Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health

Beth Israel Deaconess Plymouth

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement

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

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

The mission of Beth Israel Deaconess Hospital-Plymouth (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 its 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.

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

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

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

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

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

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

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

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

Target Populations

BID-Plymouth's Community Benefits Service Area (CBSA) includes Plymouth, Kingston, Carver and Duxbury. BID-Plymouth's FY 2019 Community Health Needs Assessment's (CHNA) findings, on which this report is based, show that youth and families, older adults, low-to-moderate income individuals and families with chronic conditions face the greatest health disparities and are most-at-risk.

As a result, these towns have been identified and prioritized as the focus for community health efforts. Collectively, these geographic, demographic, and socio-economic population segments are BID-Plymouth's priority populations. While BID-Plymouth is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated Community Benefits guidelines, BID-Plymouth's Implementation Strategy will focus on these populations.

Basis for Selection

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

Key Accomplishments for Reporting Year

The accomplishments highlighted in this report are based upon priorities identified and programs contained in BID-Plymouth's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- 95% of BID-Plymouth's ACCESS HIV/AIDS Program (AIDS Comprehensive Care, Education & Support Services) clients achieved viral suppression compared to a goal of 90% being virally suppressed.
- 400 copies of the To Your Health cookbook were distributed to low income adults with or at-risk for developing chronic health conditions compared to a goal of 350. Prior to visiting New Hope Chapel, the Community RD learned that participants were in need of bottled water. As a result, BID-Plymouth provided four 40-bottle cases to event attendees.
- 93% of Father Bill's and Mainspring (FBMS) residents with the greatest needs were maintained in permanent housing compared to a goal of 90%.
- BID-Plymouth's Behavioral Health Integration Initiative met its goal of decreasing depression scores by 50% from intake to discharge. This was accomplished by providing access to and treatment for depression in both outpatient primary care and specialty practices.
- BID-Plymouth's Cardiac Rehab Program collaborated with the Old Colony YMCA to facilitate a seamless transition into their 12-week "Keep the Beat" program for clients who were unable to pay. Since January 2021, seven Cardiac Rehab graduates have received a scholarship to attend "Keep the Beat."

Plans for Next Reporting Year

In FY19, BID-Plymouth conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, BID-Plymouth will focus its FY 20-22 Implementation Strategy on four priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in BID-Plymouth's CBSA who face the greatest health disparities. These four priority areas are:

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BID-Plymouth's priorities are also aligned with the priorities identified by the

Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine BID-Plymouth's efforts. In completing the FY19 CHNA and FY 20-22 Implementation Strategy, BID-Plymouth, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BID-Plymouth's FY 20-22 Implementation Strategy should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care and service gaps, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that targeted low-income populations, youth and families, older adults, adults with chronic diseases and complex conditions.

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

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the BID-Plymouth Community Benefits team completed a hospital self-assessment form (Section VII, page 33). The BID-Plymouth Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in BID-Plymouth's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

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

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

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

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

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

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

FY21 Community Benefits Advisory Committee Meetings

BID-Plymouth held three Community Benefits Advisory Committee meetings in Fiscal Year 2021. The meetings occurred on January 30, 2021; April 23, 2021; and June 15, 2021. The hospital's Annual Community Benefits Public Meeting was held on October 5, 2021.

Community Partners

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

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

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

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

The following is a comprehensive listing of the community partners with which BID-Plymouth joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 33).

