Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health
Beth Israel Deaconess Milton

Beth Israel Lahey Health

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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 service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of Beth Israel Deaconess Hospital-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 Beth Israel Deaconess Hospital-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 65 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 34 individuals from 15 households from becoming homeless. The grant provided an average of $844 to each household for rental assistance.
- Assisted 223 community members enroll in and receive health insurance benefits.
- Partnered with South Shore Elder Services to distribute 1,500 snack packs to home-bound seniors.
- Provided funding to support the distribution of 600 culturally appropriate meals to Asian seniors.
- Added an additional seven primary care providers to the hospital's medical staff to support preventive health and chronic disease management.

Chronic and Complex Conditions and Their Risk Factors

- Held evidence-based diabetes self-management workshops 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 via Zoom to educate community members on various chronic health conditions.
- Continued to offer low-dose CT scans for lung cancer screenings.

Behavioral Health (Mental Health and Substance Use)

- Continued to provide financial support to the Town of Milton's Interface behavioral health hotline.
- 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.
- Continued Peer Recovery Coach Program in the hospital's Emergency Department.

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 on-going 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, Beth Israel

Deaconess Hospital-Milton will focus its FY20-22 Implementation Strategy on four priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in Beth Israel Deaconess Hospital-Milton's CBSA who face the greatest health disparities. These four priority areas are:

- Social Determinants, Health Risk Factors and Equity;
- Chronic Disease Management and Prevention;
- Access to Care; and
- Behavioral Health (Mental Health and Substance Use).

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, Beth Israel Deaconess Hospital-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 Beth Israel Deaconess Hospital-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 FY19 CHNA identified the importance of supporting initiatives that targeted low-income populations, youth, older adults, racially/ethnically diverse populations, limited English proficiency populations, and LGBTQ 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.
    - Will continue to support community members with access to mental health first aid training and mental health supports.

- **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 35). The Beth Israel Deaconess Hospital-Milton Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in Beth Israel Deaconess Hospital-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 Beth Israel Deaconess Hospital-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 Beth Israel Deaconess Hospital-Milton's Community Benefits mission. Among Beth Israel Deaconess Hospital-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 Beth Israel Deaconess Hospital-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 Beth Israel Deaconess Hospital-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 Community Benefits and Relations Manager. The Community Benefits and Relations Manager has direct access and is accountable to the Beth Israel Deaconess Hospital-Milton President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom 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
The Community Benefits Advisory Committee met on the following dates in FY21: 12/11/20; 3/19/21; 6/11/21; 9/30/21

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.

The hospital is also actively involved with the Town of Randolph's Community Wellness Plan. Beth Israel Deaconess Hospital-Milton has served on the town's Community Public Health Working Group and Schools Working Group since 2020 and acts as a partner organization working alongside municipal leaders, residents and community organizations to identify and implement strategies to address mental health, access to healthcare, food insecurity while promoting health equity to meet the needs of those most impacted by chronic disease and poor health outcomes such as immigrants, youth, and older adults.

Another important partnership is Beth Israel Deaconess Hospital-Milton's involvement with the Milton Coalition (formerly known as 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 35).

Community Partners

- 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
- Fuller Village
- Gosnold Recovery Services
- Interfaith Social Services
- Manet Community Health Centers
- Milton Board of Health
- Milton Council on Aging
- Milton Coalition formerly known as Milton Substance Abuse Prevention Coalition
- Milton Police Department
- Milton Public Library
- Milton Public Schools
- Quincy Asian Resources
- Quincy Board of Health
- Quincy Community Action Programs
- Quincy Family Resource Center
- Quincy Public Schools
- Quincy Police Department

- Randolph Board of Health
- Randolph Community Wellness Plan Steering Committee
- Randolph Intergenerational Community 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

