Community Benefits Report

Fiscal Year 2019

Beth Israel Lahey Health
Beth Israel Deaconess Needham

Table of Contents

		PAGE NUMBER
SECTION I:	**MISSION STATEMENT** Target Populations and Basis for Selection Key Accomplishments Plans for Next Reporting Year	**3-10**
SECTION II:	**COMMUNITY BENEFITS PROCESS** Community Benefits Leadership/Team Community Benefits Advisory Committee Meetings Community Partners	**10-13**
SECTION III:	**COMMUNITY HEALTH NEEDS ASSESSMENT** Date of Last Assessment Completed and Current Status Approach & Methods Summary of Findings	**14-16**
SECTION IV:	**COMMUNITY BENEFITS PROGRAMS** Brief Descriptions Goal Descriptions Goal Status	**17-96**
	Health Risk Factors and Primary Prevention	**18-41**
	Physical Disease Management	**42-63**
	Behavioral Health: Mental Health & Substance Use	**64-79**
	Healthy Aging	**80-96**
SECTION V:	**EXPENDITURES**	**97-98**
SECTION VI:	**CONTACT INFORMATION**	**98**
SECTION VII:	**SELF-ASSESSMENT FORM**	**99-108**

Section I: MISSION STATEMENT

Summary and Mission

Beth Israel Deaconess Hospital–Needham (BID Needham or hospital) is a member of Beth Israel Lahey Health (BILH). BILH was established with an appreciation for the importance of caring for patients and communities in new and better ways. BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery – from academic and teaching hospitals, to community hospitals such as BID Needham, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

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

The Board of Trustees, Board of Advisors, leadership and staff at Beth Israel Deaconess Hospital–Needham are dedicated to working in partnership with residents, community leaders, and civic, social and medical organizations in the communities the hospital serves. The hospital's commitment to the community benefit ideals also includes conducting periodic community health needs assessments, providing extensive opportunities for public input, assisting financially disadvantaged patients to obtain healthcare, and participating in ongoing evaluation processes. We believe that the cooperative and collaborative partnerships we develop through our Community Benefits programs will help us address the health and welfare needs of our community.

BID Needham's Community Benefits mission is fulfilled by: working with community partners to enhance knowledge of identified key health issues in the region and promoting available resources; enhancing access to care and providing financial counseling services to help vulnerable populations gain access to health care; planning and implementing community programs and services to improve public health, promote wellness, and to increase health literacy around chronic disease prevention and management, behavioral health and healthy aging. Beth Israel Deaconess Hospital–Needham's mission is supported by the hospital's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect and collaboration; and a commitment to maintaining financial health.

The following annual report provides specific details on how Beth Israel Deaconess Hospital–Needham is honoring its commitment and includes information on the Hospital's Community Benefits Service Area (CBSA), community health priorities, target populations, and community partners, as well as detailed descriptions of its community benefits programs and their impacts.

More broadly, the Beth Israel Deaconess Hospital–Needham's Community Benefits mission is fulfilled by:

- **Involving Beth Israel Deaconess Hospital–Needham's staff**, including its leadership, as well as community partners, in the community health needs assessment process and in the development, implementation, and oversight of the Implementation Strategy;

- **Engaging and learning from residents** throughout BID Needham's service area in all aspects of the community benefits process, including assessment, planning, implementation, and evaluation. In this regard, special attention is given to engaging diverse perspectives from those who are not patients of Beth Israel Deaconess Hospital–Needham and those who are often left out of these assessment, planning, and program implementation processes;

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

- **Implementing community health programs and services** in Beth Israel Deaconess Hospital–Needham's Community Benefits Service Area that is geared towards improving current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the healthcare system, and working to decrease the burden of the leading health issues;

- **Promoting health equity** by addressing social and institutional inequities and racism, as well as ensuring that all patients are welcomed and received with respect and culturally responsiveness; and

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

Name of Target Population

Beth Israel Deaconess Hospital–Needham's Community Benefits Service Area (CBSA) includes **Dedham, Dover, Needham** and **Westwood**. BID Needham's FY 2019 Community Health Needs Assessment (CHNA) findings, on which this report is based, clearly show that populations most in need are **individuals with chronic or complex conditions, low to moderate income individuals and families, older adults, and youth**. As a result, these populations have been identified and prioritized as the focus for community benefits efforts. Collectively, these geographic, demographic, and socio-economic population segments are Beth Israel Deaconess Hospital–Needham priority populations. While Beth Israel Deaconess Hospital–Needham is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated community benefits guidelines, its' Implementation Strategy will focus on the most at-risk priority populations.

Basis for Selection

The priority population was selected based on community health needs assessments, public health data available from government (MDPH, Boston Public Health Commission, federal agencies) and private resources (foundations, advocacy groups), and from Beth Israel Deaconess Hospital–Needham's areas of expertise.

Key Accomplishments of Reporting Year

While Beth Israel Deaconess Hospital–Needham's most recent CHNA was completed during FY 2019, unless otherwise noted, the accomplishments highlighted in this report are based upon priorities identified and programs contained in the hospital's FY 2017-2019 Implementation Strategy (IS). Fiscal year 2019 was the final year of BID Needham's FY17-2019 Implementation Strategy.

Health Risk Factors & Primary Prevention

In the area of Health Risk Factors and Primary Prevention, the hospital focused on several areas of prevention including Mental Health, Substance Prevention, Chronic Disease Prevention and Access to Healthy Food.

> **Mental Health Risk Factors:** Working with local schools, parenting groups and social service organizations, efforts focused on educational events for students and parents. Highlights included an anxiety speaker at a middle school parent conference, a "Life Skills" conference for high school seniors, a social-emotional conference for underserved youth, and scholarships for underserved residents to join a local parenting support and social network.
>
> **Substance Prevention Risk Factors:** BID Needham continued to support the Substance Prevention Alliance of Needham (SPAN) with an annual grant to support substance prevention programming including alcohol-free events for students, curriculum-based resilience training for 8th graders, and parent education on Juuling. The hospital also continued to provide funding to New Year's Needham, in order to provide free access to the event for underserved residents.
>
> **Chronic Disease Prevention:** Prevention efforts in this area revolved around partnerships with local senior living and health-focused organizations to provide speakers, activities and information for educational events. These included an annual speaker series at the Boston JCC and Healthy Kids Day at the Charles River YMCA, as well as health-focused speakers at Briarwood, North Hill, Fox Hill and local Councils on Aging.
>
> **Access to Healthy Food:** BID Needham continued its partnership with The Needham Community Farm, Needham Bank and The Charles River Center to provide fresh produce and farm programming to residents in income-eligible housing in Needham. Additionally, grant support was provided to the Needham Farmer's Market and to Mass Bay Community College for their efforts to bring healthy food to residents. The hospital also participated in the pilot for "Nourishing Needham," a program highlighting healthy meal options at schools and local restaurants.

Physical Disease Management

To address the range of chronic and infectious diseases in the BID Needham service area, the Hospital focused on community education and programming, timely access to treatment and coordination of follow-up care.

Within the Hospital, efforts were made to improve education and follow-up care for patients with chronic diseases. The Hospital's Utilization Review Committee met monthly to evaluate readmission rates and discuss at-risk patients, and continued with a dedicated Congestive Heart Failure nurse to better serve patients at hospital discharge and reduce readmission rates. The Patient and Family Advisory Council (PFAC) continued to meet to look at readmission rates, as well as patient quality of care and access.

To ensure that patients are getting the proper care and coverage, BID Needham employs three Certified Application Counselors (CAC), available to help patients with insurance applications and renewals. The

hospital also provided several ways to access to Interpreter Services, to ensure culturally competent access to care for residents.

Within the community, BID Needham continued the ongoing partnership with local EMTs to provide training and to restock their Basic Life Support vehicles with medications and supplies. A similar partnership with the Needham Public Schools provided epi-pens to the schools and awarded the schools a grant to purchase an AED and Stop the Bleed Kits.

Beth Israel Deaconess Hospital–Needham provided grants to several social service organizations to address disease management in the underserved population. Family Promise MetroWest's "Family Health Initiative" provides support to homeless parents, teaching them to be advocates for their families and to address the comprehensive health needs of their families; and Neighbor Brigade offers volunteer assistance for residents facing sudden crisis such as cancer diagnosis and treatment. The hospital also provided funding to the Charles River YMCA's Livestrong program for cancer patients and to the Charles River Center for an overhead lift system in their day habilitation therapy treatment room for children and adults with developmental disabilities.

BID Needham also partnered with local organizations to host relevant, health-focused educational events for the community. These events included a presentation on the prevention of Lyme disease in Dover, three workshops for those with Alzheimer's and their caregivers, and chronic disease management classes and a hearing loss talk and screening at the Needham Council on Aging.

Behavioral Health

Behavioral Health continued to be a key area of focus for BID Needham this year, as the hospital worked to integrate behavioral health into care, reduce the burden of opioid use, and assist with enhanced care management.

BID Needham, Beth Israel Deaconess Healthcare, and Riverside Community Care completed a 27-month pilot program to provide a Licensed Social Worker (LICSW) at a local primary care office to offer free care and urgent interventions. Within the hospital, the partnership with Riverside Emergency Services continued, to evaluate and find care and placement for behavioral health patients that come into the Emergency Department. The hospital continued to offer Psychology consultations on the inpatient units and expanded its behavioral health staff with a Clinical Psychiatrist to provide weekday telephone support for providers.

Hospital efforts to address opioid misuse continued with the work of BID Needham's internal "Pain Management and Opioid Taskforce." Working on education and practices related to pain management and prescribing in order to reduce opioid misuse, this committee also maintained the prescription drug disposal kiosk and added a sharps disposal in the hospital lobby, as a safe way for the community to dispose of unwanted or unneeded prescription drugs.

Within the community, representatives from BID Needham participated in local coalitions to address mental health and substance use, including the Community Crisis Intervention Team (CCIT), the Youth Resource Network, and The Charles River Opioid Taskforce. Additionally, grants were awarded to support the Interface Mental Health Hotline in Needham and Medfield, and to CHNA 18 to provide mental health training to local librarians.

The Hospital supported several local behavioral health and substance use organizations to provide resilience training, screening, programming and support groups. These organizations included Walker, Riverside,

Dodging Addiction for Amy, New England Veteran's Liberty House, Circle of Hope, Needham Steps Up, Plugged In and Take Back the Night.

