Beth Israel Lahey Health is committed to working collaboratively with our communities to address leading health issues and create a healthy future for individuals, families and communities.
On March 1, 2019, Beth Israel Lahey Health (BILH) embarked on a journey to transform health care in Massachusetts. More than 35,000 people are now working together in new ways across professional roles, sites of care and regions to make a difference for our patients, our communities and one another.

BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery—academic medical centers 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. We know we will be able to do more together than we ever could on our own.

At BILH, we believe that everyone deserves high-quality, affordable health care. This belief defines who we are, and it’s what drives us to work with our community partners across the region to promote health, expand access and deliver the best care in the communities we serve. BILH’s Community Benefits staff are committed to working collaboratively with our communities to address leading health issues and create a healthy future for individuals, families and communities.

The Community Health Needs Assessments (CHNAs) conducted in 2019 and summarized in this system-level report identified a broad range of community strengths and assets. The assessments also identified numerous challenges and health-related disparities for population segments throughout BILH’s service areas. The organizations that are now part of BILH have always been deeply committed to serving their communities. As a show of this commitment, over the past three years BILH’s hospitals have collectively invested more than $70 million in community health and access programming designed to reinforce community strengths and address the challenges identified through the CHNAs.

These investments have had a tremendous impact because of the strong partnerships we have developed with local service providers, public health departments, social service agencies and other community health stakeholders. Through our new merged organization, our dedication to the communities we serve will remain strong, and our partnerships will continue to be a cornerstone of our ability to make a difference for patients, families and communities in the years to come.
This Community Benefits Report marks the culmination of work conducted over the past year by Beth Israel Lahey Health’s (BILH) Community Benefits staff, our hospitals’ senior leadership teams, hospitals’ Community Benefits Advisory Committees (CBACs), our community partners and thousands of community stakeholders throughout BILH’s community benefits service area who participated in BILH’s triennial community health needs assessment (CHNA). At BILH, we are proud of this important work and the efforts of all those involved. This work will help guide BILH’s commitment to promoting health, enhancing access and delivering the best care in our community.

BILH and our community partners share a common understanding that, in order to promote health and address existing health disparities, we need to care for patients and communities in new ways. Specifically, there is an appreciation for the importance of a more holistic and integrated approach focused on prevention, enhancing access, improving care coordination and addressing the underlying social determinants of health. The most recent CHNAs and the corresponding Implementation Strategies (ISs) are fully aligned with and supportive of these core concepts.

The CHNAs captured information critical to better understanding issues related to access, care coordination, service gaps, social determinants of health and the leading health issues facing our community. The assessments also identified community members who are underserved, vulnerable and experience disparities in healthcare because of race, ethnicity, immigration status, language, age, gender identity, sexual orientation and socio-economic status.

The CHNA findings have informed the development of BILH hospitals’ community benefits priorities and each hospital’s community benefits Implementation Strategy. The individual hospital Implementation Strategy includes a diverse range of programs and leverages existing initiatives and resources to address the unique needs in each hospital’s service area. The Implementation Strategies include programs that:

- address the leading social determinants of health, such as supporting the development of affordable housing, providing rental assistance to families at risk for eviction and addressing economic insecurity through improved vocational education
- support critical partnerships with community health centers that enhance access and strengthen the region’s safety net by focusing on BILH’s most underserved communities
- support chronic disease management and help those with complex conditions manage their health and better coordinate their care
- address the overwhelming behavioral health issues facing our communities, such as partnerships with law enforcement, the integration of mental health and substance use disorder services in our primary care practices and medication-assisted treatment programs for those struggling with opioid addiction.

This Community Benefits Report includes a summary of the assessment and planning approaches that were applied across BILH hospitals, as well as key findings from the assessments and examples of the range of community benefits programs being implemented by each BILH hospital. More detailed information is available in each hospital’s CHNA report and Implementation Strategy summary, which are posted on the hospitals’ websites.

Building on each hospital’s strong commitment to community, our efforts will be strengthened as we align across BILH and work together to identify, share and support best practices to meet the needs of our community.
Acknowledgments

This Beth Israel Lahey Health (BILH) Community Health Needs Assessment (CHNA) report is the culmination of a collaborative process that began in October 2018. This endeavor was driven by a desire to meaningfully engage and gather input from residents, service providers, public health officials, elected/appointed officials, BILH hospital leadership and other key stakeholders from throughout BILH’s community benefits service area. Substantial efforts were made to ensure that all segments of the community had the opportunity to participate, particularly those who are hard to reach and often left out of these types of assessment and planning processes.

BILH, including the hospital Community Benefits Advisory Committees (CBACs) that oversaw this process, would like to extend our sincere appreciation to everyone who invested their time, effort and expertise to develop the hospital Community Health Needs Assessment reports and the Community Health Implementation Strategies that resulted from this work. This system-level report summarizes the assessment and planning activities that took place across the system and presents the resulting key findings, community health priorities and strategic initiatives. Make no mistake though: almost all of the work was led at the community level by the hospital Community Benefits Department staff, was overseen by the individual hospital’s CBACs and senior leadership teams and was driven by the residents, service providers and other community stakeholders engaged in this work. BILH was created to leverage resources across the region and to support a more integrated system of care. Our true power lies in the connections that our hospitals and core partners have with the communities they serve and with the community-based health and social service organizations they collaborate with on a regular basis.

BILH’s Senior Leadership Team, including the Community Benefits staff across the system, would also like to acknowledge the commitment and work of BILH’s newly formed Community Benefits Committee (CBC). This committee will provide guidance around community benefits and explore opportunities for alignment when assessing community need, identifying community health priorities, implementing community health initiatives and evaluating the impact of BILH’s community benefits work. While the BILH CBC is a relatively new entity, its impact will be significant, and we would like to thank committee members for their commitment to BILH and to the communities we serve.

Finally, BILH would like to thank the residents who contributed to this process. Since the assessment began in October 2018, thousands of residents throughout BILH’s community benefits service area shared their needs, experiences and expertise through interviews, focus groups, surveys and community listening sessions. This assessment and planning work would not have been possible or nearly as successful had it not been for the time and effort of the residents who generously engaged in this work.
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2. Community Benefits Service Area ................................. 3
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INTRODUCTION AND PURPOSE

All nonprofit hospitals throughout the United States are required to conduct a triennial Community Health Needs Assessment (CHNA) and develop an Implementation Strategy that describes how the hospital will work with its community partners to respond to the identified needs. This requirement was initiated in 2010 with the passage of the Patient Protection and Affordable Care Act and is regulated nationally by the Internal Revenue Service (IRS). Compliance is codified by Section 501(r) of the Internal Revenue Code and is monitored through the submission of detailed documentation (Form 990, Schedule H) provided by nonprofit hospitals to the IRS. The consequences of non-compliance can result in $50,000/year excise tax and potential revocation of a hospital’s not-for-profit status.

Since 1994, the Massachusetts Attorney General’s Office (MA AGO) has posed voluntary Community Benefits Guidelines that align with federal requirements and also add more rigor and specificity. The MA AGO guidelines are designed to foster consistency and transparency, promote community engagement and inspire alignment of community benefits priorities across the Commonwealth’s nonprofit hospitals. These guidelines are articulated through a series of seven principles that the MA AGO considers fundamental to a sound Community Benefits program. These principles have greatly informed BILH’s community health needs assessment approach and have allowed our hospitals to build on their commitment to addressing the health and social needs in the communities we serve. These principles are detailed in the Commonwealth’s revised Community Benefits Guidelines and outline how hospitals should establish a community benefits vision, engage internal hospital staff and external stakeholders, assess and prioritize community needs and report on their activities and progress.

