Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Beth Israel Deaconess Milton

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SECTION I: SUMMARY AND MISSION STATEMENT

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

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BID Milton's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities. While BID Milton oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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

The mission of BID 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.

More broadly, BID 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 Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

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

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

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

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

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

The following annual report provides specific details on how BID Milton is honoring its commitment and includes information on BID Milton's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

BID Milton's CBSA includes Milton, Randolph and Quincy. In FY 2022, BID Milton conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BID Milton's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BID Milton is committed to improving

the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BID Milton's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BID Milton's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in BID Milton's CBSA were issues related to age, race/ethnicity, language, and immigration status. All three communities were diverse; the percentages of Black/African American residents in Randolph and Milton were significantly high compared to the Commonwealth, as was the percentage of Asian residents in Quincy. There was consensus among interviewees, focus group participants, and listening session attendees that immigrants, individuals best served in a language other than English, people of color, and individuals with disabilities face systemic challenges that limited their ability to access health care services. Participants reported that these segments of the population were impacted by language, racism, cultural barriers, and stigma that posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes.

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

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

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

Key Accomplishments for Reporting Year
BID Milton's most recent CHNA and IS were conducted and approved by the Board during the fiscal year ended September 30, 2022. That CHNA and IS will inform the Community Benefits mission and activities of BID Milton for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025.

This report covers BID Milton's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the BID Milton Board before September 30, 2019 and informed the BID Milton's Community Benefits initiatives for the fiscal years ending

September 30, 2020; September 30, 2021; and September 30, 2022. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2019.

Program accomplishments include:

Social Determinants of Health and Access to Care

- Grant funding provided to Quincy Community Action Program rental assistance and eviction prevention program prevented 27 individuals from 15 households from becoming homeless. The grant provided an average of $900 to each household for rental assistance.
- Assisted 445 community members enroll in and receive health insurance benefits.
- Provided grant funding to support the distribution of 600 culturally appropriate meals to Asian seniors.
- Provided grant funding to DOVE to ensure food and housing for eight survivors of domestic violence
- Provided the Friendly Food Pantry of Randolph with three full community supported agriculture shares of organic fruits and vegetables from Brookwood Community Farm. Over 20 lbs. of produce were provided each week for 14 weeks in the summer of 2022.
- Utilizing grant funding from BID Milton, Milton Early Childhood Alliance developed an 8-week Learning Through Play pre-school playgroup series focusing on improving developmental delays in children, exacerbated by the COVID-19 pandemic. A total of 25 children participated in the workshop with improvements made in gross/fine-motor and social-emotional and communication skills.

Chronic and Complex Conditions and Their Risk Factors

- Held evidence-based diabetes self-management and Matter of Balance workshops in partnership with the South Shore YMCA.
- Provided grant funding to Enhance Asian Services on Health to implement Chinese T2 Diabetes Prevention Program and Matter of Balance classes.
- 529 low-dose CT lung cancer screens were performed, a 21% increase over FY21.
- Provided grant funding provided to Simon C. Fireman Community for implementation of Nutritional Support for Seniors Program. Funding was used to hire a part-time dietitian who provided nutrition counseling and education to 121 seniors who were low-resourced.

Mental Health and Substance Use

- Continued to provide financial support to the Town of Milton's Interface behavioral health hotline and the Milton Coalition formerly known as Milton Substance Abuse Prevention Coalition

- Continued to partner with the Milton Public Schools to implement Botvin Life Skills health education programming geared around substance use prevention and social emotional learning.
- The Peer Recovery Coach Program in the hospital's Emergency Department conducted 813 consults with 64% resulting in transfer to treatments
- 432 staff members from the Milton Public Schools were trained in the "Understanding Trauma and Its Impact" program through the Trauma Sensitive Schools Training Package from the National Center on Safe and Supportive Learning Environments, made possible with BID Milton grant funding.
- 47 community members were trained in Mental Health First Aid. Two community members were trained as instructors for Teen Mental Health First Aid

Plans for Next Reporting Year

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

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BID 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 FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BID Milton's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BID Milton, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions

with a broad range of community participants, there was agreement that for BID Milton's FY 2023 - 2025 IS, it will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals and families in the communities of Milton, Quincy and Randolph. In recognition of the health disparities that exist for certain segments of the population, BID Milton's Community Benefits investments and resources will focus on the improving the health status for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; and individuals with disabilities.

BID Milton will partner with clinical and social service providers, community-based organizations, public health officials, schools, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - BID 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
  - Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.

- **Social Determinants of Health**
  - BID Milton will continue its 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.
  - Continue to provide grant funding for local partners and social service agencies such as Quincy Community Action Programs (QCAP), Father Bills & Main Spring and Interfaith Social Services who address social determinants of health to help individuals and families who are low-resourced maintain housing and prevent eviction.
  - Partner with local agencies and community partners such as the Milton Council on Aging and Randolph Inter-generational Center to promote and provide access to healthy food.
  - Increase mentorship, training, and employment opportunities to increase employment and earnings and increase financial security for youth, young adults, and adults residing in the CBSA by partnering with local partners like Quincy Asian Resources, Inc. (QARI).