Community Partners

Algonquin Heights
American Heart Association
Anchor House, Inc.
Bay State Community Services, Inc.
Beth Israel Lahey 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
Cape Cod Canal Region Chamber of Commerce
Carver Council on Aging
Carver Public Library
CleanSlate Centers
Community Health Network Area (CHNA 23)
Duxbury Council on Aging
Duxbury Free Library
Father Bill's and Mainspring
Francis Keville Memorial Trust Fund
Gosnold
Greater Attleboro-Taunton Regional Transit Authority (GATRA)
Greater Plymouth Food Warehouse
Harbor Community Health Center
Health Imperatives, Inc.
Health Resource & Services Administration (HRSA)-Ryan White Part C
Healthy Plymouth
High Point Treatment Center
Jett Foundation
Kingston Council on Aging
Kingston Public Library
Massachusetts Department of Public Health
McLean Hospital
National Alliance on Mental Illness of Massachusetts (NAMI Mass)
New Hope Chapel
Office of Adolescent Health and Youth Development
Old Colony Elder Services
Old Colony YMCA
Plymouth Area Chamber of Commerce
Pilgrims Hope
Plymouth Area Coalition
Plymouth Area Community Television (PACTV)
Plymouth Center for Active Living
Plymouth Community Outreach
Plymouth Community Outreach HOPE

Plymouth Community Outreach HUB
Plymouth Department of Public Health
Plymouth Family Network
Plymouth Family Resource Center
Plymouth Fitness Center
Plymouth Lions Club
Plymouth Police Department
Plymouth Public Library
Plymouth Public Schools
Plymouth Resource Center
Plymouth Youth Development Collaborative (PYDC)
Red Cross Blood Drive
Rotary Club of Plymouth
Salvation Army
Schwartz Center Rounds
Signature Healthcare / Brockton Hospital
South Shore Chamber of Commerce
South Shore Community Action Council
Terra Cura, Inc.
To the Moon and Back
Town of Plymouth
United Way of Greater Plymouth County
Zion Lutheran Church Associates

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment (CHNA) along with the associated FY20-22 Implementation Strategy was developed over a ten-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the BID-Plymouth's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy (IS)8889. However, these activities are driven primarily by BID-Plymouth's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, BID-Plymouth's most recent CHNA was completed during FY19. FY21 Community Benefits programming was informed by the FY19 CHNA and aligns with BID-Plymouth's FY20-FY22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods

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

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

The assessment and planning process began with the creation of a Steering Committee comprised of representatives from BID-Plymouth, Beth Israel Deaconess Medical Center (BIDMC) in Boston, and the other BID affiliate hospitals (BID-Milton and BID-Needham). These organizations worked together to ensure that a uniform, collaborative, transparent, and robust assessment and planning process was applied across the BID hospital system. In October 2018, the Steering Committee hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to support their efforts and to work with them to complete the CHNA and IS. Next, BID-Plymouth formed a Community Benefits Advisory Committee (CBAC), made up of community benefits staff, administrative and clinical staff, and representatives from the Board of Directors, local service providers, and key community stakeholders. This group met four times over the course of the assessment; they provided input on the assessment approach, vetted preliminary findings, and helped to prioritize the community health issues and priority

populations. The hospital also formed a Community Benefits Leadership Team (CBLT) made up of key hospital leadership and staff. In addition, the CHNA was discussed at the Hospital's Senior Leadership Team (SLT) meetings. The Steering Committee, CBAC, CBLT, and SLT reviewed the CHNA report and the subsequent IS before it was submitted to the Board of Directors for approval.

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

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

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

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

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

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

Summary of FY19 CHNA Key Health-Related Findings

Access to Care

- **Limited Access to Primary Care Services for Low Income, Medicaid Insured, Uninsured, and Other Vulnerable Populations Facing Health Care Disparities and Barriers to Care.** Despite the fact that Massachusetts has one of the highest rates of health insurance, there are still substantial numbers of low income, Medicaid insured, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical services. Efforts need to be made to expand access, reduce barriers to care.