Healthy Aging

The service area of BID Needham has a large population of older adults. The Hospital has focused on this population to reduce falls and isolation, increase access to care and services, and to improve care transitions.

To assist patients with getting to medical appointments, BID Needham supports a medical appointment transportation program through The Needham Community Council and provides taxi vouchers to those who need a ride home from the Hospital or medical appointments.

BID Needham, the Town of Needham, Needham Public Health and the Needham Council on Aging also partnered on a healthy aging initiative in Needham. This 5-year initiative offered personal training and fitness, evidence-based programs for balance, bone health and arthritis, men's and women's health groups, and social groups to reduce isolation.

Working with local Councils on Aging (COA) and other senior-focused organizations, the hospital continued to support programming, social opportunities and education that address healthy aging. Grants were awarded to the Dover COA to provide meals and other supports for Dover residents and to the Dedham COA for a fire prevention program for seniors in the community. In Westwood, BID Needham provided funding to the COA and HESSCO to pilot a Medical Nutrition Therapy (MNT) program. Grants were also awarded to VNA Care Network for their hospice counseling program and to Jog Your Memory for caregiver support to assist those caring for a family member with Alzheimer's disease.

BID Needham continued to support the Traveling Meals program in Needham, and to offer the senior population an opportunity to give back to the community through a volunteer program at the Hospital. Within the Hospital, Case Managers from BID Needham met with patients and families to discuss advanced care planning options and to complete Health Care proxy documents. BID Needham also continued the work of its Fall Prevention Committee.

Community Building

BID Needham continued to build relationships with community partners, provide resources in the community, and increase collaboration among community groups to address healthcare reform and reduce health disparity. The Hospital has representatives on the following community-based committees: Newton Needham Regional Chamber of Commerce, Community Crisis Intervention Team (CCIT), Local Emergency Planning Committee (LEPC), The Charles River Regional Opioid Taskforce, Youth Resource Network, Community Health Network Area (CHNA18) Steering Committee, and the SPAN Steering Committee. In addition, the hospital hosts an annual Community Benefits meeting and another meeting for local organizations to share ideas and partner on initiatives.

The hospital supports local businesses and organizations when possible and is committed to being a pillar in the community. Support was provided to community groups that afford the community with opportunities for good physical and mental health, including the Needham Boosters, Rotary Club, Needham Track Club and The Great Hall Concert Series.

Through BID Needham's "Street Team," more than 50 volunteers represented the hospital at community events. The hospital also welcomed students and promoted education, through a student volunteer program, school field trips, scout field trips and a summer camp program.

Plans for Next Reporting Year

In FY 2019, Beth Israel Deaconess Hospital–Needham conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. BID Needham also partnered with the Needham Public Health Division as part of their PHAB accreditation process during the CHNA process. The hospital and Health Department held joint focus groups and collaborated on the community forum as part of the qualitative data collection process.

These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY19 CHNA, Beth Israel Deaconess Hospital–Needham created its FY 2020 – 2022 Implementation Strategy on the following four priority areas. These three priority areas collectively address the broad range of health and social issues facing residents living in Beth Israel Deaconess Hospital–Needham's CBSA who face the greatest health disparities. These three priority areas are:

1) Social Determinants of Health and Access to Care;
2) Chronic/ Complex Conditions and their Risk Factors;
3) Mental Health and Substance Use

It should also be noted that these priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). Beth Israel Deaconess Hospital–Needham's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the social determinants of health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 19 CHNA provided new guidance and invaluable insight on quantitative trends and community perceptions that are being used to inform and refine Beth Israel Deaconess Hospital–Needham's efforts. In completing the FY 2019 CHNA and FY 2020-FY 2022 Implementation Strategy, Beth Israel Deaconess Hospital–Needham, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the assessment's quantitative and qualitative findings, including discussions with a broad range of community participants, there was an agreement that Beth Israel Deaconess Hospital–Needham's FY 2020-2022 IS should prioritize certain demographic, socio-economic and geographic population segments that have complex needs, face barriers to care and service gaps, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY 2019 CHNA identified the importance of supporting initiatives that targeted youth, older adults, low-to-moderate income individuals and families, and individuals with chronic/complex conditions.

Beth Israel Deaconess Hospital–Needham partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses. Through the hospital's participation with local and regional coalitions and taskforces, dedication to providing mini-grants to local community-based organizations, and partnerships with local social service organizations, BID Needham will provide training, community-based education and support services to address the needs identified in the CHNA, in addition to the Implementation Strategy initiatives highlighted below:

Social Determinants of Health and Access to Care

- **Enhance access to care and reduce the impact of social determinants**
  - Support farmers markets and food access initiatives that provide fresh, locally-grown produce to low to moderate income, underserved populations
  - Provide enrollment counseling/ assistance and patient navigation support services to uninsured or underinsured residents to enhance access to care
  - Provide linguistically and culturally appropriate health education and care management support
  - Explore transportation access partnerships with regional transportation providers and other community partners to enhance access to affordable, safe, accessible transportation options

- **Reduce elder falls and promote aging in place**
  - Organize Matter of Balance workshops for priority populations
  - Support other elder service programming to encourage aging in place
  - Continue 5-year commitment to address healthy aging, with Needham Public Health and Needham Council on Aging

Chronic/ Complex Conditions and Their Risk Factors

- **Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings**
  - 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 chronic/complex conditions after discharge from the Hospital

- **Reduce the prevalence of tobacco use**
  - Support smoking cessation programs geared to reducing tobacco, vaping and e-cigarette use
  - Provide community education on the risks of vaping and tobacco use

Mental Health and Substance Use:

- **Educate about and reduce stigma associated with mental health and substance use issues**
  - Support mental health trainings in targeted community-based settings to raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use
  - 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
  - Support substance use prevention programming and curriculum in local schools

- **Enhance access to mental health and substance use screening, assessment, and treatment services**
  - 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

- Explore partnerships 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

- **Decrease the number of prescription drugs and other harmful drugs from the community**
    - 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 opioids in the hospital, and to educate patients on opioid use and alternatives for pain management

Self-Assessment Form:

Working with its Community Benefits Leadership Team (CBLT) and Community Benefits Advisory Committee (CBAC), the Beth Israel Deaconess Hospital–Needham Community Benefits team completed a self-assessment form (Section VII – page 99). Additionally, the Beth Israel Deaconess Hospital–Needham Community Benefits team shared and solicited the Community Representative Feedback Form to many CBAC and community stakeholders who participated in the Beth Israel Deaconess Hospital–Needham CHNA.

Section II: Community Benefits Process

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

The Board of Trustees, Board of Advisors, Community Benefits Advisory Committee (CBAC), leadership and staff at Beth Israel Deaconess Hospital–Needham (BID Needham or hospital) are dedicated to working in partnership with residents, community leaders, and civic, social and medical organizations in the communities the hospital serves. The membership of Beth Israel Deaconess Hospital–Needham’s Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations of Beth Israel Deaconess Hospital–Needham’s programmatic endeavors including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board and senior leadership that are held accountable in fulfilling Beth Israel Deaconess Hospital–Needham’s Community Benefits mission. Consistent with Beth Israel Deaconess Hospital–Needham’s core values is the recognition that the most successful community benefits programs are those that are implemented organization-wide and integrated into the very fabric of the hospital’s culture, policies and procedures. It is not a stand-alone effort that is the responsibility of one staff or department but rather an orientation and value manifested throughout Beth Israel Deaconess Hospital–Needham’s structure, reflected in how it provides care at both at the hospital and in affiliated practices.

Beth Israel Deaconess Hospital–Needham is a member of Beth Israel Lahey Health (BILH). While Beth Israel Deaconess Hospital–Needham oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local and system strategic and regulatory priorities.

The Beth Israel Deaconess Hospital–Needham Community Benefits Program is spearheaded by the Director, Community Benefits. The Director, Community Benefits has direct access and is accountable to the Beth Israel Deaconess Hospital–Needham President and the BILH Vice President of Community Benefits and Community Relations, the latter of who reports directly to the BILH Chief Strategy Officer. It is the responsibility of these senior managers to ensure that Community Benefits is addressed by the entire organization and the needs of the underserved populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize the extent to which efforts across the organization are fulfilling the mission and goals of community benefits.

Community Benefits Advisory Committee Meetings

BID Needham held three Community Benefits Advisory Committee meetings in Fiscal Year 2019. The meetings were held on April 4, 2019, June 17, 2019 and September 19, 2019. The meeting on June 17, 2019 also served as the Hospital's Annual Community Benefits meeting.

Community Partners

BID Needham works closely with several community partners to support programming, services, and to provide health education and information to area residents. Beth Israel Deaconess Hospital–Needham's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BID Needham's staff, its health and social service partners, and the community at-large. Beth Israel Deaconess Hospital–Needham's community benefits program exemplifies the spirit of collaboration that is such a vital part of the Hospital's mission.

Beth Israel Deaconess Hospital–Needham serves and collaborates with all segments of the population. However, in recognition of its long-standing ties to the surrounding communities and the health disparities that exist for these communities, Beth Israel Deaconess Hospital–Needham focuses its community benefits efforts on improving the health status of the low income and underserved populations living in Dedham, Dover, Needham and Westwood.

Beth Israel Deaconess Hospital–Needham currently supports many educational, outreach, community health improvement, and health system strengthening initiatives within the community. In so doing, the hospital collaborates with many local leading healthcare, public health, and social service organizations. Beth Israel Deaconess Hospital–Needham works closely with the Public Health Departments in the area, as well as local Councils on Aging, to address substance abuse prevention, mental health, healthy aging and transportation. We also support local organizations that provide opportunities to prevent and manage chronic disease, such as the Boston JCC and the Charles River YMCA. The hospital provides funding to and programming with mental health organizations such as the Charles River Center, Walker and Riverside.

Hospital staff serve on committees organized through local substance prevention coalitions and provide funding for substance prevention curriculum in the schools. The hospital supports organizations that provide access to healthy food, training and other basic necessities to the underserved, such as Family Promise MetroWest, Needham Community Council, Ripples of Hope, Three Squares New England, Circle of Hope, and Needham Community Farm. We provide education to the aging population with local Councils on Aging, VNA Care Network, HESSCO, and senior living/care facilities such as Fox Hill, North Hill and Briarwood.