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Certified Application Counselors & System Navigation** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	The Certified Application Counselors (CACs) program provides underserved and uninsured patients with information on all insurance programs offered by the Executive Office of Health and Human Services and the MA Health Connector (or simply The Commonwealth). The CACs also provide financial counseling, benefit enrollment assistance, and payment planning. The program's goals are to increase the number of patients served, to have more financial counseling staff become CACs in accordance with state regulations, and for all financial counseling staff to attend ongoing training to maintain state certification.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of people assisted with insurance and other public program enrollment, and patient navigation
Goal Status	In FY21, BID Milton's CACs assisted 223 community members and successfully enrolled 112 individuals in Mass Health, 66 individuals in Commonwealth Care, and assisted 45 people in applying for the Health Safety Net.
Program Year: Year 2	**Of 3 Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Primary Care Support** **Health Issue: Chronic Disease, Additional Health Needs (Access to Care)**	
Brief Description or Objective	Access to a usual source of primary care is particularly important, since it greatly affects the individual's ability to receive regular preventive, routine and urgent care and to manage chronic diseases. Data from the hospital's community health needs assessments indicated a need for additional providers specializing in supporting chronic disease prevention and maintenance.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase number of providers able to support chronic disease prevention
Goal Status	In FY21, seven new primary care/family practitioners were recruited to the hospital's medical staff to increase access to healthcare in Quincy and surrounding area.

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Culturally Responsive Care – Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	Free interpreter services (IS) are available to non-English speaking, limited English speaking, deaf, and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team, and an interpreter; and through a video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase the capacity of the Interpreter Services department interactions
Goal Status	Goal met: Total face-to-face plus phone encounters increased 28% vs FY20 to 6,890 in 51 languages
Program Year: Year 2	**Of 3 Years: Year 3** / **Goal Type: Process Goal**
Goal Status	Increase utilization of Video Remote Interpreting (VRI) devices. Interpreter Services Department will obtain more VRI for the units that are highly utilized for interpreter services.
Program Goal(s)	An additional 5 VRI devices were obtained for patient floors
Program Year: Year 2	**Of 3 Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Rental Assistance/Eviction Prevention Grant** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	Financial assistance provided by BID Milton supports Quincy Community Action Programs (QCAP) to help prevent homelessness for local at-risk families and individuals. QCAP's Housing Program 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By end of FY21, decrease the number of people who struggle with financial insecurity/rent insecurity to prevent at a minimum 12 families/households from eviction
Goal Status	Direct rental assistance averaging $844 was provided to 15 at-risk households, preventing 34 individuals from homelessness.
Program Year: Year 2	**Of 3 Years: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Blessings in a Backpack** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	BID Milton formed a partnership with the national organization Blessings in a Backpack and the Randolph Public Schools to ensure students most in need have access to food on the weekends. The program works with elementary school-aged children whose families cannot afford enough food; and distribute pre-packaged meal kits, containing enough food for three meals for two days.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to healthy food on the weekends to at least 50 identified at risk elementary aged children
Goal Status	Weekend food packs were provided to 65 children during the 2020-2021 school year