- **Mental Health and Substance Use**
  - BID 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.
  - 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 individuals with recovery, case management, and navigation support.
    - Continue to build community members' capacity to help reduce negative stereotypes, bias and stigma around mental illness and substance use disorders by providing grants to Aspire Health Alliance and other local partners to provide access to Mental Health First Aid training and other mental health supports.

- **Complex and Chronic Conditions**
    - Ensure older adults have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.
    - BID Milton will partner will local service agencies including the YMCA to provide evidence-based health education and self-management support programs.
    - Address barriers to timely cancer and chronic disease screenings and follow-up care through culturally appropriate navigation and innovative programs in partnership with local partners like Enhance Asian Communities on Health (EACH).

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), BID Milton Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 46). The BID Milton Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BID Milton's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BID Milton's Board of Trustees along with its clinical and administrative staff is committed to improving the health of our community by providing exceptional, personalized health care with dignity, compassion and respect. BID Milton's Community Benefits Department, under the direct oversight of BID Milton's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BID Milton's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

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

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The BID Milton Community Benefits program is spearheaded by the Community Benefits and Relations Manager. The Community Benefits and Relations Manager has direct access and is accountable to the BID Milton President and the BILH Vice President of Community

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

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

Community Benefits Advisory Committee (CBAC)
The BID Milton Community Benefits Advisory Committee (CBAC) works in collaboration with BID Milton's hospital leadership, including the hospital's governing board and senior management to support BID Milton's Community Benefits mission to serve its patients compassionately and respectfully, to improve the health and well-being of residents in BID Milton's community. The CBAC provides input into the development and implementation of BID Milton's Community Benefits programs in furtherance of BID Milton's Community Benefits mission. The membership of BID Milton's CBAC aspires to be representative of the constituencies and priority cohorts 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.

The BID Milton CBAC met on the following dates:

- December 10, 2021
- March 10, 2022
- May 13, 2022
- June 10, 2022
- September 8, 2022

Community Partners
BID Milton recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BID Milton's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BID Milton's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. BID Milton's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BID Milton's mission.

BID Milton currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BID Milton collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations.

BID Milton is an active participant in the Blue Hills Community Health Alliance (CHNA 20). Joining with such grass-roots community groups and residents, BID Milton strives to create a vision for both city-wide and neighborhood-based health improvement. In working with the CHNA 20, BID 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.

BID Milton is a proud supporter of Quincy Asian Resources, Inc. (QARI) and regularly sponsors their events throughout the year that celebrate cultural diversity, workforce development, mental health and education initiatives that engage the Asian community.

The hospital is also actively involved with the Town of Randolph's Community Wellness Plan. BID 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 BID 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 the Town of Milton, primarily amongst youth. The Coalition actively supports the Milton Youth Advocates for Change, a community-based youth-led, adult-supported group for 6th – 12th graders, with a mission to help teens find their voices, celebrate diversity and differences, as well as to make a more aware, accepting community and improve mental, emotional, social, and physical health.

The following is a comprehensive listing of the community partners with which BID Milton collaborated with on its FY 2020 – 2022 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 46).

Community Partners

- A New Way Recovery Center
- 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)

- Brookwood Community Farm
- Curry College
- DOVE, Inc
- Enhance Asian Communities on Health
- Father Bills & Mainspring House
- First Baptist Church, Randolph
- Friendly Food Pantry
- Fuller Village
- Gosnold Recovery Services
- Interfaith Social Services
- Manet Community Health Centers
- May Institute
- Metropolitan Area Planning Council
- Milton Board of Health
- Milton Chamber of Commerce
- Milton Council on Aging
- Milton Coalition formerly known as Milton Substance Abuse Prevention Coalition
- Milton Early Childhood Alliance
- Milton Housing Authority
- Milton Police Department
- Milton Public Library
- Milton Public Schools
- Milton Youth Advocates for Change
- Quincy Asian Resources
- Quincy Board of Health
- Quincy Chamber of Commerce
- Quincy Commission on Disabilities
- Quincy Community Action Programs
- Quincy Family Resource Center
- Quincy Public Schools
- Quincy Police Department
- Randolph Board of Health
- Randolph Chamber of Commerce
- Randolph Community Wellness Plan Steering Committee
- Randolph Community Partnership
- Randolph Educational Collaborative
- Randolph Intergenerational Community Center
- Randolph Public Schools
- Randolph Veteran Affairs
- Signature Healthcare
- Simon C. Fireman Community
- South Cove Community Health Center
- South Shore Elder Services

- South Shore YMCA
- United Parkway Methodist Church

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill BID 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 BID Milton's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BID Milton's most recent CHNA was completed during FY 2022. FY 2022 Community Benefits programming was informed by the FY 2019 CHNA and aligns with BID Milton's FY 2020 – FY2022 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

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

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

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

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

Between October 2021 and February 2022, BID Milton conducted 19 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 500 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers and other community partners.