Beth Israel Deaconess Hospital–Needham's Board of Trustees, along with its clinical and administrative staff, is committed to improving the health and well-being of residents throughout its service area and beyond. The hospital's Community Benefits Department, under the direct oversight of Beth Israel Deaconess Hospital–Needham's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its community benefits obligations.

The following is a comprehensive listing of the community partners with which Beth Israel Deaconess Hospital–Needham joins in assessing community need as well as planning, implementing, and overseeing its community benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Self-Assessment (Section VII).

Alzheimer's Association of MA & NH

American Cancer Society

Avita of Needham

Beth Israel Deaconess Healthcare

Cape Cod Cooperative Extension

Charles River Center

Charles River School

Charles River YMCA

CHNA 18

Circle of Hope

Dedham Council on Aging

Dedham Fire Department

Dedham Food Pantry

Dedham Public Health Division

Dodging Addiction for Amy

Dover Church

Dover Council on Aging

Dover Parks & Recreation

Family Dinner Project

Family Promise MetroWest

Fox Hill Village

Great Hall Performance Foundation

Greater Boston Food Bank

Greater Boston JCC

Hebrew SeniorLife

HESSCO

High Rock Pollard PTC

Jog Your Memory

Kyle Shapiro Foundation

Livestrong at the YMCA

Mass Bay College Food Resources

Medfield Coalition for Suicide Prevention

Medfield Public Schools

Needham Bank

Needham Community Council

Needham Community Education

Needham Community Farm

Needham Council on Aging

Needham Education Foundation

Needham Emergency Management

Needham Exchange Club

Needham Farmer's Market

Needham Fire Department

Needham History Center and Museum

Needham Housing Authority

Needham Junior Football and Cheer

Needham Police Department

Needham Public Health

Needham Public Library

Needham Public Schools

Needham Rotary Club

Needham Steps Up

Needham Touchdown Club

Needham Track Club

Needham Traveling Meals Program

Needham Youth & Family Services

Neighbor Brigade

New England Veteran's Liberty House

New Year's Needham

Newton Needham Regional Chamber

Newton Wellesley Hospital

North Hill

Parent Talk

Plugged In Band

William James College

REACH Beyond Domestic Violence

Ripples of Hope

Riverside Community Care

Students Advocating Life without Substance Abuse (SALSA)

Sean D. Biggs Memorial Foundation

Sodexo

Substance Prevention Alliance of Needham (SPAN)

The Bulfinch Group

Three Squares New England

Town of Dedham

Town of Needham

Town of Westwood

VNA Care Network

Walker

Westwood Cares

Westwood Council on Aging

Westwood Public Health Division

Westwood Youth & Family Services

Section III: Community Health Needs Assessment

Date Last Assessment Completed and Current Status

The FY 2019 Community Health Needs Assessment (CHNA) along with the associated FY 2020 - 2022 Implementation Strategy was developed over a ten-month period from October 2018 to August 2019. These community health needs assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill Beth Israel Deaconess Hospital–Needham's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by BID Needham's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, BID Needham's most recent CHNA was completed during FY 2019 but its FY 2019 Community Benefits programming was informed by the FY 2016 CHNA and aligns with BID Needham's FY 2017 – FY 2019 Implementation Strategy. The following is a summary description of the FY 2019 CHNA approach, methods, and key findings.

Approach and Methods

The FY 2019 CHNA was conducted in three phases, which allowed Beth Israel Deaconess Hospital–Needham to: 1) compile an extensive amount of quantitative and qualitative data, 2) engage and involve key stakeholders, Beth Israel Deaconess Hospital–Needham clinical and administrative staff, and the community at-large, 3) develop a report and detailed strategic plan, and 4) comply with all Commonwealth Attorney General and Federal IRS community benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, focus groups, a community forum, and a survey.

The CHNA used a participatory, collaborative approach to look at health in its broadest context. The assessment process included synthesizing existing regional data on social, economic and health indicators as well as information from key informant interviews, focus groups with residents and social service organizations, a community forum for all residents in the service area, and online and in-person surveys. Community dialogues and key informant interviews were conducted with individuals from across the four towns that comprise the BID Needham service area and with a range of people representing different audiences, including leaders in emergency response, education, health care and social service organizations focusing on vulnerable populations (e.g., youth and aging) (Schedule H, Part V, Section B, Questions 3 and 5). The hospital worked collaboratively with Needham Public Health to share information from their respective needs assessment activities relative to their efforts to become an accredited health department. Ultimately, the qualitative research engaged more than 500 people.

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

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

Summary of Key Health-Related Findings from FY 2019 CHNA

Beth Israel Deaconess Hospital–Needham's CHNA resulted in Key Findings related to social determinants of health, substance use and mental health and access to these services, chronic and acute physical health conditions, health risk factors, and challenges related to navigating the health care system and coordination of care. The following summarizes the assessment's key findings.

Social Determinants of Health Continue to Have a Substantial Impact on Many Segments of the Population

One of the dominant themes from the assessment's findings was the impact that the underlying social determinants of health are having on those living in the CBSA. The segments of the population most challenged by these issues are older adults, low income individuals/families, racial/ethnic minorities, non-English speakers, and those with disabilities or with chronic / complex conditions. More specifically, these segments struggle with financial insecurity, safe/affordable housing, transportation, access to healthy/affordable food, lack of social support, social isolation, and language access /cultural humility. These issues impact many people's and families' ability to access or pay for the services, housing, food, or other essential items they need and/or to live a happy, fulfilling, productive life.

The Burden of Substance Use and Mental Health Issues

Mental health and substance use issues continue to be one of the region's most relevant and challenging issues and are having a profound impact on individuals, families, and communities throughout the CBSA. These issues are also a major burden on the health and social service system. Health and social service providers, public health agencies, first-responders, and community-based organizations are confronted on a daily basis with people struggling with acute or chronic conditions and struggle to provide or link them to the care they need. With respect to mental health issues, depression/anxiety, stress, social isolation, and the impacts of trauma are the leading issues. With respect to substance use, the opioid crisis continues to have a tremendous impact on the region, along with alcohol use, marijuana use, and vaping in youth. The fact that physical health, mental health and substance use issues are so intertwined compounds the impact of these issues. Of particular concern are the increasing rates of opioid use and the impacts of trauma.

Limited Access to Behavioral Health (Mental Health and Substance Use) Services

Despite the prevalence of mental health and substance use issues and the impact that these issues are having on individuals, families, and communities, the behavioral health service system in the region is extremely limited. There are major shortages of specialized providers, such as psychiatrists, therapists, addiction specialists, and case managers, who are capable of providing the full breadth of preventive, screening, assessment, treatment, and recovery support services that the community needs. This is particularly true for those who have limited English skills or different cultural perspectives that require specialized care, such as immigrants, racial/ethnic minorities, and LGBTQ individuals. Uninsured individuals, those covered by

Medicaid, and those in low to moderate income brackets also struggle to access or pay for the services they need or to find providers who are able to take their coverage or insurance.

High Rates of Chronic and Acute Physical Health Conditions

Another major finding from the assessment is the high rates of chronic and complex conditions that exist for many of the leading physical health conditions (e.g., heart disease, hypertension, cancer, and asthma) in the CBSA. Overall, the rates of illness and death are not statistically higher than the rates for the Commonwealth, however, it is important to note that these chronic physical health conditions are still the leading causes of death and must be addressed to improve the region's health status.

High Rates of the Leading Health Risk Factors

Based on information gathered from focus groups, interviews, community meetings, the community health survey, and quantitative sources, the assessment found that there were substantial concerns related to the leading health risk factors, such as healthy eating, physical activity, obesity, tobacco use/vaping, alcohol use, and stress. Many of those who were involved in the assessment believed that there was a need for more health education and a greater emphasis on health promotion and prevention.

Challenges Navigating the System and Coordinating Needed Services

Another major theme from the interviews, focus groups, and community meetings conducted for the assessment was the challenges that many people in the CBSA face navigating the health and social service system. There was a general sense that there was a broad range of health and social services available in the region but that many did not know where to go for services or struggled to access the services even when they knew where to go. Once again, the population segments who struggle most to navigate the system are older adults, low income individuals/families, racial/ethnic minorities, non-English speakers, and those with disabilities or chronic/complex conditions. Many people said that there was a need for a resource inventory that would help residents access services, along with counselors or case managers who could further assist people to obtain and access the services they needed.

Priority Populations

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. With this in mind, BID Needham's Implementation Strategy 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. The assessment identified the following priority populations to be included in the Implementation Strategy.

1) Youth

2) Older adults

3) Low to moderate income individuals and families

4) Individuals with chronic and complex conditions

Section IV: Community Benefits Programs

1. Health Risk Factors & Primary Prevention - Needham Community Farm Mobile Market

Brief Description or Objective	BID Needham, Needham Bank, Charles River Center and Needham Community Farm continued a partnership to provide fresh, locally-grown produce to the underserved in Needham through a "Mobile Market." A weekly produce delivery was taken to Needham Housing Authority sites and distributed free of charge from June through October. A guide to storing, prepping and using produce, created by the nutrition team at BID Needham, was distributed with the produce. Translations for specific recipes are available in English, Chinese and Russian.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English, Chinese, Russian** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Healthy Food, Nutrition

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to healthy food for underserved residents in subsidized housing during the harvest season, through Needham Community Farm.	This program has grown consistently over the past three years, up 10% from FY18 to FY19, primarily through word of mouth between residents. 110 families received food through the mobile market at a value of more than $9,100 during the 2019 harvest season.	4	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Community Farm	www.needhamfarm.org
Needham Bank	www.needhambank.com
Charles River Center	www.charlesrivercenter.org
Needham Housing Authority	www.needhamhousing.org
Needham Community Council	www.needhamcommunitycouncil.org

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2. Health Risk Factors & Primary Prevention - Needham Community Farm Programming

Brief Description or Objective	BID Needham, Needham Bank and the Needham Community Farm (NCF) continued an ongoing partnership to provide gardening programming and education in the Needham Housing Authority units at Linden Chambers (for elderly and disabled) and an after-school program at Captain Robert Cook (for families). The programs involve NCF staff who have built gardening beds and provide plants, seeds, supplies, education and growing support throughout the season to teach residents how to plan, plant, maintain and harvest from the garden.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Healthy Food, Nutrition