Chronic Disease Management

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

Social Determinants and Health Risk Factors

- **Social Determinants of Health (e.g., economic stability, education, and community/social context) Continue to Have a Tremendous Impact on The Entire Population.** The dominant theme from the assessment's key informant interviews and community forums was the continued impact that the underlying social determinants of health are having on the entire population of the CBSA. More specifically, determinants such as affordable housing, navigation of the healthcare system, poverty, employment, and food insecurity limit many people's ability to care for their own and/or their families' health. These social determinants of health, particularly poverty, underlie the access to care issues that were prioritized in the assessment: navigating the health systems (including health insurance), chronic disease management, and access to culturally and linguistically competent care.

Behavioral Health

- **High rates of Substance Use (e.g., Alcohol, Prescription Drug/Opioids, Marijuana) and Mental Health Issues (e.g., Depression, Anxiety, and Stress).** The burden of mental health and substance use on individuals, families, communities and service providers in BID-Plymouth's CBSA is overwhelming. Nearly every key informant interview, focus group and community forum included discussions on these topics. Depression, anxiety/stress, social isolation, opioids, alcohol, and e-cigarette/vaping were

the leading issues. Despite increased community awareness and sensitivity about the underlying issues and origins of mental health and substance use issues, there is still a great deal of stigma related to these conditions. There is however a deep appreciation of and a growing understanding of the role that trauma plays for many of those dealing with mental health/substance use issues.

- **Limited Access to Behavioral Health Services, Particularly for Low Income, Medicaid Insured, Uninsured, and those with Complex, Multi-faceted Issues**. Despite the burden of mental health and substance use on all segments of the population, there is an extremely limited service system available to meet the needs that exist for those with all mild to moderate episodic issues or those with more serious and complex, chronic conditions. Efforts need to be made to expand access, reduce barriers to care (including stigma), and improve the quality of primary care and specialized behavioral health services.

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 FY21, the number of interpreter sessions to patients and families at BID Plymouth will increase due to the provision of Video Remote Interpretation (VRI).
Goal Status	During FY21, 5235 interpreter sessions were provided to patients and families at BID Plymouth compared to 3432 in FY20.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Financial Assistance Program** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	BID Plymouth works with the State to communicate new health coverage plans for the uninsured and enroll those who qualify. Financial counselors screened and enrolled patients for Mass Health, Health Safety Net, Medical Hardship and Commonwealth Care.
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 FY21, Financial Counselors will reach out to at least 10 former inpatients that received the Financial Assistance Form during admission but did not complete it. Former patients will be encouraged to complete the form and work with Financial Counselors to facilitate their enrollment with an insurance provider.
Goal Status	BID Plymouth Financial Counselors reached out to 1,233 patients to help them get coverage through Mass Health or apply for Financial Assistance.
Program Year: Year 2	**Of X Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care
Program Name: Primary Care Support
Health Issue: Chronic Disease, Additional Health Needs (Access to Care)

To ensure access to primary care and screening, the hospital supports Beth Israel Deaconess HealthCare offices in their Community Benefits Service Area (CBSA).

☐ Direct Clinical Services
☐ Community Clinical Linkages
☐ Total Population or Community Wide Intervention
☒ Access/Coverage Supports
☐ Infrastructure to Support Community Benefits

Increase number of providers able to support chronic disease prevention

BID Plymouth provided financial support to Beth Israel Deaconess HealthCare Primary Care Offices within the Community Benefits Service area to ensure access to care for local residents.

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

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: 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 Human Services Agencies, including BID Plymouth, is a replication of a successful transportation pilot program in the Attleboro area that provided ride hailing services to qualified users at no or low cost when public transportation was not available. Funds donated by organizations are matched through a state grant (up to 40K limit) to provide defrayed costs of transportation to clients through LYFT. BID Plymouth has the authority to determine eligibility for rides as part of the TPP and each participating organization may not exceed the number of rides their contribution entitles the organization (based on average ride cost of approximately $21). In 2021, BID Plymouth gave additional funds to extend the program's longevity and usage.
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 30 rides per month to adults age 60 or older and/or with a disability to medical care who do not have any other resources.
Goal Status	51 rides were provided to adults age 60 or older and/or with a disability to medical care who do not have any other resources.