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

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

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

Social Determinants of Health

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

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

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

Mental Health and Substance Use

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

Complex and Chronic Conditions

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

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

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health 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 FY22, BID Milton's CACs assisted 445 community members and successfully enrolled 155 individuals in Mass Health, 74 individuals in Commonwealth Care, and assisted 89 people in applying for the Health Safety Net.
Time Frame Year: Year 3	**Time Frame Duration: 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 FY22, two additional family practitioners were recruited to the hospital's medical staff to increase healthcare access in Randolph and Quincy.

Time Frame Year: Year 3	**Time Frame Duration: 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	6,567 total face-to-face plus phone encounters were conducted in 53 languages.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	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.	
Goal Status	Goal met: Interpreter Services department obtained 10 dual handset phones to help reduce the time to access to interpreters.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Emergency Flex Funding for Domestic Violence Survivors** **Health Issue: Additional Health Needs (SDOH)**	
Brief Description or Objective	DOVE is committed to partnering with diverse communities, families and individuals impacted by domestic violence or partner violence by promoting hope, healing, safety, and social change by providing a broad range of preventive and responsive services. The grant will be used to provide emergency financial assistance or "flex funds" to domestic violence survivors, helping to address immediate concerns for well-being including housing security and access to healthy food. For example, funds may cover rental assistance and landlord negotiation.
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 the financial safety and stability of victims of domestic violence through providing emergency economic support to approximately 8 survivors annually.
Goal Status	Eight survivors were provided with emergency economic assistance.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal(s)	80% of clients that receive emergency flex funds will participate in some form of economic empowerment (budgeting, career support, enrolling in school/work programs, enrolling in other eligible benefits).
Goal Status	All clients enrolled participated in economic empowerment classes
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal(s)	80% of program participants will gain knowledge of forms of affordable housing or will begin the application process to obtain various forms of affordable housing.
Goal Status	All clients maintained housing and 37% of clients were provided with rental assistance.
Time Frame Year: Year 1	**Time Frame Duration: 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 families and individuals at greatest risk. QCAP's Housing Program works to secure and stabilize housing for renters and homeowners, thereby reducing the number of individuals and families experiencing homelessness. 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 FY22, decrease the number of people who struggle with financial insecurity/rent insecurity to prevent at a minimum of 12 families/households from eviction.
Goal Status	Goal met: Direct rental assistance averaging $900 was provided to 15 households, preventing 27 individuals from experiencing homelessness.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal(s)	By the end of FY 22 (September 30), QCAP will refer 80% of the BID Milton fund families to other area resources (including QCAP services).
Goal Status	At the end of FY22, QCAP referred 93% of BID Milton fund families to other area resources (including QCAP resources and services).
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Learning Through Play Preschool Playgroup Series** **Health Issue: Additional Health Needs (Education)**	
Brief Description or Objective	The Milton Early Childhood Alliance, a program of Discovery Schoolhouse and mainly funded through the MA Department of Early Education and Care, is a community-wide organization that provides families and children access to locally available comprehensive services and supports that strengthen families, promote optimal child development, and bolster school readiness. This grant will fund an 8-week developmentally appropriate preschool playgroup series for 20-25 children with a focus on supporting and enhancing gross and fine motor skills and development. The series is aimed at providing quality early learning experience for children whose opportunity for an education preschool experience was interrupted by the COVID-19 pandemic.
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 8-week program, children will successfully demonstrate improvement in fine motor skills, gross motor skills, personal and social communication, and problem-solving skills by participating in specifically designed weekly activity plans and at-home extension activities with parents.
Goal Status	A total of 25 children and 18 parents participated in the weekly activities. Of those children where a delay was indicated in one or more developmental areas, most children re-assessed showed improvement in at least one developmental area. Children also showed improvement in more than one developmental area. Parents reported they saw marked improvement in their child's communication and personal-social skills.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: CSA Farm Shares for Local Food Pantries** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	Partnering with Brookwood Community Farm, BID Milton provided three full Community Supported Agriculture (CSA) shares of both locally grown and organic fruits and vegetables to benefit the Randolph Friendly Food pantry.
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 fresh locally grown produce to underserved populations in Randolph.
Goal Status	Three full vegetable and three full fruit shares of organic produce, averaging 20-25 lbs were purchased through Brookwood Community Farm and distributed to Friendly Food Pantry clients in Randolph for 14 weeks in the summer of 2022.

