Community Benefits Report

Fiscal Year 2020

Beth Israel Lahey Health

Beth Israel Deaconess Plymouth

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SECTION I: SUMMARY AND MISSION STATEMENT

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

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

The mission of BID Plymouth is to serve our patients compassionately and effectively, and to create a healthy future for them and their families. BID Plymouth's mission is supported by its commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect and collaboration; and a commitment to maintaining financial health. Serving the Greater Plymouth region, the hospital collaborates with community leaders, public and private agencies and businesses. Together, we provide health promotion, health protection, health education and preventive services to meet the broad range of our community's health and wellness needs, identified through community feedback and formal community needs assessments. Service to community is at the core and an important part of our mission. BID Plymouth founders made a covenant to care for the underserved in their service area, attend to unmet needs, and address disparities in access to care and health outcomes. BID Plymouth's commitment to this covenant and the people we serve remains steadfast today.

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

More broadly, BID Plymouth's Community Benefits mission is fulfilled by:

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

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

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

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

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

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

Name of Target Population

BID Plymouth's Community Benefits Service Area (CBSA) includes Plymouth, Kingston, Carver and Duxbury. BID Plymouth FY 2019 Community Health Needs Assessment's (CHNA) findings, on which this report is based, clearly show that low income, older adults, youth and adults with chronic or behavioral health conditions in BID Plymouth's Service Area face the greatest health disparities and are most at-risk. As a result, these towns have been identified and prioritized as the focus for community health efforts. Collectively, these geographic, demographic, and socio-economic population segments are BID Plymouth's priority populations.

Basis for Selection

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

Key Accomplishments for Reporting Year

The accomplishments highlighted in this report are based upon priorities identified and programs contained in BID Plymouth's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS). Despite COVID, many of these programs were able to meet their goals.

Key Accomplishments include the following:

- BID Plymouth's ACCESS Program enrolled ten new HIV clients and six into case management services. Many of the services/appointments pivoted to a virtual platform due to the COVID-19 pandemic.
- BID Plymouth partnered with Brewster Ambulance to provide flu shots to the residents of the Plymouth Area Coalition for the Homeless. A total of 28 people received the vaccination (12 adults, 10 children and six staff).

- BID Plymouth partnered with the Plymouth Center for Active Living, Plymouth Philharmonic, South Shore Chamber of Commerce, Old Colony Elder Services and the Town of Plymouth to declare September 16 as Senior Appreciation Day. The goal was to recognize seniors who are feeling isolated, depressed and left out due to the COVID-19 pandemic. The Philharmonic played outside four of the low income senior housing complexes. The day was filled with music, prizes, and a formal declaration. To gauge whether the event was successful, senior completed an evaluation and recorded that the day helped make them feel appreciated and not so alone.
- BID Plymouth's Cancer Center screened 374 cancer patients to evaluate any psychosocial and financial support needed and helped them complete forms for grant applications. Thirty six people were provided funds from a variety of organizations.
- BID Plymouth's Behavioral Health Integration Initiative provided access and treatment of depression in outpatient primary and specialty practices and were able to decrease depression scores by 54%, from intake to discharge.
- The Greater Plymouth Area Transportation Consortium, also known as the Transportation Pilot Program (TPP), consists of a group of 17 Human Services Agencies, including BID Plymouth, is a replication of a successful pilot program providing ride hailing services to qualified users at no or low cost to their medical appointments when public transportation is not available. BID Plymouth funded fifty percent of the rides for eligible adults (48 rides for 60 plus years and older, and 164 rides for individuals with disabilities) to their medical appointments when public transportation wasn't available, the other fifty percent was funded through a variety of resources and grants.

Plans for Next Reporting Year

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

- Social Determinants
- Access to Care
- Chronic Disease Management and Prevention
- Behavioral Health (Mental Health and Substance Use)

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BID Plymouth's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which

underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

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

BID Plymouth partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses.

Community Partners

Community Health Network Area (CHNA 23)
Duxbury Council on Aging
Harbor Community Health Center
Healthy Plymouth
High Point Treatment Center
Old Colony Elder Services
Old Colony YMCA
Plymouth Center for Active Living
Plymouth Public Schools
South Shore Community Action Council
Town of Plymouth
United Way of Greater Plymouth County
South Shore Chamber of Commerce

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the BID Plymouth Community Benefits team completed a hospital self-assessment form (Section VII, page 45). BID Plymouth's Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in BID Plymouth's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)

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

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

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

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

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

FY20 Community Benefits Advisory Committee Meetings

January 30
April 23 – cancelled due to COVID
June 22

September 16 (Public Meeting)
December 10

Community Partners
BID Plymouth recognizes its role as a community hospital belonging to a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BID Plymouth's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BID Plymouth's staff, its health and social service partners, and the community at-large. BID Plymouth's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BID Plymouth's mission.

These community partners have been a vital part of BID Plymouth's community health improvement strategy. Historically, BID Plymouth has relied heavily on its community partners, as well as a number of other key community health partners, to implement its Community Benefits initiatives. In this regard, BID Plymouth has leveraged its community partners' expertise and the vital connections that these organizations have with the residents and other community-based organizations that operate in the communities they serve.

