Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

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SECTION I: SUMMARY AND MISSION STATEMENT

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

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

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

The mission of BID-Plymouth is to help improve the health and wellbeing of our patients and community by providing a full continuum of healthcare services with excellence and compassion. Serving the Greater Plymouth region, the hospital collaborates with community leaders, public and private agencies and businesses to provide health promotion, health protection and preventive services. All are designed to meet the broad range of our community's health and wellbeing, as identified through community feedback and formal community needs assessments. As part of it mission to support community health, BID-Plymouth is committed to assessing root causes of health disparities and to assisting in improving healthcare for the disadvantaged and underserved.

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

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

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

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

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

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

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

Priority Cohorts

BID-Plymouth's CBSA includes Carver, Duxbury, Kingston and Plymouth. In FY 2022, BID-Plymouth conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BID-Plymouth's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BID-Plymouth is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BID-Plymouth's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BID-Plymouth's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in the CBSA were issues related to age, race/ethnicity, language, immigration status, and disability. While the majority of the residents in the

CBSA were white and born in the United States, there were non-white, people of color, recent immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than young, white, English speakers who were born in the United States. Interviewees, focus groups, and listening session participants also identified barriers to care and disparities for individuals with disabilities. These segments of the population were impacted by barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes.

For its FY 2023 – 2025 IS, BID-Plymouth is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.

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

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

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

This report covers BID-Plymouth's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the BID-Plymouth Board of Trustees before September 30, 2019 and informed the BID-Plymouth's Community Benefits initiatives for the fiscal years ending September 30, 2020; September 30, 2021; and September 30, 2022. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2019.

Program accomplishments of the BID-Plymouth FY 2020-2022 Implementation Strategy include:

Mental Health and Substance Use
As a key community partner, BID-Plymouth collaborates with Plymouth County Outreach Hope to proactively provide a safe gateway to substance use information, resources, support and hope for

individuals and their loved ones struggling with mental illness/mental health, substance use and addiction. As a result, 1500 people have been trained to administer Narcan.

BID-Plymouth supports the PreVenture program in the Plymouth Public Schools with an annual $23,000 grant. PreVenture is an evidence-based prevention program that uses personality targeted interventions to promote mental health and skill development and delay youth substance use. School personnel completed PreVenture training and began the curriculum in 2020, but it was put on hold due to COVID until FY22. During this year, a total of seven (7) 90-minute workshops ran in the two middle schools servicing 62 students.

Chronic and Complex Conditions and their Risk Factors
The ACCESS HIV/AIDS Program provides medical care, education, support, medical case management, medical transportation, testing and counseling services to people living with HIV/AIDS in the Greater Plymouth area. During the FY21, 95% of ACCESS clients remained virally suppressed and during FY22 the percentage virally suppressed went up to 97%.

BID-Plymouth's Keep the Beat – Post-Cardiac Program at the Old Colony YMCA provides up to 20 graduates of BID Plymouth's Cardiac Rehab Program the opportunity to attend the 12-week program for free if they are unable to pay.

Social Determinants of Health and Access to Care
BID-Plymouth's Taking People Place (TPP) provided rides to 476 adults ages 60 or older and those that have disabilities and do not have other resources to medical care appointments.

BID-Plymouth's Community Nutrition Program delivers nutrition education and resources for people experiencing food insecurity. The Registered Dietician created 29 different healthy recipes (6 of which included a QR code with a video demonstration) and monthly articles and handouts were distributed to more than 5,000 individuals monthly. In addition, the To Your Health cookbook was created and distributed to 400 low-resourced, older adults and/or individuals at-risk for developing chronic health conditions.

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

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BID-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 FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BID-Plymouth's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BID-Plymouth, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BID-Plymouth's FY2023 – 2025 IS, it will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas. Priority cohorts include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; and individuals with disabilities.

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

- **Equitable Access to Care**
  - BID-Plymouth will continue to support the Enrollment/Counseling Assistance and Patient Navigation Support programs, to uninsured/underinsured patients and increase access to culturally appropriate and responsive care.
  - BID-Plymouth will work towards the formation and integration of a Diversity, Equity, and Inclusion (DEI) Council.

- **Social Determinants of Health**
  - BID-Plymouth will take an active role through the Senior Task Force to secure the Age and Dementia Friendly designations for the Town of Plymouth.
  - BID-Plymouth will continue to work with and support Father Bill's & MainSpring's shelter and outreach programs to address homelessness in the CBSA.
  - BID-Plymouth will work with NeighborWorks Housing Solutions to provide housing support and self-sufficiency within the CBSA.
  - BID-Plymouth will work with the Plymouth County Sheriff's Department to establish an Aquaponics Lab that addresses food insecurity in the community and workforce development for the inmates.

- **Mental Health and Substance Use**
  - BID-Plymouth will provide training for First Responders to identify and intervene around suicide and suicidal ideation.
  - BID-Plymouth will continue to support and be actively involved with Plymouth County Outreach, Plymouth County Outreach Hope and Plymouth County HUB to

address substance use disorder through prevention, intervention and recovery programs.

- **Complex and Chronic Conditions**
    - BID-Plymouth will continue its partnership with the Old Colony YMCA to support the Keep the Beat Post-Cardiac Program for individuals recovering from cardiac surgeries to build their capacity to recover and build healthy habits.
    - BID-Plymouth will work with the Old Colony Elder Services to promote access to chronic disease education and self-management programs.