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

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Transportation Initiatives** **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. 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.
Goal Status	The BHRCC has been focusing on items identified in the action plan. Pilot projects are being identified in Quincy and Randolph to address three priority areas: Communication, Ensuring Translation, Community Hubs. The BHRCC has also engaged with regional transportation planning processes and meetings by MassDOT and the Boston MPO to advance local and regional transportation goals.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal(s)	Provide patients with access to transportation for medical appointments.
Goal Status	$6,978 worth of free taxi vouchers were provided to patients without access to transportation.
Time Frame Year: Year 3	**Time Frame Duration: 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 June 2021 to November 2021: 65 (44 children, 21 adult); Number of cases from December 2021 to April 2022: 40 (24 children, 16 adult); top presenting concerns were anxiety and depression, family related issues and COVID-19 exacerbating current mental health issues.
Time Frame Year: Year 3	**Time Frame Duration: 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	In order to increase access to mental health services, BID Milton has implemented the Collaborative Care model, a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, 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 treat a variety of medical and mental health conditions.
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 22, behavioral health clinicians were provided at three BID Milton primary care practices, reaching 368 patients.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: 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 FY22, 65% of consults conducted by a Recovery Specialist will result in a transfer to treatment.
Goal Status	813 consults were performed by Recovery Specialists in the Emergency Department and on the Medical Floors with 518 (64%) of consults resulting in treatment. Treatment modalities include detox, Medication Assisted Therapy (MAT) or transfer to inpatient treatment facility.

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

Priority Health Need: Mental Health and Substance Use **Program Name: Trauma Informed Schools** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Grant funding provided by BID Milton was used to implement curriculum and training on trauma and its effects on students to all staff at Milton's six public schools to improve social and emotional learning and resiliency.
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 2021-2022 school year, all Milton Public School staff will receive training the "Understanding Trauma and Its Impact" Training.
Goal Status	All 432 staff members were trained.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal(s)	By the end of the 2021-2022 school year, complete and assess Staff Readiness for Change Survey and establish working groups to make specific recommendations for schools.
Goal Status	All staff completed survey and working groups formed. From the working groups it was determined that Social Emotional Learning Leads should be in place. To date, 12 Social Emotional Learning leads have been identified/hired with two being placed at each of the district's schools.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Support for Milton Substance Abuse Prevention Coalition** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The Milton Coalition is a community coalition focused on preventing and reducing youth substance use and promoting mental health in Milton, MA. The Coalition brings together health, social service professionals, public leaders in education, religion, media, recreation, business, public safety, policy and planning, as well as diverse residents- including students, parents and affected family members – to work collaboratively on preventing and addressing substance use and preventable mental illness in the Town of Milton, with a focus on youth. Coalition leadership and volunteer members are committed to analyzing local community problems, raising community awareness, and supporting efforts to tackle these issues. The Coalition follows the Strategic Prevention Framework (SPF) to address youth substance use and developed strategies to reduce youth substance use, specifically underage usage of alcohol, nicotine (vaping), marijuana, and prescription drugs not prescribed to them and to increase the community capacity to address mental health issues among youth. Strategies include hosting webinars and presentations for parents to enhance their skills in addressing youth substance use and mental health, supporting its youth coalition, the Milton Youth Advocates for Change (MYAC), collaborating with local stakeholders such as the schools and police to provide resources for youth and families struggling with substance use, and implementing best practices for substance use prevention such as Sticker Shock. Through the Drug Free Communities grant from the Center of Disease Control (CDC), the Coalition primarily focuses on youth substance use prevention, but the coalition serves all Milton residents of any age.
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 12/29/2021, build capacity of the Coalition's new youth coalition by recruiting 5 additional students.
Goal Status	The youth coalition now has 20 members.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal(s)	By 5/30/2022, build staff, youth and community partners' knowledge, skills, and networks by attending 1 CADCA-sponsored national training and participation in 4 regional youth substance use collaboratives, as documented by meeting minutes and/or attendance sheets.
Goal Status	1 CADCA training attended Youth members attended the Norfolk County District Attorney's Team Rival Leadership Conference. They are also a member of SparkShare which is a place where youth from across the world come together to support and learn from each other. Four MYAC members traveled to the Community Anti-Drug Coalitions of America conference in Florida in July 2022.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Program Goal(s)	By 9/29/2022, increase Coalition visibility and community awareness of youth substance use through the communication of research, community data, and coalition progress to 3,000 residents.
Goal Status	More than 3,000 residents were reached.

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

Program Goal(s)	By March 2022, reduce by 5% the number of 9th-12th graders who report feeling that their mental health was not good in the past 30 days, as measured by the YRBS implemented in March 2019.
Goal Status	59% of students reported their mental health was not good in the past 30 days.

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

Program Goal(s)	By March 2022, reduce by 3% the number of teens using prescription medications not prescribed to them, comparing YRBS data from March 2019.
Goal Status	2% reduction of number of teens using prescription medication not prescribed to them from 2019 to 2022.

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

Program Goal(s)	By March 2022, reduce by 2% the number of 9th to 12th graders who report 30 day use of vaping tobacco as measured by comparing the YRBS administered in March 2019.
Goal Status	Reduction of 8% of MHS students who reported 30 day use of vaping tobacco from 2019 to 2022.