BID Plymouth is an active participant in Healthy Plymouth and CHNA 23. Joining with such grass-roots community groups and residents, BID Plymouth strives to create a vision throughout BID Plymouth's community service area's health improvement. Another important partnership is BID Plymouth's involvement with the Greater Plymouth Area Transportation Consortium that provides no or low cost ride hailing services to qualified users to their medical appointments when public transportation is not available.

Organization	Name and Title of Key Contact	Brief Description of Engagement	Level of Engagement
Plymouth Center For Active Living (PCAL)	Michelle Bratti, Director	To help with seniors' increased depression and isolation during COVID, the hospital partnered with PCAL and other local non-profits to bring classical music to four low-income senior housing complexes. Musicians played outside of each complexes and residents opened their windows to listen. We asked the Town of Plymouth to deem each September 16 Senior Appreciation Day and they have officially declared it.	Collaborate
CHNA 23	Michael Jackman, Chair	BID Plymouth has received funding from CHNA 23 to create a healthy community cookbook. They also provided funds to the Behavioral Health program.	Empower

Outreach, Inc.	Jeff Stone, fundraiser and volunteer coordinator for the Food Packaging Event	For the second year in a row, BID Plymouth helped fund the annual food packaging event that provides ready-made meals to the food insecure (all the food pantries located on the South Shore) during COVID. This year, they met their goal of providing 1,000,000 packaged meals.	Community Driven
Healthy Plymouth	Malissa Kenney, Director	As one of the founding members of Healthy Plymouth, BID Plymouth is helping to support Healthy Plymouth with becoming a 501c3 so that they may become a self-sustaining organization with fundraising capabilities. BID Plymouth continues to provide a nutritionist to deliver programming at Healthy Plymouth events to engage low-income, vulnerable populations and educate them about healthy choices.	Collaborate

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

The following is a comprehensive listing of the community partners with which BID Plymouth joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 45).

Community Partners

AD Makepeace
American Heart Association
Anchor House, Inc.
Bay State Community Services, Inc.
Beth Israel Deaconess Medical Center
BID Plymouth Community Business Partners (approximately 69 businesses)
Boston Public Health Commission-Ryan White Part A
Boston Medical Center
Bourne Substance Use Coalition
Cape Cod Canal Region Chamber of Commerce
CleanSlate Centers
Column Health
Community Health Network Area (CHNA 23)

Department of Public Health
Duxbury Council on Aging
Father Bill's and Mainspring
Gosnold
Greater Attleboro-Taunton Regional Transit Authority (GATRA)
Greater Plymouth Food Warehouse
Habilitation Assistance Corp
Harbor Community Health Center
Health Imperatives, Inc.
Health Resource & Services Administration (HRSA)-Ryan White Part C
Healthy Plymouth
High Point Treatment Center
Massachusetts Department of Public Health
Massachusetts Department of Public Health Pediatric Palliative Care Network
McLean Hospital
National Alliance on Mental Illness of Massachusetts (NAMI Mass)
Old Colony Elder Services
Old Colony Planning Council
Old Colony YMCA
Plymouth Area Chamber of Commerce
Plymouth Area Community Television (PACTV)
Plymouth Community Outreach
Plymouth Community Outreach HOPE
Plymouth Community Outreach HUB
Plymouth Council on Aging
Plymouth County District Attorney's Office
Plymouth Family Network
Plymouth Lions Club
Plymouth Police Department
Plymouth Public Schools
Plymouth Resource Center
Plymouth Sherriff's Office
Plymouth Youth Development Collaborative (PYDC)
Red Cross Blood Drive
Region V Massachusetts DPH Bio-Terrorism Committee
Rotary Club of Plymouth
Schwartz Center Rounds
Sodexo
South Shore Community Action Council
Terra Cura, Inc.
To The Moon and Back
Town of Plymouth
United Way of Greater Plymouth County
Village at Duxbury
Wildlands Trust
Zion Lutheran Church Associates
Boys & Girls Club of Plymouth
Boys & Girls Club of Brockton
Office of Adolescent Health and Youth Development

Signature Healthcare / Brockton Hospital
South Shore Chamber of Commerce

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Approach and Methods

The FY19 CHNA was conducted in three phases, which allowed BID Plymouth to:

- Compile an extensive amount of quantitative and qualitative data;
- Engage and involve key stakeholders, BID Plymouth clinical and administrative staff, and the community at-large;
- Develop a report and detailed strategic plan, and;
- Comply with all Commonwealth Attorney General and Federal IRS Community Benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, and four community forums.

The assessment and planning process began with the creation of a Steering Committee comprised of representatives from BID Plymouth, Beth Israel Deaconess Medical Center (BIDMC) in Boston, and the other BID affiliate hospitals (BID-Milton and BID-Needham). These organizations worked together to ensure that a uniform, collaborative, transparent, and robust assessment and planning process was applied across the BID hospital system. In October 2018, the Steering Committee hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to support their efforts and to

work with them to complete the CHNA and IS. Next, BID Plymouth formed a Community Benefits Advisory Committee (CBAC), made up of community benefits staff, administrative and clinical staff, and representatives from the Board of Directors, local service providers, and key community stakeholders. This group met four times over the course of the assessment; they provided input on the assessment approach, vetted preliminary findings, and helped to prioritize the community health issues and priority populations. The hospital also formed a Community Benefits Leadership Team (CBLT) made up of key hospital leadership and staff. In addition, the CHNA was discussed at the Hospital's Senior Leadership Team (SLT) meetings. The Steering Committee, CBAC, CBLT, and SLT reviewed the CHNA report and the subsequent IS before it was submitted to the Board of Directors for approval.