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BID-Plymouth Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 45). The BID-Plymouth Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BID-Plymouth's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BID-Plymouth's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. Utilizing the integrated resources of the Beth Israel Lahey Health system, BID-Plymouth will deliver the full continuum of healthcare services to the communities of southeastern Massachusetts. BID-Plymouth's Community Benefits Department, under the direct oversight of BID-Plymouth's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BID-Plymouth Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

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

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- ***E****quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

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

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

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

The BID-Plymouth CBAC met on the following dates:

- December 9, 2021
- March 24, 2022
- May 17, 2022
- June 22, 2022
- September 7, 2022

Community Partners
BID-Plymouth's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BID-Plymouth's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. BID-Plymouth's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BID-Plymouth's mission.

BID-Plymouth currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BID-Plymouth collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. BID-Plymouth has a particularly strong relationship with Father Bill's & MainSpring. This relationship includes providing support for seasonal housing and a case worker who provides links to services for those experiencing homelessness in the greater Plymouth area.

The following is a comprehensive listing of the community partners with which BID-Plymouth collaborated with on its FY 2020 – 2022 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 45).

Algonquin Heights
American Heart Association
Anchor House, Inc.
Bat State Community Services, Inc.

Beth Israel Leahy Health
BID-Plymouth Community Business Partners (approximately 69 businesses)
Boston Public Health Commission-Ryan White Part A
Boston Medical Center
Bourne Substance Use Coalition
Boys and Girls Club of Plymouth
Brazilian Church
Brazilian Point Store
Brazilian Silva Store
Brazilian Steakhouse
Brazilian Market (Uai Brazil)
Cape Cod Canal Region Chamber of Commerce
Carver Council on Aging
Carver Public Library
CleanSlate Centers
Community Health Network Area (CHNA 23)
Councils on Aging in the CBSA
Community Servings
Duxbury Council on Aging
Duxbury Free Library
EMS providers in the CBSA
Father Bills & MainSpring
Francis Keville Memorial Trust Fund
Food Pantries in the CBSA
Gosnold Behavioral Health
Great Island Social Club
Greater Attleboro Taunton Regional Transit Authority (GATRA)
Greater Plymouth Food Warehouse
Hadassah
Harbor Health Services, Inc.
Health Imperatives
Healthy Plymouth
Health Resource & Services Administration (HRSA)-Ryan White Part C
Herring Pond Wampanoag Tribe
High Point Treatment Center
Jett Foundation
Kingston Council on Aging
Kingston Public Library
Laurelwood at the Pinehills
Libraries in the CBSA
Marshfield Council on Aging
Massachusetts Department of Public Health
McLean Hospital
National Alliance on Mental Illness (NAMI) - Plymouth
National Institutes of Health, HEAL Initiative – Plymouth
NeighborWorks
New Hope Chapel
Office of Adolescent Health and Youth Development
Old Colony Elder Services
Old Colony YMCA

Plymouth Area Community Access Television (PAC TV)
Peer Group Advisors, Inc. DBA TAB-Plymouth
Pilgrims Hope
Plymouth Area Chamber of Commerce
Plymouth Area Coalition for the Homeless
Plymouth Area Community Access Television (PACTV)
Plymouth Bay House
Plymouth Boys & Girls Club
Plymouth Center for Active Living
Plymouth County District Attorney's Office
Plymouth County Sheriff's Office
Plymouth County Suicide Prevention Coalition
Plymouth County HUB
Plymouth County Outreach
Plymouth County Outreach – Hope
Plymouth Department of Developmental Services
Plymouth Department of Public Health
Plymouth Family Network
Plymouth Family Resource Center
Plymouth Fitness Center
Plymouth Housing Authority
Plymouth Lions Club
Plymouth Police Department
Plymouth Pride
Plymouth Public Library
Plymouth Recovery Center
Plymouth Recreation Department
Plymouth Public Schools
Plymouth Youth Development Collaborative (PYDC)
Police Departments in the CBSA
Public Health Departments in the CBSA
Red Cross Blood Drive
Rotary Club of Plymouth
Salvation Army
Schwartz Center Rounds
Signature Healthcare / Brockton Hospital
Schools in the CBSA
Senior Housing in the CBSA
South Shore Alliance of LGBTQ+ Youth (SShAGLY)
South Shore Chamber of Commerce
South Shore Community Partners in Prevention
South Shore Community Action Council
South Shore Continuum of Care
South Shore Partners in Prevention (CHNA 23)
Taking People Places/The Alternative Board
Terra Cura, Inc.
To the Moon and Back
Town of Plymouth
Quincy Asian Resources, Inc. (QARI)
U-Mass Extension

United Way Greater Plymouth
Zion Lutheran Church Associates

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

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

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

BID-Plymouth's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that BID-Plymouth serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. BID-Plymouth's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the

prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, BID-Plymouth conducted 17 one-on-one interviews with key collaborators in the community, facilitated 4 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 460 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers and other community partners.

The articulation of each specific community's needs (done in partnership between BID-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 collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BID-Plymouth's Implementation Strategy that is adopted by the BID-Plymouth's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

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

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.
- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

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

Complex and Chronic Conditions

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

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

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	BID Plymouth is committed to meeting the needs of all of our patients and to serving our community. We strive to honor all cultural preferences and work diligently to communicate effectively with all of our patients, English speaking, non-English speaking and limited-English speaking as well as our deaf and hard of hearing patients.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	During FY22, the number of interpreter sessions to patients and families at BID Plymouth will increase due to the provision of Video Remote Interpretation (VRI) as well as increased hours for the Director of the program (part-time to full-time).
Goal Status	During FY22, 8111 interpreter sessions were provided to patients and families at BID Plymouth compared to 5235 in FY21. In FY 2022, of the total 8,111 interpreter sessions, 1,410 were in-person/on site, 3,775 were telephonic/over the phone (OPI) and 2,926 were video remote interpretations (VRI).