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

Program Goal(s)	By March 2022, increase by 5% the amount of Milton High School students who believe that their friends would feel it was wrong for them to smoke marijuana, as asked on the 2019 YRBS survey.
Goal Status	2% less of Milton High School students believed that their friends would feel it was wrong for them to smoke marijuana.

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

Priority Health Need: Mental Health and Substance Use **Program Name: Getting the Teens Out** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Grant funding provided by BID Milton to Quincy Asian Resources Inc. help fund a series of social groups for immigrant teens and their caregivers who are bi-cultural and low-resourced, led by a youth development specialist and mental health specialist from Walker Therapeutic and Educational Programs to relieve emotional stress from social isolation and facilitate connections to further mental health resources.
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 emotional well-being and decrease social isolation in teen youth by organizing a variety of social events to help youth cope with and recover from psycho social stress of the COVID-19 pandemic.
Goal Status	150 teenagers participated in 6 events. High school students report increased understanding of ways to cope with stress, self-image, and connectedness to friends and families.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**
Program Goal(s)	Provide educational workshops for parents to combat cultural stigma around accessing mental health services and teach how to identify when mental health services are needed, and how to access such services in their native languages.
Goal Status	28 parents participated in educational workshops. Exit surveys indicated that the parent workshop has increased their understanding on how to raise multicultural children. The average was 8.75 on a scale of 1 to 10, with 1 being the least and 10 being the most. Parents shared their experiences in exploring the cultural differences with children, how they chose the language(s) to speak at home, and how they value their cultures with children as well as building parent-child communication.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Botvin Life Skills** **Health Issue: Mental Health/Mental Illness and Substance Use Disorder**		
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	Over 250 students were administered the Botvin Life Skills curriculum across four elementary schools. Unfortunately, assessments were not able to be administered. However, instructors were engaged and reflective during the curriculum and found it beneficial in social emotional learning.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes 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	Emergency Service Providers evaluated 275 patients.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Mental Health First Aid** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	Free Mental Health First Aid Trainings are 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.	
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 FY22, establish a Teen Mental Health First Aid site in Randolph with at least two community facilitators and raise awareness, reduce stigma, and educate 20 residents about mental health and substance use.	
Goal Status	Two community residents were trained and became certified instructors in Teen Mental Health First Aid. A total of 47 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.	
Time Frame Year: Year 3	**Time Frame Duration: 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)	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	One workshop took place in Randolph, resulting in 11 community members taking the class with 64% 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.

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

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: EACH Diabetes Education** **Health Issue: Chronic Disease**		
Brief Description or Objective	BIDM supports EACH, Inc. (Enhance Asian Community on Health) for pre-diabetes and Type 2 diabetes prevention. The program offers health education and fairs in Chinese to increase awareness of diabetes and pre-diabetes, and provides the Centers for Disease Control's 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 FY22, EACH was able to secure DPP (Diabetes Prevention Program) Certification through the Centers for Disease Control (CDC). Two bi-lingual coaches were trained in the program. 11 community members participated in the workshop with 5 participants showing improvements in A1c. An additional 150 community members participated in a pre-diabetes informational workshop.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: Nutritional Supports for Seniors in Affordable Housing** **Health Issue: Chronic Disease**	
Brief Description or Objective	Simon C. Fireman Community offers seniors affordable, independent living that supports personal wellness. Through a BID Milton grant, a part-time nutritionist provides one-on-one and group nutritional support classes for seniors in affordable housing and the greater community helping to create healthier eating habits to better manage chronic medical conditions and decrease social isolation.
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 2022, grant funding will be used to hire a part-time nutritionist, develop programming and schedule of events, recruit participants and conduct baseline assessments.
Goal Status	Nutritionist was hired. Baseline assessments were conducted on senior's nutrition and chronic disease self-management goals and knowledge as well as feelings of isolation and depression. Programming included individualized nutrition support, group education classes, coffee chats and written educational information. A total of 121 seniors received written educational materials, 7 of which participated in individualized counseling; 32 in group education classes and 8 in coffee chats.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: Matter of Balance Classes** **Health Issue: Additional Health Needs Identified by the Community (Healthy Aging)**	
Brief Description or Objective	Partnering with Enhance Asian Communities on Health (EACH), BID Milton covered the cost of providing 2 Matter of Balance Workshops for Non-English Speaking Chinese residents in Quincy. Matter of Balance is an evidence-based program designed to reduce the fear of falling and increase activity levels among older adults.
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)	Promote independence and aging in place and reduce fear of falling by hosting at least two Matter of Balance Workshops for older adults.
Goal Status	Five Matter of Balance workshops were conducted with 75 community members participating.