Purpose

The CHNA reports created across the system are integral to BILH’s efforts to promote health, enhance access and deliver the best care in the communities BILH serves. Assessment findings in each of the reports provide vital information that BILH’s hospitals and community partners can use to ensure that all services and programs are appropriately focused, delivered in ways responsive to those in its service areas and address unmet community needs. These assessments and the associated prioritization and planning processes are a critical component of BILH’s ongoing community engagement efforts.

They also provide an important opportunity for our hospitals to engage their communities and to strengthen partnerships that are essential to BILH’s success. The CHNA efforts and Implementation Strategies led BILH hospitals to meet the MA AGO and the IRS’s Community Benefits obligations, but in some ways they remain secondary to BILH’s efforts to promote healthier communities and to engage residents and community partners.

The primary goals of the CHNA and Implementation Strategy process were to:

<table>
<thead>
<tr>
<th>ASSESS</th>
<th>Community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGAGE</td>
<td>Members of the community including local health departments, service providers, community residents and leadership and staff</td>
</tr>
<tr>
<td>IDENTIFY</td>
<td>Leading health issues/population segments most at risk for poor health, based on a review of quantitative and qualitative evidence</td>
</tr>
<tr>
<td>DEVELOP</td>
<td>A three-year Implementation Strategy (IS) to address community health needs in collaboration with community partners</td>
</tr>
</tbody>
</table>

Moreover, the CHNAs are used as a source of information and guidance to:

- Clarify issues related to community characteristics, barriers to care, existing service gaps, unmet community needs and other health-related factors
- Prioritize and promote community health investments
- Inform and guide a comprehensive, collaborative community health improvement planning process
- Facilitate discussion within and across sectors regarding community need, community health improvement and health equity
- Serve as a resource to others working to address health inequities

BILH is committed 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 avoidable inequalities, socioeconomic barriers to care and both historical and contemporary injustices. Throughout the assessment process, efforts were made to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes and are deemed most vulnerable. The Implementation Strategies developed as a result of these processes focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs.
At the core of both federal and Commonwealth guidance is a requirement that nonprofit hospitals conduct population-based community health needs assessments, inclusive of information on the characteristics, health status and barriers to care for all who live within the hospitals’ designated community benefits service areas. Understanding the geographic and demographic characteristics of BILH’s service area is critical to recognizing inequities, identifying vulnerable populations and targeting strategic responses.

The BILH Community Benefits Service Area—made up of the individual CBSAs from each of BILH’s licensed hospitals—includes 53 municipalities and six Boston neighborhoods. It stretches as far south as Plymouth and as far north as Amesbury. The specific hospital CBSAs are listed below and are shown in Figure 1 on page 4. For the most part, the hospital CBSAs are distinct and do not overlap, but as the map shows, there are cities and towns that are part of more than one service area. This creates opportunities for collaboration and alignment with respect to addressing unmet need and the leading community health priorities.

The set of cities and towns that make up BILH’s overall community benefits service area is diverse with respect to demographics (e.g., age, race and ethnicity), socioeconomics (e.g., income, education and employment) and geography (e.g., urban, suburban and semi-rural). There is also diversity with respect to community need. There are segments of the BILH CBSA population that are extremely healthy and have limited unmet health needs and other segments that face extreme disparities in access, underlying social determinants and health outcomes. BILH hospitals are committed to promoting health, enhancing access and delivering the best care for those who live in all the communities we serve. BILH’s hospital Community Benefits staff share this commitment and collaborate with community partners to create a healthy future for all individuals, families and communities through its CBSAs. To maximize the impact of BILH’s community benefits investments, address disparities and promote health equity, more of BILH’s resources are being directed to those who are most vulnerable.

- **Anna Jaques Hospital’s CBSA** includes Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Rowley, Salisbury and West Newbury.

- **Beth Israel Deaconess Medical Center’s (BIDMC) CBSA** includes the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva (Dorchester), Chinatown, Fenway/Kenmore and Roxbury/Mission Hill. The CBSA also includes municipalities where BIDMC operates licensed outpatient facilities: Brookline, Chelsea, Chestnut Hill (including parts of Boston, Brookline and Newton), Lexington and Needham.
- **Beth Israel Deaconess Hospital–Milton’s CBSA** includes Milton, Quincy and Randolph.
- **Beth Israel Deaconess Hospital–Needham’s CBSA** includes Dedham, Dover, Needham and Westwood.
- **Beth Israel Deaconess Hospital–Plymouth’s CBSA** includes Carver, Duxbury, Kingston and Plymouth.
- **Beverly Hospital/Addison Gilbert Hospital’s CBSA** includes Beverly, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester-by-the-Sea, Middleton and Rockport.
- **Lahey Hospital & Medical Center and Lahey Medical Center–Peabody’s CBSA** includes Arlington, Bedford, Billerica, Lexington, Lowell, Lynnfield and Peabody.
- **Mount Auburn Hospital’s CBSA** includes Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown.
- **New England Baptist Hospital’s CBSA** includes Brookline, Chestnut Hill, Dedham and two Boston neighborhoods: Roxbury and Mission Hill.
- **Winchester Hospital’s CBSA** includes Medford, North Reading, Reading, Stoneham, Tewksbury, Wilmington, Winchester and Woburn.

**FIGURE 1: BILH Community Benefits Service Areas**
Each of the hospital’s CHNA and Implementation Strategy efforts were guided by the same federal requirements and were implemented with similar approaches that included:

- **Quantitative/Qualitative Data Collection**
- **Community Engagement**
- **Asset Inventory**
- **Impact Evaluation**
- **Hospital Leadership Involvement**

In conducting this assessment and planning process, it would be difficult to overstate BILH’s commitment to community engagement and a robust, collaborative and transparent assessment and planning process. BILH’s Community Benefits staff and Community Benefits Advisory Committees (CBACs) dedicated countless hours to ensure a sound, objective and inclusive process. This approach involved extensive quantitative and qualitative data collection, substantial efforts to engage community residents and a thoughtful prioritization and planning process. Throughout this process, great care was taken to engage and gather information related to hidden population segments often left out of similar assessments.

Each of the hospital’s CHNA and IS efforts were guided by the same federal requirements and were implemented with similar approaches with similar timelines. For example, all the hospitals were careful to: 1) engage their local health departments and other key health and social service providers in their services areas, 2) gather quantitative and qualitative health-related data from federal, Commonwealth and local sources, 3) develop a resource inventory of the lead service providers to identify service gaps, 4) evaluate the impact of their prior community benefit activities, and 5) involve senior hospital leadership. Whenever possible, hospitals collaborated with one another or with other community partners to conduct their assessments. For example, Beth Israel Deaconess Hospital–Needham and all of the hospitals that were part of the former Lahey Health system collaborated with their local municipal health departments to conduct joint activities and share their results. BIDMC’s CHNA was facilitated in large part through its participation in two collaborative assessment and planning efforts: the Boston CHNA/CHIP Collaborative— involving nearly all of Boston’s teaching hospitals and many other community-based providers—and the CHNA Collaborative in Chelsea—involving the major service providers in Chelsea, Everett and Revere.