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

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Financial Assistance** **Health Issue: Additional Health Needs (Access to Care)**			
Brief Description or Objective	BID Plymouth works to provide underserved and uninsured patients with information on all insurance programs offered by the Executive Office of Health and Human Services (EOHHS) and the MA Health Connector. Financial counselors also provide financial counseling, benefit enrollment assistance and payment planning.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	By contracting with Change Healthcare, BID-Plymouth will have the ability to provide services to more patients.		
Goal Status	BID-Plymouth Contracted with Change Healthcare in July as an effort to serve more patients and to streamline the process.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health and Access to Care
Program Name: The Greater Plymouth Area Transportation Consortium (Taking People Places Program - TPP)
Health Issue: Additional Health Needs (Transportation)

Brief Description or Objective	The Greater Plymouth Area Transportation Consortium, also known as Taking People Places or TPP consists of a group of 17 Social Services Agencies, including BID Plymouth. This program 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 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).
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-Provide 360 rides per year to adults ages 60 or older and/or with a disability who need to access medical care and do not have any other resources. -Provide 500 rides to patients needing access to cancer treatment appointments
Goal Status	-A total of 327 rides were provided in FY22; 85 rides to adults ages 60 or older and 242 rides for those with a disability who needed to access medical care and do not have any other resources. -700 rides were provided to patients needing access to cancer treatment appointments

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

Priority Health Need: Mental Health and Substance Abuse
Program Name: Behavioral Health Integrated Care Initiative
Health Issue: Mental Health and Mental Illness

Brief Description or Objective	This initiative is a co-located behavioral health model that embeds licensed clinical social workers in the hospital with access to primary care and specialty care practices They work with 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 primary care practice operations. With behavioral health services available in the Emergency Department (ED), patients may begin treatment in this setting rather than waiting until psychiatric beds are available. Medical staff in primary care, specialty care, and the ED have on-site access to behavioral health support so that they can provide comprehensive healthcare that is convenient, efficient, and cost effective.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-Decrease depressive symptoms via PHQ9 scores (Patient Health -Questionnaire-9) and anxiety via GAD7 scores (General Anxiety Disorder-7) by 50% -Refer 1,000 patients to Behavioral Health providers
Goal Status	-Depressive symptoms (PHQ9) decreased by 62% and anxiety score (GAD7) decreased by 65% -1,470 patients were referred to Behavioral Health providers

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

Priority Health Need: Mental Health and Substance Use **Program Name: Plymouth County Outreach (PCO)** **Health Issue: Substance Use Disorders**		
Brief Description or Objective	Plymouth County Outreach (PCO) is a collaboration of 27 municipal police departments in Plymouth County working together to make treatment more accessible for individuals living with substance use disorder and their families. PCO provides home visits with a plainclothes officer and recovery coach or clinician following an overdose to discuss treatment options with the individual and help them engage with a treatment program as soon as possible. The 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.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-Conduct 600 successful home visits in FY22 -Mobile Medication for Opioid Use Disorder (MOUD) induction will occur through an expedited referral process with local Office-Based Addiction Treatment (OBAT) providers.	
Goal Status	-A total of 696 successful home visits were conducted -Due to staffing issues, Mobile Medication for Opioid Use Disorder (MOUD) program did not run.in FY 2022	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Plymouth County Outreach (PCO) Hope** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	PCO Hope is a non-profit 501(c)(3) that 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 offering 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.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	- Decrease the availability of unused prescription drugs by 100 gallons each quarter - Distribute 20 Narcan kits following the trainings each month for a total of 240 for the year - Train 20 people per month in how to recognize an overdose and administer Narcan, resulting in 240 people trained
Goal Status	-The availability of unused prescription drugs was decreased by 96 gallons per quarter/384 gallons during the year. -The total number of Narcan kits distributed during the year was 911 -The total number of people trained on how to recognize and overdose and administer Narcan during the year was 837
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Plymouth County HUB** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	Plymouth County HUB, in partnership with 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. This approach brings together collaborations between law enforcement, behavioral health providers, and other resources to deal with social determinants that factor into one's behavioral health needs. BID Plymouth's Director of Social Work is on the Executive Committee which guides program development and oversight.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	50% of situations closed due to connection to services leading to a decreased risk
Goal Status	57.7% of situations were closed due to connection to services leading to a decreased risk

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

Priority Health Need: Mental Health and Substance Use
Program Name: PreVenture Program
Health Issue: Mental Illness and Mental Health; Substance Use Disorders

Brief Description or Objective	PreVenture is a research-based addiction prevention program targeting personality traits that correlate with increased risk of developing substance use issues. Middle school students with high-risk personality profiles are identified to participate in two 90-minutes group workshops. Students learn how their personality style leads to certain emotional and behavior reactions. Students receive manuals that illustrate scenarios designed by similar teens to promote relevance. This program has proven both feasible and effective when delivered by school staff.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-BID Plymouth will continue to support Plymouth Public Schools with facilitation of the PreVenture Program until the five-year mark (2022) and/or otherwise identified as independently sustainable-Conduct workshops at the two middle schools - Run workshops for the middle school students -Continue to survey students and compare results to prior years to provide clarity of focus
Goal Status	-Financial support was not needed for FY22 as the school is now able to sustain the program through internal funding. -A total of 7 90-minute workshops ran in the two middle schools servicing 62 students -The Plymouth Schools reported a 200% increase in Anxiety Sensitivity in students surveyed for FY22 compared to the year prior, which aided in their decisions around support for mental health.