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to healthy food and encourage increased use of fresh produce, through gardening programs at Needham Housing Authority sites during the harvest and growing seasons.	The program at Captain Robert Cook focused on making the gardens an inviting place for residents to learn about growing and eating vegetables. It engaged 20 youth and 15 adults in planting, maintaining and harvesting from the communal garden bed with weekly support from the farm. Two adult workshops were also hosted, with a focus on healthy eating. Harvests from the garden, in excess of 250 pounds of vegetables, were distributed to families from the neighborhood.	4	5	Process Goal
Increase access to healthy food and encourage increased use of fresh produce, through gardening programs at Needham Housing Authority sites during the harvest and growing seasons.	At Linden Chambers, the program engaged 8 residents and provided 20 weeks of on-site gardening support, 50+ organic seed packets donated and 200+ organic vegetables starts donated.	4	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Community Farm	www.needhamfarm.org
Needham Bank	www.needhambank.com
Charles River Center	www.charlesrivercenter.org
Needham Housing Authority	www.needhamhousing.org
Needham Community Council	www.needhamcommunitycouncil.org

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3. Health Risk Factors & Primary Prevention - Community Disease Prevention Education

Brief Description or Objective	BID Needham's staff and clinicians share their knowledge with the community to prevent chronic disease and encourage healthy lifestyles. Working together with local organizations such as The Greater Boston JCC, senior living facilities, Councils on Aging and Needham Community Education, these workshops educate their residents and members about pertinent health issues.
Target Population	• **Regions Served: Dedham, Dover, Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health – Physical Activity, Infectious Disease – Lyme Disease, Injury – First Aid, Maternal/Child Health – Menopause, Social Determinants of Health - Nutrition

Partners	
Partner Name, Description	**Partner Web Address**
Greater Boston JCC	www.bostonjcc.org
Charles River YMCA	www.ymcaboston.org/charlesriver
Beth Israel Deaconess Medical Center	www.bidmc.org
Newton Needham Regional Chamber	www.nnchamber.com/
Dover Parks & Recreation	www.doverma.org/town-government/town-offices/parks-and-recreation/

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Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Raise awareness and educate public on chronic disease prevention through a partnership with the Boston JCC and BIDMC to provide an annual series of health-focused talks.	The 2019 health series at the JCC featured talks on menopause, sleep, brain health, and exercising with joint pain. The talks were free and open to the community with 25-50 attending each talk. The hospital also provides a $3,500 grant for chronic disease programming.	7	10	Process Goal
Raise awareness and educate families on chronic disease prevention and healthy living through Healthy Kids Day.	BID Needham participates annually in a community-wide education event for young children and families, called "Healthy Kids Day," through the Charles River YMCA. Children were given passports to stop at different health stations, learning about ways to be healthy including fitness, healthy eating, handwashing, and first aid. 250 people attended the event.	5	10	Process Goal
Raise awareness and educate public on chronic disease prevention, through education at community fairs.	BID Needham has a presence at local community fairs and uses the opportunity to share information about chronic disease prevention, the importance of screenings and PCP visits, nutrition and exercise. The hospital attended fairs in Needham and Dover in FY19, with approximately 100 people taking information at each event.	8	10	Process Goal

Raise awareness and educate public on chronic disease prevention through educational talks.	Hospital staff spoke at local senior living facilities including Fox Hill, North Hill, Briarwood and the Needham and Westwood Councils on Aging.	8	10	Process Goal
Raise awareness and educate public on chronic disease prevention by serving on local committees and coalitions that support resident health and safety.	Staff from BID Needham serve on the Local Emergency Planning Committee (LEPC) in Needham. The hospital also convenes local organizations for two meetings per year to share resources and ideas for helping the community.	3	5	Outcome Goal

4. Health Risk Factors & Primary Prevention - Community Nutrition Education and Access

Brief Description or Objective	BID Needham is committed to providing nutrition and health information not only within the hospital, but also within the community. Cooking demonstrations, talks on healthy eating and lunches were done throughout the year to educate the community on how to integrate fresh, healthy food into your diet to avoid chronic disease. The hospital also supports the Needham Farmer's Market, allowing fresh, locally-grown produce to be brought into Needham during the harvest season, and supported a healthy eating pilot program in Needham.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Nutrition, Access to Healthy Food

Partners

Partner Name, Description	Partner Web Address
Needham Farmer's Market	www.homesharetours.com/needhamfarmersmarket-2/
Needham Council on Aging	www.needhamma.gov/519/Council-on-Aging
Needham Community Education	www.needham.k12.ma.us/community_ed
Needham Public Health	https://www.needhamma.gov/85/Public-Health
Needham Public Schools	www.needham.k12.ma.us/

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Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to healthy food through cooking demonstrations and healthy eating talks.	The BID Needham nutrition team and clinicians presented at local senior organizations and held a community class through Needham (Adult) Community Education (NCE), to educate on the importance of eating healthy. The classes, "Energy Boosting Nutrition," "Eat Smart for a Healthy Heart," and "Keep Your Heart Healthy," were attended by nearly 100 people.	3	10	Process Goal
Increase access to healthy food by supporting the Needham Farmer's Market.	The hospital provided funding to the Needham Farmer's Market in FY19, bringing fresh produce to Needham's town center every Sunday from mid-June to late October. The market accepts SNAP EBT cards.	3	5	Outcome Goal
Raise awareness of the connection between healthy food intake and human and environmental health, by participating in "Nourishing Needham" week.	BID Needham was one of 16 organizations to participate in this program that highlights healthy meal options that meet nutritional criteria for the week. The effort was led by Needham Public Health and local partners included the Needham Public Schools and 13 local restaurants	1	5	Outcome Goal

5. Health Risk Factors & Primary Prevention - Community Substance Prevention Programming

Brief Description or Objective	BID Needham has partnered with several groups to support community programming around substance prevention and mental and emotional well-being.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: Adults, Elderly, Teenagers** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Education/Learning, Substance Use

Partners

Partner Name, Description	**Partner Web Address**
Needham Public Health	https://www.needhamma.gov/85/Public-Health
SPAN	https://www.spanneedham.org/
New Year's Needham	www.newyearsneedham.org/
Students Advocating Life without Substance Abuse (SALSA)	n/a

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Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Promote youth substance prevention and mental and emotional well-being by providing funding and support for the SALSA program to teach middle school students resilience and refusal skills.	BID Needham provided funding for Students Advocating Life without Substance Abuse (SALSA) and their 8th grade resilience and refusal training in Needham Public Schools. This program, which has become part of the 8th grade curriculum, trains high school students to go into 8th grade classrooms and talk about the pressures of using substances, and how to say no. Students are taught refusal skills and have the opportunity to practice them in role play exercises with the high school students. 500 8th graders are taught each year by 100 high school students.	5	10	Outcome goal
Promote youth substance prevention and mental and emotional well-being through support of Needham High School's 5th Quarter program.	The hospital provided funding for the 5th Quarter program in Needham, allowing students to have a safe, fun and alcohol-free place to gather after games. 300 students attended each event; hosted after home football games, and provided pizza, games, music and prizes.	5	5	Process goal
Promote youth substance prevention and mental and emotional well-being by providing access to a safe and alcohol-free event on New Year's Eve.	BID Needham sponsors New Year's Needham annually, which provides more than 4,000 people a safe, substance-free celebration on New Year's Eve. The hospital's contribution provides admission buttons to approximately 100 people who could otherwise not afford to attend.	3	5	Process goal

6. Health Risk Factors & Primary Prevention – CPR and First Aid Education

Brief Description or Objective	The hospital works with local nurses, EMTs, schools, local businesses, youth and parents in the community to train on CPR and first aid.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: Adults, Teenagers** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Injury - First Aid/ACLS/CPR

Partners

Partner Name, Description	**Partner Web Address**
The Bulfinch Group	www.bulfinchgroup.com/
Parent Talk	www.parenttalk.info/
Needham Community Education	www.needham.k12.ma.us/community_ed
Needham Public Schools	www.needham.k12.ma.us/

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Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Raise awareness and educate public on chronic disease prevention, by teaching CPR and first aid classes.	The hospital conducted CPR and first aid classes for the community, including a local parents group, a local business, students in the hospital summer camp program, emergency response workers and other community members. Approximately sixty-five community members (non-employees) were trained by BID Needham nurses in FY19.	8	15	Process Goal

7. Health Risk Factors & Primary Prevention – In-Hospital Education

Brief Description or Objective	In order to educate staff, patients and the general community on health literacy, the hospital set up information tables throughout the year with staff available to provide information and answer questions. Tables were set up in February for heart month, March for colorectal cancer awareness month and nutrition month, and in May for stroke month. In addition, the hospital displayed information on digital screens throughout the hospital, and also posted this health information on the BID Needham website and social media accounts to increase visibility.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Health Issues Tags	Cancer – Colorectal, Social Determinants of Health – Nutrition, Cardiovascular, Stroke

Partners

Partner Name, Description	**Partner Web Address**
Sodexo	www.sodexousa.com/

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Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Raise awareness and educate public on chronic disease prevention by holding annual information tables for hospital patients and the community on pertinent health topics.	Clinical staff provided information to staff, patients and the general community about heart health, colorectal cancer prevention and stroke prevention. Approximately 100 people stopped to get information at each event.	10	20	Process Goal
Raise awareness and educate public on chronic disease prevention by staffing weekly education events in the hospital for National Nutrition Month, for hospital patients, staff and the community.	The nutrition team held a weekly information table during the month of March (National Nutrition Month) with samples, recipes and information on healthy eating. Each week had a different theme with easy, fresh and healthy foods. An estimated 150 people stopped by each table to get information.	3	10	Process Goal
Raise awareness and educate public on chronic disease prevention, by promoting health-related events and information in the hospital.	BID Needham installed digital screens in public waiting areas of the hospital to increase communication to staff, patients and the general public about health-related community events, health tips and other hospital information. Visuals rotate on the screen on a daily basis.	10	20	Process Goal

8. Health Risk Factors & Primary Prevention – Mental Health Prevention Programming

Brief Description or Objective	BID Needham partnered with local organizations to educate on mental health risk factors and healthy behaviors. Through parent workshops and support, the community was offered strategies to engage in conversations, reduce stigma, increase awareness, and learn practical application for tools to address mental health.
Target Population	• **Regions Served: Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health – Mental Health, Stress Management