Finally, consistency in assessment and planning approaches was facilitated in part by the fact that prior to the creation of BILH, the Beth Israel Deaconess Hospital Network, Lahey Health, New England Baptist Hospital and Mount Auburn Hospital all hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to conduct their CHNA activities and support

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2 Anna Jacques Hospital (AJH) conducted its CHNA and developed its Implementation Strategy independently in 2018-2019. Because AJH implemented a slightly different process, the information gathered did not always align with that of the other hospitals. AJH’s information is cited and included wherever possible. It should also be noted that Mount Auburn Hospital’s CHNA and IS process occurred in 2017-2018.
the development of their CHNA reports and Implementation Strategies. The following summary of the assessment and planning approach includes a discussion of the oversight and advisory structures, quantitative and qualitative data collection methods, community engagement activities and prioritization and planning and reporting processes that were applied across the system.

Summary Approach, Methods and Data Sources

The assessments were completed in three phases. The table below summarizes the activities by phase. This section describes the oversight and advisory committee structures, data collection and community engagement methods, and prioritization, planning and reporting. Collectively, these efforts show BILH’s commitment to a comprehensive, inclusive, engaged, collaborative assessment and planning processes. The Steering Committees comprised of staff from the hospital Community Benefits departments as well as, in some cases, other key hospital staff. We worked with JSI to develop and carry out effective assessment and planning processes. JSI met monthly with the Steering Committees to review project activities, vet preliminary findings, address challenges and ensure alignment in the CHNA approach and methods across their respective systems.

Oversight and Advisory Committee Structures

Steering Committees. BILH’s assessment and planning activities began with the involvement of two CHNA Steering Committees, both of which were created in 2016 to oversee the last CHNA and Implementation Strategy activities. One of the Steering Committees included representatives from the hospitals that were part of the legacy Beth Israel Deaconess Hospital network (Beth Israel Deaconess Medical Center, Beth Israel Deaconess–Milton, Beth Israel Deaconess–Needham, Beth Israel Deaconess–Plymouth, Mount Auburn Hospital and New England Baptist Hospital). The other Steering Committee included representatives from the hospitals that were part of the legacy Lahey Health network (Beverly Hospital and Addison Gilbert Hospital, Lahey Hospital & Medical Center and Winchester Hospital).

Community Benefit Advisory Committees (CBAC). Each hospital also has its own CBAC made up of local service providers, public officials, business persons, advocacy organizations, community residents, hospital leaders and other key community stakeholders. These CBACs met three to four times during the course of the assessment and planning process and were responsible for overseeing the assessment approach, vetting findings and prioritizing the leading community health issues and population segments most in need. The CBACs also

<table>
<thead>
<tr>
<th>TABLE 1: Assessment and Planning Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHASE I: PRELIMINARY ASSESSMENT &amp; ENGAGEMENT</td>
</tr>
<tr>
<td>• Formation of Steering Committees</td>
</tr>
<tr>
<td>• Formation of new or engagement of existing CBACs</td>
</tr>
<tr>
<td>• Quantitative data collection/analysis</td>
</tr>
<tr>
<td>• Key informant interviews</td>
</tr>
<tr>
<td>• Community Benefits evaluation</td>
</tr>
<tr>
<td>• Preliminary CHNA assessment reports to CBACs</td>
</tr>
</tbody>
</table>
reviewed and provided input on the hospital Implementation Strategies.

**Data Collection and Community Engagement Methods**

**Quantitative Data Collection.** To meet the federal and Commonwealth community benefits requirements, BILH’s hospitals collected objective, quantitative data to characterize the populations and communities across BILH’s service areas. The hospitals measured health status to develop a comprehensive understanding of the leading health-related issues. Whenever possible, data were collected for specific geographic, demographic or socioeconomic cohorts to identify disparities and clarify the needs for specific communities or population segments. JSI, in conjunction with the hospitals, used proven scientific methods to test for statistical significance, identifying when there was a significant difference between a municipality’s data finding and the Commonwealth benchmark. The assessments also included more refined analyses of hospital discharge data compiled from the Massachusetts Center for Health Information and Analysis. This analysis focused on both identifying the leading conditions addressed in the hospital setting and analyzing ambulatory care-sensitive (ACS) conditions. An analysis of ACS conditions allowed the assessments to evaluate the strength of a community’s primary care system and its ability to prevent or avoid hospitalizations. Finally, assessments included data compiled at the local level from school districts, police/fire departments and other sources.

**Qualitative Data Collection and Community Engagement.** BILH’s hospitals recognize that authentic community engagement is critical to assessing community need, identifying the leading community health priorities, prioritizing segments of the population most at risk and crafting a collaborative, evidenced-informed Implementation Strategy. Accordingly, in collaboration with its assessment and community engagement partners, BILH’s hospitals applied Massachusetts Department of

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**FIGURE 2: Quantitative Data Types**

<table>
<thead>
<tr>
<th>Demographic, SES* &amp; SDOH** Data</th>
<th>Commonwealth/ National Health Status Data</th>
<th>Hospital Utilization Data</th>
<th>Municipal Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, SOGI***, Race, Ethnicity</td>
<td>Vital Statistics</td>
<td>Inpatient Discharges</td>
<td>Public School District</td>
</tr>
<tr>
<td>Poverty, Employment, Education</td>
<td>Behavioral Risk Factors</td>
<td>Emergency Department Discharges</td>
<td>Police/ Fire Departments</td>
</tr>
<tr>
<td>Crime/ Violence</td>
<td>Disease Registries</td>
<td>Prevention Quality Indicators</td>
<td>Public Housing</td>
</tr>
<tr>
<td>Food Access</td>
<td>Substance Use Data</td>
<td>Ambulatory Care Sensitive Conditions</td>
<td>Ambulance Services</td>
</tr>
<tr>
<td>Housing/ Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*Socioeconomic status  
**Social determinants of health  
***Sexual orientation and gender identity
Public Health’s Community Engagement Standards for Community Health Planning as a guide. To meet these standards, the hospitals employed a variety of strategies to ensure that community members were informed, consulted, involved and empowered throughout the assessment process. JSI worked with BILH’s Community Benefits staff to develop a multipronged approach to community engagement. Care was taken to ensure that everyone had the opportunity to participate and to ensure the collection of information from across the full breadth of community stakeholders. This facilitated an understanding of the underlying issues and challenges facing residents, service providers, public officials and other stakeholders. All hospitals conducted key informant interviews that captured information from a range of stakeholders, including BILH hospital staff. Additionally, focus groups were convened with key segments of the resident populations and certain service provider types.

FIGURE 3: Community Engagement Continuum

**INFORMED:**
BILH’s hospitals informed the community of assessment activities (e.g., key informant interviews, Community Health Survey, focus groups) and provided summary quantitative and qualitative data findings at public meetings.

**CONSULTED:**
BILH’s hospitals consulted the community by posting their current CHNAs for public comment, holding focus groups with service providers, hospital leadership, community stakeholders and community residents; completing key informant interviews; conducting a community meeting; and disseminating a Community Health Survey.

**INVOLVED:**
BILH’s hospitals formed Community Benefits Advisory Committees (CBACs) made up of representative, cross-sector groups of key community-based stakeholders, including representatives from health and social service providers, educational institutions, business, advocacy organizations, and community residents as well as hospital leadership and representatives from the hospitals’ Boards of Directors.

**EMPOWERED:**
BILH’s hospitals, along with many of their core community partners (e.g., local health departments, YMCAs, Councils on Aging), worked collectively to conduct joint community engagement activities, share data and existing reports, prioritize health needs, and identify the most vulnerable population segments. The CBACs were also consulted in the drafting of the Implementation Strategy.