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Food/Snack Distribution** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	BID Milton worked with various organizations to support access to healthy food. Working with South Shore Elder Services, to provide Snack Packs to homebound seniors to assist with additional nutritional supplement especially during COVID. Snack packs provide additional options for our seniors should they not be able to heat up a shelf stable meal due to power outage, or simply find that they would like some light to supplement in-between meals. Funding from BID Milton supported the Lunch program with Asian American Service Association to prepare culturally appropriate Chinese style lunches for seniors during COVID-19.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY21, provide additional nutritional assistance to home-bound seniors by distributing 1,500 stable Snack Packs
Goal Status	Goal met: 1,500 snack packs were distributed to identified in-need seniors of the Meals on Wheels Program
Program Year: Year 1 | **Of 1 Years: Year 1** | **Goal Type: Process Goal**	
Program Goal(s)	By the end of FY21, provide 600 culturally appropriate grab-n-go meals to Chinese seniors
Goal Status	600 meals distributed
Program Year: Year 1 | **Of 3 Years: Year 2** | **Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Transportation Initiatives- Blue Hills Regional Coordinating Council** **Health Issue: Additional Health Needs (Transportation)**	
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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase and promote collaboration with community partners that enhance access to affordable, safe, accessible transportation options. By the end of Year 1, the Blue Hills Regional Coordinating Council (BHRCC) will develop a regional action plan based on the findings from the needs assessment.
Goal Status	Goal met: the action plan was completed in August 2021 and outlines 6 overall strategies and over 25 actions to address transportation equity in the region
Program Goal(s)	Provide patients with access to transportation for medical appointments
Goal Status	Free taxi vouchers were provided to patients without access to transportation.
Program Year: Year 2	**Of 3 Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Interface Hotline** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Behavioral health and substance misuse continues to be a major concern across the Commonwealth. BID Milton continues 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and nonclinical support services for those with mental health and substance use issues
Goal Status	Support and collaborate with town agencies to facilitate access to behavioral care. Number of cases from December 2020 to May 2021: 63 (44 children, 19 adult) Presenting concerns were anxiety and depression, along with COVID-19 as a reason for exacerbating current mental health conditions.
Program Year 2: Year 3	**Of 3 Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The National Alliance on Mental Illness (NAMI) reports that one-in-four individuals experiences a mental illness each year, underscoring a critical need for mental healthcare access across all patient populations. In the 2019 BID Milton 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 improve access to behavioral health, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model (CoCM) in employed primary care practices over a 5-year period (starting in March 2019). Collaborative Care is a nationally recognized integrated model that specializes in providing behavioral health services in the primary care setting. The services are provided by an embedded licensed behavioral health clinician and they include short-term brief interventions, case review with a consulting psychiatrist, and care coordination. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of behavioral health conditions. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals. The behavioral health clinician uses therapies that are proven to work within the primary care setting. A consulting psychiatrist may advise the primary care provider on medications that may be helpful.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to behavioral health services
Goal Status	In FY 21, behavioral health clinicians were provided at two BID Milton primary care practices, reaching 363 patients.
Program Year: Year 2	**Of 3 Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Reducing the Burden of Behavioral Health** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	BID Milton continues its partnership with Aspire Health Alliance to care for behavioral health patients in its Emergency Department and reduce 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 reducing risk of symptom escalation, 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.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Enhance access to mental health and substance use screening, assessment, and treatment services
Goal Status	Clinician is on call 7 days/week-24hrs/day and is onsite 5 days/week.
Program Year: Year 2	**Of 3 Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Botvin Life Skills with Milton Public Schools** **Health Issue: Mental Health/Mental Illness and Substance Use**	
Brief Description or Objective	BID Milton partners with the Milton Public Schools to implement the Botvin Life Skills health curriculum for fifth-grade students across the town's four elementary schools. 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the school year, 80% of 5th grade students will report learning a new coping skill to better manage stress and anxiety and learn about the dangers of tobacco/vaping use
Goal Status	Out of 268 students, 87% indicated they had learned something new about tobacco/vaping use and its dangerous effects. 82% indicated they learned a new coping mechanism for stress and/or anxiety such as progressive relaxation or guided imagery.

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use
Program Name: Support for Milton Substance Abuse Prevention Coalition
Health Issue: Mental Health/Mental Illness and Substance Use

Brief Description or Objective	As member of the coalition, the hospital supports programming that is focused on educational resources and skills-building for the community concerning mental health and substance use prevention. Programming is conducted virtually via webinars, with the audience primarily being parents and guardians of teens. Each webinar is followed by a short survey to determine whether the presentation was worthwhile and inspired changes in beliefs and/or behaviors. The hospital has also supports the coalition through other various events and training including Mental Health First Aid.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide community education resources and increase awareness of substance use/misuse and healthy mental, emotional, and social health
Goal Status	Support from BID Milton provided for 2 virtual presentations centered around youth transitions and ever-changing adjustments as a result of COVID-19, 100 community members attending virtually. Funding also provided for a 3-part training on youth engagement.

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Recovery Coach Program** **Health Issue: Substance Use**	
Brief Description or Objective	A Gosnold Recovery Specialist works in the emergency department to assist and intervene with individuals in 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 goal 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.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY21, 65% of consults conducted by a Recovery Specialist will result in a transfer to treatment
Goal Status	In FY21, 145 patients were seen by a Recovery Specialist in the Emergency department with 68% resulting in transfer to treatment. Treatment modalities included inpatient detox, medication assisted therapy, intensive outpatient programs or hospital transfer.
Program Year: Year 2	**Of 3 Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Substance Use **Program Name: Reducing Vaping and Tobacco Use** **Health Issue: Substance Use**	
Brief Description or Objective	To address the concerns of vaping in the community, especially in youth, BID Milton partners with Quincy Public Schools to educate high school students on the dangers of vaping through a comprehensive vaping education curriculum and prevention program. The program includes two parent education nights and a Healthy Decisions intervention group for students who are caught vaping on school grounds overseen by a licensed mental health clinician.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the 2020-2021 school year, increase access to tobacco, vaping/e-cigarette cessation programs and prevention education
Goal Status	In the 2020-2021 school year, 204 students were presented with the vaping curriculum. During post-assessments 97% of students reported learning new information such as health risks, peer influence and pressure, media use and tactics and vaping withdrawal.