Partners

Partner Name, Description	Partner Web Address
Parent Talk	www.parenttalk.info/
High Rock Pollard PTC	www.highrockpollardptc.org/
Needham Public Schools	http://www.needham.k12.ma.us/
Needham Education Foundation	www.nefneedham.org
Needham High School	http://www.needham.k12.ma.us/
Ripples of Hope	www.ripplesofhope.org
Westwood Cares	www.westwoodcaresma.org
Westwood Youth & Family Services	www.townhall.westwood.ma.us/departments/youth-family-services

Contact Information

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Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Raise awareness and educate public on mental health issues by providing mental health education to parents of middle school students.	The hospital provided funding to the local PTC to support a Middle School Parent Conference. The keynote speaker talked on Anxiety in teens and provided parents with tools to talk with and help teens deal with anxiety. 140 parents attended the event.	1	1	Process Goal
Raise awareness and educate public on mental health issues by working with Parent Talk to provide resources to parents of young children, which allow for positive experiences and good mental health.	BID Needham provided a scholarship fund to Parent Talk, a local organization for parents of young children. The organization provides a network for parents, along with programming and opportunities to play and connect. The organization was receiving requests from parents who wanted to be a part of this group but did not have the financial means to do so. In order to provide all parents with an equal opportunity, BID Needham set up a scholarship fund for the annual cost of membership to Parent Talk. Eight families were given a scholarship in FY19.	3	5	Process Goal
Raise awareness and educate public on mental health issues by working with Westwood Youth &Family Services to provide education to local parents.	Westwood Cares and Westwood Youth and Family Services brought Jon Mattleman to educate local parents on “The Secret Life of Teens.” Nearly 80 parents attended the workshop.	1	5	Process Goal
Raise awareness and educate public on mental health issues by supporting the Needham Education Foundation and their grant program to provide mental health curriculum in schools.	The hospital provided financial support to Needham Education Foundation for their programming around mindfulness and sensory pathways.	2	5	Process Goal
Raise awareness and educate public on mental health issues by providing mental health education to students.	The hospital provided grant support to Ripples of Hope for a 2020 Youth Conference; to Needham High School for a “Life Skills” Conference for seniors; and to Take Back the Night for their domestic violence and sexual assault education event.	1	5	Process Goal

9. Health Risk Factors & Primary Prevention – Support Hunger Relief

Brief Description or Objective	BID Needham annually supports hunger relief organizations in order to provide healthy food to the underserved populations in our community.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Healthy Food

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to healthy food by supporting Three Squares Ride for Food.	BID Needham is an ongoing supporter of The Three Squares Ride for Food. The event has nearly 300 riders from 18 local hunger relief organizations, and raises over $500,000 for these organizations. With funding from organizations such as BID Needham to cover the event costs, fundraisers are able to keep 100% of the money raised for their causes. The hospital also provides free first aid at the event.	5	10	Outcome Goal
Increase access to healthy food by supporting the Greater Boston Food Bank.	BID Needham donates annually to The Greater Boston Food Bank, which provides access to food for the underserved in 190 Eastern Massachusetts cities and towns.	3	3	Outcome Goal
Increase access to healthy food for underserved college students by supporting the Mass Bay Food Access Program.	The hospital provided funding to the Mass Bay Food Access Program, which was established in response to the increasing awareness of food insecurity among their student population, as 52% of students surveyed suffer from food insecurity.	2	5	Process Goal

gPartners

Partner Name, Description	Partner Web Address
Three Squares New England	www.threesquaresne.org/ride-for-food/
Greater Boston Food Bank	www.gbfb.org/
Mass Bay Food Resources	www.massbay.edu/snacc

Contact Information

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10. Health Risk Factors & Primary Prevention – Reduce Tobacco Use

Brief Description or Objective	Recognizing the risks and prevalence of vaping, particularly among youth, the hospital will work with SPAN and Needham Public Schools to offer education to students and parents about vaping to reduce tobacco use.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Substance Addiction – Smoking/Tobacco Use

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Reduce tobacco and alcohol use by partnering with SPAN to educated parents and students on the risks of vaping.	BID Needham and the Substance Prevention Alliance of Needham (SPAN) brought Dr. Jonathan Winickoff to speak to the community/parents on "Juuling and Schooling," the realities of vaping among youth. This talk was paired with "Hidden in Plain Sight," a demonstration and mock set-up of a teen's bedroom, where parents could tour and learn about hidden dangers and risky behaviors associated with substance use. Approximately 100 people attended the event and toured the demonstration. The parent survey showed that parents left with a better understanding of how addicting vaping can be, and with tools and ideas about how to speak with their children about vaping.	2	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Public Schools	www.needham.k12.ma.us/
SPAN	www.spanneedham.org/

Contact Information

Alyssa Kence
781-453-5460
148 Chestnut Street, Needham, MA 02492
akence@bidneedham.org

11. Health Risk Factors & Primary Prevention – Physical Activity

Brief Description or Objective	In order to promote physical activity and encourage a healthy lifestyle, BID Needham supports local runs and walks, and promotes physical activity in the community.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health – Physical Activity, Cancer, Chronic Disease – Overweight & Obesity

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase physical activity by supporting local road races where the community can be active.	BID Needham provided free first aid services and financial support to local road races that encourage the community to be active and also support local health organizations. These races include the BIGGSteps 5K, Great Bear Run, Charles River 5K and the Charles River YMCA Fourth of July Road Race.	7	10	Process Goal

Partners

Partner Name, Description	Partner Web Address
Charles River YMCA	https://ymcaboston.org/charlesriver
Charles River Center	https://www.charlesrivercenter.org/
Sean D. Biggs Memorial Foundation	http://www.seandbiggsmemorialfoundation.org/
Needham Track Club	http://www.needhamtrack.org/

Contact Information

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12. Physical Disease Management – Health Insurance Enrollment

Brief Description or Objective	To ensure that patients are getting the proper care and coverage, BID Needham employs three Certified Application Counselors (CAC) who are available to help patients with insurance applications and renewals.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English, Spanish, Chinese, Russian** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Care

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve access to care by providing assistance with insurance enrollment.	In FY19 our financial counselors successfully enrolled 89 patients in MassHealth. Financial assistance applications and information are available in English, Spanish, Chinese and Russian.	7	10	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information	Wendy Leong-Lum 781-453-3841 148 Chestnut Street, Needham, MA 02492 wleonglu@bidneedham.org

13. Physical Disease Management – Reduce Incidence of Lyme Disease

Brief Description or Objective	The hospital partnered with local community groups in Dover, which has a high incidence rate of Lyme disease, to provide information on preventing tick bites and Lyme.
Target Population	• **Regions Served: Dover** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Infectious Disease – Lyme Disease

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Educate about the prevention of Lyme disease in Dover.	BID Needham hosted a talk at The Charles River School in Dover called "One Bite Can Save Your Life." More than 50 people attended this event. The talk was presented by Larry Dapsis, an Entomologist from The Cape Cod Cooperative Extension. The hospital also distributed insect repellent and information on how to prevent tick bites at this event and at The Dover Days town fair.	3	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Charles River School	https://www.charlesriverschool.org/
Cape Cod Cooperative Extension	www.capecodextension.org
Dover Park & Recreation	http://doverma.org/town-government/town-offices/parks-and-recreation/

Contact Information

Alyssa Kence
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14. Physical Disease Management – EMT Partnerships	
Brief Description or Objective	BID Needham works closely with local EMT's to provide the best possible care in the community. The hospital provides training for local EMT's and works with the Needham Fire Department to provide medications and training.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Chronic Disease, Stroke, Emergency Preparedness, Social Determinants of Health – Access to Care, Public Safety

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve chronic disease management by training and partnering with first responders to care for stroke patients.	BID Needham has an ongoing partnership with local EMTs to train first responders and allow them to identify a stroke in the field. When the EMT alerts the hospital of a stroke patient coming in, the patient is met at the door by registration, a nurse and a physician and taken to CT scan. This process expedites care for stroke patients, ensuring that they receive life-saving care as soon as possible. BID Needham and local EMTs continued this partnership in FY19.	7	10	Process Goal
Improve chronic disease management by partnering with the Needham Fire Department to provide medications and supplies for their vehicles.	The hospital's pharmacy restocks the medications needed for Needham Fire Department's Basic Life Support vehicles on a monthly basis. The hospital donated more than $800 worth of medications in FY19 to the Needham Fire Department.	4	10	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Fire Department	www.needhamma.gov/63/Fire

Contact Information

Leeann Wood
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Lwood3@bidneedham.org

15. Physical Disease Management – Family Health Initiative	
Brief Description or Objective	BID Needham partnered with Family Promise MetroWest to support "The Family Health Initiative." This program empowers homeless parents who are part of the Family Promise program to become stronger health advocates while addressing the comprehensive health needs of their families. Services include education on accessing and maintaining health insurance, establishing primary care physicians, accessing mental health services and addressing all outstanding physical health needs, including dental care. Goals are set with case managers and reviewed on a weekly basis. This program reinforces the importance of regular health care, visits and screenings.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English, Spanish** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☒ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health, Social Determinants of Health – Access to Care, Dental Health, Chronic Disease

Partners

Partner Name, Description	**Partner Web Address**
Family Promise MetroWest	www.familypromisemetrowest.org/

Contact Information	Alyssa Kence 781-453-5460 148 Chestnut Street, Needham, MA 02492 akence@bidneedham.org

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Improve chronic disease management by supporting "The Family Health Initiative" for homeless families through Family Promise MetroWest.	107 individuals in the Family Promise MetroWest program were supported with this initiative. Results included: 100% of uninsured families obtained health insurance 100% of families secured a primary care physician for each family member 100% of families who needed mental health services secured the services 100% of families addressed outstanding medical and dental needs 79% of families participated in health and safety training.	4	10	Process Goal

16. Physical Disease Management – Reduce Readmissions	
Brief Description or Objective	The hospital is working towards reducing readmission rates by meeting regularly to review readmissions and making changes to protocols and follow-up care as needed. The cardiology department has a nurse dedicated to follow-up with CHF patients, in order to reduce readmissions.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☒ None/Not Applicable
Health Issues Tags	Cancer, Chronic Disease – Cardiac Disease, Diabetes, Other – Senior Health Challenges/Care Coordination

Partners	
Partner Name, Description	**Partner Web Address**
Contact Information	Gregory McSweeney, M.D. 781-453-4511 148 Chestnut Street, Needham, MA 02492 gmcsween@bidneedham.org