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Some hospitals also held community forums and listening sessions designed to gather information from the community at large, especially residents, and a community survey was designed to capture information, particularly from hard-to-reach, isolated segments that are often left out of these types of assessments. In total, more than 10,000 residents, service providers, public officials and other key stakeholders were engaged across the BILH CBSA. Table 2 below shows the breadth of stakeholders and population segments that were engaged in this work. Table 3, on page 10, provides details on the breadth and magnitude of the specific activities.

More detailed descriptions of CHNA activities can be found in individual CHNA reports on hospital websites.

**Approach and Methods**

**TABLE 2: Engagement of Providers, Stakeholders and Populations**

<table>
<thead>
<tr>
<th>SERVICE PROVIDER/STAKEHOLDER CATEGORIES</th>
<th>POPULATION CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILH and hospital leadership/staff</td>
<td>Individuals in recovery</td>
</tr>
<tr>
<td>Business sector/employers</td>
<td>Individuals with disabilities</td>
</tr>
<tr>
<td>Community-based clinical providers (e.g., primary care, behavioral health, oral health)</td>
<td>LGBTQ+</td>
</tr>
<tr>
<td>Education sector</td>
<td>Limited English proficiency</td>
</tr>
<tr>
<td>Elder service agencies</td>
<td>Low-income individuals/family</td>
</tr>
<tr>
<td>Elected officials</td>
<td>Older adults</td>
</tr>
<tr>
<td>Public health officials</td>
<td>Racially/ethnically diverse (e.g., African American/Black, Asian, Hispanic/Latino)</td>
</tr>
<tr>
<td>Social service/housing/community agencies</td>
<td>Youth/adolescents</td>
</tr>
</tbody>
</table>
Approach and Methods

TABLE 3: Qualitative Activities and Community Engagement Across BILH

<table>
<thead>
<tr>
<th>QUALITATIVE DATA SOURCE &amp; COMMUNITY ENGAGEMENT METHODS</th>
<th>#</th>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>Interviews with hospital and system leadership</td>
</tr>
<tr>
<td></td>
<td>230</td>
<td>Interviews with community stakeholders</td>
</tr>
<tr>
<td></td>
<td>52</td>
<td>Focus groups with providers and stakeholders</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>Community forums with community residents</td>
</tr>
<tr>
<td></td>
<td>8,900</td>
<td>Community health surveys gathering input from community residents</td>
</tr>
<tr>
<td></td>
<td>40</td>
<td>Advisory Committee meetings with CBACs, hospital Patient Family Advisory Councils and hospital Senior Leadership Team</td>
</tr>
</tbody>
</table>

Prioritization, Planning and Reporting

During Phases I and II, JSI updated the CBACs across all BILH hospitals on their CBSA assessments’ progress, gathered insights on how to improve the assessment process, and provided them the opportunity to vet and comment on preliminary findings. At the outset of Phase III, a prioritization meeting was held with each of the hospital CBACs. During this meeting, quantitative and qualitative data findings were reviewed in depth. Each CBAC then discussed all of the findings and voted to approve a set of community health priorities and priority population segments that would be used to develop its hospital’s Implementation Strategy. In most cases, following the CBAC planning and prioritization meeting, JSI organized a similar meeting with the hospital’s senior leadership team. These meetings gave senior leadership the chance to review both the key findings and the priorities agreed upon by the CBAC. The senior leadership team then voted on a set of priorities that were incorporated into the hospital’s CHNA and Implementation Strategy.

After the prioritization process was completed, JSI worked with each of the hospital’s community benefits staff to develop a final CHNA report. JSI also worked with each of the hospital’s community benefits staff to revise the hospital’s existing Implementation Strategy. This process retained the community health initiatives that were working well and aligned with the identified priorities. JSI and community benefits staff also identified new, evidenced-informed strategies to fill in gaps related to the identified priorities or to augment the existing portfolio of programs.

After each hospital finalized its CHNA report and completed its Implementation Strategy, each hospital’s Board of Directors reviewed and formally approved both documents. The report and accompanying strategy were then posted on the hospital’s website.
4 SUMMARY OF KEY FINDINGS

KEY FINDINGS: COMMUNITY CHARACTERISTICS

Age is a fundamental factor to consider when assessing individual and community health status. Older adults (65+) and youth/adolescents (13–17) were identified as vulnerable/priority population segments by all BILH hospitals.

Older adults typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources than young people. Many individuals engaged in the assessment processes identified the older adult cohort as a vulnerable segment of the population; there were many concerns about the ability of the health and service system to meet their needs adequately. There are active Councils on Aging, senior centers and organizations dedicated to serving this population throughout BILH’s CBSA, although residents could face transportation, mobility and/or financial barriers when trying to access them.

Youth/adolescents were also identified as a vulnerable population segment. Individuals engaged through the assessment processes were concerned about the impacts of poor mental health and substance use on this population. Although young people tend to be healthy, many struggle with health and social issues, including poor nutrition, lack of physical activity, depression, anxiety and stress, substance use disorder and sexual health issues. Issues might be exacerbated for young people who identify as lesbian, gay, bisexual, transgender or queer/questioning (LGBTQ+) and for those who have had adverse childhood experiences.

TABLE 4: Priority Issues for Older Adults and Youth/Adolescents

<table>
<thead>
<tr>
<th>OLDER ADULTS</th>
<th>YOUTH/ADOLESCENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depression</td>
<td>• Depression and anxiety</td>
</tr>
<tr>
<td>• Social isolation</td>
<td>• Substance misuse</td>
</tr>
<tr>
<td>• Financial insecurity</td>
<td>• LGBTQ+ specific issues</td>
</tr>
<tr>
<td>• Chronic disease</td>
<td>• Adverse childhood experiences/trauma</td>
</tr>
<tr>
<td>• Access to care</td>
<td></td>
</tr>
</tbody>
</table>

The key findings in this chapter include information related to:

COMMUNITY CHARACTERISTICS

SOCIAL DETERMINANTS OF HEALTH

HEALTH STATUS ISSUES

ACCESS TO CARE
Racially, ethnically and culturally diverse populations and non-English speakers experience disparities in health outcomes and access to care. This includes individuals of color, immigrants, refugees and undocumented individuals. Fear around immigration status, inability to navigate an unfamiliar health system, lack of health literacy and providers’ lack of understanding about a patient’s cultural background were identified as factors that affect if, when and how individuals seek care. The impacts of racism and discrimination, and resulting disparities in health care access and outcomes, are documented in literature and confirmed by data captured in the assessments. The burden of these disparities was greater in the more urban communities, including Boston, Cambridge, Lowell, Lynn, Quincy, Randolph and Somerville.

DATA FINDINGS: AGE

- The median age was higher than the Commonwealth overall in many communities, especially in the Beverly Hospital/Addison Gilbert Hospital, Lahey Hospital & Medical Center, Winchester Hospital, BID-Needham and BID-Plymouth CBSAs.

DATA FINDINGS: RACE/ETHNICITY

- Black/African American and non-Hispanic/Latino residents make up a larger proportion of the population in Roxbury (40.8%) and North/South Dorchester (44.8% and 49.0%) compared to Boston overall (22.7%).
- 39% of the population in Randolph is Black/African American.
- 39% of the population in Lynn is Hispanic/Latino.
- 66% of the population in Chelsea is Hispanic/Latino and 45% of the population is foreign born.
- 29% of the population in Quincy is Asian.
- Winchester had 180% growth in its Asian-American population between 2000 and 2016.