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

Priority Health Need: Chronic and Complex Conditions and Their Risk Factors **Program Name: ACCESS Program** **Health Issue: Chronic Disease**			
Brief Description or Objective	BID Plymouth's ACCESS HIV/AIDS Program (Comprehensive Care, Education & Support Services) provides medical care, education, support, medical case management, and medical transportation services to people living with HIVAIDS in the Greater Plymouth area. In addition to patient care, the program offers HIV education to the community as well as 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 (BPHC) 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.		
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	-Enroll 10 new clients into Medicare (Part C) -Enroll three new clients into non-medical case management services (Part A)		
Goal Status	-10 new clients were enrolled into Part C Medicare by the end of FY22 -10 new clients were enrolled into non-medical case management services (Part A)		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	-90% of ACCESS clients will be virally suppressed		
Goal Status	-97% of ACCESS clients are virally suppressed at the end of FY22		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	

Priority Health Need: Chronic and Complex Conditions and Their Risk Factors
Program Name: Cancer Patient Support Services Program
Health Issue: Chronic Disease

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). Finally, this program 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.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-Continue to offer the mentorship program -Financial support through the Francis Keville Memorial Trust Fund given to those in need of food and other supplies -The Wig Share Program will provide wigs for patients and assistance on fit and care - After diagnosis, provide every cancer survivor a free option to join Plymouth Fitness Center's Bridge to Wellness Program that builds their strength without any injuries. - Plan to evaluate the number of mammograms performed on women 40-70 years old living in a low-income housing area in Plymouth; schedule education and the opportunity to have a screening exam.
Goal Status	-5 cancer survivors were trained through the mentorship program to work with patients to provide support and resources -76 gift cards were provided to those in need through the Francis Keville Memorial Trust -40 wigs were provided to patients using a wig specialist 2 days per month to provide assistance - The Bridge to Wellness program was put on hold due to COVID concerns - Due to COVID and staffing issues, mammograms for women in low-cost housing did not occur.

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

Priority Health Need: Chronic and Complex Conditions and Their Risk Factors
Program Name: Community Nutrition Program
Health Issue: Chronic Disease and Additional Health Needs (Food Insecurity)

Brief Description or Objective	The Community Nutrition Program 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-One food drive will be held in collaboration with the Plymouth Food Warehouse -8 Delicious and Nutritious shows will be provided to clients of the COA programs in the Community Benefits Service Area (CBSA)- -5 food demonstration programs emphasizing healthy/low-cost recipes will be provided to food pantry clients in the CBSA -Three nutrition education programs focused on preventing and managing chronic conditions will be provided to older adults in the CBSA -Two nutrition education programs focused on preventing and managing chronic conditions will be provided to adults living in the CBSA -At least three nutrition programs focused on healthier eating will be provided to youth and families living in the CBSA -Provide 3 agencies in the CBSA with nutrition information including posters, recipes, and educational handouts that they can distribute to their clients Monthly Nutrition Notes will be sent to at least 5 local agencies serving individuals living in the CBSA - In FY21, a healthy cookbook was created and distributed to 350 low income, older adults, and/or individuals at risk for developing chronic health conditions. For FY22, a reprint of the cookbook will provide 500 books to be distributed to the same cohorts.
Goal Status	-Food drive held in August 2022; 113 pounds of high-quality food was donated to South Shore. Community Action's Food Warehouse. This amount of food translates to providing 87 meals to those in need in our community. -8 shows were provided in collaboration with PCAL, PACTV, local Chef Jerry Levine, and BID-Plymouth. BID-Plymouth's Registered Dietician (RD) presented nutrition information in concert with Jerry Levine's monthly recipe demonstration. D&N is provided via Zoom; participants watched a video of Jerry preparing a healthy recipe then listened to the RD's presentation on related nutrition content. 110 attended the 8 shows via zoom. The show is recorded, edited and published by PACTV and then shown on their YouTube channel - there are 364 "views" for 6 of the shows. Nutrition education provided includes eating the

	Mediterranean way, health benefits of fish, benefits of vitamins A, B, and C, benefits of spices, health benefits of barley and other whole grains, and food safety. Chronic disease prevention is woven into each education topic including heart health, weight management, diabetes prevention and management, heart disease prevention and management, and overall healthy eating strategies. All information is evidence-based and consistent with recommendations from professional organizations such as American Heart Association, American Diabetes Association, Academy of Nutrition and Dietetics, and CDC. -Monthly Nutrition Notes were sent to 10 agencies serving individuals living in the CBSA including Councils on Aging (COAs), Salvation Army, Father Bill's & MainSpring, Plymouth Family Resource Center and Algonquin Heights. Agencies can place nutrition information within their newsletters and other social media. Monthly topics included inflammation, diabetes, fat facts, using spices, hydration, packing a health lunch, and the recent Community Health Needs Assessment. All information is based on evidence-based data. -Three food demonstration programs were provided to Algonquin Heights in Plymouth. These recipes are healthy, easy to prepare, budget friendly and ingredients are easily sourced from food pantries. Visits were made to 2 other local pantries - New Hope Chapel and Plymouth Area Coalition. Food demonstrations were not done, but nutrition education via handouts and recipes were provided. -8 programs were provided to older adults living in the CBSA, with 359 older adults attending programs in person and via Zoom. Topics included nutrition and mental health, benefits of cranberries, heart healthy eating, spices, feeding your brain, and healthy eating as we age. All information is based on evidence-based research. -346 adults attended 9 sessions focused on meal planning for health, nutrition during recovery, benefits of fish, and healthy eating 101; education was provided to 1,100 individuals during two community health fairs. Education focused on decreasing overall sugar and sodium in the diet. Educational models were available to strengthen education and participants received associated written information and the BID-Plymouth To Your Health cookbook. -Nine programs were provided to 170 adolescents living in the CBSA. Topics included label reading, building a healthy lunch/snack, energy drinks. Several programs included experiential learning through recipe creation. -Six programs were provided to 228 youth and families living in the CBSA. Topics included eating from the five food groups, sometimes/anytime - decision making, and healthy snacks. Several programs allowed children to "interact" with food. Each activity included an opportunity for kids and caretakers to learn how to make foods consistent with the 5 food groups. Research supports better eating behaviors when kids are involved. Sessions provided the opportunity to reinforce the importance of healthy eating to caretakers. -Plymouth Area Coalition, Salvation Army, and Plymouth Family Recovery were provided with resources to distribute to their clients during food pantry hours. - 500 cookbooks were printed and are available for distribution at events and presentations

