Appendix D: Summary Implementation Strategy

Beth Israel Deaconess–Milton
Implementation Strategy
2020 - 2022

Between October 2018 and April 2019, Beth Israel Deaconess–Milton (BID–Milton) Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) that included an extensive review of existing quantitative data as well as the collection of qualitative information through interviews, focus groups and community meetings. A resource inventory was also completed to identify existing health-related assets and service gaps. During this process, the Hospital made substantial efforts to engage administrative and clinical staff at the Hospital (including senior leadership) and community health stakeholders throughout the Hospital's community benefits service area. A detailed review of the CHNA approach, data collection methods, and community engagement activities are included in Appendix A of BID–Milton's 2019 CHNA Report.

Once BID–Milton's CHNA activities were completed, the Hospital's Community Benefits (CB) Program staff convened the BID–Milton Community Benefits Advisory Committee (CBAC) and the Hospital's Community Benefits Senior Leadership Team (CBSLT) and conducted a series of strategic planning meetings. These meetings allowed Hospital staff and a representative group of external community health stakeholders to review the quantitative and qualitative findings from the CHNA, prioritize the leading community health issues, identify segments of the population most at-risk (Priority Populations), review existing community benefits programming, and begin to develop the Hospital's 2020 – 2022 Implementation Strategy (IS). After these strategic planning meetings, the Hospital's CB Staff continued to work with the CBAC, CBSLT, and other community partners to develop draft and final versions of BID–Milton's 2020-2022 Implementation Strategy.

CORE IS PLANNING PRINCIPLES AND STATE PRIORITIES

In developing the IS, care was taken to ensure that BID–Milton's community health priorities were aligned with the Commonwealth of Massachusetts priorities set by the Commonwealth's Department of Public Health (MDPH). The table below outlines the four Community Benefit focus issues identified by MDPH and the Executive Office of Health and Human Services. In addition to the four focus issues, MDPH identified six health priorities to guide investments funded through the Determination of Need Process. The Massachusetts Attorney General's Office encourages hospitals to consider these priorities in the Community Benefits planning process.

Also included below is a brief discussion of a series of guiding principles that informed the Hospital's IS development process.

State Community Health Priorities

Community Benefits Priorities	Determination of Need Priority Areas
Chronic disease with a Focus on Cancer, Heart Disease, and Diabetes	Built Environment
Housing Stability/Homelessness	Social Environment
Mental Illness and Mental Health	Housing
Substance Use Disorders	Violence
	Education
	Employment

The following are a range of programmatic ideas and principles that are critical to community health improvement and have been applied in the development of the IS provided below.

- **Social Determinants of Health:** With respect to community health improvement, especially for low income and disadvantaged populations, there is growing appreciation for the importance of addressing the underlying social determinants of health, "the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities."[1] The leading social determinants of health include issues such as poverty, housing, food access, violence, racism/bigotry, and transportation. It is important that hospital implementation strategies include collaborative, cross-sector initiatives that address these issues.

- **Health Education and Prevention:** Primary prevention aims to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aims to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared to

[1] O. Solar and A. Irwin, World Health Organization, "A Conceptual Framework for Action on the Social Determinants of Health," Social Determinants of Health Discussion Paper 2 (Policy and Practice), 2010, available at http://www.who.int/social_ determinants/corner/SDHDP2.pdf.

helping people to manage health conditions, lessen a condition's impact, or slow its progress. Targeted efforts across the continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

- **Screening and Referral:** Early identification of those with chronic and complex conditions following by efforts to ensure that those in need of education, further assessment, counseling, and treatment are critical to preventing illness before it takes hold or managing illness so as to lessen or slow its impacts. A critical component of screening and referral efforts is taking steps to ensure that people are fully engaged in treatment, including linkages to a primary care provider.

- **Chronic Disease Management:** Learning how to manage an illness or condition, change unhealthy behaviors, and make informed decisions about your health can help you live a healthier life. Evidence-based chronic disease management or self-management education (SME) programs, implemented in community-based setting by clinical and non-clinical organizations, can help people to learn skills to manage their health conditions, improve eating and sleeping habits, reduce stress, maintain a healthy lifestyle.