![FIGURE 4: Percent of the Population Hispanic/Latino, 2013–2017](image)
KEY FINDINGS: SOCIAL DETERMINANTS OF HEALTH

Financial insecurity was identified as a leading social determinant of health across BILH’s community benefits service area. Socioeconomic status, as measured by income, employment status, occupation, education and the extent to which one lives in areas of economic disadvantage, is closely linked to morbidity, mortality and overall well-being. Lower-than-average life expectancy is highly correlated with low-income status.¹

Financial insecurity emerged as a concern in all CBSAs, regardless of whether the CBSA was considered to be urban, non-urban or affluent. Lack of gainful and reliable employment, inability to pay for health care services and copays, and inability to pay for transportation to receive health services were all identified as barriers to care. In many key informant interviews and focus groups, individuals shared that while unemployment rates are low in most communities, many people live on fixed incomes or are underemployed, situations that cause chronic stress. Certain populations struggle to find and retain employment for many reasons, including mental and physical health issues, lack of child care, transportation issues, and other factors. While the median household income in most communities was significantly higher than in the Commonwealth overall, individuals engaged in the assessments reported individuals and families living in poverty, even in towns that were considered affluent.

DATA FINDINGS: INCOME

• In some Boston neighborhoods (Allston/Brighton, Dorchester, Fenway/Kenmore, Roxbury, South End) and the municipalities of Beverly, Cambridge, Chelsea, Gloucester, Lowell, Lynn, Medford, Peabody, Quincy, Randolph/Somerville and Waltham, over 20% of the population lived below 200% of the federal poverty level.

“Our region is at a critical stress point. The cost of living does not match up with the average person’s wage. People are operating in a cycle of chronic stress, which sets people up for health issues.”

— Beverly Hospital/Addison Gilbert Hospital survey respondent

Issues related to housing, including affordability and homelessness, were identified as leading barriers to health and well-being across BILH’s community benefits service area. Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases and poor mental health. At the extreme are those without housing, including those who are homeless or living in unstable or transient housing situations. They are more likely to delay medical care and have mortality rates up to four times higher than do those who have secure housing.

Adults who are homeless or living in unstable situations are more likely to experience mental health issues, substance use, intimate partner violence and trauma; children in similar situations have difficulty in school and are more likely to exhibit antisocial behavior. Many key informants and focus group/forum participants engaged throughout the assessment processes expressed concern over the limited options for affordable housing. Specific concerns included the ability of seniors on fixed incomes to remain in their homes—continued increases in housing prices in the Greater Boston area are pushing more people into the suburbs, thus driving up home prices.

DATA FINDINGS: HOUSING

- Over one-third of the population has monthly ownership costs that exceed 30% of total household income in some Boston neighborhoods (Allston/Brighton, Dorchester, Fenway/Kenmore) and in the municipalities of Bedford, Carver, Dover, Essex, Fenway/Kenmore, Gloucester, Ipswich, Lowell, Lynn, Lynnfield, Manchester-by-the-Sea, Middleton, Quincy, Randolph, Rockport, Peabody, Plymouth and Watertown.
- During the 2017–2018 school year, there were 462 homeless youth attending Chelsea public schools.

“I wish housing was less expensive so that we had less financial pressure. This would open up more time to spend with our daughter and more time to spend on healthy activities, like exercise.”

— Winchester Hospital survey respondent

7Ibid.
Lack of access to affordable and reliable transportation was identified as an issue throughout BILH’s community benefits service area, but especially in non-urban communities that are not as well served by systems of public transport. Lack of transportation has a significant impact on access to health care services and is a determinant of whether an individual or family has the ability to access the basic resources that allow them to live productive and fulfilling lives. Access to affordable and reliable transportation widens opportunity and is essential to addressing poverty and unemployment.

There is very limited quantitative data to characterize issues related to transportation. Many interviewees, focus group participants and survey respondents felt that lack of transportation was a critical barrier to accessing care and community and social services (e.g., senior centers, community centers, grocery stores) and the ability to socialize, especially for older adults without access to a personal vehicle. Transportation was also a limiting factor for low-resource individuals and families; it affects one’s ability to get to work, school and child care in a timely and efficient manner.

“Transportation is a major barrier to health services. Going to the ER late at night in an ambulance means a very long walk home for many of us.”
— BID-Plymouth survey respondent

Issues related to food insecurity, food scarcity and hunger were discussed as risk factors for poor health for adults and children. Throughout BILH’s CBSA, most residents have adequate access to grocery stores. Individuals engaged throughout the assessment processes were more concerned with the quality and nutritional value of food offerings. Research shows that a number of factors influence healthy eating, including the quality and price of fruits and vegetables, marketing of unhealthy food and limited education of food preparation.8

“[There is a] lack of information and training on making healthy choices and preparing healthy foods...”
— BID-Milton survey respondent

DATA FINDINGS: FOOD INSECURITY

• Certain Boston neighborhoods (Dorchester and Roxbury) had significantly higher percentages of residents who reported being food insecure compared to Boston overall.

• The percentage of residents who received SNAP (food stamp) benefits in the past year was significantly higher in Chelsea, Lowell, Lynn, Randolph and Somerville than in the Commonwealth overall.

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Domestic/interpersonal violence, community violence and the impacts of trauma were identified as issues of concern, particularly in urban communities. These issues impact health on many levels, from death and injury to emotional trauma, anxiety, isolation and absence of community cohesion. They were particularly relevant in urban communities (Boston, Chelsea and Lynn).

DATA FINDINGS: COMMUNITY SAFETY

• 25% of respondents to the Boston CHNA-CHIP Collaborative survey described their neighborhoods as unsafe or extremely unsafe. Black/African American, non-Hispanic/Latino and Hispanic/Latino respondents were more likely to respond this way compared to respondents of other races/ethnicities.

KEY FINDINGS: HEALTH STATUS & OUTCOMES

Deaths from all causes (all-cause mortality), deaths before the age of 75 (premature mortality) and disease-specific mortality rates (e.g., deaths due to cancer and heart disease) were significantly higher in many municipalities than in the Commonwealth. Several communities emerged as geographic hotspots—Billerica, Burlington, Carver, Haverhill, Kingston, Lowell, Lynn, Merrimac, Salisbury and Tewksbury—where mortality rates were higher than those in the Commonwealth across several conditions.

Chronic disease risk factors (e.g., high blood pressure, physical inactivity, poor nutrition, tobacco/alcohol use) were concerns for nearly all segments of the population. Among key informant interviewees, survey respondents, focus group participants and community forum/listening session respondents, chronic disease risk factors were prioritized. All BILH levels, from death and injury to emotional trauma, anxiety, isolation and absence of community cohesion. They were particularly relevant in urban communities (Boston, Chelsea and Lynn).

DATA FINDINGS: MORTALITY

• All-cause mortality rates were highest in Beverly, Billerica, Burlington, Carver, Danvers, Haverhill, Kingston, Lowell, Lynn, Merrimac, Plymouth, Salisbury and Tewksbury.
• Premature mortality rates were highest in Carver, Haverhill, Lowell, Lynn, Randolph and Salisbury.
• Heart disease mortality rates were highest in Amesbury, Beverly, Billerica, Burlington, Essex, Georgetown, Haverhill, Kingston, Merrimac, Lynn, Newbury, North Reading, Rowley, Salisbury, Tewksbury and Westwood.
• Cancer (all-types) mortality rates were highest in Billerica, Boston, Burlington, Carver, Danvers, Dedham, Groveland, Gloucester, Haverhill, Kingston, Lowell, Lynn, Merrimac, North Reading, Quincy, Stoneham, Somerville, Salisbury Tewksbury and Wilmington.
hospitals prioritized health education and prevention, identification and risk screening/assessments and chronic disease management programs in their Implementation Strategies to address and control these issues within their CBSAs.