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

Priority Health Need: Chronic and Complex Conditions and Their Risk Factors
Program Name: Keep the Beat - Post-Cardiac Program
Health Issue: Chronic Disease

Brief Description or Objective	BID Plymouth wants to ensure that any patient graduating from their Cardiac Rehab program has the opportunity to continue their journey, despite cost. BID Plymouth funds graduates of its Cardiac Rehab program, who would like to continue to improve their heart health, to participate in the 12-week "Keep the Beat" program at the Old Colony YMCA. The program offers small group classes that provide support and education to maintain a heart healthy lifestyle, focusing on exercise, diet and stress management.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-Provide up to 20 graduates of BID Plymouth's Cardiac Rehab Program the opportunity to attend the 12-week Old Colony YMCA's Keep the Beat post-cardiac rehab program if they are unable to pay the fee of $105.
Goal Status	-BID-Plymouth provided 11 patients with a scholarship to attend the post-cardiac program, Keep the Beat, at the Old Colony YMCA at no cost to them.

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

Program Goal(s)	-Comfort level of fitness: Goal is for participants to report by the end of the program that they "agree or "strongly" to "More confidence to make changes in my lifestyle to improve my medical conditions" and "Confident that I can maintain these lifestyle changes such as diet, exercise even during times of stress" from post satisfaction survey provided to patients at end of program -Modifying/improving in key cardiac risk factors, including weight loss goals for participants to lose average of 0.5 lbs. for each week in the program (benchmark goal is 6lbs weight loss)
Goal Status	-100% of patients who completed the program "agreed" or "strongly agreed" to feeling confident to maintain the lifestyle changes, such as diet and exercise, even during times of stress. -Participants lost an average of 2.4lbs.

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

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Father Bill's and MainSpring (FBMS) Overnights of Hospitality & Outreach** **Health Issue: Housing Stability/ Homelessness**	
Brief Description or Objective	BID Plymouth helps fund full-time case managers in the Father Bill's & MainSpring's (FBMS) Plymouth office to provide the housing insecure with wraparound support services to help them avoid or permanently end their homelessness. These support services include seasonal emergency shelter called "Overnights of Hospitality" from November through March utilizing local churches.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-FBMS case managers will connect with at least 15 unsheltered individuals in Greater Plymouth annually via street outreach services. -FBMS will serve at least 30 unduplicated individuals via the Overnights of Hospitality seasonal emergency shelter
Goal Status	-FBMS case managers connected with 93 unsheltered individuals in greater Plymouth via street outreach services during FY22. -FBMS served 54 unduplicated unsheltered individuals via the Overnights of Hospitality seasonal emergency shelter in FY22.

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

Program Goal(s)	-90% of residents in FBMS' 70+ units of permanent supportive housing in Greater Plymouth will remain housed for a year or more.
Goal Status	-During the reporting period, 97% of residents in FBMS units (located in Plymouth County) were retained in housing or successfully exited FBMS housing to another source of permanent housing

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

Priority Health Need: Mental Health and Substance Use; Chronic and Complex Conditions and Their Risk Factors; and Social Determinants of Health and Access to Care **Program Name: Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals** **Health Issue: Chronic Disease; Housing Stability/Homelessness; Mental Illness and Mental Health; Substance Use Disorders; and Additional Health Needs (Food Insecurity and Access to Care)**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	-By September 30, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees. -By September 30, 2022, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	-All 10 BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan. -All FY22 regulatory reporting data were entered into the Community Benefits Database.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and Their Risk Factors
Program Name: HouseCalls-Community Health Education Lectures
Health Issue: Chronic Disease

Brief Description or Objective	HouseCalls are free community health educational lectures. Hospital physicians and clinicians volunteer to present. The event is one hour and allows attendees to ask questions. The 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, and how they heard about the lecture. A light dinner or refreshments are available at no cost to the attendee when done in person. Programs have included snoring and sleep apnea, lung cancer, weight loss surgery, and back pain.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide three free community health lectures on a health topic of interest
Goal Status	Three lectures were provided, but due to impacts of staffing shortages, they were provided via Zoom to the BID-Plymouth Community Advisory Board only. The topics were Breast Health, the Emergency Department & Behavioral Health and Diversity, Equity & Inclusion, and each session had an average audience of 40 participants.