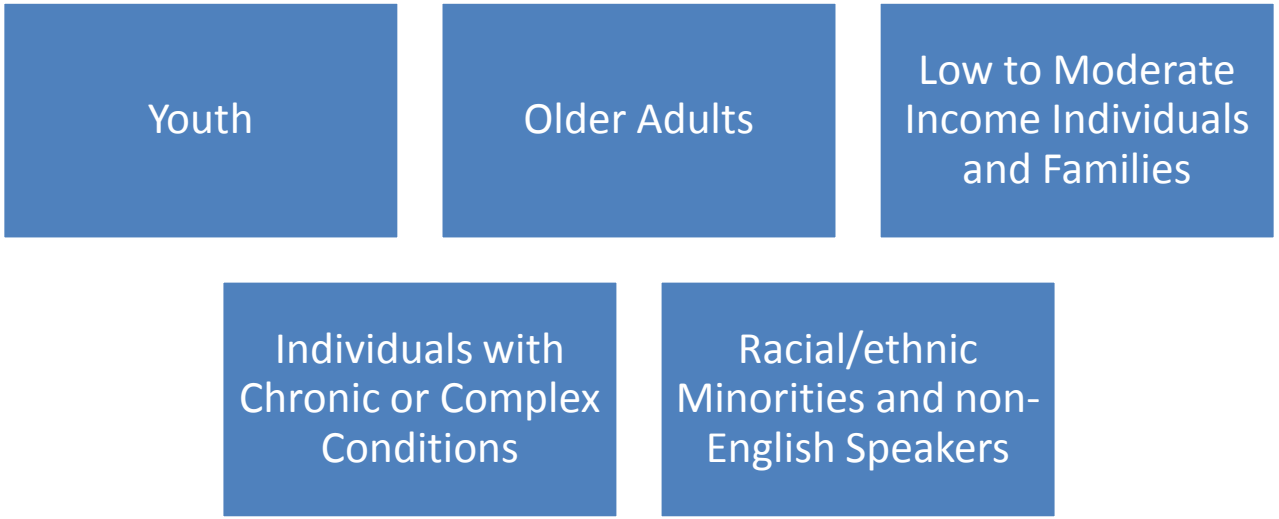
- **Care Coordination and Service Integration:** Efforts to coordinate care and integrate services across the health care continuum are critical to community health improvement. These efforts involve bringing together providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care.

- **Patient Navigation and Access to Health Insurance:** One of the most significant challenges that people face in caring for themselves or their families across all communities is finding the services they need and navigating the health care system. Having health insurance that can help people to pay for needed services is a critical first step. The availability of Insurance enrollment support, patient navigation, and resource inventories are important aspects of community health improvement.

- **Cross-sector Collaboration and Partnership:** When it comes to complex social challenges, such as community health improvement, there is a clear consensus that success will only be achieved through partnership and collaboration across organizations and health-related sectors. No one organization or even type of organization can have a sustained impact on these types of issues on their own. Hospital implementation strategies need to be collaborative and include partnerships with service providers across multiple sectors (e.g., health, public health, education, public safety, and community health)

COMMUNITY HEALTH PRIORITY POPULATIONS AND NEEDS

BID–Milton is committed to improving the health status and well-being of all residents living throughout its service area. Certainly all geographic, demographic, and socioeconomic segments of the population face challenges of some kind that can hinder their ability to access care or maintain good health. Regardless of age, race/ethnicity, income, family history, or other characteristics, everyone is impacted in some way by health-related risks. With this in mind, BID–Milton's IS includes activities that will support residents throughout its service area, across all segments of the population.



However, based on the assessment's quantitative and qualitative findings there was broad agreement that BID–Milton's IS should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health that put them at greater risk. More specifically, the assessment identified youth, older adults, low to moderate income populations, individuals with chronic/complex conditions and immigrants non-English speakers as priority populations that deserve special attention.

BID-Milton's CHNA approach and process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the Hospital's Community Benefit staff, along with the CBAC, CBSLT, and other stakeholders identified three community health priority areas, which together embody the leading health issues facing residents living in BID–Milton's Community Benefit Service Area. These three strategic domains are: 1) Mental Health and Substance Use, 2) Chronic/Complex Conditions and Risk Factors, and 3) Social Determinants and Access to Care.

Community Health Needs not Prioritized by BID-Milton's CBAC

It is important to note that there are community health needs that were identified by BID-Milton's assessment that, due to the limited burden that these issues present and/or the feasibility of having an impact in the short- or long-term on these issues, were not prioritized for investment. Namely, workforce development and education were identified as community needs but these issues were deemed by the CBAC and the CBSLT to be outside of BID-Milton's primary sphere of influence and have opted to allow others in its CBSA and the Commonwealth to focus on these issues. This is not to say that BID-Milton will not support efforts in these areas. BID-Milton remains open and willing to work with hospitals across Beth Israel Lahey Health's network and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

The following is BID-Milton's Implementation Strategy and provides details on BID-Milton's goals, priority populations, objectives, strategic activities, and measures of performance by priority area. Also included, is a listing of the state priorities that align with the activities included in the IS as well as a listing of the core partners that BID-Milton has been and will continue to work with to implement these activities. With respect to the core community partners listed, this is certainly not a complete list but rather many of its core partners. BID-Milton collaborates and partners with dozens of public and private service providers, community-based organizations, and advocacy organizations spanning all sectors and CBSA communities. BID-Milton is extremely appreciative of the efforts of all of its partners and looks forward to expanding this list as it implements its community benefits and IS activities in the years to come.