Time Frame Year: Year 1	**Time Frame Duration: 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. The hospital continues 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 by 20% as compared to previous year.	
Goal Status	The lung cancer screening program surpassed its FY22 goal of 609 by conducting 646 scans.	
Time Frame Year: Year 3	**Time Frame Duration: 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 worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees.
Goal Status	All 10 BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	By September 30, 2022, 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 data to more accurately capture and quantify CB/CR activities and expenditures.	
Goal Status	All FY22 regulatory reporting data were entered into the Community Benefits Database.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and their Risk Factors **Program Name: Primary Care Navigation** **Health Issue: Chronic Disease (Diabetes), Additional Health Needs (Access to Care)**	
Brief Description or Objective	In collaboration with Beth Israel Lahey Health, primary care sites within the BID Milton network are enhancing their existing care model at the sites serving the largest number of Black and Hispanic patients with uncontrolled diabetes. These sites will embed a clinical pharmacist and a patient navigator within the care team to improve patient access and reduce barriers to implementing diabetes care plans.
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)	Improve health outcomes and reduce barriers to care of Black and Latinx patients with A1c above 8.5 by embedding a Patient Navigator into a primary care setting.
Goal Status	Total number of Black and Latinx patients with A1c of 8.5 or above reduced from 85 to 29. Of the 29 patients, all were screened for social determinants of health with two patients being referred to community health work for assistance with food and transportation insecurity.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Grab N Go Chinese Lunch Box Program** **Health Issue: Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	In partnership with the Asian American Service Association, funding provided to prepare culturally appropriate Chinese style lunches for seniors at Wollaston Senior Center in Quincy.
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 FY22, provide 600 culturally appropriate free grab-n-go meals to Chinese older adults.
Goal Status	600 meals were distributed.

Time Frame Year: Year 3	**Time Frame Duration: 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	$1,914,929.00	$36,000.00
Community-Clinical Linkages	$109,975.00	$70,000.00
Total Population or Community Wide Interventions	$243,096.00	$102,418.00
Access/Coverage Supports	$303,765.00	
Infrastructure to Support CB Collaborations	$7,789.00	
Total Expenditures by Program Type	$2,579,554.00	$208,418.00
CB Expenditures by Health Need		
Chronic Disease	$1,335,832.40	
Mental Health/Mental Illness	$267,072.75	
Substance Use Disorders	$227,620.50	
Housing Stability/Homelessness	$47,557.25	
Additional Health Needs Identified by the Community	$701,471.10	
Total by Health Need	$2,579,554.00	
Leveraged Resources	$10,000.00	
Total CB Programming	$2,589,554.00	
Net Charity Care Expenditures		
HSN Assessment	$586,579.32	
Free/Discounted Care		
HSN Denied Claims	$191,979.92	
Total Net Charity Care	$778,559.24	
Total CB Expenditures	$3,368,113.24	

Additional Information	
Net Patient Services Revenue	**$134,817,000.00**
CB Expenditure as % of Net Patient Services Revenue	**2.50%**
Approved CB Budget for FY23 (*Excluding expenditures that cannot be projected at the time of the report)	**$2,500,000.00**
Bad Debt	**$ 3,173,896.84**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments: BID Milton contributed $109,301 to subsidize behavioral health services outside of its Community Benefits Service Area. In addition to the above amounts, Beth Israel Lahey Health contributed $1 million to The Latino Equity Fund and the New Commonwealth Racial Equity and Social Justice Fund in support of addressing health disparities related hypertension, diabetes and obesity and further integration and alignment, particularly regarding stakeholder engagement and convening with the Health Equity Compact.	

SECTION VI: CONTACT INFORMATION

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Beth Israel Deaconess Hospital-Milton
Community Benefits
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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1

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

I. Community Benefits Process:

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

     Beth Israel Deaconess Hospital-Milton (BID Milton) is a member of Beth Israel Lahey Health (BILH). While BID Milton oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – **We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.**

2. Community Benefits Advisory Committee (CBAC)
   - Members (and titles):
     Rita Bailey, Coordinator of Health Services, Quincy Public Schools
     Tim Carey, Director of Program Development, South Shore Elder Services
     Dr. Daurice Cox, CEO, Baystate Community Services
     Catherine Denny, CEO, Choice Community Supports
     Richard Doane, Executive Director, Interfaith Social Services
     Dr. Nancy Drew, Primary Care Physician BILH
     Melissa Drohan, Social Worker, BID Milton
     Marian Girouard-Spino, Chief System Integration & Quality Officer, Aspire Health Alliance
     Tina Ho, Integrated Service Lead of Family and Community Engagement, Quincy Asian Resources
     Melissa Horr-Pond, Senior Principal Planner, City of Quincy
     Caroline Kinsella, Public Health Director, Town of Milton
     Laureane Marquez, Community Benefits Manager, BID Milton