Program Year: Year 2	**Of X Years: 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 primary care and specialty care settings. 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% and actual of 78% of patients who completed the tool upon admission and discharge	
Goal Status	Depressive symptoms decreased by 50% and actual of 72% as measured by the PHQ9 administered at intake and discharge	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process 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)	Expand upon PCO services and infrastructure by adding mobile Medication for Opioid Use Disorder (MOUD) induction.
Goal Status	Mobile Medication for Opioid Use Disorder (MOUD) induction will occur through an expedited referral process with local Office-Based Addiction Treatment (OBAT) providers.

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

Priority Health Need: Mental Health and Substance Use **Program Name: 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 150 gallons each quarter -Distribute 20 Narcan kits following trainings each month -Train 20 people per month on how to recognize an overdose and administer Narcan
Goal Status	The availability of unused prescription drugs was decreased by 122.5 gallons per quarter/490 gallons during the year. 262 Narcan kits were distributed each quarter bringing the total to 1048 kits given out during the year. 111 people were trained in the use of Narcan each quarter bringing the total number of people trained to 444 during the year.
Program Year: Year 2	**Of X Years: 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 approximately 24 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)	Provide linkage to services to 20 individuals/families meeting criteria for the HUB program per quarter.
Goal Status	Provided linkages to services for 17 individuals/families referred per quarter with the top risk factors being housing, mental health, substance use disorder, and basic needs.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process 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.
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 -Develop a Memoranda of Understanding (MOU) with Plymouth School Systems for the PreVenture Program -Increase participation of identified (at risk) youth by 10%
Goal Status	Support continued in FY21 BID Plymouth developed an MOU with the Plymouth School System PreVenture Program was put on hold due to COVID-19 restrictions

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

Priority Health Need: Mental Health and Substance Use **Program Name: Project MATTER** **Health Issue: Substance Use Disorders**			
Brief Description or Objective	BID Plymouth offers Medication for Opioid Use Disorder (MOUD) to any patient who is brought to the ED that had a Naloxone reversal, is seeking substance use treatment (i.e., detox) or presented with a medical condition related or unrelated to opioid use. To implement the program, ED physicians received additional training and were provided an "X waiver" to prescribe Suboxone. New clinical pathways were developed including implementation of the Rapid Opioid Dependence Screen (RODS) and the Clinical Opiate Withdrawal Scale (COWS). Additional resources were also secured through grant funding, including Recovery Navigators through a subcontract with Gosnold. This initiative is funded through the Health Policy Commission SHIFT Challenge and evaluated by Brandeis University.		
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)	The addiction nurse/psych NP team will engage 20 people per month that are being treated for primary and secondary substance use disorder (SUD) at the hospital and offer MAT and linkage to community partners.		
Goal Status	The addiction nurse/psych NP team engaged 20 people per month that are being treated for primary and secondary SUD at the hospital and offered MAT and linkage to community partners.		
Program Year: Year 2	**Of X Years: 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)	-90% of ACCESS clients will be virally suppressed -By December 31, 2020 90% of ACCESS Clients will receive a flu shot -Enroll 10 new clients into medical care (Part C) -Enroll three new clients into non-medical case management services (Part A)
Goal Status	95% of ACCESS clients are virally suppressed 97% of clients received a flu shot 10 new clients were enrolled into medical care (Part C) 5 new clients were enrolled into non-medical case management services (Part A)