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

Priority Health Need: Social Determinants of Health and Access to Care
Program Name: Emergency Assistance Program
Health Issue: Additional Health Needs (Food Insecurity) and (Financial Security)

Brief Description or Objective	The goals of the South Shore Community Action Council's Emergency Assistance program are to work with and empower individuals and families to achieve greater financial stability and long-term well-being. Food, financial and social service assistance for individuals and families in need is provided with tailored outreach to LatinX and Brazilian households in the CBSA. Note: Funding began 3/1/22, so the goal status covers 7 months, not the full year.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	-In one year: 37 households will complete applications for long-term housing support -In one year: 75 households in the BID-Plymouth service area will access emergency food -South Shore Community Action Council (SSCAC) will increase engagement with community partners, especially those working with Latinx and Brazilian households
Goal Status	-In 7 months: SSCAC provided referrals for long-term housing and other supports for 43 households in Carver, Duxbury, Kingston, and Plymouth. -In 7 Months: SSCAC provided case management, referrals, and financial assistance to stabilize housing for residents in crisis living in Carver, Duxbury, Kingston, and Plymouth. Emergency Assistance services helped to remedy rent arrearages and to remedy mortgage arrearages for 4 households (composed of 15 household members). -In 7 months: 13 households in the BID-Plymouth service area accessed emergency food - SSCAC engaged with 2 new partners around increasing DEI and linguistic accessibility of services - the DEI Coordinator for the Plymouth Public Schools and the Director of the Plymouth Center for Active Living.

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

Program Goal(s)	-In one year: 5 households in the BID-Plymouth service area will avoid a utility shut-off -In one year: 37 households will have stable housing for 3 months
Goal Status	-In 7 months: 4 households in Plymouth and Kingston avoided a utility shut-off with assistance from SSCAC. -In 7 Months: SSCAC provided case management, referrals, and financial assistance to stabilize housing for residents in crisis living in Carver, Duxbury, Kingston, and Plymouth.

	Emergency Assistance services helped to prevent eviction for 26 households (composed of 74 household members).

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

Priority Health Need: Chronic and Complex Conditions and Their Risk Factors
Program Name: Stroke Community Education
Health Issue: Chronic Disease

Brief Description or Objective	Community Education aimed at the older adult population around chronic disease, and in particular, strokes. The education covers types of stroke, effects of stroke, stroke prevention, how to recognize the signs of a stroke (for the individual or for someone else is having a stroke).
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Attend at least 2 community events and provide a presentation to those at risk.
Goal Status	Provided one presentation at the Plymouth Center for Active Living and one at the Plymouth Health & Wellness Fair, educating a total of 40 older adults.

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

Priority Health Need: Mental Health and Substance Use; Social Determinants of Health and Access to Care
Program Name: Grant Writing Services
Health Issue: Mental Health and Substance Use and Social Determinants of Health

Brief Description or Objective	BID Plymouth partners with many community organizations and coalitions in its efforts to address and prevent identified health needs in the community. By offering grant writing services to smaller organizations that do not have access to these specialized skills, BID Plymouth engages experts in grant writing and organizational readiness to provide needed support for these Community Based Organizations and coalitions in an effort to become more community driven and led.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Engage a grant writer in order to provide direct consulting and workshops for CBOs and coalitions providing social services in the BID-Plymouth CBSA
Goal Status	A total of 4 grant writers with varying specialties ranging from food insecurity to mental health & substance use disorder, to more generalized and high-level skills development were awarded contracts. A total of 264 hours will be available in FY23 to Community Based Organizations (CBOs) through trainings, presentations and individualized office hours.

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

Priority Health Need: Social Determinants of Health and Access to Care
Program Name: Family Housing Programs & Support
Health Issue: Housing Stability/ Homelessness

Brief Description or Objective	NeighborWorks® Housing Solutions (NHS) is a non-profit organization that helps find and maintain safe, affordable, high-quality housing and growing financial skills and resources, supporting individuals and families need. Services include rental assistance; emergency financial help; shelter and homelessness prevention; first-time homebuyer education and counseling; financial coaching; foreclosure prevention; affordable residential and small business loans; and construction and management of high-quality rental housing across Southern Massachusetts. BID Plymouth supports programs from NeighborWorks with a focus on the BIDP CBSA. The two programs supported are: **Family Self-Sufficiency Program:** provides families who have a housing subsidy with services that promote deeper financial security—financial education, credit repair, and assistance with setting and pursuing goals such as higher education, job training, and homeownership. The goal is to help families move to market-rate housing and put them on the path to financial security and family wellbeing. **Family Shelter Program:** provides families fleeing domestic violence with a safe and stable living environment while case managers work to help them develop the economic and life skills needed to establish long term stability.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Contract and allocate funding to engage NeighborWorks to provide the Family Sufficiency Program and the Family Shelter Program for the towns in the CBSA.
Goal Status	Funding was allocated to provide these programs the towns in the CBSA

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

Priority Health Need: Social Determinants of Health and Access to Care
Program Name: Aquaponics Lab Initiative
Health Issue: Additional Health Needs (Food Insecurity) and (Jobs & Financial Security)

Brief Description or Objective	The Plymouth County Sheriff's Department (PCSD) owns and operates a farm that contains a successful Horticulture Center. This initiative provides approximately 30,000 lbs. of food for the local food bank yearly while also providing job skills for the inmates at the jail. In order to grow the program (providing more food) and to offer new job skills (for their inmates), PCSD would like to model a new program of an Aquaponics Lab that is being done successfully through the Berkshires Sheriff's Department.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide funding for the Plymouth County Sheriff's Department to conduct a feasibility study for the addition of an Aquaponics program to be added to their existing Horticulture Program.
Goal Status	Funding was provided for a feasibility study for converting an existing greenhouse into an Aquaponics Lab to be completed in FY23.