I. Community Health Priorities

Priority Area 1: Mental Health and Substance Use

Brief Description: As it is throughout the Commonwealth and the nation, the burden of mental and substance use on individuals, families, communities and service providers in BID–Milton's service area is overwhelming. Nearly every key informant interview, focus group and community meeting included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, social isolation, opioids, alcohol, and e-cigarette/vaping were the leading issues in this domain. Despite increased community awareness and sensitivity about the underlying issues and origins of mental health and substance use issues, there is still a great deal of stigma related to these conditions. There is a general lack of appreciation for the fact that these issues are often rooted in genetics, physiology and environment, rather than an inherent, controllable character flaw. There is, however, a deep appreciation and a growing understanding for the role that trauma plays for many of those with mental and/or substance use issues, with many people using illicit or controlled substances to self-medicate and cope with loss, stress, abuse, pain, and other unresolved traumatic events.

Resources / Financial Investment: BID–Milton will commit direct, community health program investments, and in-kind resources of staff time and materials. BID–Milton will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners.

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies
Address stigma associated with mental health and substance use Issues	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions • Immigrants and non-English speakers	• Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health • Reduce the stigma associated with mental illness/ mental health and substance use/misuse, and addiction	• Organize **Mental Health First Aid** trainings in targeted community-based settings to raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use • Provide **Community Health Grants** to local departments of Health or other community-based partners to support evidence-based programs that promote mental health and substance use education and prevention • Organize **Mental Health and Substance Use Support Groups** for those with or recovering from mental health or substance use and their family/friends/caregivers to raise awareness, reduce stigma, educate, and promote coping/recovery • Support **Community-based Health Education Events** with community partners to raise awareness, and educate on risk/protective factors, and services available in the community
Enhance access to mental health and substance use screening, assessment, and treatment services	• Youth • Adults • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions • Immigrants and non-English speakers	• Promote cross-sector partnership, collaboration, and information sharing across the broad health system to address access to mental health and substance use services • Increase access to clinical and non-clinical support services for those with mental health and substance use issues, with an emphasis on priority populations • Increase access to Peer Support Groups for those with mental health and substance use and their family, friends, and caregivers	• **Participate in task forces and coalitions** to promote collaboration, share knowledge, and coordinate community health improvement activities • Support the **Interface Mental Health Hotline,** which provides education and referral services for those seeking mental health counseling services • Support efforts to develop **Integrated Behavioral Health Services (mental health and substance use) in Primary Care and Other Specialty Care Settings** (Impact Model) for those with or at-risk of mental health issues, including screening, assessment, and treatment • Explore **Partnerships with Elder Service Providers to Promote Care Coordination and Reduce Isolation** that reach out to and serve isolated older adults not currently engaged in Council on Aging activities • Explore partnerships with Local Health Departments, substance use providers, and BID-Milton departments to implement **Peer Recovery Coach Programs** geared to linking those with substance use/misuse issues to peer recovery coaches who provide recovery, case management, and navigation support

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies
		• Reduce inappropriate use of ED and other acute care services • Increase access to screening, education, referral, and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and non-clinical settings, with an emphasis on priority populations • Increase access to insurance, patient navigation support, and other enabling/ supportive services for those with mental health and substance use issues, with an emphasis on priority populations • Increase access to peer recovery coaches for those with substance use/misuse issues • Reduce elder health isolation and depression • Provide support to ncrease the number of practice settings with integrated behavioral health and primary care/specialty care services	• Support efforts to develop a **BID-Milton Bridge Program** for those suffering from substance use disorder that screens, identifies, assesses, initiates treatment, and links participants to long-term SUD services in the community

Priority Area 2: Chronic and Complex Conditions and Their Risk Factors

Brief Description: While mental health and substance use were perceived to be the leading issues in BID–Milton's service area, one cannot lose sight of the fact that heart disease, stroke and cancer are the leading causes of death in the nation and the Commonwealth. Roughly, 6 in 10 deaths may be attributed to these three conditions combined. If you include respiratory disease (e.g., asthma, COPD) and diabetes, which are in the top 10 leading causes across all geographies, then one can account for the vast majority of causes of death. All of these conditions are typically considered to be chronic

and complex and can often strike early in one's life, quite often ending in premature death. Within this priority area, according to those who participated in interviews, focus groups, the community meeting, and the Community Health Survey, cardiovascular disease, cancer, diabetes, and Alzheimer's disease and other dementias were thought to be of the highest priority. It is also important to note that the risk factors for nearly all chronic/complex conditions are much the same, including lack of physical activity, poor nutrition, obesity, tobacco use, and alcohol use.