Vicki McCarthy, Milton resident
Rev. Baffour Nkrumah-Appiah, Pastor, First Baptist Church, Randolph
Kristen Schlapp, Chief Operating Officer, Quincy Community Action Programs
Cynthia Sierra, CEO, Manet Community Health Centers
Christine Stanton, Executive Director, Milton Council on Aging
Heidi Stucker, Assistant Director of Public Health, Metropolitan Area Planning Council
Katelyn Szafir, Executive Director, South Shore YMCA
Sara Tan, Executive Director, Enhance Asian Community on Health
Christine Tangishaka, Randolph resident
Brian Tatro, Executive Director, Milton Housing Authority
Jeannette Travaline, Executive Director, Randolph Chamber of Commerce
Michelle Tyler, Director of Planning, Town of Randolph
Din Shih, BID Milton Board of Trustees

- Leadership:
  Dr. Sheila Ryan Barnett, MD, Chief Medical Officer
  Lynn Cronin, Vice President of Nursing and Chief Nursing Officer
  Jeannette Currie, Chief Information Officer
  Angela Fenton, Vice President of Ambulatory & Clinical Services
  Richard Fernandez, President
  Cheryl Freed Loew, Vice President, Human Resources
  David Hyman, Vice President, Philanthropy
  Sheilah Rangaviz, Chief Financial Officer

- Frequency of meetings:
  BID Milton's CBAC met quarterly during FY 2022 and also attended the hospital's annual Community Benefits public meeting.

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

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

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

At BILH, our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our community partners, our Community Benefits Committee (CBC) and the Community Benefits team, such commitment is shared by staff at all levels within BID Milton:

Hospital Board:

- BID Milton Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy
- BID Milton Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process

Senior Leadership:

- Richard Fernandez, President - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBAC; participated in prioritization process
- Lynn Cronin, Chief Nursing Officer - participated in prioritization process and provided input on Implementation Strategy
- Dr. Sheila Barnett, Chief Medical Officer - participated in prioritization process provided input on Implementation Strategy

Staff-level Managers:

- Laureane Marquez, Manager of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy
- Maggie Luu Director of Interpreter Services - assisted with language translation, interpretation, and prioritization process
- Melissa Drohan, Social Worker- provided input on Implementation Strategy

BILH Community Benefits Committee (CBC):

- BILH CBC - guided the process for the system

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

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

BID Milton undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of assessments. The assessment was supported by BID Milton's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members, service providers, and other stakeholders that either live in and/or work in BID Milton's CBSA. BID Milton's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: food insecurity and nutrition, housing affordability and home ownership, transportation, workforce development opportunities and financial security.

- How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

BID Milton and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout BID Milton's assessment process, BID Milton worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. BID Milton's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

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

BID Milton's IS includes a diverse range of programs and resources to addresses the prioritized needs within the BID Milton Community Benefits Service Area. The majority of BID Milton's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. BID Milton's strategies include collaborating with many community partners to own, catalyze and/or support total population and community-wide interventions that not only address physical health but also mental health and substance use prevention including the Milton Public Schools, Milton Council on Aging, Enhance Asian Communities on Health (EACH) and the Hale Family YMCA (formerly known as the South Shore YMCA).

II. Community Engagement

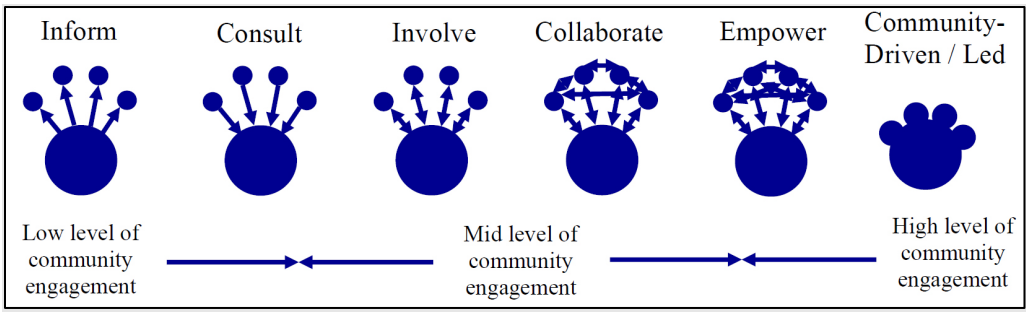
1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
South Shore Elder Services	Tim Carey, Director of Program Development	Social service organizations	South Shore Elder Services (SSES) recommends and coordinates resources for elders to help them to remain as independent as possible. The hospital collaborates with the agency frequently to assist patients in discharge planning and obtaining needed resources and services. SSES assisted BID Milton during the CHNA process to engage with older adults who are either home-bound or with limited transportation by distributing BID Milton's community health survey to their Meals on Wheels clients. SSES has been active participant providing input into the formation of BID Milton's CHNA and IS, especially in how to best address the social determinants of health and aging in place.