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: Diabetes Self- Management Workshops** **Health Issue: Chronic Disease**	
Brief Description or Objective	To assist community members with how to better manage their diagnosis of Type 2 diabetes or pre-diabetes, BID Milton continues 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY21, offer at least two My Life, My Health Diabetes workshops to increase the number of adults who are able to better manage their diabetes
Goal Status	Due to COVID, only one workshop was able to take place in summer of 2021. Resulting in 10 community members taking the class with 80% indicating a change in behavior to better manage their diabetes. Seven participants were provided with the free 3-month membership to the YMCA to continue on a healthy lifestyle.

Program Year: Year 2	**Of 2 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: Enhance Asian Communities on Health (EACH) Diabetes Education** **Health Issue: Chronic Disease**	
Brief Description or Objective	BID Milton supports EACH, Inc. (Enhance Asian Community on Health) for pre-diabetes and Type 2 diabetes prevention. The program offers health education and health fairs in Chinese to increase awareness of diabetes and pre-diabetes, and provides the Centers for Disease Controls Prevent T-2: A Proven Program to Prevent or Delay Type 2 Diabetes workshops.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of adults who are engaged in evidence- based self-management support, chronic disease management, for diabetes
Goal Status	In FY21, a total of five virtual Chronic Disease Self-Management Program workshops were conducted virtually with a total of 82 community members being engaged.

Program Year: Year 2	**Of 2 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors
Program Name: Community Education Lectures & Workshops
Health Issue: Chronic Disease

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. BID Milton is partnered with the Milton Council on Aging to present a series of free, lunchtime educational lectures to seniors at the Milton Senior Center. Programs are then presented by the hospital's employees and/or medical staff.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of people who are educated about chronic disease risk factors and protective behaviors by providing a minimum of 10 health education opportunities
Goal Status	Education was provided in a virtual setting with the Milton Council on Aging and Milton Public library. 6 programs were conducted reaching 57 community members. Topics included cancer, healthy eating, arthroscopic surgery, COVID-19/Flu, osteoarthritis and thyroid disorders.

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: Cancer Screenings** **Health Issue: Chronic Disease**	
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. The hospital is able to continue its low-dose computerized tomography screening program to identify early-stage lung cancers.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Continue to offer screenings to increase number of adults screened for cancer
Goal Status	Due to COVID, skin and oral head and neck cancer screenings were not conducted. The lung cancer screening program surpassed its FY21 goal of 263 by conducting 508 scans.

Program Year: Year 2	**Of 3 Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals** **Health Issue: Chronic Disease, Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with Mass General Brigham, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies
Goal Status	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement
Program Goal(s)	By September 30, 2021, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits Committee data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	All 20 BILH Community Benefits staff were trained on the Community Benefits Database and began data entry for FY21 regulatory reporting.
Program Year: Year 1	**Of 3 Years: Year 3** | **Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$1,785,496.00	$33,000.00
Community-Clinical Linkages	$100,265.00	$74,753.00
Total Population or Community Wide Interventions	$205,919.00	$86,904.00
Access/Coverage Supports	$276,911.00	
Infrastructure to Support CB Collaborations	$4,696.00	$4,696.00
Total Expenditures by Program Type	$2,373,287.00	$199,353.00
CB Expenditures by Health Need		
Chronic Disease	$1,298,188.10	
Mental Health/Mental Illness	$167,529.95	
Substance Use Disorders	$215,776.05	
Housing Stability/Homelessness	$42,338.40	
Additional Health Needs Identified by the Community	$649,454.50	
Total Expenditures by Health Need	$2,373,287.00	
Total Community Benefits Program Expenditures	$2,373,287.00	
Leveraged Resources		
Total Leveraged Resources	$0	
Net Charity Care Expenditures		
HSN Assessment	$870,916.00	
Free/Discounted Care	-	
HSN Denied Claims	($8,881.00)	
Total Net Charity Care	$862,035.00	
Total CB Expenditures	$3,235,322.00	

