Beth Israel Deaconess–Needham Implementation Strategy 2020 - 2022

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

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

CORE IMPLEMENTATION STRATEGY PRINCIPLES AND STATE PRIORITIES

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

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

State Community Health Priorities

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

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

- **Social Determinants of Health:** With respect to community health improvement, especially for low income and disadvantaged populations, there is growing appreciation for the importance of addressing the underlying social determinants of health, “the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities.”[1] The leading social determinants of health include issues of poverty, housing, food access, violence, racism/bigotry, and transportation. It is important that hospital implementation strategies include collaborative, cross-sector initiatives that address these issues.
- **Health Education and Prevention:** Primary prevention aims to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aims to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared to helping people to manage health conditions, lessen a condition’s impact, or slow its progress. Targeted efforts across the continuum to raise

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

awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

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

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

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

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

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

COMMUNITY HEALTH PRIORITY POPULATIONS AND NEEDS

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

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

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

Community Health Needs not Prioritized by BID–Needham's CBAC

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

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

I. Community Health Priorities

Priority Area 1: Mental Health and Substance Use

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Educate about and reduce stigma associated with mental health and substance use Issues	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase community education and awareness of substance use/misuse and healthy mental, emotional, and social health • Reduce the stigma associated with mental illness/ mental health and substance use/misuse, and addiction	• Support **Mental Health First Aid** trainings in targeted community-based settings to raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use • Provide **Community Health Mini Grants** to local departments of Health or other community-based partners to support evidence-based programs that promote mental health and substance use education and prevention • Support **Mental Health and Substance Use Support Groups** for those with or in recovery from mental health or substance use and their family/friends/caregivers to raise awareness, reduce stigma, educate, and promote coping/recovery • Support **Community-based Health Education Events** and programming with community partners to raise awareness, and educate on risk/protective factors, and services available in the community.	• # of Mental Health First Aid, or other education/awareness events supported • # of participants participating in Mental Health First Aid trainings, or other education/awareness events • Pre- and post-test assessments of knowledge or perceptions at events (If possible) • # of mini grants funded • Amount of $s distributed • # students trained by substance use	• CHNA 18 • Local Police, Fire, and Public Health Departments • Local Town Governments • Public Schools • BH Outpatient Service Providers • Elder Services Providers • Other community partners

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
			• Support **Substance Use Prevention Programming** and curriculum in local schools.	curriculums developed in schools • Other more outcome related measures for tracking impact of community benefit activities (TBD)	
Enhance access to mental health and substance use screening, assessment, and treatment services	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Promote cross-sector partnership, collaboration, and information sharing across the broad health system to address access to mental health and substance use services • Increase access to clinical and non-clinical support services for those with mental health and substance use issues, with an emphasis on priority populations • Increase access to peer support for those with mental health and substance use and their family, friends, and caregivers • Reduce inappropriate use of ED and other acute care services • Increase access to screening, education, referral, and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and non-clinical settings, with an emphasis on priority populations • Increase access to insurance, patient navigation support, and	• **Participate in local and regional coalitions and task forces** to promote collaboration, share knowledge, and coordinate community health improvement activities • **Provide health insurance enrollment counseling/assistance and patient navigation support services** to uninsured or underinsured residents and patients with mental health and substance use issues • Support the **Interface Mental Health Hotline,** which provides education and referral services for those seeking mental health counseling services • Look into developing **integrated behavioral health services (mental health and substance use) in Primary Care and other specialty care settings** (Impact Model) for those with or at-risk of mental health issues, including screening, assessment, and treatment • Explore **partnerships with elder service providers** that reach out to and serve isolated older adults not currently engaged in Council on Aging activities • Explore partnerships with Local Health Departments, substance use providers,	• # of community meetings attended by hospital staff to promote collaboration, share information, and integrate best practice ideas • # of people supported by Interface Mental Health Hotline • # of primary care or specialty care practices involved in behavioral integration efforts • # of patients receiving treatment • # of people supported by the CCIT program • # of people referred for services by CCIT program	• CHNA 18 • Local Police, Fire, and Public Health Departments • Public Schools • BH Outpatient Service Providers • Elder Services Providers • Other community partners

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
		other enabling/ supportive services for those with mental health and substance use issues, with an emphasis on priority populations • Increase access to peer recovery coaches for those with substance use/misuse issues • Reduce elder health isolation and depression • Increase the number of practice settings with integrated behavioral health and primary care/specialty care services • Increase primary care and specialty care follow-up after discharge from hospital settings	and BID–Needham departments to implement **Peer Recovery Coach Programs** geared to linking those with substance use/misuse issues to peer recovery coaches who provide recovery, case management, and navigation support • Research implementation of a **BID–Needham Bridge Program** for those suffering from substance use disorder that screens, identifies, assesses, initiates treatment, and links participants to long-term SUD services in the community • Support the **Community Crisis Intervention Team (CCIT)**, a partnership between hospital emergency departments, public safety officials, and behavioral health providers geared to reaching out to, referring, and engaging substance users/misusers in treatment • Support organizations that provide support or engagement activities to promote social engagement for those who are isolated or struggling with mental health		
Decrease the number of prescription drugs and other harmful drugs from the community	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex	• Decrease the availability of unused prescription drugs • Increase the # of opportunities that residents of the service area can give back unused prescriptions	• Support **“Drug Take Back Days”** with Commonwealth and local law enforcement and other community-based partners • Maintain **Prescription Drug Disposal Kiosk** in the lobby of the hospital to provide a safe place for the community to dispose of unwanted/ unneeded drugs • Continue BID–Needham Opioid Taskforce to decrease use of and prescribing of	• # of “Drug Take Back Day” Events held • # of pills or # of pounds of prescription drugs taken back • Can we add something to track Opioid Taskforce such as “Initiatives	• US Drug Enforcement (DEA) • Local Police and Fire • Public schools • Councils on Aging • Health Departments