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process 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)	-After diagnosis, provide every cancer survivor a free option to join Plymouth Fitness Center's Bridge to Wellness Program that helps build their physical strength without any injuries -Host the 5th biannual free Women's Health Symposium -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. -Provide free education and screening to the community about lung, breast, and skin cancer
Goal Status	Plymouth Fitness Center's Bridge to Wellness Program was closed for 2021 due to COVID-19 restrictions Women's Health Symposium was cancelled due to COVID-19 restrictions An educational visit to Algonquin Heights was completed and mammogram screening data was shared Breast programs and skin screening were cancelled due to COVID-19 restrictions; education is available in the clinic for current screening opportunities
Program Year: Year 2	**Of X Years: 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)	-By the end of FY21, 9 different healthy recipes and health-related handouts with a total distribution of 700 will be provided through BID Plymouth's Healthy Market Program. -By the end of FY21, a healthy cookbook will be created and distributed to 350 low income, older adults, and/or individuals at risk for developing chronic health conditions. -By the end of FY21, two nutrition education programs focused on promoting increased fruit and vegetable intake will be provided to youth in Plymouth, Kingston and Carver. -By the end of FY21, two nutrition education programs focused on improving health will be provided to older adults in Plymouth, Kingston, and Carver. -By the end of FY21, two nutrition programs focused on preventing and managing chronic conditions will be provided to low income adults in both Kingston and Carver.
Goal Status	-Created 29 different healthy recipes - 6 included a QR code with a video demonstration of how to prepare it; monthly articles and handouts distributed to more than 5000 individuals each month. -To Your Health Cookbook was created and has been distributed to 400 low income, older adults and/or individuals at risk for developing chronic health conditions. -14 programs have been provided to 388 youth in Plymouth, Kingston and Carver. -19 programs were provided to 232 older adults; 17 were provided via Zoom format. -3 events focused on chronic disease prevention and management were provided to 65 low income adults in Kingston and 3 programs provided to 20 individuals through the Carver Council on Aging (COA).

Program Year: Year 2	**Of X Years: 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. 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 two free community health lectures on a health topic of interest
Goal Status	One HouseCalls was provided on Diabetes Management with 27 individuals attending
Program Year: Year 2 | **Of X Years: 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)	-Comfort level of fitness: Goal is for participants to report by the end of the program that they "agree" or "strongly agree" 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" based upon post-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) and improvement in cardiovascular fitness goals by 50% measured using METS (metabolic equivalent of a task). -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	All participants selected "agree or "strongly agree" to both questions on the satisfaction survey Total weight loss = -6.97 lbs. METS improvement = 43% Since the program started in January BID Plymouth provided seven patients with a scholarship to attend the post-cardiac program, Keep the Beat, at the Old Colony YMCA at no cost to them.
Program Year: Year 1	**Of X Years: Year 2** / **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Father Bill's and MainSpring (FBMS)** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	BID Plymouth helps fund full-time case managers in the Plymouth office to provide the housing insecure with wraparound support services to help them avoid or permanently end their homelessness.
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)	-90% of residents in FBMS' 70+ units of permanent supportive housing in Greater Plymouth will remain housed for a year or more -Case managers will connect with at least 10 unsheltered individuals annually via street outreach services -Provide 30 homeless individuals with seasonal emergency shelter
Goal Status	93% of residents, who are often participants with the greatest needs, have maintained housing during the grant period. The majority of residents exiting FBMS permanent supportive housing, do so for a more independent home of their own (Section 8-unit, unsubsidized unit, etc.). Staff work with any participant exiting housing to ensure a successful transition, and continued progress toward self-sufficiency. Staff connected with 14 individuals living outdoors in Greater Plymouth. Case managers meet participants where they are outdoors and provide for their basic needs, before bringing them into our programs, and referring them to more specialized services. Provided 25 individuals with seasonal emergency shelter via Overnights Hospitality group in Plymouth.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process 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 have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with MGB, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies By September 30, 2021, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits Committee data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement. All 20 BILH Community Benefits staff were trained on the Community Benefits Database and began data entry for FY20 regulatory reporting.
Program Year: Year 1	**Of X Years: Year 2** | **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	$2,542,605	
Community-Clinical Linkages	$79,182	$1,555
Total Population or Community Wide Interventions	$121,090	$2,000
Access/Coverage Supports	$143,768	
Infrastructure to Support CB Collaborations	$180,777	
Total Expenditures by Program Type	$3,067,422,	$3,555
CB Expenditures by Health Need		
Chronic Disease	$1,198,144	
Mental Health/Mental Illness	$1,002,785	
Substance Use Disorders	$291,192	
Housing Stability/Homelessness	$52,829	
Additional Health Needs Identified by the Community	$522,473	
Total Expenditures by Health Need	$3,067,422	
Total Community Benefits Program Expenditures	$3,067,422	
Leveraged Resources		
Total Leveraged Resources	$350,409	
Net Charity Care Expenditures		
HSN Assessment	$1,481,611	
Free/Discounted Care	-	
HSN Denied Claims	$47,561	
Total Net Charity Care	$1,529,172	
Total CB Expenditures	$4,947,003	