“[The hospitals] should provide information on basic preventive care that can be passed through community organizations to residents. It would be helpful for people to be reminded about why prevention is important.”
— Mount Auburn Hospital key informant

Leading mental health issues were depression, anxiety, stress, suicidality, social isolation and the impacts of trauma. Mental health issues underlie many health and social concerns, and their impacts were discussed in nearly all key informant interviews and focus group/listening sessions across BILH’s CBSA. Individuals from across the health services spectrum discussed the burden of mental health issues, specifically the prevalence of depression and anxiety, for all segments of the population. For youth/

“Mental health care is the hardest to access—for kids and adults. It’s nearly impossible to find someone who takes standard/good insurance and will see a kid or family after school or on weekends in this area.”
—BID-Needham survey respondent

adolescents, key informants and focus group/listening session participants were concerned about depression, anxiety, chronic stress and suicidality.

Many key informants and focus group/listening session participants identified social isolation as an issue for older adults. Participants suggested several reasons for this—lack of friends of family, inability to leave the home due to frailty or limited access to transportation or unwillingness to leave the home for unknown reasons. While there are many active senior centers and Councils on Aging throughout BILH’s CBSA, it could be difficult for older adults to attend activities or utilize services because of transportation or mobility issues.

DATA FINDINGS: MENTAL/BEHAVIORAL HEALTH MORTALITY

• Deaths due to mental/behavioral health issues were significantly higher in Beverly, Danvers, Medford, Peabody, Wakefield and Wilmington than in the Commonwealth.
Leading substance use issues were opioids, vaping and e-cigarette use (especially for youth/adolescents, LGBTQ+), alcohol misuse and marijuana. Along with mental health, individuals who engaged in assessment processes named substance use as a leading health issue. Behavioral health providers reported that individuals struggle to access behavioral health services, including rehabilitation and detoxification, inpatient and outpatient treatment, counseling and supportive services. As with mental health services, there are a number of community partners working to fill service gaps and address needs.

The opioid epidemic continues to be a critical concern for individuals, families and communities at large. Key informants, focus group/listening session participants and survey respondents were concerned about the traumatic effect the opioid epidemic has had on the children of parents with opioid issues and grandparents caring for these children.

People were concerned about vaping and e-cigarette use, especially among youth and adolescents. Recent legislation banning the sale of these products will have an impact on their use. Alcohol misuse and marijuana use were also concerns for this population.

DATA FINDINGS: SUBSTANCE USE MORTALITY

- Fatal opioid overdoses were highest in Boston (245), Lowell (72), Lynn (48), Quincy (39), Haverhill (25), Burlington (20), Plymouth (20), Gloucester (16) and Woburn (14) in 2018.

“There is also an intergenerational challenge [with substance use]… Older folks are now taking care of their grandchildren; that must place a lot of stress on them if they weren’t expecting or prepared for it.”

—Boston CHNA/CHIP Collaborative key informant
KEY FINDINGS: ACCESS TO CARE

Though Massachusetts has one of the highest health insurance coverage rates in the nation, there are individuals who struggle to enroll in, understand and maintain their health insurance. This was particularly an issue for older adults attempting to navigate Medicaid/MassHealth eligibility, costs and coverage; those who do not meet eligibility requirements for public insurance and/or public assistance programs and who struggle to afford the rising costs of health care premiums; and non-English speakers who face language and cultural barriers when navigating the health system.

Underinsurance was a commonly identified barrier to care. While many individuals are insured, coverage might not be enough for all health care needs. For individuals covered under Medicaid/MassHealth, there might be a limited number of specialty providers who accept their insurance or who accept it only for a limited number of visits.

Residents in BILH’s community benefits service area reported shortages and difficulty accessing mental health, substance use and specialty care (e.g., geriatrics, dermatology) services. Though many of the communities in BILH’s CBSA have strong systems of safety net providers, there are many low-income, Medicaid insured, uninsured and other vulnerable people who struggle to access specialty care services and the continuum of behavioral health care services. Issues that impede the ability of individuals to access these services include insurance coverage, shortages of providers (particularly non-English speaking providers), costs of care and challenges in navigating the health system.

Many barriers to care are related to social determinants of health—cost of care, lack of transportation and lack of health literacy. The complexity of the health insurance and health care systems overall was frequently identified as a barrier to care. Many individuals engaged throughout the assessment processes recognized that Greater Boston has a wealth of world-class medical providers, facilities and resources. Despite this, many reported that segments of the population—namely frail elders, non-English speakers, individuals with disabilities and low-resource individuals and families—struggle to understand what services are available and how to access them.

DATA FINDINGS: HEALTH INSURANCE

- The percentage of the population that was uninsured was significantly higher in Boston, Chelsea and Lowell than in the Commonwealth.
- The percentage of the population with public insurance (e.g., Medicaid/MassHealth, Medicare) was significantly higher in Boston, Chelsea, Gloucester, Lowell, Lynn and Randolph than in the Commonwealth.
As mentioned earlier in this report, BILH and all of its hospitals are committed to promoting health, enhancing access and delivering the best care for those who live throughout its service area. Certainly all geographic, demographic and socioeconomic segments of the population face challenges of some kind that can hinder their ability to access care or maintain good health. Regardless of age, race/ethnicity, income, family history or other characteristics, health-related risks have an impact on everyone. With this in mind, BILH’s hospital Community Benefits Departments are charged with working collaboratively with their community partners to develop programming geared to improving overall well-being and creating a healthy future for all individuals, families and communities throughout its CBSAs. However, recognizing the considerable health disparities that exist for certain demographic and socioeconomic segments of the population and in some geographic communities, BILH and representatives on its CBAC direct investments and resources toward improving the health status of those who are underserved and most vulnerable throughout its CBSA. By doing so, BILH is able to maximize the impact of its Community Benefits resources.

Priority Populations and Community Health Priorities

As discussed in Section 3, Summary Approach and Methods, each hospital CBAC was responsible for reviewing the findings from its CHNA and identifying the segments of the population believed to be most vulnerable by race/ethnicity, socioeconomic status, health status issues and other factors. While there was some variation across hospital CBSAs, the majority of the hospitals CBACs and senior leadership teams voted to prioritize the following population segments: youth and adolescents, older adults, low-resource individuals and families, individuals with chronic/complex conditions, racially/ethnically diverse populations and non-English speakers and LGBTQ+ populations.

**FIGURE 8: BILH Community Health Priority Populations**

<table>
<thead>
<tr>
<th>Youth and Adolescents</th>
<th>Older Adults</th>
<th>Low-resource Individuals and Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with Chronic/Complex Conditions</td>
<td>Racially/Ethnically Diverse; Non-English Speakers</td>
<td>LGBTQ+</td>
</tr>
</tbody>
</table>
All 10 of BILH’s hospital CBACs chose to prioritize older adults and low-resource individuals and families. Nine of 10 BILH’s hospital CBACs chose to prioritize youth and adolescents. Six out of 10 CBACs chose to prioritize those with chronic and complex conditions. Many communities prioritized racially and ethnically diverse population segments, non-English speakers and LGBTQ+ population segments, but the CBACs in some communities did not feel the assessment findings warranted prioritizing these segments over larger, more vulnerable segments.