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

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Plymouth Center for Active Living Senior Task Force** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	The Plymouth Center for Active Living is leading a Senior Task Force that exists to address collaboratively any concerns in the community that affect the growing older adult population. Towards the end of FY22, this group began the process of applying to become Age and Dementia Friendly in the Town of Plymouth. BID-Plymouth has two staff members that sit on the task force, contributing their time and expertise as well as financial contributions to the process.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Contribute both financially and through in-kind staff time for the Senior Task Force in the Town of Plymouth to address needs of the older adult population and to start the process of obtaining the Age and Dementia Friendly designation.	
Goal Status	In-kind support staff time and funding was provided to the Senior Task Force to address the needs of the growing population of older adults and to aid in the process of obtaining the Age & Dementia Friendly designation.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Recovery Fest** **Health Issues: Mental Health/Mental Illness and Substance Use Disorder**	
Brief Description or Objective	Recovery Fest is an event designed to be a safe space for individuals in any stage of recovery. It brought together family members, loved ones, and allies to celebrate recovery. The event included music from a local band, recovery speakers, food trucks and resource tables, This event was presented by the Plymouth Recovery Center, PCO HOPE, and Plymouth County Outreach
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Support education and awareness efforts in the community around substance use prevention and stigma
Goal Status	BID-Plymouth financially supported the first year of Recovery Fest which brought together 3 organizations along with 25 resource tables providing support for those in need and awareness for the community at large.

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

Priority Health Need: Mental Health and Substance Use **Program Name: Paving the Path** **Health Issues: Mental Health/Mental Illness and Substance Use Disorder**		
Brief Description or Objective	PCO Hope's Paving the Path Initiatives currently includes two treatment scholarship funds and a newly introduced program awarding resources to individuals further along the recovery process. The needs covered range from actual treatment to food and other financial needs that arise.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide financial support for community programs aimed at substance use recovery efforts	
Goal Status	BID-Plymouth made a financial contribution that supported one year of recovery resources for 10 participants	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Hidden in Plain Sight Mobile Unit** **Health Issues: Mental Health/Mental Illness and Substance Use Disorder**		
Brief Description or Objective	BID-Plymouth sponsored the mobile unit for a program called Hidden in Plain Sight. This program is designed to educate parents and caregivers on possible concerns that they should be watching for with their teens around substance use and risky behaviors.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide funding for the mobile Hidden in Plain Sight unit through PCO Hope	
Goal Status	BID-Plymouth provided funding to support the Hidden in Plain Sight Mobile Unit through PCO Hope	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$1,164, 374	
Community-Clinical Linkages	$195,175	$6,842
Total Population or Community Wide Interventions	$271,392	$137,500
Access/Coverage Supports	$150,464	$8,313
Infrastructure to Support CB Collaborations	$108,878	
Total Expenditures by Program Type	$1,890,283	$152,655
CB Expenditures by Health Need		
Chronic Disease	$745,853	
Mental Health/Mental Illness	$439,669	
Substance Use Disorders	$99,108	
Housing Stability/Homelessness	$98,143	
Additional Health Needs Identified by the Community	$507,510	
Total by Health Need	$1,890,283	
Leveraged Resources	$340,409	
Total CB Programming	$1,890,283	
Net Charity Care Expenditures		
HSN Assessment	$1,424,059	
Free/Discounted Care	0	
HSN Denied Claims	($240,389)	
Total Net Charity Care	$1,183,670	
Total CB Expenditures	$3,414,362	

Additional Information	
Net Patient Services Revenue	$327,466,000
CB Expenditure as % of Net Patient Services Revenue	1.04%
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	$3,000,000
Bad Debt	$3,341,839
Bad Debt Certification	Yes

Optional Supplement	
Comments: In addition to the above amounts, Beth Israel Lahey Health contributed $1 million to The Latino Equity Fund and the New Commonwealth Racial Equity and Social Justice Fund in support of addressing health disparities related hypertension, diabetes and obesity and further integration and alignment, particularly regarding stakeholder engagement and convening with the Health Equity Compact. BID-Plymouth also subsidized $400,000 in Behavioral Health services outside of its CBSA.	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1

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

I. Community Benefits Process:

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

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

2. Community Benefits Advisory Committee (CBAC)
   - Members (and titles):

- Mike Babini,BID Plymouth Board of Trustees
- Lyle Bazzinotti, BID Plymouth Board of Trustees
- Dennis Carman, Executive Director, United Way of Greater Plymouth
- Sarah Cloud, Director of Social Work, BID Plymouth
- Betty DeBenedictis, Legislative Director for Representative Matt Muratore, Commonwealth of Massachusetts
- Christina Degazon, Practice Manager, BID Plymouth
- Alisa DeLage, Chief Programs Officer, Old Colony Elder Services
- Peter Forman, Executive Director, South Shore Chamber of Commerce
- Sue Giovanetti, Executive Director, Plymouth Area Coalition for the Homeless
- Vedna Heywood, Plymouth Community Member
- Nate Horwitz-Willis, Executive Director of Advocacy Fund and Executive Vice President of External Affairs, Planned Parenthood League of Massachusetts
- Adrienne Ing, Director of Operations, Harbor Health Services, Inc.
- Mike Jackman, Chair, South Shore Community Partners for Prevention
- Karen Keane, Director, Plymouth Public Health Department
- Malissa Kenney, President/CEO, Healthy Plymouth

- Joanne LaFerrara, Director, Customer Relations, Greater Attleboro Taunton Regional Transit Authority (GATRA)
- Derek Paiva, Vice President, Old Colony YMCA
- Ami Tanner, Director of Resident Services, Algonquin Heights

- Leadership:

- Kevin Coughlin, President
- Wendy Baker, Vice President, HR Business Partner
- Mary Chapin, Vice President, Ambulatory Services and Process Improvement
- Donna Doherty, Senior Vice President, Patient Care Services and Chief Nursing Officer
- Andrea Holleran, Vice President, Strategic Planning and External Affairs
- Mary Dwyer, Interim Chief Financial Officer
- Jennifer Rice, Vice President of Philanthropy
- Ron Rutherford, Vice President and Chief Information Officer
- Dr. Tenny Thomas, Chief Medical Officer

- Frequency of meetings:

  BID-Plymouth's CBAC met quarterly during FY 2022 and also attended the hospital's annual Community Benefits public meeting.