Additional Information	
Net Patient Services Revenue	**$316,976,000**
CB Expenditure as % of Net Patient Services Revenue	**2%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$2,000,000**
Bad Debt	**$2,548,222**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      BID Plymouth has worked to align its Community Benefits Advisory Committee membership to reflect the demographics included in BID Plymouth's Community Benefits Service Area (CBSA). Additionally, BID Plymouth has worked to have the Community Benefits Advisory Committee membership include the following sectors: residents/private sector, additional municipal staff, community health center, education, community-based organizations, housing, local public health department, regional planning and transportation agency, social services agencies. New members and their sectors include Vedna Heywood, resident; Christina Degazon, Affiliated Physicians Group primary care manager; and Christopher Campbell, education.

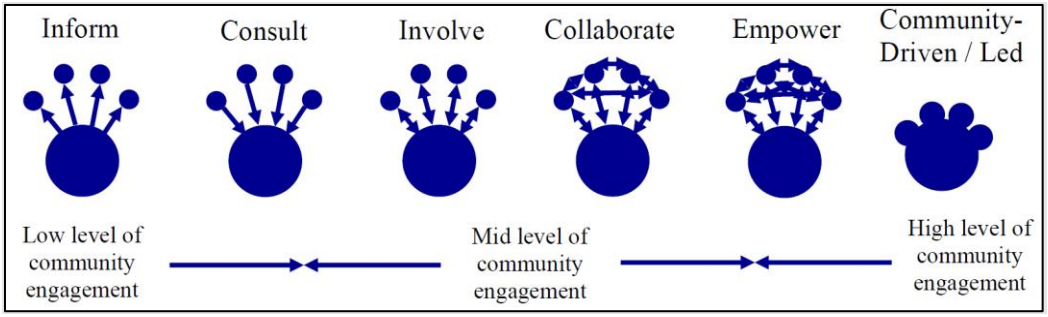
II. Community Engagement:

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

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Old Colony YMCA	Derek Pavia, Vice President	Social service organizations	In FY21, BID Plymouth's Cardiac Rehab partnered with the Y to give graduates of BID Plymouth's Cardiac Rehab program the opportunity to continue their journey, despite cost. BID Plymouth funds graduates who are unable to pay the fee to attend the Y's Keep the Beat post-cardiac program.
Salvation Army	Captain Debora Coolidge, Director	Social service organizations	BID Plymouth's Community Nutritionist Liaison partners with Salvation Army to provide healthy recipes and monthly nutritional articles to low-income individuals
Carver Council on Aging	Connie Kelly, Director	Other	BID Plymouth's Community Nutritionist presents educational information sessions with COA members on nutrition for older adults