Similarly, each hospital CBAC reviewed the findings from its CHNA and identified the leading community health priorities that it believed would be the most important drivers of community health improvement. There was limited variation across the hospital CBSAs with the vast majority of hospitals CBACs and senior leadership teams voting to prioritize the following community health issues: mental health, substance use, chronic and complex conditions and their risk factors, access to care and social determinants of health.

**FIGURE 9: BILH Community Health Priority Areas**

**Community Health Priorities:**

- All 10 of BILH’s hospital CBACs chose to prioritize chronic/complex conditions and their risk factors
- 9 out of 10 hospitals chose to prioritize mental health and substance use, social determinants of health and access to care
- 1 hospital chose to prioritize healthy aging
- 1 hospital chose to prioritize cancer
- 1 hospital chose to prioritize health systems issues (e.g., care coordination, health literacy and service integration)
In developing the hospital Implementation Strategies, the CBACs were careful to ensure that they were aligned with Commonwealth of Massachusetts priorities as set by the Massachusetts Department of Public Health (MDPH) and the Massachusetts Health Policy Commission (MHPC). With this in mind, Commonwealth priorities were reviewed at the hospital prioritization retreats and considered during the prioritization process. In this regard, there was clear alignment with priorities selected by the CBACs and leading community health issues identified by the assessments. Mental health, substance use, chronic disease, obesity and fitness and the social determinants of health were the leading concerns and issues discussed at the CBAC meetings and community engagement activities. With respect to the social determinants of health, housing was the leading concern, followed by financial insecurity, food access and transportation. With respect to chronic disease, heart disease, diabetes and cancer were the leading issues, along with the risk factors related to these conditions (e.g., obesity, fitness and nutrition). Violence was a major concern in many communities, particularly in the more urban service areas; domestic violence was mentioned as a concern in nearly every CHNA.

### TABLE 5: Commonwealth Community Health Priority Areas

<table>
<thead>
<tr>
<th>MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH</th>
<th>MASSACHUSETTS HEALTH POLICY COMMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY BENEFIT PRIORITY</td>
<td>DETERMINATION OF NEED PRIORITIES</td>
</tr>
<tr>
<td>• Housing stability and homelessness</td>
<td>• Built environments</td>
</tr>
<tr>
<td>• Mental illness and mental health</td>
<td>• Social environments</td>
</tr>
<tr>
<td>• Substance use disorders</td>
<td>• Housing</td>
</tr>
<tr>
<td>• Chronic disease, with a focus on cancer, heart disease and diabetes</td>
<td>• Violence</td>
</tr>
<tr>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td>• Employment</td>
</tr>
</tbody>
</table>
The hospitals worked to ensure that their Implementation Strategies included a broad range of evidenced-informed initiatives, drawn from the Commonwealth’s Community Benefit Guidelines and the literature, that are thought to be critical to improving health status, promoting engagement in care, enhancing access and facilitating collaboration. The following is a framework of initiatives that the CBAC used to ensure that they had a well-balanced Implementation Strategy.

**Cross-Sector Collaboration and Partnership:**
There is a growing realization that when it comes to improving health status and addressing the underlying determinants of health, no one organization can be successful on its own. Success requires investments to support community collaboratives and partnerships between service providers and community organizations within and across multiple sectors (e.g., health, public health, education, public safety and community health).

**Social Determinants of Health (SDOH) Programming (Food Access, Transportation, Housing and SDOH Screening):** With respect to promoting health and addressing disparities, sustained success relies on addressing the underlying social determinants of health. These social determinants have been defined as “the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities.” The leading social determinants of health include issues such as poverty, housing, food access, violence, racism/bigotry and transportation. It is important that hospital Implementation Strategies include collaborative, cross-sector initiatives that address these issues.

**Primary and Secondary Prevention (Awareness, Health Education and Prevention):** Initiatives that aim to prevent disease or injury before it occurs by reducing risks, preventing exposures to hazards or altering unhealthy behaviors are essential to all Implementation Strategies. Programs may also include targeted efforts to raise awareness or reduce the stigma related to a particular condition or provide information on risks and protective factors.

**Outreach, Screening and Engagement in Care or Referral (chronic/complex disease screening, assessment and navigation):** Screening and assessment programs for specific disease conditions that identify those at risk early and reduce the chances of death or ill health are also critical. Screening on its own, however, is not enough. Once people are identified as having a condition, it is crucial that those in need are referred to appropriate care through warm hand-offs to providers or through referral processes that maximize the chances of engagement.

**Behavior Modification and Chronic Disease Management:** Evidence-based behavioral modification, self-management support and other chronic disease management programs that encourage individuals to manage their health conditions, change unhealthy behaviors and make informed decisions about their health are critical to addressing chronic and complex conditions.

**Care Coordination and Patient Navigation:** Initiatives that support patients as they navigate the complex health care system and coordinate their care across multiple providers or service settings are critical to enhancing access and sustaining appropriate engagement in care. Implementation Strategies need to include eligibility and enrollment, case management or peer navigation initiatives.

**Service Integration and Access to Care:** Efforts aimed at integrating services within or across sectors, such as primary care and behavioral health services or housing and employment supports, are important components of Implementation Strategies. Equally important are efforts to expand capacity and address gaps in a particular service or program area, such as expanding medical specialty care or mental health and substance use treatment.

Finally, the hospital community benefits staff reviewed their current portfolio of community benefits programs to understand which activities were having a positive impact and still aligned with community need. In this regard, there was an understanding that partnerships and programs take time to develop and become effective. Any programs that were working well and aligned with need were retained.
Selected Examples of Interventions from Implementation Strategies

BILH hospitals support programs were carefully selected to address the priorities identified through our assessment and planning processes. In addition to targeting social determinants of health such as housing, transportation and food insecurity, the selected programs work to strengthen service delivery systems, promote cross-sector collaboration, support care coordination and service integration and address the leading health challenges facing its communities, such as depression, opioid use, diabetes and obesity. All initiatives, delivered both directly and in collaboration with community-based organizations, are aligned with the Commonwealth’s Community Benefits priorities and designed to have positive impacts on both individual and population health.

The following are examples of community benefits interventions that have been included across BILH’s hospital Implementation Strategies for each of the service or programmatic strategies articulated above.

Anna Jaques Hospital: The Persist Program

The Persist Program at Anna Jaques Hospital supports women with substance use disorder and/or neonatal abstinence syndrome, a condition that impacts about 14.5 cases per 1,000 births in Massachusetts. A dedicated Patient Care Navigator champions women throughout their pregnancies and into the first year of motherhood, working in collaboration with Women’s Health Care and the Anna Jaques Birth Center & Neonatal Care Center. Since the beginning of the program, there has been a steady decline in the number of substance-exposed babies from a high of 91 in 2017 to 56 in 2018 and 24 in 2019.

Beth Israel Deaconess Hospital–Milton: Addressing Substance Misuse and Social Emotional Learning Needs in the Milton Public Schools

A Youth Risk Behavior Survey undertaken by the Milton Public Schools in 2017 highlighted the number of students struggling with anxiety, depression, underage drinking and substance use disorder. In addition, results of a town-wide survey of parents reflected their interest in developing more skills to navigate the social and emotional development of their children. Beth Israel Deaconess Hospital–Milton (Bid-Milton) partnered with the Milton public schools by providing community benefits funding to implement parent, staff and student education related to substance use disorder as well as social and emotional learning. The Promoting Awareness and Resources for the Emotional Nurturing of Teens (PARENT) Speaker Series included presentations from child development and behavioral health experts and provided parents with the skills and education needed to build emotional resilience in their children. In the first year of the PARENT Speaker Series, eight programs were conducted and attended by 1,100 parents and 4,000 students.