Resources / Financial Investment: BID–Milton will commit direct, community health program investments, and in-kind resources of staff time and materials. BID–Milton will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners.

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies
Enhance Access to Health Education, Screening, Referral, and Chronic Disease Management Services in Clinical and Non-Clinical Settings	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions • Immigrants and non-English speakers	• Increase the number of people who are educated about chronic disease risk factors and protective behaviors • Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services for diabetes, hypertension, asthma, cancer, and other chronic/ complex conditions • Increase the number of people with chronic/complex conditions whose conditions are under control	• P**articipate in task forces and coalitions** to promote collaboration, share knowledge, and coordinate community health improvement activities • **Organize BID-Milton "Lecture Series"** in community-based settings related to awareness, education, and the management of chronic and complex conditions • Provide **Wellness, Fitness Education and Other events** as part of comprehensive chronic disease management program • Provide evidence-based **health education on risk/protective factors, and Self-Management Support Programs** through partnerships with community-based organizations with an emphasis on Priority Population Segments • Support **screening, education, and referral Programs** in clinical and non-clinical settings that screen, educate, and refer patients in need of further assessment and chronic disease management supports • Provide **Community Health Grants** to community partners to support evidence-based programs that promote health education, screening, referral, and chronic disease management for priority populations
Reduce the prevalence of vaping/tobacco use	• Youth • Adults • Older Adults • Low to Moderate	• Increase the number of people who quit smoking cigarettes, vaping, or using e-cigarettes • Increase access to tobacco, vaping/e-cigarette cessation programs	• Organize, facilitate, or support ***Smoking Cessation Programs*** geared to reducing tobacco, vaping and e-cigarette use

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies
	Income Populations • Individuals with Chronic/ Complex Conditions		

Priority Area 3: Social Determinants and Access to Care

Brief Description: A dominant theme from the assessment was the tremendous impact that underlying social determinants of health, particularly access to affordable housing, transportation, poverty/employment, and food insecurity have on the entire population. The social determinants of health are often the drivers or underlying factors that create or exacerbate mental health issues, substance misuse, and chronic/complex conditions. These social determinants of health, particular poverty, underlie the access to care issues that were prioritized in the assessment: navigating the health system (including health insurance), chronic disease management, and access to culturally and linguistically competent care.

Resources / Financial Investment: BID–Milton will commit direct, community health program investments, and in-kind resources of staff time and materials. BID–Milton will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners.

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies
Enhance access to care and reduce the impact of social determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase partnerships and collaboration with social service and other community-based organizations • Increase educational opportunities related to the importance and impact of social determinants • Decrease the number of people who struggle with financial insecurity/rent insecurity	• Community Benefit and other Hospital staff p**articipate in coalition and 0ther Community Meetings** to promote collaboration, share knowledge, and coordinate community health improvement activities • Provide **Community Health Grants** to community partners to support evidence-based programs that address social determinants and access to care **(e.g., Quincy Community Action Program)** • Organize **Fresh Truck Outings Program** to provide fresh, locally-grown produce to low to moderate income, underserved populations • Support the **Blessings in a Backpack Program** in school-based settings to promote food access and nutrition exercise for low to moderate income families

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies
	• Immigrants and non-English speakers	• Increase access to low cost healthy foods with an emphasis on priority population segments • Increase access to affordable, safe transportation options with an emphasis on priority population segments • Increase the number of people assisted with insurance and other public program enrollment, and patient navigation • Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports	• Support the **Grocery Shopping Tours Program** to provide nutrition education and food access to low and moderate income populations living in public housing, Councils on Aging, and other community venues • Organize **Wellness and Nutrition Education events** in partnership with community partners targeting older adults, low to moderate income individuals and families, and those at-risk of chronic disease • Enhance access to healthy food for older adults and low to moderate income individuals and families • Provide **Enrollment Counseling/ Assistance and Patient Navigation Support Services** to uninsured or underinsured residents to enhance access to care • Provide **Linguistically and Culturally Appropriate Health Education and Care Management Support** though targeted community events for those with or identified as at-risk of chronic/ complex conditions with an emphasis on priority populations • Explore **Transportation Access Partnerships** with regional transportation partners and other community partners to enhance access to affordable, safe, accessible transportation options •
Promote independence and "Aging in Place"	• Older Adults	• Reduce fear of falling • Reduce Falls • Increase activity levels • Reduce preventable Emergency Department and inpatient visits • Increase the number of older adults living independently in their homes	• Support **Safety at Home Program** for older adults to promote aging in place and reduce falls • Organize **Matter of Balance workshops** for priority populations