Kingston Council on Aging	Paula Rossi-Clapp, Director	Other	BID Plymouth's Community Nutritionist presents educational information sessions with COA members on nutrition for older adults
Father Bill's and MainSpring	Lynn Calling, Associate Director of Development	Housing organizations	BID Plymouth is partnering with Father Bill's to help fund their homelessness prevention program in Plymouth
New Hope Chapel	Tami Edson	Social service organizations	BID Plymouth provides cases of water quarterly to the homeless at their food pantry and free meal program
Harbor Community Health Center	Adrienne Ing, Practice Manager	Community Health Centers	BID Plymouth's Community Dietitian provides healthy recipes for patients.
Healthy Plymouth	Malissa Kenney, President and CEO	Other	As one of the founding members of Healthy Plymouth, BID Plymouth helped to support Healthy Plymouth becoming a 501(c)(3). Today it is self-sustaining organization with fundraising capabilities. BID Plymouth continues to provide a nutritionist to deliver programming at Healthy Plymouth events to engage low-income, vulnerable populations and educate them about healthy choices.

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



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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	The hospital was able to meet most of its goals, despite the continuation of COVID-19. We reached out to new community partners to work together on new areas such as food insecurity and housing instability	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	BID Plymouth shared its resources dedicated to its Community Benefits programs during its Community Benefits Annual Public Meeting	Collaborate
Implementing Community Benefits programs	Collaborate	Most of the Community Benefits programs were implemented. Some were put on hold due to COVID-19. Most of the programs were provided virtually.	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Community Benefits Program overseers must update their programs quarterly and the Manager of Community Benefits reviews for impact.	Empower
Updating Implementation Strategy annually	Involve	BID Plymouth updated its Implementation Strategy and shared those updates with the community at the virtual Annual Public Meeting.	Collaborate

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

  BID Plymouth remains committed to community engagement. In FY 21, BID Plymouth developed a first-ever grant program to fund community projects and programs that meet the identified health needs and populations gleaned from the FY19 CHNA. Also, a grant review committee was established for grant proposals. This new RFP process is just one of the ways BID Plymouth seeks to engage, collaborate and empower the community. In FY 22, BID Plymouth will continue to work with its CBAC and community partners to engage the community by sharing updates on the Community Benefits programs.

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

  While in-person meetings were hindered in the community, BID Plymouth sought creative ways of engaging with our community that included: 1. Pivoting in-person programs to a virtual platform. 2. Developed online newsletters in place of hard copies 3. Pivoting in-person healthy food demos to videoing the demos and sending to community-based organizations to share with their clients.

  Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded, in others; programs were cut or significantly reduced because of the pandemic.

  BID Plymouth dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. BID Plymouth was intentional when assessing risk factors within our CBSA and worked closely with our local health department. Clinical staff provided infection control expertise to the local health department during their reopening plans. BID Plymouth worked to expand community testing access and worked with the communities most impacted by COVID-19 to help slow the spread. BID Plymouth redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer and other critical items.

- 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 held a virtual public meeting in conjunction with its CBAC on October 5, 2021. BID Plymouth shared updates to its Implementation Strategy, highlights of its Community Benefits programs and asked for feedback from the community. Additionally, BID Plymouth developed an informational flyer that highlighted some of BID Plymouth's Community Benefits programs. The flyer was shared via email with community partners, patients and visitors, BID Plymouth's website and with the CBAC.

III. Updates on Regional Collaboration:

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

   BID Plymouth along with the Plymouth School System and The Town of Plymouth were founding members of Healthy Plymouth-a collaboration that identifies meaningful ways to stay healthy and combining expertise and resources to bring opportunities for good health to youth and families in Plymouth. BID Plymouth provided support for Healthy Plymouth to become a 501(c)(3) in FY 21 by hiring a lawyer to manage the process and providing Healthy Plymouth with an off-site office location.

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

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Father Bill's and MainSpring	Lynn Calling, Associate Director of Development	Housing organizations	BID Plymouth helps to fund Father Bill's homelessness prevention program in Plymouth
Old Colony YMCA	Derek Pavia, Vice President	Chronic and Complex Conditions / Heart disease	In FY21, BID Plymouth's Cardiac Rehab partnered with the Y to give graduates of BID Plymouth's Cardiac Rehab program the opportunity to continue their journey, despite cost. BID Plymouth funded graduates who were unable to pay the fee to attend the Y's Keep the Beat post-cardiac program.