3. Involvement of Hospital's Leadership in Community Benefits:

   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits Process.

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

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

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

Hospital Board:

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

Senior Leadership:

- Kevin Coughlin, President - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBC; participated in prioritization process
- Andrea Holleran, Vice President of Strategic Planning and External Affairs – helped to facilitate a Listening Session for prioritization
- Dr. Anthony Weiss, BIDMC Chief Medical Officer - participated in Key Informant Interview

Staff-level Managers:

- Nancy Kasen, BILH VP of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy
- Angela Harrington, Director of Interpreter Services - assisted with language translation, interpretation, and prioritization process
- Sarah Cloud, Director of Social Work participated in a focus group and the prioritization process

BILH Community Benefits Committee (CBC):

- BILH CBC - guided the process for the system

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

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

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

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

BID-Plymouth and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address

avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout BID-Plymouth's assessment process, BID-Plymouth worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. BID-Plymouth's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

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

BID-Plymouth's IS includes a diverse range of programs and resources to addresses the prioritized needs within the BID-Plymouth Community Benefits Service Area. The majority of BID-Plymouth's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. BID-Plymouth's strategies include increasing access to care through Change Healthcare services, , participating in the Plymouth County Outreach and Plymouth County HUB to address individuals and families at risk, and supporting food insecurity and healthy eating through our community nutrition programs. Additionally, BID-Plymouth collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions including Father Bill's & MainSpring, South Shore Community Action Council, and the Old Colony YMCA.

II. Community Engagement

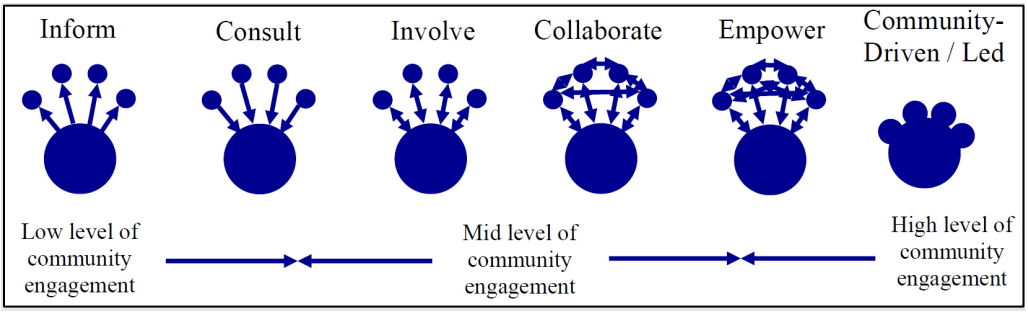
1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Algonquin Heights	Ami Tanner, Director of Residential Services	Housing organizations	Algonquin Heights is a housing development that offers lower rents for its apartments for those qualifying for low income or HUD subsidies. BID-Plymouth collaborates with them regularly through-out the year by offering onsite nutrition programs as well as a partner in the mobile farmers market and gardening projects. During the CHNA, Ami Tanner represented Algonquin Heights on the CBAC and she also helped to organize and facilitate a focus group with Spanish speaking residents.
Plymouth County Outreach	Vicki Butler, Program Director	Behavioral health and mental health organizations	Plymouth County Outreach (PCO) is a multi-faceted collaboration of the 27 municipal police departments in Plymouth County, as well as Bridgewater State University Police Department, working together with Recovery Coaches and community organizations, and coalitions to make treatment, resources, and harm reduction tools more accessible to those living with substance use disorder and their loved ones. BID-Plymouth's Director of Social Work, Sarah Cloud meets regularly with the towns in the CBSA to discuss specific cases of those presenting with mental health and substance use disorders. This collaborative approach has shown success in connecting over 60% of cases to needed resources thereby lowering their risk. Vicki Butler was engaged during the CHNA process as a key informant interviewee to discuss needs and gaps in the CBSA.

Old Colony YMCA	Derek Paiva, Vice President	Social service organizations	BID-Plymouth has a history of collaborating with the Old Colony YMCA through the schools and coalition work around transportation. This relationship led to a program called Keep the Beat which involves a clinical to community referral from BID-Plymouth's cardiac rehabilitation department to the YMCA for continued oversight of exercise and nutrition. BID-Plymouth Community Benefits pays for any participant that is unable to afford this post-rehabilitation program. Derek Paiva, VP, is also an active member of the CBAC and contributed in the prioritization process of the CHNA.
Town of Plymouth, Public Health Department	Karen Keane, Director of the Plymouth Public Health Department	Local health department	BID-Plymouth has worked closely with the Plymouth Public Health Department in order to support each other around messaging and communication around COVID-19 efforts. Karen Keane participated in a key informant interview for the FY22 CHNA and as an active CBAC member, she also participated in the prioritization process.

2. Level of Engagement Across CHNA and Implementation Strategy

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



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

1

A. Community Health Needs Assessment

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

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

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

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

B. Implementation Strategy

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

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

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

3. <u>Opportunity for Public Feedback</u>

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

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

4. Best Practices/Lessons Learned

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

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

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

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

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

III. Regional Collaboration

1. Is the hospital part of a larger community health improvement planning process?

☒Yes ☐No

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

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

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

- Collaboration:
  BID-Plymouth worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals.

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

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

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

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