Enhance Asian Communities on Health (EACH)	Sara Tan, Executive Director	Other	EACH strives to enhance the health and wellness of families and individuals in the Asian community by providing quality access to information on healthcare options and social services. EACH assisted in expanding BID Milton's community engagement with the Asian community during the CHNA and IS process. EACH was an active participant in distributing BID Milton's community health survey to non-English speaking residents of Quincy and provided translation and interpretation services during a focus group for Asian, non-English speaking community members. EACH has been an active participant on the hospital's CBAC and provided input into the formation of the CHNA and IS especially in how to best address the unmet health needs non-English speakers.
Simon C. Fireman Community	Stephanie Small Executive Director	Housing organizations	BID Milton collaborates with Simon C. Fireman community in providing funding and nutrition education to older adults who are low-resourced. Simon C. Fireman Community assisted BID Milton in community engagement efforts by distributing and collecting the hospital's community health survey during the CHNA process.
Milton Health Department	Caroline Kinsella, Health Director	Local health department	BID Milton engages with the Milton Health Department on a number of programs, including the Milton Coalition in which the hospital is an active member, collaborating on programming aimed at addressing youth substance use and mental health needs. Additionally, BID Milton collaborated with the Health Department to assess the health needs of the community. The Health Department participated in a key informant interview and helped facilitate a focus group of Milton youth, assisting the hospital to capture further data to inform the CHNA and IS.

2. Level of Engagement Across CHNA and Implementation Strategy

   Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community.



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

A. Community Health Needs Assessment

Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Empower	Goal was met.	Collaborate
Collecting data	Empower	Goal was met – BID Milton built capacity for community residents to co-facilitate/facilitate focus groups and breakout sessions during listening sessions.	Collaborate
Defining the community to be served	Collaborate	Starting several months before launching the CHNA, BID Milton worked with its CBAC to identify the community, those to be engaged and ways to engage them.	Collaborate
Establishing priorities	Empower	Working with BILH, BID Milton actively engaged with the CBAC and the community to identify and select priorities.	Collaborate

[1]

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

  BILH and BID Milton are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

B. Implementation Strategy

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal met – community listening sessions with breakout sessions facilitated by community members, with active CBAC engagement in prioritization discussions and decisions.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Inform	Goal met – FY 2022 was the last year of BID Milton's FY 2020 – 2022 Implementation Strategy (IS) and its CBAC was informed regarding how CB resources were allocated. BID Milton will collaborate with its CBAC to select programs to invest its resources in for the FY 2023 – 2025 IS.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of BID Milton's FY 2020-2022 Implementation Strategy (IS). BID Milton will be collaborating with the community on new and existing programs for its FY 2023-2025 IS.	Collaborate
Evaluating progress in executing Implementation Strategy	Involve	Goal met - BILH and BID Milton held multiple evaluation workshops to build evaluation and data capacity of community organizations, CBAC members and community residents.	Collaborate
Updating Implementation Strategy annually	Inform	Goal met – FY 2022 was the last year of the current FY2020-2022 IS. BILH and BID Milton are working to develop, track and share data on a routine basis with the CBAC.	Collaborate

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

  Click or tap here to enter text.

3. Opportunity for Public Feedback

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

   BID Milton has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. BID Milton engaged with the leadership team and the community to identify and select priorities for the new (FY2023-2025) IS. The IS was shared with the CBAC, the leadership team, adopted by the Board of Trustees and widely distributed.

4. Best Practices/Lessons Learned

   The AGO seeks to continually improve the quality of community engagement.

   - What community engagement practices are you most proud of? (150-word limit)

     BID Milton is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. BID Milton is proud of their collaboration with these and other organizations that allowed BID Milton to engage with hard-to-reach cohorts. BID Milton is particularly proud of how it was able to reach community members who had not previously been engaged.

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

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

III. Regional Collaboration

1. Is the hospital part of a larger community health improvement planning process?
   ☒Yes ☐No

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

  For its FY 2022 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals, including BID Milton, encompassing 49 municipalities and six Boston neighborhoods. While BID Milton focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing the significant health disparities and barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.

- Collaboration:
  BID Milton worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals. In addition, BID Milton collaborated with Signature Healthcare Brockton hospital on engaging the community of Randolph for both hospital's needs assessments. The hospitals hosted a community listening session engaging with residents of Randolph.

- Institutions involved:
  - Anna Jaques Hospital
  - Beth Israel Deaconess Hospital - Milton
  - Beth Israel Deaconess Hospital - Needham
  - Beth Israel Deaconess Hospital - Plymouth
  - Beth Israel Deaconess Medical Center
  - Beverly and Addison Gilbert Hospitals
  - Lahey Hospital and Medical Center
  - Mount Auburn Hospital

- New England Baptist Hospital
- Winchester Hospital

- Brief description of goals of the collaboration:
  BID Milton collaborated with the other 9 hospitals in the BILH system to add rigor to the hospitals' assessments and planning processes, promoting alignment across hospital efforts and strengthening relationships between and among BILH hospitals, community partners and the community-at-large.

- Key communities engaged through collaboration:
  BID Milton collaborated with the other 9 hospitals in the BILH system to engage the 49 municipalities and six Boston neighborhoods who were part of the individual Community Benefits Service Areas from each of the licensed hospitals.

- If you did not participate in a collaboration, please explain why not:
  Click or tap here to enter text.