Substantial efforts were taken to ensure that the assessment included efforts to engage community residents, local public health officials, and other community stakeholders. The assessment was completed in three phases. Below is a summary of the activities that were associated with each phase of the assessment and planning process.

Phase One involved collection and analysis of quantitative data in addition to qualitative data via key informant interviews and taking inventory of existing community programs.

Phase Two involved engagement activities that included internal and external focus groups with stakeholders; a public meeting with the community and other stakeholders from the CBSA; and dissemination and analysis of a Community Health Survey that captured residents' perceptions of barriers to good health and leading health issues, and opportunities for the hospital to improve the services they offer to the community.

Phase Three involved meetings with the BID Plymouth's CBAC (including members of the Board of Directors), CBLT, and SLT to present CHNA findings, prioritize community health issues, identify vulnerable populations, and discuss potential responses; created a catalogue of local organizations and community assets that have the potential to address identified needs; review of evidence-based strategies to respond to identified health priorities; and developed a final CHNA report and IS.

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

The articulation of each specific community's needs (done in partnership between Beth Israel Deaconess Hospital-Plymouth and community partners) is used to inform BID Plymouth's decision-making about priorities for its Community Benefits efforts. BID Plymouth works in

concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BID Plymouth's Community Benefits Plan that is adopted by the Board of Directors.

Summary of FY19 CHNA Key Health-Related Findings

Behavioral Health

- **High rates of Substance Use (e.g., Alcohol, Prescription Drug/Opioids, Marijuana) and Mental Health Issues (e.g., Depression, Anxiety, and Stress).** The burden of mental health and substance use on individuals, families, communities and service providers in BID Plymouth's CBSA is overwhelming. Nearly every key informant interview, focus group and community forum included discussions on these topics. Depression, anxiety/stress, social isolation, opioids, alcohol, and e-cigarette/vaping were the leading issues. 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 however a deep appreciation of and a growing understanding of the role that trauma plays for many of those dealing with mental health/substance use issues.
- **Limited Access to Behavioral Health Services, Particularly for Low Income, Medicaid Insured, Uninsured, and those with Complex, Multi-faceted Issues**. Despite the burden of mental health and substance use on all segments of the population, there is an extremely limited service system available to meet the needs that exist for those with all mild to moderate episodic issues or those with more serious and complex, chronic conditions. Efforts need to be made to expand access, reduce barriers to care (including stigma), and improve the quality of primary care and specialized behavioral health services.

Chronic Disease Management

- **High Rates of Chronic and Acute Physical Health Conditions.** While mental health and substance use were perceived to be the leading issues in BID Plymouths' service area, one cannot ignore that heart disease, stroke and cancer are the leading causes of death in the nation and the Commonwealth. When including respiratory disease and diabetes, one can account for the vast majority of all 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. Considering key informant interviews, focus groups, forums and the Community Health Survey, cardiovascular disease, cancer, diabetes, asthma and Alzheimer's disease and other dementias are believed to be the highest priorities. It's important to note that the risk and protective factors for nearly all chronic/complex conditions are much the same, including lack of physical activity, poor nutrition, obesity, tobacco use and alcohol use.

Social Determinants and Health Risk Factors and Access to Care

- **Social Determinants of Health (e.g., economic stability, education, and community/social context) Continue to Have a Tremendous Impact on The Entire Population:** The dominant theme from the assessment's key informant interviews and community forums was the continued impact that the underlying social determinants of health are having on the entire population of the CBSA. More specifically, determinants such as affordable housing, navigation of the healthcare system, poverty, employment, and food insecurity limit many people's ability to care for their own and/or their families' health. These social determinants of health, particularly poverty, underlie the access to care issues that were prioritized in the assessment: navigating the health systems (including health insurance), chronic disease management, and access to culturally and linguistically competent care.
- **Limited Access to Primary Care Services for Low Income, Medicaid Insured, Uninsured, and Other Vulnerable Populations Facing Health Care Disparities and Barriers to Care.** Despite the fact that Massachusetts has one of the highest rates of health insurance, there are still substantial numbers of low income, Medicaid insured, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical services. Efforts need to be made to expand access, reduce barriers to care.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

CHRONIC DISEASES & COMPLEX CONDITIONS ***ACCESS Program***	
Brief Description or Objective	BID Plymouth's ACCESS HIV/AIDS Program (AIDS Comprehensive Care, Education & Support Services) provides medical care, education, support, medical case management, and medical transportation services to people living with HIV/AIDS in the Greater Plymouth area. In addition to patient care, the program offers HIV education to the community and free and anonymous HIV counseling and testing. Parts A and C funding are received for these services through the Ryan White CARE Act. Part C funding is provided through the U.S. Health Resources and Services Administration (HRSA) for Early Intervention Services. Part A funding is provided through the Boston Public Health Commission (BHPC) for non-medical case management and medical transportation. The ACCESS Program provides primary medical care to HIV/AIDS clients. Care includes physical examinations; adherence and treatment counseling; laboratory testing; immunizations and screening; referrals to