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve care transitions for those with chronic health conditions, by employing a Congestive Heart Failure (CHF) nurse to follow up with patients.	BID–Needham employs a CHF nurse for 36 hours a week. The nurse follows high risk CHF patients by making frequent calls to assess for symptoms, medication changes, tests or procedures that need to be done, education on prevention of CHF exacerbation, dietary teaching and referrals. The nurse also sees inpatients to ensure they are receiving proper care and review information with inpatient nursing.	3	5	Outcome Goal
Improve care transitions for those with chronic health conditions, by reducing readmission rates.	BID–Needham has a Utilization Review Committee that meets monthly to review all readmissions to the hospital within 30 days of discharge. The committee looks to identify specific causes for the readmission, such as discharge plans, care transitions and previous conditions. The committee reviews individual readmission, but also looks at trended data. The Committee identified CHF patients as a high priority area for review, and has two cardiologists on the committee who are tasked with reviewing all CHF readmissions.	2	5	Outcome Goal

17. Physical Disease Management – Interpreter Services	
Brief Description or Objective	Providing culturally-responsive care, especially for those whom English is not their first language, is an essential piece of access to care and managing physical disease. The hospital offers several options for Interpreter Services for patients. LanguageU is an Interpreter iPad on Wheels that allows patients immediate access to a face-to-face interpreter via video services. It also allows a patient who is deaf or hard of hearing to interact via video with an American Sign Language interpreter. Over the phone interpreting is offered via Pacific Interpreters, in over 180 languages and dialects. For patients who prefer an in-person service, the hospital can arrange this service in advance.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Other – Cultural Competency, Social Determinants of Health – Access to Health Care

Partners

Partner Name, Description	**Partner Web Address**
Language Line Pacific Interpreters	https://www.languageline.com/pacific_interpreters

Contact Information	
	Jane East 781-453-5252 148 Chestnut Street, Needham, MA 02492 jeast@bidneedham.org

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve access to care and physical disease management by offering culturally responsive care, including interpreter services.	LanguageU video remote interpretive services were accessed 1,028 times in FY19 at BID Needham, allowing ESL patients to access care in a culturally-competent way.	6	30	Outcome Goal
Improve access to care and physical disease management by offering culturally responsive care, including interpreter services.	Face-to-face interpretations were used 112 times in FY19 at BID Needham, allowing ESL patients to access care in a culturally-competent way.	20	30	Outcome Goal
Improve access to care and physical disease management by offering culturally responsive care, including interpreter services.	Telephonic interpretation sessions were used 1,169 times in FY19 at BID Needham, allowing ESL patients to access care in a culturally-competent way.	15	30	Outcome Goal

18. Physical Disease Management – School Partnerships	
Brief Description or Objective	BID–Needham partners with the Needham Public Schools to ensure all students have access to the medication and medical supplies needed. The hospital provides annual donations of epi-pens to school nurse offices throughout the district. In FY19, the schools requested a one-time grant to update AED stations throughout the district with Stop the Bleed kits and tourniquets, and to add an additional AED at the high school.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: Children, Teenagers** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Chronic Disease – Asthma/Allergies, Cardiac Disease

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve chronic disease management by providing local schools with essential medical supplies, enabling them to be prepared for emergency care.	The hospital provided a one-time grant to Needham Public Schools to update their medical supplies across the district. Stop the Bleed kits and tourniquets were purchased and added to all AEDs in the district (total 20). The school also purchased a new AED for the high school. The district now has the recommended supplies in the AED cabinets and staff can be trained for better preparation.	1	1	Outcome Goal
Improve chronic disease management by providing local schools with essential medical supplies, enabling them to be prepared for emergency care.	BID–Needham provides Epi-Pens to the Needham Public School Nurse Office for use in case of emergency.	5	10	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Needham Public Schools	http://www.needham.k12.ma.us/

Contact Information	
	Alyssa Kence 781-453-5460 148 Chestnut Street, Needham, MA 02492 akence@bidneedham.org

19. Physical Disease Management – LiveStrong at the YMCA	
Brief Description or Objective	BID Needham provides an annual grant to the Charles River YMCA for their LiveStrong Program. This program, for past or present cancer patients, helps develop and maintain cardiorespiratory fitness, muscular strength and endurance and flexibility and balance. It also connects local cancer patients and gives them strength and confidence as they recover.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Cancer, Health Behaviors/Mental Health – Physical Activity

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve chronic disease management by supporting The Charles River YMCA's LiveStrong program.	BID Needham provided a grant to cover scholarships, which allow the YMCA to offer the program free of charge to cancer patients. Approximately 40 individuals participated in FY19, regaining strength and the ability to return to activity after cancer.	2	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Charles River YMCA	https://ymcaboston.org/charlesriver

Contact Information

Alyssa Kence
781-453-5460
148 Chestnut Street, Needham, MA 02492
akence@bidneedham.org

20. Physical Disease Management – Charles River Center	
Brief Description or Objective	Charles River Center's Day Habilitation program serves 130 residents with intellectual disabilities. While BID Needham has an ongoing partnership with the organization, a one-time grant was requested in FY19 to purchase an overhead lift system for the therapy treatment room within the day habilitation program. This lift prevents patient and caregiver injury by enabling staff to easily, comfortably, and safely, move patients from their wheelchairs onto treatment tables, and then back to the wheelchair.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☒ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Care

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve chronic disease management for those with developmental disabilities.	A one-time grant was provided to The Charles River Center (CRC) to purchase an overhead lift for their Day Habilitation Center. This lift provides a safe way to lift patients, provides dignity for the patients and decreases staff injury. CRC saw a decrease in injury from 4 injuries due to back trauma with 16 days missed and 4 weeks of restriction without the system, to two injuries with no days missed with the system. Approximately 40 patients use the lift for treatment.	1	1	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Charles River Center	https://www.charlesrivercenter.org/

Contact Information

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21. Physical Disease Management – Neighbor Brigade	
Brief Description or Objective	Neighbor Brigade organizes volunteers that can be mobilized to help residents facing sudden crisis, such as cancer diagnosis and treatment, to manage day-to-day tasks such as meal preparation, rides, and basic household chores. BID Needham partnered with this organization for the first time in FY19 to provide a grant to translate and distribute brochures into five languages.
Target Population	• **Regions Served: Dedham, Needham** • **Gender: All** • **Age Group: Adults** • **Ethnic Group: All** • **Language: English, Chinese, Japanese, Portuguese, Spanish** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Cancer, Social Determinants of Health – Access to Healthcare, Access to Healthy Food, Other – Cultural Competency

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve chronic disease management for those whom English is not their first language.	BID Needham provided a grant to the Dedham and Needham Chapters to print and distribute outreach brochures in 5 languages including English, Chinese, Japanese, Spanish and Portuguese, to enable non-English speakers to access their services.	1	3	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Neighbor Brigade	https://www.neighborbrigade.org/

Contact Information

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22. Physical Disease Management – Alzheimer’s Caregiver Workshop	
Brief Description or Objective	The hospital partnered with several community organizations including the Dover Council On Aging, Dover Church, Alzheimer's Association, Avita of Needham, Hebrew SeniorLife, and Jog Your Memory to offer three panel discussions for residents with Alzheimer’s and their caregivers. BID Needham case managers attended to urge attendees to think about end of life and proxy care planning, and offered assistance with completing the forms
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: Elderly, Adults** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Chronic Disease – Alzheimer’s Disease, Health Behaviors/Mental Health, Senior Health Challenges – Care Coordination

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve chronic disease management by providing education and resources for those caring for family or friends with Alzheimer's.	Two sessions were held in Dover at the Dover Church. Attendance was 60 people. One session was held at BID Needham with 40 people in attendance.	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Alzheimer's Association of MA & NH	https://www.alz.org/manh
Avita of Needham	https://northbridgecos.com/avita-needham-assisted-living-memory-care/
Dover Church	https://www.thedoverchurch.org/
Dover Council on Aging	http://doverma.org/town-government/town-offices/council-on-aging-2/
Hebrew SeniorLife	https://www.hebrewseniorlife.org/
Jog Your Memory	http://www.jogyourmemory5k.org/

Contact Information

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23. Behavioral Health – Integrated Behavioral Health Care	
Brief Description or Objective	BID Needham worked to integrate behavioral health into care, both in PCP offices and in the hospital. A partnership with Riverside and Beth Israel Deaconess Healthcare (BIDHC) provided a Licensed Social Worker (LICSW) at a local primary care office. Within the Hospital, BID Needham has several measures in place to provide for mental healthcare. A Psychologist is employed to provide consultations on the inpatient units, and in FY19, BID Needham also hired a Director of Clinical Liaison Psychiatry to provide weekday telephone support for providers, related to Psychiatry patient care issues. For behavioral health patients that come into the Emergency Department at BID Needham, the hospital has a referring partnership with Riverside to provide evaluations, care and placements.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☒ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health, Social Determinants of Health – Access to Care

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Promote behavioral health integration by providing a behavioral health care at a Primary Care office.	During this 27-month program, BID Needham provided a grant that supported non-billable activities, free care, and urgent interventions for patients that have insurances that did not include Riverside in their panel. The social worker worked 33 hours per week, with a portion of the social worker's time being spent on consults with the Primary Care Physicians.	3	3	Process Goal
Promote behavioral health integration through an Emergency Department partnership with Riverside.	For behavioral health patients that come into the Emergency Department at BID Needham, the hospital has a referring partnership with Riverside to provide evaluations, care and placements. 221 patients were seen through this partnership in FY19.	14	20	Process Goal
Promote behavioral health integration by providing mental health services in the hospital.	A Psychologist is employed to provide consultations on the inpatient units. In FY19, a Director of Clinical Liaison Psychiatry was hired to provide weekday telephone support for providers.	6	20	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Beth Israel Deaconess Healthcare	https://www.bidmc.org/centers-and-departments/bidhc-primary-care
Riverside Community Care	https://www.riversidecc.org/

Contact Information

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24. Behavioral Health – Pain Management & Opioid Taskforce	
Brief Description or Objective	The work of BID Needham's internal "Pain Management & Opioid Taskforce" continued to address pain management, prescribing practices and clinician education for the Hospital, in order to reduce opioid misuse. The team is made up of surgery, pharmacy, medical staff, physical therapy, anesthesiology, quality, case management and representatives from other clinical departments who can contribute to improving practices around opioid prescribing and education.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Substance Addiction – Opioid Use