Beth Israel Deaconess Hospital–Needham: Medical Appointment Transportation Program through Needham Community Council

Transportation is a barrier to accessing health care. Research shows that lack of transportation leads to rescheduled or missed appointments, delayed care and missed or delayed medication use. Beth Israel Deaconess Hospital–Needham (Beth Israel Deaconess-Needham) supports a medical appointment transportation program through Needham Community Council to assist patients with getting to medical appointments, a key step in managing chronic disease. The Council originally relied on a volunteer driver program to fulfill demand, but to meet growing transportation needs, a supplemental program was started using the ride-share service Lyft. This program is becoming a statewide model for transportation and was highlighted in the Governor’s Transportation Work Group Recommendations.

Beth Israel Deaconess Hospital–Plymouth: PreVenture Program with Plymouth Public Schools

Knowing that the onset of substance use disorders can occur during adolescence, Beth Israel Deaconess–Plymouth and Plymouth public schools are collaborating to address this risk within a targeted program. PreVenture is an evidence-based prevention and education program that uses personality testing to identify, understand and prevent youth from engaging in destructive behaviors and to strengthen mental well-being and skills development. PreVenture has been shown to be effective in delaying the onset of adolescent substance use as well as in reducing the frequency of drug use and binge drinking and other alcohol-related problems.

Beth Israel Deaconess Medical Center: Center for Violence Prevention and Recovery

The effects of trauma and violence on the physical and mental health of individuals, families and communities are both deeply personal and a public health concern. For 45 years, Beth Israel Deaconess Medical Center’s Center for Violence Prevention and Recovery (CVPR) has provided confidential and free services and programs for survivors of sexual assault, domestic violence, community violence,
homicide, terrorism and trafficking. Supporting 700 individuals each year, the CVPR’s expert clinicians not only help reduce the barriers to mental and physical health care that survivors often need, but also train health care providers to identify and respond to people who are experiencing or have previously experienced violence.

**Beverly and Addison Gilbert Hospitals: Compass/Moms Do Care Program**

The devastating effects of the opioid crisis touch the lives of people across the Commonwealth, with the youngest affected most often being the children of parents with substance use disorder. Beverly and Addison Gilbert Hospitals identified an urgent need for mental health and substance use treatment for pregnant and parenting women and newborns in Essex County; in 2017, they launched the Compass/Moms Do Care Program. Through a multidisciplinary approach, a care team delivers trauma-informed, evidence-based maternal and neonatal care, while providing comprehensive support for substance-exposed newborns and their families. Since the program began, the hospitals have seen a reduction in overall hospital stays and neonatal intensive care unit lengths of stay for substance-exposed newborns, a decrease in neonatal abstinence treatment and referrals for early intervention, and strong staff engagement.

**Lahey Hospital & Medical Center Senior Farmers Markets**

Proper nutrition is essential to good health, particularly for seniors and individuals with chronic diseases. Yet lack of access to food and food insecurity are serious concerns for many senior citizens in the region. Lahey Hospital & Medical Center has established a successful partnership with World PEAS, an organization that grows local organic produce for Middlesex County. The organizations host a series of farmers markets for 20 weeks at the Burlington, Arlington and Billerica Councils on Aging—targeting communities where the need for fresh, healthy foods is most acute. The markets have become extremely successful in making fresh fruits and vegetables more accessible and affordable for seniors in the community, with more than 30,000 pounds of produce distributed over the course of the program.

**Mount Auburn Hospital: Partnering with Local Health Departments**

Realizing that local health departments have unique perspectives on the needs of the community members they serve, Mount Auburn Hospital has instituted an annual non-competitive grant program for the cities and towns in its service area. In addition to the grant funding, Mount Auburn Hospital offers training and technical assistance with program implementation. Grants support the departments’ efforts to address one or more of the top health concerns identified in its most recent CHNA. These include mental health, substance use, chronic/complex conditions and healthy aging, as well as projects related to social determinants of health and health care access.

**New England Baptist Hospital: Senior Celtics Program**

Chronic disease and social isolation are significant issues for the older adult population living in the Boston neighborhoods of Mission Hill and Roxbury. Lack of physical fitness and poor nutrition are among the leading risk factors associated with obesity and chronic health issues. New England Baptist Hospital has partnered with the Boston Celtics to offer the Senior Celtics Program that provides fitness classes and health education for older adults living in these two neighborhoods. The program helps decrease elder isolation, prevent obesity, improve nutrition, increase physical activity to reduce the risk for many chronic conditions and improve emotional health. Over the past six years, the program has grown from 38 participants per class to more than 125 older adults participating overall.

**Winchester Hospital: Community and Hospital Asthma Management Program**

Asthma is the leading chronic disease in children, affecting approximately 10% of the population under the age of 18. In fact, it is the number one reason for missed school days. Winchester Hospital’s Center for Healthy Living developed and launched the Community and Hospital Asthma Management Program (CHAMP), a model of care incorporating a team approach proven to help children with asthma manage the condition more effectively. The team consists of family members, caregivers, the child’s pediatrician and/or primary care physician, clinical staff from Winchester Hospital, the child’s school nurse, child care personnel, teachers and anyone else who may be in a position to advise the child and the child’s parents about his/her asthma management. CHAMP is making an impact. Over the past year, 2,121 contacts were made with families of the children enrolled in the program to support, update and educate; in the same time period, 461 asthma plans have been filed with physicians, parents and schools.
Beth Israel Lahey Health’s commitment to the well-being of the communities we serve is as fundamental as our commitment to patient care. BILH embraces the opportunity to make a difference in neighborhoods, schools and workplaces by developing tailored programs that promote health, enhance access and create healthy futures for individuals and families. The hospitals that are part of the BILH system invested tremendous resources to fulfill their community benefits missions. It is important to note, however, that we do not do this alone. BILH and its hospitals are committed to collaborating with local service providers, public health departments, businesses, community residents and other stakeholders, because we know that by working together we can do much more than we can on our own.

BILH’s 2019 community health assessment activities show that there is tremendous work to be done to reduce the impacts of the leading health issues and to eliminate disparities with respect to race, ethnicity, gender identity, sexual orientation and poverty. BILH’s leadership is extremely proud of the work that has been accomplished over the past years to assess community need, engage the communities it serves, identify those most at risk, prioritize the leading health issues and develop strong, collaborative Implementation Strategies. This will provide a strong foundation to guide BILH’s efforts over the next three years to implement community initiatives and achieve our community benefits mission.

BILH was created with the understanding that to keep our patients and our communities healthy we must develop a more integrated approach to health care focused on prevention, improved access, service integration, care coordination and the underlying social determinants of health. There is power in coming together as a system, and BILH’s leadership is working to leverage resources in ways that will help ensure that we provide the highest quality care to our patients and communities. BILH will not, however, lose sight of the fact that our strength lies in our ability to tailor services, develop partnerships and make connections at the community level. Moving forward, BILH’s CBAC will continue to play a central role in overseeing and guiding hospital community benefit activities. BILH’s Community Benefits staff will explore opportunities to align efforts with respect to assessment, community engagement, program implementation and evaluation to maximize our impact in the communities we serve.