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
	Conditions		opioids in the hospital, and to educate patients on opioid use and alternatives for pain management.	started by Opioid Taskforce”	

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

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who are educated about chronic disease risk factors and protective behaviors • Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services • Increase the number of people with chronic/complex conditions whose conditions are under control	• **Participate in coalitions and task forces** to promote collaboration, share knowledge, and coordinate community health improvement activities • Partner with community groups to offer **wellness, fitness education and other events** as part of comprehensive chronic disease management for underserved community members, and other priority population segments • Provide **First Aid, CPR and Stroke Management Trainings** to residents, service providers, and first responders as part of comprehensive chronic disease prevention and management efforts • Provide evidence-based **health education on risk/protective factors, and self-management support programs** through partnerships with community-based organizations • Support **screening, education, and referral programs** in clinical and non-clinical settings • Promote enhanced **care transitions, care coordination and follow-up care programs** targeting those with	• # of community meetings attended by hospital staff to promote collaboration, share information, and integrate best practice ideas • # of health education, fitness, wellness, CPR, or other chronic disease management events supported by type, setting, and priority population • # of people participating in education, fitness, wellness, CPR, or other chronic disease management events by type, setting, and priority population • # of patients referred for more intensive	• CHNA 18 • Local Police, Fire, and Public Health Departments • Public Schools • BH Outpatient Service Providers • Elder Services Providers • Other community partners • BID–Needham hospital inpatient / ED staff and other outpatient specialty, and primary care staff • Charles River YMCA • VNA Care Network • Local Councils on

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
			chronic/complex conditions after discharge from the Hospital • Provide **Community Health Mini Grants** to community partners to support evidence-based programs that promote health education, screening, referral, and chronic disease management for priority populations	care management, or specialty care support • # of mini grants funded • Amount of $s distributed	Aging
Reduce the prevalence of tobacco use	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who quit smoking cigarettes, vaping, or using e-cigarettes • Increase access to tobacco, vaping/e-cigarette cessation programs	• Support ***Smoking Cessation Programs*** geared to reducing tobacco, vaping and e-cigarette use • Provide community education on the risks of vaping and tobacco use	• # of smoking cessation programs supported • # of people participating in smoking cessation programs • Pre- and post-test assessment of those participating in Freedom from Smoking Program • # of people educated on the risks of tobacco use/vaping	• American Cancer Association • Local Schools • Local health departments

Priority Area 3: Social Determinants of Health and Access to Care

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Enhance access to care and reduce the impact of social determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions s	• Increase partnerships and collaboration with social service and other community-based organizations • Increase educational opportunities related to the importance and impact of social determinants • Decrease the number of people who struggle with financial insecurity • Increase access to low cost healthy foods with an emphasis on priority population segments • Increase access to affordable, safe transportation options with an emphasis on priority population segments • Increase training and employment opportunities for low to moderate income residents with an emphasis on priority population segments • Increase the number of people assisted with insurance and other public program enrollment, and patient navigation • Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports	• **Participate in regional and local task forces and coalitions** to promote collaboration, share knowledge, and coordinate community health improvement activities • Provide **Community Health Mini Grants** to community partners to support evidence-based programs that address social determinants and access to care • Support farmers markets and other food access initiatives that provide fresh, locally-grown produce to low to moderate income, underserved populations • **Support local food access organizations and initiatives** to provide nutrition education to low and moderate income populations living in public housing, school-based after-school programs, Councils on Aging, and other community venues • Support **wellness and nutrition education events** in partnership with community partners • Support partners and initiatives that **enhance access to healthy food** for older adults and low to moderate-income individuals and families • Provide **enrollment counseling/ assistance and patient navigation support services** to uninsured or underinsured residents to enhance access to care • Provide **linguistically and culturally**	• # of community meetings attended by hospital staff to promote collaboration, share information, and integrate best practice ideas • # of mini grants funded • Amount of $s distributed • # of people assisted with insurance enrollment or provided navigation support • Pre- and post-test assessments of knowledge or perceptions at events (If possible) • # of Transportation Access Partnerships • # of people supported with transportation through Transportation Partnerships • # of workforce partnership programs supported	• CHNA 18 • Local Police, Fire, and Public Health Departments • Public Schools • BH Outpatient Service Providers • Elder Services Providers • Other community partners • BID–Needham hospital inpatient / ED staff and other outpatient specialty, and primary care staff

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
			appropriate health education and care management support • Organize and support **workforce mentorship and training programs** to enhance job training, skills development, and career advancement • Collaborate with community organizations to provide **transportation to medical appointments**.	• # of people supported by Workforce Partnership by program and priority population • # of health literacy events scheduled	
Reduce Elder Falls and Promote Aging in Place	• Older Adults	• Reduce fear of falling • Reduce Falls • Increase activity levels • Reduce preventable Emergency Department and inpatient visits • Increase the number of older adults living independently in their homes	• Support **Safety at Home Program** for older adults to promote aging in place and reduce falls • Support the **Fall Prevention Committee** to reduce Falls • Organize **Matter of Balance workshops** for priority populations • Support other elder service programming to encourage aging in place	• # of Matter of Balance events supported • # of people participating in Matter of Balance or other events to encourage aging in place • Pre- and post-test assessment of those participating in Matter of Balance events	• Elder Service Providers • Local Councils on Aging