Partners	
Partner Name, Description	**Partner Web Address**

Contact Information	
	Rebecca Stone, MD 781-444-4722 148 Chestnut Street, Needham, MA 02492 rstone@bidneedham.org

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Reduce the burden of opioid use and address prescribing at the hospital through a Pain Management & Opioid Taskforce.	In FY19, the Pain Management & Opioid Taskforce included educating clinicians about prescribing practicing, including patient fact sheets and non-opioid directives; creating pain and physical therapy resources and distributing to clinicians to educate on alternatives to opioids; conducting an on-going prescribing query to review and modify prescribing practices within the hospital; and creating a “comfort menu” offering opioid alternatives for inpatients.	2	5	Outcome Goal

25. Behavioral Health – Prescription Drug Disposal	
Brief Description or Objective	The Hospital maintained the prescription drug disposal kiosk in the lobby, as a safe way for the community to dispose of unwanted or unneeded prescription drugs. Based on requests from the community, BID Needham also installed a sharps disposal kiosk in the same area. Hospital employees also volunteered, along with Needham Police, at the semi-annual DEA Drug Take Back Days in Needham, in April and October.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: All** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Substance Use – Opioid Use

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Reduce the burden of opioid use by providing a place for the public to dispose of unused and unwanted prescription drugs.	Nearly 320 pounds of prescription drugs were disposed of in FY19.	2	10	Process Goal
Reduce the burden of opioid use by providing a safe place for the public to dispose sharps.	At the end of FY19 the hospital installed a sharps kiosk next to the prescription drug kiosk. Collection data will be shared in FY20.	1	10	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information	
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26. Behavioral Health – Community Taskforce Participation	
Brief Description or Objective	BID Needham staff participate in local task forces directed at addressing mental health and substance use issues. The Community Crisis Intervention Team (CCIT) is a group of community partners consisting of health departments, first responders, local hospitals, schools, and behavioral health organizations, with a goal to confidentially address chronic resident needs related to substance use disorders, mental health conditions and domestic violence. Staff also participate in the Charles River Opioid Taskforce, created by Newton Wellesley Hospital to address the opioid crisis on a regional level. The hospital is also participates in Needham's Youth Resource Network, comprised of representatives from numerous youth and family-serving organizations that come together monthly during the academic year to address specific needs of school-age youth and families that reside and/or attend public school in Needham.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☒ Housing • ☒ Violence • ☒ Education • ☒ Employment • ☐ None/Not Applicable

Health Issues Tags	Health Behaviors – Mental Health, Social Determinants of Health – Access to Health Care, Domestic Violence, Education/Learning, Income & Poverty, Violence & Trauma, Substance Addiction – Substance Use

Partners

Partner Name, Description	Partner Web Address
Needham Public Health	https://www.needhamma.gov/85/Public-Health
Riverside Emergency Services	https://www.riversidecc.org/
Needham Police Department	https://www.needhamma.gov/78/Police
Needham Fire Department	https://www.needhamma.gov/63/Fire
Needham Public Schools	http://www.needham.k12.ma.us/
Newton Wellesley Hospital	https://www.nwh.org/
Needham Youth & Family Services	https://www.needhamma.gov/79/Youth-Family-Services
Walker	www.walkercares.org

Contact Information	Kathy Davidson 781-453-3003 148 Chestnut Street, Needham, MA 02492 Kdavids2@bidneedham.org

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Identify those at risk for mental health and substance use issues, and provide enhanced care management through participation in the Community Crisis Intervention Team.	The BID Needham Chief Nursing Officer and/or Chief Medical Officer participated in quarterly CCIT meetings. BID Needham shared emergency department data on behavioral health, substance use, violence (including domestic violence) and falls, to help the team track and address these issues in the community.	3	10	Process Goal
Identify those at risk of opioid abuse and provide enhanced care and management through regional, multi-disciplinary taskforce.	Hospital pharmacy staff participated in the taskforce in order to identify ways to work together to address opioid misuse in the region.	1	5	Process Goal
Identify those at risk and provide enhanced care management that will enable families to change their situation.	The hospital participated in Youth Resource Network roundtable discussions, which served 10 Needham families. The goal of the meeting is to identify specific needs and identify potential resources that will help the family and change their current situation.	3	5	Outcome Goal

27. Behavioral Health – Interface Mental Health Hotline	
Brief Description or Objective	BID Needham continued the on-going partnership with Needham Public Health, The Kyle Shapiro Foundation, and William James College to provide a free mental health referral hotline to those who live and/or work in Needham. The “Interface” helpline offers callers an opportunity to work with a counselor who will provide matches to services, as well as provide information and resources about mental health and wellness. The hospital also contributed to the Interface program in Medfield, a new program for the community. While Medfield is a secondary Community Benefits service area for the hospital, the town has experienced an increase in teen suicide attempts and has a great need for the service, so BID Needham felt compelled to be one of the organizations contributing to this initiative.
Target Population	• **Regions Served: Needham, Medfield** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English, Spanish, Haitian-Creole, Chinese, Portuguese** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health – Depression, Mental Health, Stress Management, Social Determinants of Health – Access to Care

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Identify those at risk and provide enhanced care management through assistance with finding mental health services.	Needham's Interface Helpline served approximately 150 cases in FY19. The majority of the calls were from parents calling on behalf of their children; however the helpline saw an increase in the number of adult callers. Anxiety was the top self-reported issue for callers.	5	10	Process Goal
Identify those at risk and provide enhanced care management through assistance with finding mental health services.	Medfield's Interface program was funded in FY19, but will be effective in FY20.	1	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Division of Public Health	https://www.needhamma.gov/85/Public-Health
Needham Youth & Family Services	https://www.needhamma.gov/79/Youth-Family-Services
William James College	https://www.williamjames.edu/
Kyle Shapiro Foundation	http://www.kwsfoundation.com/
Medfield Public Schools	https://www.medfieldcsp.org/
Medfield Coalition for Suicide Prevention	https://www.medfieldcsp.org/

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28. Behavioral Health – Community Behavioral Health Support	
Brief Description or Objective	The Hospital supported several local behavioral health organizations within the community to provide resilience training, screening, and programming for students and others in the community.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: All** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☒ Health Professional/Staff Training • ☐ Health Screening • ☒ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☒ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Provide enhanced care management through access to extracurricular activities for those experiencing significant behavioral, emotional and learning challenges.	BID Needham provided a $2,500 grant to Walker for community-based extracurricular activities such as dance, soccer and karate, for students ages 5-14 and who are in their therapeutic residential programs. Approximately five children will be served through this grant.	2	5	Process Goal
Identify those at risk and provide and enhanced care management through community screening and training programs focused on mental health.	The Hospital provided a $4,000 grant to Riverside for their community mental health training, consultation and screening programs. These funds support the Gatekeeper suicide prevention training in local school districts for approximately 300 people, and Suicide Assessment and Intervention Training for Mental Health Professionals in the four BID Needham CBSA communities.	1	5	Process Goal
Identify those at risk and provide and enhanced care management by supporting a one-on-one mentorship program for income-eligible high school students.	BID Needham supported the peer mentorship program, Needham Steps Up, with a $500 grant. This organization pairs income-eligible high school students with experienced faculty and staff members to help them access the vital resources they need to successfully navigate high school.	3	5	Process Goal
Identify those at risk and provide and enhanced care management through extracurricular programming for underserved students.	The hospital provided Plugged In Band program a $1,000 grant, which will cover summer camp scholarships for 2 underserved students.	2	5	Process Goal
Identify those at risk and provide and enhanced care management by supporting homeless college students.	BID Needham also granted $500 to Circle of Hope to provide dignity bags to homeless college students in the MetroWest area.	1	5	Process Goal
Identify those at risk and provide and enhanced care management by supporting local librarians to recognize and respond to behavioral health issues.	A $2,000 grant to CHNA 18 provided mental health QPR training for local librarians. The event was hosted at Needham Public Library, but was attended by 60 staff members from area libraries.	1	2	Process Goal

Partners

Partner Name, Description	Partner Web Address
Walker	http://www.walkercares.org/
Riverside Community Care	www.riversidecc.org
Needham Steps Up	https://www.needhamstepsup.com/
Plugged In Band	https://pluggedinband.org/
Circle of Hope	www.circleofhopeonline.org
CHNA 18	www.chna18.org
Needham Public Library	http://www.needhamma.gov/4747/Library

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29. Behavioral Health – Community Substance Abuse Support	
Brief Description or Objective	The Hospital supported local organizations which provide access to resources needed for recovery and addiction support.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: Adults** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☒ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities	• ☒ Built Environment • ☐ Social Environment • ☒ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Substance Use – Alcohol Use, Opioid Use

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Reduce the burden of opioid use by providing transitional housing for veterans suffering from addiction.	New England Veteran's Liberty House was awarded $1,000 for their sober transitional housing program for veterans.	2	5	Process Goal
Reduce the burden of opioid use by supporting those in recovery.	BID Needham supported "Dodging Addiction for Amy," an organization started by a hospital employee, with a $250 grant to assist recovering addicts with housing costs for sober living facilities.	3	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
New England Veteran's Liberty House	https://nevlh.wordpress.com/
Dodging Addiction for Amy	https://www.facebook.com/dodgingaddictionforamy/

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30. Healthy Aging – Transportation Assistance	
Brief Description or Objective	To assist patients with getting to medical appointments, BID Needham supported a medical appointment transportation program through the Needham Community Council, and provided taxi vouchers to patients who need a ride. The transportation program utilizes the ride-share service, Lyft, with The Community Council providing a concierge dispatch service operated by two staff members. Individuals requesting rides call the Needham Community Council and are scheduled with either a volunteer driver, if available, or a Lyft ride. The dispatcher relays logistics, such as car model and color, driver name, pick-up location, and estimated time of arrival, to the rider. When a Lyft ride is used, the dispatcher can track the ride and update the rider via phone as needed.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: Adults, Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☐ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Healthcare, Access to Transportation

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to transportation services through a medical appointment transportation program with the Needham Community Council.	The program has grown annually. In FY19, 408 rides were provided with a grant from BID Needham in the amount of $3,500. A notable finding of riders who were surveyed through this program was that over 60% of these riders would have cancelled their medical appointment if it wasn't for the ride.	3	5	Process Goal
Increase access to transportation services by providing taxi vouchers to those who need a ride to/from medical appointments at the hospital.	The hospital spent $1,839 on taxi vouchers in FY19 and provided 73 rides to patients who needed transportation home from the hospital.	12	20	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Community Council	http://needhamcommunitycouncil.org/