	specialty care and clinical trials; medical nutrition therapy, and medical case management.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Plymouth and Barnstable Counties • **Gender:** All • **Age Group:** Adults • **Race/Ethnicity: All** • **Language: English, Spanish, Portuguese** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☒ Incarceration History ☒ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☒ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Enroll five new clients into medical care (Part C) by September 30, 2020	**Goal met/exceeded:** Enrolled 10 new clients by September 30, 2020.	1	3	Process Goal
Enroll three new clients into case management services (Part A) by September 30, 2020	**Goal met/exceeded:** Enrolled six new clients into case management services by September 30.	1	3	Process Goal
Have three clients complete the "Managing Our Blood Pressure" program by September 30, 2020	**Goal met/exceeded:** Five clients completed the Managing our Blood Pressure program by Sept. 30.	1	3	Process Goal
Ensure 90% of clients are virally suppressed by September 30	**Goal met/exceeded:** 98% were virally suppressed by September 30.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
AIDS Bureau of US Health Resources and Services Administration: approves grants, budget and work plans, which are submitted annually	http://hab.hrsa.gov
Plymouth Resource Center: they refer clients to ACCESS as needed	https://baystatecs.org

BPHC Dental Health Program: we refer our clients to BPHC dental	https://www.bphc.org/whatwedo/infectious-diseases/Ryan-White-Services-Division/Pages/Dental-Services.aspx
Father Bill's and Mainspring: we refer our clients when housing is needed and they refer their clients to ACCESS if needed	https://helpfbms.org
Habilitation Assistance: we use their service to transport our clients to and from appointments	https://hac.center/
Clean Slate helps people suffering from alcohol and substance use: we refer our clients to them and they to ACCESS	https://www.cleanslatecenters.com/plymouth-ma
Harbor Community Health Center: we refer our clients for dental services and primary care; they refer clients to ACCESS for HIV care	https://www.hhsi.us
High Point treats people with substance use disorders and mental illness: we refer clients to them and they refer to ACCESS	http://www.hptc.org
Plymouth Family Planning provides sexual and reproductive health care and other health services: we refer clients to them and they refer to ACCESS	https://healthimperatives.org/repro-health

Contact Information

Ruth Cooper, RN
ACCESS HIV/AIDS Program Director
Beth Israel Deaconess Hospital – Plymouth
rcooper@bidplymouth.org
508-732-8981

CHRONIC DISEASES & COMPLEX CONDITIONS

Cancer Patient Support Services

Brief Description or Objective	A cancer diagnosis often creates financial and emotional stress for patients and families. The Cancer Patient Support Program identifies cancer patients with extreme emotional and financial hardship and matches them with counseling and financial support when possible. This program is free to cancer patients whenever sources of support are available. BID Plymouth provides support for patients and families through a social worker, resource nurse, and nurse navigator. This team provides counseling, support, and works to find resources to help alleviate out-of-pocket expenses typically not covered by insurance. The team may also help to find funding sources to cover the cost of household expenses (e.g., groceries, car payments, heating, and electric). This program also finds resources to promote cancer screenings and education about wellness and prevention to help keep the community healthier and decrease risk factors that are associated with a cancer diagnosis.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Plymouth and Barnstable Counties** • **Gender: All** • **Age Group: Adults, Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

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

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Identify all new patients with barriers to care	**Goal met:** Screened 374 patients for barriers to care, of the 374, 36 were identified and received financial support.	1	3	Process Goal
Provide education to community about cancer through screenings for lung, skin, breast cancer	**Goal partially met:** Held one educational event in the community on Lung Cancer with 10 people in attendance. Due to the COVID-19 pandemic, we cancelled our skin screening and breast cancer awareness events in the community. We continued to educate using social media.	1	3	Process Goal
BID Plymouth partnered with Plymouth Fitness to offer every cancer survivor the option to join the Bridge to Wellness Program. This program is funded through the Cancer Center and helps to build cancer survivors physical strength without risk of injuries	**Goal partially met:** Funded 12 survivors to attend the Bridge to Wellness Program. None reported any injuries. Due to the COVID-19 pandemic, this program was been put on hold.	1	3	Process Goal
Provide three different support groups with 10 individuals in attendance	**Goal met:** 37 patients attended the general support group. 12 attended the Stage 4 support group and 23 attended the caregiver support group. Due to the COVID-19 pandemic, in-person support groups were cancelled. In its place, a newsletter was developed and mailed to support group members. Articles included updates on wellness, featured articles and messages from cancer providers.	1	3	Process Goal
Host the 5th biannual free Women's Health Symposium	**Goal was not met:** Event cancelled due to the COVID-19 pandemic.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Keville Foundation: provides funding directly to BID Plymouth who then distributes to patients that meet criteria	http://www.keville.com/mission/php
Ellie Fund: assists patients with filing applications for breast cancer treatment costs	https://elliefund.org
Joe Andruzzi Foundation: assists patients with filing a request for financial assistance	https://joeandruzzifoundation.org

Contact Information

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CHRONIC DISEASES & COMPLEX CONDITIONS
HouseCalls – Community Health Educational Lectures

Brief Description or Objective	HouseCalls are free community health educational lectures that have been in existence since 2005. Hospital physicians and clinicians volunteer their time to present on a health topic of community interest. The event is one hour and allows for attendees to ask questions. Community Benefits manager collects data through an evaluation that attendees complete at the end of each lecture. The evaluation includes their feedback on the lecture, what other future topics they are interested in hearing about, and how they heard about the lecture (i.e., newspaper, social media). A light dinner or refreshments are available at no cost to the attendee. Programs have included: snoring, and sleep apnea, lung cancer, weight loss surgery, back pain.