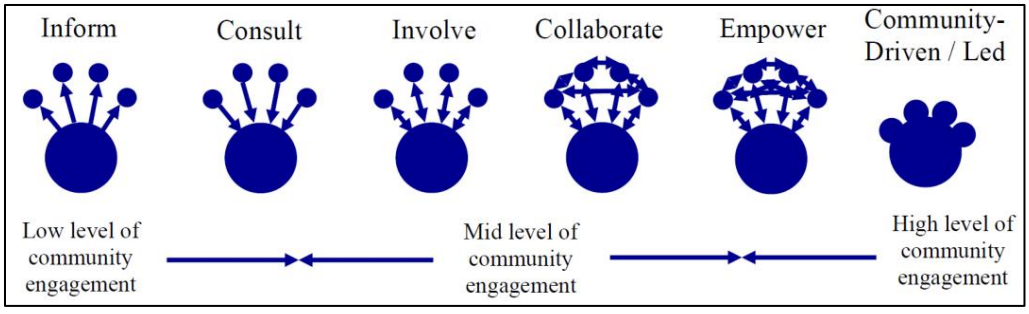
SECTION VIII: COMMUNITY REPRESENTATIVE FEEDBACK FORM

Hospital Community Benefits - Community Representative Feedback Form

Instructions: *You have been asked to complete this form based on your role as a community representative with whom a hospital has engaged in developing its Community Health Needs Assessment and/or Implementation Strategy. Please submit a copy of the completed form to the hospital (please see the hospital's most recent Community Benefits report for contact information) and to the Attorney General's Office (at CBAdmin@state.ma.us).*

1. **Background Information**
   - **Your Name**
     Click or tap here to enter text.
   - **If You Represent an Organization, Name of Organization and Your Position**
     Click or tap here to enter text.
   - **Name of Hospital**
     Click or tap here to enter text.
   - **Are you a member of the hospital's Community Benefits Advisory Committee (CBAC)?** ☐ Yes ☐ No
     - If no, please briefly describe your involvement in the hospital's Community Benefits process.
       Click or tap here to enter text.

2. **Level of Engagement Across CHNA and/or Implementation Strategy**
   Please use the spectrum below from the Massachusetts Department of Public Health[2] to assess the hospital's level of engagement with the community.



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

A. Community Health Needs Assessment:

Based on your knowledge and experience, please assess the hospital's level of engagement with the community in developing its Community Health Needs Assessment ("CHNA"). If your knowledge and/or experience do not encompass a particular category, please select "N/A" from the drop-down menu.

Category	Level of Engagement
Overall engagement in assessing community health needs	Choose an item.
Defining the community to be served	Choose an item.
Establishing priorities	Choose an item.

B. Implementation Strategy:

Based on your knowledge and experience, please assess the hospital's level of engagement with the community in developing and implementing its plan to address the significant needs documented in its CHNA. If your knowledge and/or experience do not encompass a particular category, please select "N/A" from the drop-down menu.

Category	Level of Engagement
Overall engagement in developing and implementing hospital's plan to address significant needs documented in CHNA	Choose an item.
Selecting Community Benefits programs	Choose an item.
Implementing Community Benefits programs	Choose an item.
Evaluating progress in executing Implementation Strategy	Choose an item.

3. Engagement Experience
Please indicate the degree to which you agree or disagree with the following statements:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
When the CBAC comes together, I feel comfortable sharing my opinion	☐	☐	☐	☐	☐	☐
I am satisfied with my/my organization's participation in this process	☐	☐	☐	☐	☐	☐

- **What is an example of a community engagement strategy by the hospital that has worked well over the past year?**
  Click or tap here to enter text.

- **What change, if any, would you most like to see in your engagement going forward?**
  Click or tap here to enter text.