BID Milton will continue to involve its partners in the community to implement programming.	Collaborate
Evaluating progress in executing Implementation Strategy	Inform	BILH Community Benefits will be hiring a Director of Evaluation which will work with all hospitals to build staff and community evaluation capabilities. BID Milton will be collaborating with the community on evaluation of CB programming and execution for FY21-22.	Consult

Updating Implementation Strategy annually	Consult	Beth Israel Deaconess Hospital-Milton will work with its CBAC, its community partners, and the BILH Evaluator to review its IS and update, as appropriate, at the end of FY 21.	Involve

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

  Beth Israel Deaconess Hospital-Milton remains committed to community engagement. During FY20 and the onset of COVID, BID Milton could not engage as much with its community members in implementing programs but did try to involve and consult with its CBAC on impact that COVID has had on the community. In FY21, BID Milton will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, BID Milton will engage with our community by continuing to be an involved member in the local CHNA 20 and coalitions.

3. 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.

   Beth Israel Deaconess Hospital-Milton held a public meeting in conjunction with its CBAC. Additionally, BID Milton shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the triannual CHNA. The public meeting was held on September 24, 2020 via Zoom.

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.
   During the CHNA process, Beth Israel Deaconess Hospital-Milton collaborated with members of CHNA 20 in a focus group to gain their feedback and perspective. BID-Milton continues to be an active member of the CHNA 20 and initiatives associated with CHNA 20 including the Blue Hills Regional Coordinating Council, a group of voluntary stakeholders working together to address community transportation in the Blue Hills region of Massachusetts, which covers the communities of Braintree, Hingham, Hull, Milton, Quincy, Randolph, and Weymouth. BID Milton has worked with the Blue Hills RCC to provide funding to launch a needs assessment and has met regularly to discuss transportation, accessibility, and mobility challenges in the area.

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.**

Beth Israel Deaconess Hospital-Milton is part of the Beth Israel Lahey Health (BILH) system community health improvement planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government payer patient populations in the communities. Guided by the CBC, hospitals' Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact. As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.

Optional FY20 Q: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits program.

As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.