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

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

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Provide three to four free community health lectures on a health topic of interest.	**Goal not met** Held one community health lecture on lung cancer. 10 people attended the lecture. All other HouseCalls were cancelled due to the COVID-19 pandemic.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Carver Public Library – location of the HouseCall lecture	https://www.plymouth-ma.gov

Contact Information

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CHRONIC DISEASES & COMPLEX CONDITIONS ***Community Nutrition Program***	
Brief Description or Objective	Community Nutrition emphasizes the delivery of nutrition education and resources for the food insecure and includes people at risk for complex/chronic health conditions, youth, and their families, and those living in poverty.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Plymouth County** • **Gender: All** • **Age Group: Adults, Elderly, Youth** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

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

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
400 youth to receive nutrition-related chronic disease prevention and education	**Goal met/exceeded:** 600 youth received information during the Plymouth Family Network Health Fair (prior to COVID-19).	1	3	Process Goal
Increase education about consumption of fruits/vegetables to 60 individuals	**Goal met:** 60 individuals attended three healthy eating programs. 45 received education and 60 received squash recipes.	1	3	Process Goal

Provide 250 older adults with healthy-aging education	**Goal partially met:** 22 attended two programs. Due to the COVID-19 pandemic, nutritionist was furloughed and therefore was unable to meet goal.	1	3	Process Goal
Provide 300 low-income families with meal planning and prep education	**Goal partially met:** 55 families received this education at the Plymouth Area Coalition and the New Hope Chapel. Due to COVID-19 pandemic, nutritionist was furloughed and therefore was unable to meet goal.	1	3	Process Goal
Donate 250 lbs of food to the Greater Plymouth Food Warehouse	**Goal partially met:** 37 pounds were donated. Due to the COVID-19 pandemic, nutritionist was furloughed and therefore was unable to meet goal.	1	3	Process Goal
Develop a healthy and nutritious cookbook to provide, for free, to targeted populations at educational events	**Goal was not met:** Project delayed due to the COVID-19 pandemic. Will be completed during FY21.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Plymouth Center for Active Living: partner to provide nutrition programs for Plymouth older adults	https://www.plymouth-ma.gov
Plymouth School System: provide nutrition education to youth/children	https://www.plymouth.k12.ma.us/
Women, Infants and Children: provide nutrition education for clients and work together on community events	https://healthimperatives.org/nutrition-assistance-wic/
Mayflower Municipal Health Group: provide nutrition education for their clients	https://www.mayflowerinsurance.com/

Healthy Plymouth: partner to provide and facilitate nutrition programming to youth	https://www.healthyplymouth.org/
Terra Cura: partner to provide nutrition programs in the community	http://www.terracura.org/
Plymouth Area Coalition for Homeless: provide nutritional education to homeless shelter clients and to the food pantry	https://www.plymouthareacoalition.org
Plymouth Recreation: partner to provide nutrition education to Plymouth youth	https://plymouthma.myrec.com/
Plymouth Family Network: partner to provide nutritional education to mom and children	https://www.plymouthfamilynetwork.com/

Contact Information

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ADDITIONAL HEALTH NEEDS

Financial Assistance Program

Brief Description or Objective	BID Plymouth's Financial Assistance Program works with the State to communicate new health coverage plans for the uninsured and enroll those who qualify. Financial counselors screen and enroll patients for MassHealth, Health Safety Net, Medical Hardship and Commonwealth Care.

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

Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase the number of patients placed into entitlement programs from 9,152 to 10,500	**Goal not met:** Enrolled 2,205 into entitlement programs (didn't meet goal due to COVID).	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Mass Dept of Public Health	www.mass.gov/orgs/department-of-public-health
MassHealth	https://www.mass.gov/topics/masshealth
Executive Office of Health and Human Services	www.mass.gov/executive-office-of-health-and-human-services

Contact Information

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ADDITIONAL HEALTH NEEDS ***The Greater Plymouth Area Transportation Consortium (Transportation Pilot Program-TPP)***	
Brief Description or Objective	**The Greater Plymouth Area Transportation Consortium (Transportation Pilot Program - TPP)** The Greater Plymouth Area Transportation Consortium, also known as the Transportation Pilot, consists of a group of 17 Human Services Agencies, including BID Plymouth, is a replication of a successful transportation pilot program in the Attleboro area that provided ride hailing services to qualified users at no or low cost when public transportation was not available. Funds donated by organizations are matched through a state grant (up to 40K limit) to provide defrayed costs of transportation to clients through Uber and LYFT. BID Plymouth has the authority to determine eligibility for rides as part of the TPP and each participating organization may not exceed the number of rides their contribution entitles the organization (based on average ride cost of approximately $21). In 2020, BID Plymouth gave additional funds to extend the program's longevity and usage.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Plymouth** • **Gender: All** • **Age Group: Youth** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