Additional Information	
Net Patient Services Revenue	**$135,730,000.00**
CB Expenditure as % of Net Patient Services Revenue	**2.38%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$2,000,000**
Bad Debt	**$2,563,298.00**
Bad Debt Certification	**Yes**
Optional Supplement	In FY21, BID Milton contributed $63,713 to the Center for Health Information and Analysis (CHIA) and $19,169.93 to the Health Policy Commission. BID Milton also contributed $173,295 to subsidize behavioral health services outside of its community benefits service area.
Comments	In FY 21, Beth Israel Lahey Health and its member hospitals, in collaboration with Mass General Brigham, designed, built, and launched a new Community Benefits Reporting Tool (CBRT). The CBRT allows our teams and community partners to more accurately capture, track, and report data related to community benefits programs and initiatives. As part of our design and launch of the CBRT, the BILH and MGB teams undertook a multi-faceted quality improvement project to improve the alignment of definitions and categories for program expenditure reporting across our member hospitals; this may be a contributing driver for differences in trend with AGO reporting categories.

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      Beth Israel Deaconess Hospital- Milton (BID Milton) has worked to align its Community Benefits Advisory Committee membership to reflect the demographics included in BID Milton's Community Benefits Service Area (CBSA). Additionally, BID Milton has worked to have the Community Benefits Advisory Committee membership include the following sectors of Housing and Regional Planning and Transportation, as well as residents.
      Rita Bailey, Health Services Coordinator, Quincy Public Schools
      Tim Carey, Director of Program Development, South Shore Elder Services
      Daurice Cox, CEO, Baystate Community Services
      Nancy Drew, MD, Primary Care Physician, Beth Israel Lahey Health
      Richard Doane, Director, Interfaith Social Services
      Melissa Drohan, Social Worker, BID Milton
      Marian Girouard-Spino, Chief System Integration and Quality Officer, Aspire Health Alliance
      Tina Ho, Integrated Service Lead, Family & Community Service, Quincy Asian Resources
      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
      Din Shih, Board of Trustees, Beth Israel Lahey Health
      Cynthia Sierra, Executive Director, Manet Community Health Centers
      Christine Stanton, Director, Milton Council on Aging
      Heidi Stucker, Assistant Director of Public Health, Metropolitan Area Planning Council
      Katelyn Szafir, Director of Medical Wellness, South Shore YMCA
      Sara Tan, Director, Enhance Asian Community on Health
      Christine Tangishaka, Randolph Resident
      Brian Tatro, Executive Director, Milton Housing Authority
      Jeanette Travaline, Executive Director, Randolph Chamber of Commerce
      Michelle Tyler, Planner, Town of Randolph

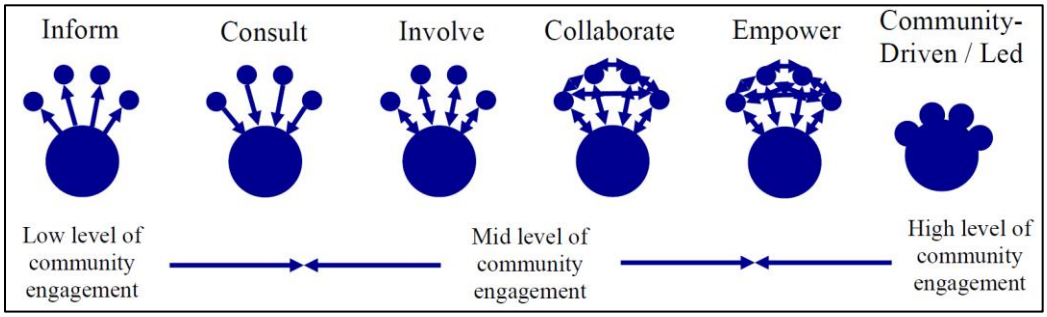
II. Community Engagement:

- 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
South Shore Elder Services	Tim Carey, Director of Program Development	Social service organizations	Due to COVID, there has been an increased need for additional food, especially to those populations who may be at greater-risk of the disease or homebound. BID Milton worked with SSES to implement snack pack program to provide additional nutritional assistance to seniors.
Enhance Asian Communities on Health	Sara Tan, Executive Director	Social service organizations	Received grant funding from hospital to implement Chinese chronic disease self-management programs. Classes transitioned to a virtual setting due to the pandemic.
Aspire Health Alliance	Marian Girouard-Spino, Chief System Integration and Quality Officer	Behavioral health and mental health organizations	A clinician from Aspire Health Alliance is embedded in BID Milton's Emergency Department to provide evaluations and assist with placement of behavioral health patients.
Randolph Public Schools	Hana Walsh, Director of ELL	Schools	Prior to COVID, BID Milton worked with Randolph Public Schools to provide additional nutritional assistance to at-risk students identified by the school. This program continues.

- 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	BID Milton met regularly throughout the year with its CBAC to seek input and provide updated on additional needs of the community.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Resident member of the hospital's CBAC reviewed competitive grant proposals by community partners and determined allocation of funding and recipients awarded.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met. 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	Empower	BID Milton Community partners were provided with the opportunity to attend free workshops to build/increase their capacity on CB program evaluation and progress.	Collaborate

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 22	Collaborate

- 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 FY22, BID Milton will undertake its triennial community health needs assessment and prioritization process. Guided by BID Milton's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative's guiding principles include community engagement, equity, collaboration and capacity building. In FY22, 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 conducting focus groups with community partners such as Enhance Asian Communities on Health and Milton Youth Advocates for change. In addition, BID Milton will work alongside Signature Healthcare Brockton Hospital in engaging Randolph resident during a community listening session.

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

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. Beth Israel Deaconess Hospital-Milton was intentional when assessing risk factors within our CBSA and worked closely with our local health department(s). Clinical staff provided infection control expertise to local health departments during their reopening plans. Beth Israel Deaconess Hospital-Milton worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. Beth Israel Deaconess Hospital-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.

While in-person meetings were hindered in the community, Beth Israel Deaconess Hospital-Milton sought creative ways of engaging with our community including transitioning meetings and classes to virtual settings

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 expanded. In others, programs were cut or significantly reduced because of the pandemic.

- 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 30, 2021 via Zoom.

Additionally, BID Milton regularly shares updates about its community benefits programs during various coalition meetings including the Milton Substance Abuse Prevention Coalition, The Randolph Community Wellness Plan Workgroup Meetings and the Blue Hills Regional Coordinating Council.

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.

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 was established in January of 2019.

Since that time, a group of 20+ stakeholders have been meeting on a quarterly basis to understand the needs and assets related to transportation and accessibility and implement a regional plan to address identified barriers. The first two phases of this project included a comprehensive community needs assessment (conducted September 2019 – March 2020) and subsequent regional action plan (completed Summer 2020).

Through a series of action plan feedback sessions and community meetings in Fall 2020 and early 2021, the BHRCC solidified its plans to move forward with eight prioritized actions, which were further combined and reworked into three priority areas that will guide pilot programs in Quincy, Weymouth, and Randolph:

· Improve communication of transportation options and how to navigate those options safely and efficiently

· Create new processes and systems that ensure ongoing translation efforts

· Increase access to crucial services and resources by creating more centralized delivery systems

Our goal with the pilot projects is to partner with organizations to address the above priorities, thereby increasing access for older adults, people with disabilities, people who have experienced

racial and/or economic discrimination, and/or residents with limited English proficiency. Key outcomes of the transportation initiative include the following:

· Priority populations will have increased access to public and/or private transportation options that are reliable, affordable, and safe.

· Community-based organizations, municipal leaders, and other stakeholders will embrace transportation as a social determinant of health and work collaboratively (both across and within their respective sectors) to address relevant determinants.

· Municipal officials and community-based organizations will make decisions that elevate the priorities of residents who have historically been underserved and discriminated against by transportation policy.

· Blue Hills RCC communities will have designated and designed spaces and routes for the needs of walkers, bikers, and transit riders of all ages and abilities.

· There will be an increase in the proportion of local, regional, and state level funding allocated towards projects making streets safer and healthier and make public transportation options more reliable and affordable.

· Individuals and families of the BHRCC region will see health improvements due to reduced social isolation, fewer missed medical and social service appointments, and improved access to the places that are important to them.

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.**
   Click or tap here to enter text.