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

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
TPP Pilot - Provides rides to adults age 60 or older and those that are disabled to medical care who do not have any other resources	A total of forty-eight rides were provided, via Uber and Lyft, to eligible adults age 60 or older to their medical appointments. An additional 164 were provided to people with a disability during this reporting period.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
The Greater Plymouth Area Transportation Consortium	N/A

Contact Information

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BEHAVIORAL HEALTH AND SUBSTANCE ABUSE
Integrated Care Initiative

Brief Description or Objective	**Integrated Care Initiative** This initiative is a co-located behavioral health model that embeds licensed clinical social workers in primary care and specialty care settings. They work with the practices primary care providers, an advanced practice nurse practitioner with mental health training, and a psychiatrist to integrate behavioral health screening, assessment, and treatment services into the practices operations. This team has also worked with other community based organizations to

address barriers to access and expand the availability of behavioral health services.

BID Plymouth currently has two social workers and one nurse practitioner, all of whom work under a psychiatrist. BID Plymouth continued this work in FY19 and FY20 and embedded behavioral health clinicians in a growing number of primary care and specialty care practices.

Additionally, in response to the opioid crisis, BID Plymouth added substance use clinicians and a nurse practitioner to its overall initiative and collaborated with Gosnold for Recovery Navigators to provide integrated services in the emergency department. These clinicians collaborate with community treatment providers to address the high number of substance use related cases and provide the right level of care in the emergency setting. With behavioral health services available in the emergency department, patients may begin treatment in this setting rather than delaying treatment until psychiatric beds are available. This immediate access to care often decreases the level of intervention required.

With the hospitals fully integrated system, patients can address medical and behavioral health needs in one location. Medical staff in primary care, specialty care, and the emergency department have on-site access to behavioral health support so that they can provide comprehensive healthcare in a convenient, efficient and cost-effective manner.

In addition, the hospitals behavioral health clinicians collaborate with local schools, law enforcement and other community-based organizations to coordinate care and ensure the community is able to access the needed breadth of educational, outreach, and treatment services to address the ever-increasing substance use issue in BID Plymouth's Community Benefits Service Area.

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

Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Provide access and treatment of depression in outpatient PCP and specialty practices	Provided access to treatment to 623 patients through the ICI Program. 56% decrease in depressive symptoms as captured on the PHQ9 scores of patients who completed the tool upon admission and discharge.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Affiliated Physicians Group (APG): BID Plymouth Partners with APG to provide the ICI program	https://www.bidmc.org

Contact Information

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BEHAVIORAL HEALTH AND SUBSTANCE ABUSE ***Plymouth County Outreach (PCO)***	
Brief Description or Objective	**Plymouth County Outreach (PCO)** PCO is a county-wide initiative reaching 27 communities. PCO is a collaboration of Public Safety Agencies, healthcare providers, and treatment organizations to provide community follow-up after an opioid overdose. Providers created this program to respond to the every-growing number of opiate overdoses by conducting follow-up visits within 24-48 hours after an overdose with an outreach team (plain clothed police officer and a behavioral health professional) to discuss treatment options with the individual and help them engage with a treatment program as soon as possible. This program is not limited to those addicted to opiates, but rather everyone impacted by addiction. BID Plymouth's Chief of Psychiatry is on the Chief Advisory Board and the Director of Social Work provides triage for this program, routing the appropriate care responder to each call.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served: Plymouth and Barnstable Counties** • **Gender: All** • **Age Group: Adults, Elderly, Youth** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

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

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Expand upon PCO services and infrastructure by adding behavioral health resources	**Goal met:** Assisted PCO in recruiting, hiring and training a program coordinator for behavioral health services.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Gosnold: BID Plymouth partners with Gosnold to provide their recovery navigators in the Emergency Department, Med/Surg, and Critical Care to engage and link patients with Substance Use Disorder to treatment	www.gosnold.org
Plymouth County Outreach (PCO): PCO is in partnership with the Police Assisted Addiction Recovery Initiative (PAARI), and BID Plymouth received a grant from South Shore Health to integrate a "team approach" to provide Behavioral Health services to residents of Plymouth County	http://plymouthcountyoutreach.org

Contact Information

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BEHAVIORAL HEALTH AND SUBSTANCE ABUSE
PCO Hope

Brief Description or Objective	PCO Hope offers real-time support to anyone needing help/or information about drug and alcohol addiction through a collaboration with representatives from local treatment centers as well as counselors. In addition to offer support and linkages to treatment, PCO Hope identifies high risk areas, including sober homes and housing developments in conjunction with PCO, for outreach education specific to harm reduction. BID Plymouth's Director of Social Work

	visits these sites with another representative from PCO Hope to discuss strategies and distribute Naloxone.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** • **Gender:** • **Age Group:** • **Race/Ethnicity:** • **Language:** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use

	☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Increase access to 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 emphasis on priority populations	Goal met: 74 people trained in harm reduction strategies, including how to recognize signs of an opioid overdose and how to administer Narcan. 37 Narcan kits distributed. Support pivoted from in-person to a virtual format at drop-in centers due to the COVID-19 pandemic	1	3	Process Goal
Reduce the stigma associated with mental illness/mental health, substance use and addiction	Goal met: A 60 Seconds of Hope campaign and weekly PACTV messages were created to help get the message out to the public. Two awareness campaign in process: one related to substance use and one on emotional wellbeing.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
PCO: works closely with PCO works closely with PCO Hope to identify high-risk areas for outreach education specific to hear reduction	http://plymouthcountyoutreach.org
PACTV: partnered with PACTV to help create the 60 Seconds of Hope Campaign and weekly messages to viewers to help reduce stigma	www.pactv.org
Gosnold: BID Plymouth partners with Gosnold to provide their recovery navigators in the Emergency Department, Med/Surg, and Critical Care to engage and link patients with Substance Use Disorder to treatment	www.gosnold.org

Contact Information

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BEHAVIORAL HEALTH AND SUBSTANCE ABUSE
Project Matter

Brief Description or Objective	In May of 2019 Beth Israel Deaconess Hospital-Plymouth began offering Medication for Opioid Use Disorder (MOUD) to any patient who is brought to the ED that had a Naloxone reversal, is seeking substance use treatment (i.e. detox) or presented with a medical condition related or unrelated to opioid use. To implement the program, ED physicians received additional training and were provided an X waiver to prescribe Suboxone. New clinical pathways were developed including implementation of RODS and COWS scales, and additional resources were secured through grant funding, including Recovery Navigators through a sub-contract with Gosnold. This initiative is funded through Health Policy Commission SHIFT

	Challenge, evaluated by Brandeis University and led internally by Sarah Cloud and Dr. Mendoza.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** • **Gender:** • **Age Group:** • **Race/Ethnicity:** • **Language:** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☒ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use

	☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Provide MOUD to 100% of eligible individuals in BID Plymouth's Emergency Dept.	Goal met: Offered MOUD to 100% of eligible individuals in the ED. Two accepted this type of treatment/pathway to recovery.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Gosnold: BID Plymouth partners with Gosnold to provide their recovery navigators in the Emergency Department, Med/Surg, and Critical Care to engage and link patients with Substance Use Disorder to treatment	www.gosnold.org

Contact Information

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Behavioral Health AND SUBSTANCE ABUSE ***PreVenture Program***	
Brief Description or Objective	**PreVenture (Addiction Prevention Program)** In an effort to address the addiction crisis, BID Plymouth funds the PreVenture program for the Plymouth middle schools. PreVenture is a research-based addiction prevention program targeting personality traits that correlate with increased risk of developing substance use issues. Brief coping skill interventions that target personality risk factors have been tested in randomized controlled trials and have demonstrated benefits that last up to three years. Students that screened for high-risk personality profiles were identified to participate in two 90-minute group workshops. Workshops focused on developing specialized coping skills relevant to: Sensation Seeking; Impulsivity; Anxiety Sensitivity; Negative Thinking. The intervention included psycho-educational approaches, motivational interviewing, and cognitive behavioral components. Students learn how their personality style leads to certain emotional and behavioral reactions. Students received manuals that illustrate scenarios designed by similar teens to promote relevance. The program has proven both feasible and effective when delivered by trained school staff.

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

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

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Complete PreVenture Trainer Certification process while supporting Plymouth Public Schools with Year 3 of workshop facilitation	**Goal met**	1	3	Process Goal
Increase participation of identified [at-risk] youth by 15%-20%	**Goal partially met:** **2019/2020 School year SURPS data:** Total numbers from both schools: 293/552 students identified as high risk and invited to participate in the intervention. That's 53% of Plymouth's 8th grade students identified high risk. The program was put on hold until the fall of 2021 due to the COVID-19 pandemic.	1	3	Process Goal
BID Plymouth will continue to support Plymouth Public Schools with facilitation of PreVenture Program until five-year mark [2022] and/or otherwise identified as independently sustainable	BID Plymouth funded the third year of the PreVenture Program in the Plymouth Middle Schools.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Plymouth Public Schools:	www.plymouth.k12.ma.us

Contact Information

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SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$1,316,308	$26,760
Community-Clinical Linkages	$11,374	$2,000
Total Population or Community Wide Interventions	$27,621	
Access/Coverage Supports	$827,653	$1,000
Infrastructure to Support CB Collaborations	$193,750	
Total Expenditures by Program Type	$2,376,706	
CB Expenditures by Health Need		
Chronic Disease	$445,019	
Mental Health/Mental Illness	$790,319	
Substance Use Disorders	$98,881	
Housing Stability/Homelessness	0	
Additional Health Needs Identified by the Community	$1,042,487	
Total by Health Need	$2,376,706	
Leveraged Resources	$888,315	
Total CB Programming	$2,376,706	
Net Charity Care Expenditures		
HSN Assessment	$1,248,162	
Free/Discounted Care	0	
HSN Denied Claims	$692,629	
Total Net Charity Care	$1,940,791	
Total CB Expenditures	$5,205,812	

Additional Information	
Total Revenue	
Net Patient Services Revenue	$282,750,371
CB Expenditure as % of Net Patient Services Revenue	1.84%
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	$5,412,742
Bad Debt	$1,342,463
Bad Debt Certification	
Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☐ Yes ☒ No
    - If so, please list updates:

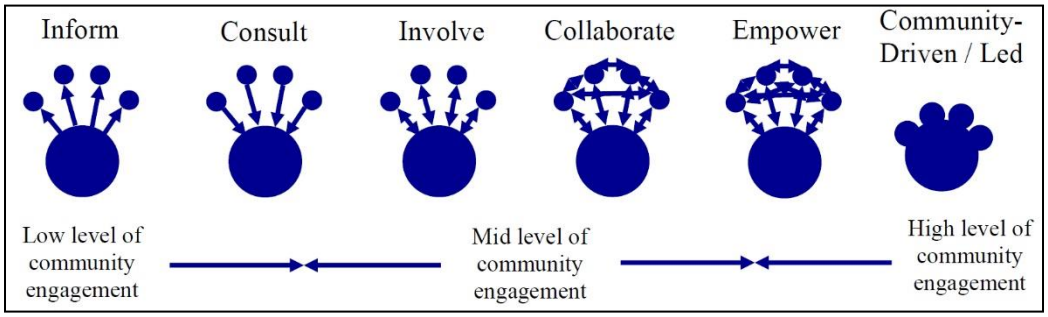
II. Community Engagement:

1. If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Plymouth Center For Active Living (PCAL)	Michelle Bratti, Director	Other	To help with seniors' depression and isolation during COVID, the hospital partnered with PCAL and Plymouth Philharmonic to bring classical music to 4 of the low-income senior housing complexes. Musicians played outside of each complex and residents opened their window to listen. We asked the Town of Plymouth to deem each September 16 Senior Appreciation Day and they have officially declared it.
CHNA 23	Michael Jackman, Chair	Local health community organization that provides grants to local nonprofits for programming that seeks to improve the health of the local communities it serves.	BID Plymouth has received funding from CHNA 23 for its programming in Behavioral Health and Community Nutrition.
Outreach, Inc.	Jeff Stone, fundraiser and volunteer coordinator for the Food Packaging Event	Other	For the second year in a row, BID Plymouth has funded the annual food packaging event that provides 1,000,000 packaged meals to the food insecure (all the food pantries located on the South Shore) during COVID.

Healthy Plymouth	Malissa Kenney, Director	Other	As one of the founding members of Healthy Plymouth, BID Plymouth is helping to support Healthy Plymouth with becoming a 501c3 so that they may become a self-sustaining organization with fund raising capabilities. BID Plymouth continues to provide a nutritionist to deliver programming at Healthy Plymouth events to engage low-income, vulnerable populations and educate them about healthy choices.

2. Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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	The hospital was able to meet most of its goals despite COVID. There were some challenges but we reached out to our community partners and developed creative ways to stay engaged. Many programs moved to virtual while others	Involve

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, *available at*: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

		had to either be cancelled or postponed.	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	BID Plymouth shared its resources dedicated to its Community Benefits programs during the Annual Community Benefits Public meeting.	Involve
Implementing Community Benefits programs	Collaborate	Most of the Community Benefits programs were implemented. There were a few, due to COVID, that were cancelled or still trying to find ways to deliver the program virtually.	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Quarterly, each program overseer sends their program updates to the Community Benefits Manager to monitor the progress.	Empower
Updating Implementation Strategy annually	Involve	BID Plymouth updated its Implementation Strategy and shared those updates with the community at the virtual Community Benefits Public Meeting.	Collaborate

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

  BID Plymouth remains committed to community engagement. During FY20, BID Plymouth undertook its triennial community health needs assessment and prioritization process. Guided by BID Plymouth's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative employed a comprehensive community engagement process. In FY21, BID Plymouth will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, BID Plymouth will engage with our community by sharing updates on the Community Benefits programs via social media or Constant Contact; moving more in-person programs to virtual programming to ensure that the unmet needs of the community continued to be addressed.

3. Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback

on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

Due to COVID, BID Plymouth held a virtual community public meeting in conjunction with its CBAC on September 16. BID Plymouth shared updates to its Implementation Strategy, highlights of its Community Benefits programs and asked for feedback from the community.

III. Updates on Regional Collaboration:

1. If the hospital reported on a collaboration in its **Year 1 Hospital Self-Assessment,** please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

   BID Plymouth along with the Plymouth School System and The Town of Plymouth are founding members of Healthy Plymouth--a collaboration that identifies meaningful ways to stay healthy and combining expertise and resources to bring opportunities for good health to Plymouth. BID Plymouth is supporting Healthy Plymouth to become a 501c3 by hiring a lawyer to manage the process and providing Healthy Plymouth with an off-site office location.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form.**

   Organization: Plymouth County Outreach/HUB
   Key Contact: John Rogers, Vicky Butler
   Org. Focus Area: County-wide Model for Behavioral Health

   Description of Engagement: Plymouth County Outreach (PCO) in partnership with the Police Assisted Addiction Recovery Initiative (PAARI), and Beth Israel Deaconess Leahy Health in Plymouth has received a grant from South Shore Health to integrate a "Team Approach" to provide Behavioral Health Services to residents of Plymouth County.

   This "Team Approach" commonly referred to as the HUB Model was developed and used with great success in Canada as well as the city of Chelsea and sections of Boston. This HUB Model brings together collaborations between Law Enforcement, Behavioral Health providers, and other resources to deal with approximately 24 social determinants that factor into one's behavioral health needs.

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

   As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals

reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.