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31. Healthy Aging – Needham Healthy Aging Initiative	
Brief Description or Objective	Partnering with the Town of Needham, Needham Public Health and the Needham Council on Aging, the hospital dedicated more than $31,000 of DON funds annually, for five years, to a healthy aging initiative in Needham. The funding includes fitness training, health and balance classes, a multi-generational program, and other social groups and classes. Funding for the fitness center provided access to personal trainers at the Senior Center's on-site fitness facility. This allowed residents to get advice on exercising to suit their specific health and wellness needs, ensured they know how to properly use the equipment and were exercising safely, and reduced barriers to exercising. New programs were also piloted as part of this initiative, including "Bridging the Gap," an intergenerational program that brings together middle school youth with members of the Senior Center Community. This collaboration between the divisions of Youth and Family Services and Aging Services provides a monthly opportunity to gather and play pool and other games, have dinner, and engage in conversation, learning and laughter. Due to planning and implementation schedules, approximately one-third of the funding was carried over to FY2020 for similar programming.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities	• ☒ Built Environment

	• ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Chronic Disease – Arthritis, Cardiac Disease, Diabetes, Hypertension, Overweight & Obesity, Stroke, Health Behaviors – Mental Health, Other – Senior Challenges/Care Coordination, Social Determinants of Health – Access to Care, Nutrition

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Reduce falls in the community by providing access to fitness facilities and personal trainers for the aging population.	One third of the DON funding went to providing personal trainers at the Senior Center's fitness center, which saw an average of 45 users per day.	1	5	Process Goal
Reduce falls in the community and support older adults and caregivers to age in place by providing health and balance classes for the aging population.	One third of the funding was used to offer free, on-going, evidence-based programs for balance, bone health and arthritis on a weekly basis; and for monthly men's and women's health groups. The classes average 15-25 people.	1	5	Process Goal
Reduce isolation of older adults by offering a multi-generational program for adults and youth to interact.	The "Bridging the Gap" program was successful with both the youth and older adults, with 30 youth and adults participating.	1	5	Process Goal
Reduce isolation of older adults by offering a social programming for aging adults.	Social programs such as art classes were offered as additional reasons for seniors visit the Center, to reduce isolation and encourage socializing. The classes were popular with 30+ people participating.	1	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Town of Needham / Needham Council on Aging	https://www.needhamma.gov/519/Council-on-Aging
Needham Youth & Family Services	http://www.needhamma.gov/youth

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32. Healthy Aging – Council on Aging Programming	
Brief Description or Objective	Local Councils on Aging are a wonderful resource for aging adults and a great community partner for the hospital. BID Needham supported programming at the Dover and Dedham Councils on Aging, to support aging adults to age in place. The Dover COA provided meals and other supports for aging Dover residents. The Dedham COA hosted a fire prevention program with the Dedham Fire Department and distributed CO Detectors with Smoke Detectors to attendees and other seniors in the community who requested them.
Target Population	• **Regions Served: Dedham, Dover** • **Gender: All** • **Age Group: Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors – Mental Health, Other – Emergency Preparedness, Other – Senior Health Challenges/Care Coordination, Social Determinants of Health – Access to Healthy Food

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Support older adults and caregivers to age in place by providing meals and support services.	The Dover COA was provided a $1,500 grant for meals and other supports for Dover residents.	2	3	Process Goal
Support older adults and caregivers to age in place by providing safety training and supplies.	The Dedham COA was granted $1,500 for a fire prevention program, and provided approximately 40 CO Detectors with Smoke Detectors to seniors in the community.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Dover Council on Aging	http://doverma.org/town-government/town-offices/council-on-aging-2/
Dedham Council on Aging	https://www.dedham-ma.gov/departments/council-on-aging
Dedham Fire Department	https://www.dedham-ma.gov/departments/fire

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33. Healthy Aging – Medical Nutrition Therapy	
Brief Description or Objective	BID Needham provided funding to the Westwood Council on Aging (COA) and HESSO to pilot a Medical Nutrition Therapy (MNT) program. MNT is a comprehensive and holistic assessment of an older adults' nutrition that factors in medical conditions, functional abilities, and social supports. MNT is completed by a Registered Dietitian in individual sessions and includes referral to additional supports and resources, as well as follow-up as needed, in order to improve their opportunity to achieve their health and nutrition goals.
Target Population	• **Regions Served: Westwood** • **Gender: All** • **Age Group: Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Chronic Disease – Cardiac Disease, Diabetes, Hypertension, Overweight & Obesity

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve care transitions for older adults with a Medical Nutrition Therapy program at the Westwood Council on Aging.	With a $1,800 grant from BID Needham, the program served 48 individuals in FY19, and has a wait list of seniors in Westwood seeking the service. The program will continue in FY20.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Westwood Council on Aging	https://www.townhall.westwood.ma.us/government/boards-committees/council-on-aging
HESSCO	https://hessco.org/

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34. Healthy Aging –Bereavement & Counseling Services	
Brief Description or Objective	The hospital partnered with and supported the hospice counseling program at the Stanley R.Tippett Home through VNA Care Network, to provide hospice bereavement and counseling services.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☒ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health – Bereavement, Other – Senior Health Challenges/Care Coordination

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to palliative care through partnership with VNA Care Network.	BID Needham awarded a $2,500 grant to VNA Care Network for their hospice counseling program, which provided 1,370 people hospice bereavement and counseling services in FY19.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
VNA Care Network	https://vnacare.org/patients/stanley-r-tippett-home

Contact Information

Alyssa Kence
781-453-5460
148 Chestnut Street, Needham, MA 02492
akence@bidneedham.org

35. Healthy Aging – Caregiver Grant Programs	
Brief Description or Objective	Jog Your Memory is a local non-profit that provides grants to help families and caregivers in our community who have a loved one suffering from Alzheimer's disease. BID Needham contributed to their caregiver grant program, which provides grants to local families to help caregivers with respite care costs, funding for tracking devices, music programs, in-home care, and other services that will provide relief.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: Adults, Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☐ Prevention • ☐ Research • ☒ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Chronic Disease – Alzheimer's Disease, Health Behaviors/Mental Health – Mental Health, Other Senior Health Challenges/Care Coordination

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Improve care transitions for older adults through caregiver support.	Jog Your Memory was awarded $1,000 to support their caregiver grant program. Families may be given a grant up to $2,500 per year to help cover costs associated with caring for a loved one with Alzheimer's disease.	2	5	Process Goal

Partners

Partner Name, Description	Partner Web Address
Jog Your Memory 5K	http://www.jogyourmemory5k.org/

Contact Information

Alyssa Kence
781-453-5460
148 Chestnut Street, Needham, MA 02492
akence@bidneedham.org

36. Healthy Aging – Traveling Meals	
Brief Description or Objective	BID Needham continued to support the Traveling Meals program in Needham, which provides healthy meals for home-bound seniors. The meals are made at BID Needham and delivered Monday-Friday from September to June to homebound seniors. BID Needham donated space in the Hospital's café, where volunteers package the meals for delivery.
Target Population	• **Regions Served: Needham** • **Gender: All** • **Age Group: Elderly** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☒ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Social Determinants of Health – Access to Healthy Food

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Support older adults and caregivers to age in place by providing meals to homebound seniors.	The Traveling Meals program prepared and delivered 7,390 healthy meals for home-bound seniors in FY19.	27	40	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Public Health Traveling Meals Program	https://www.needhamma.gov/399/Traveling-Meals

Contact Information

Katie Laycock
781-453-3000
148 Chestnut Street, Needham, MA 02492
klaycock@bidneedham.org

37. Healthy Aging – Senior Volunteer Program	
Brief Description or Objective	BID Needham offers the senior population an opportunity to give back to the community through a volunteer program at the Hospital. This experience provides social camaraderie with other volunteers, a positive outlet for helping others and a way to stay connected to the community. Volunteers are also provided with free parking during volunteer hours and a free lunch in The Trotman Family Glover Cafe.
Target Population	• **Regions Served: Dedham, Dover, Needham, Westwood** • **Gender: All** • **Age Group: Adult-Elder** • **Ethnic Group: All** • **Language: English** • **Environment Served:** ☐ All ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Description Tags	• ☐ Community Education • ☐ Community Health Center Partnership • ☐ Health Professional/Staff Training • ☐ Health Screening • ☐ Mentorship/Career Training/Internship • ☐ Physician/Provider Diversity • ☒ Prevention • ☐ Research • ☐ Support Group
DoN Health Priorities	• ☐ Built Environment • ☒ Social Environment • ☐ Housing • ☐ Violence • ☐ Education • ☐ Employment • ☐ None/Not Applicable
Health Issues Tags	Health Behaviors/Mental Health

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Reduce isolation of older adults by offering a volunteer program at the hospital for aging adults.	There are 65 volunteers in the older adult volunteer program.	15	20	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information

Tracy Murphy
781-453-5499
148 Chestnut Street, Needham, MA 02492
tvmurphy@bidneedham.org

Section V: Expenditures

CB Expenditures by Program Type	Amount	Subtotal Provided to Outside Organizations (Grants/Other Funding)
Direct Clinical Services	$1,125,092	$59,445
Community-Clinical Linkages	$61,230	$48,300
Total Population or Community-Wide Interventions	$116,406	$60,500
Access/Coverage Supports	$85,880	$3,500
Infrastructure to Support CB Collaborations Across Institutions	$61,740	$350

CB Expenditures by Health Need	Amount
Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes	$1,095,108
Mental Health/Mental Illness	$202,603
Housing/Homelessness	$18,134
Substance Use	$36,267
Additional Health Needs Identified by the Community	$98,236

Other Leveraged Resources $5,000.00

Charity Care Expenditures	Amount
HSN Assessment	$581,972.61
HSN Denied Claims	$105,411.14
Free/Discount Care	$0
Total Net Charity Care	$687,383.75

Total CB Expenditures	**$2,142,731.75**

Additional Information	**Amount**
Net Patient Service Revenue:	$100,008,000
CB Expenditure as Percentage of Net Patient Services Revenue:	2.14%
Approved CB Program Budget for FY2020: **(*Excluding expenditures that cannot be projected at the time of the report)**	**$1,450,000**

Bad Debt:

Bad Debt Certification:

Optional Supplement:

Comments:

Total Charity Care is $6,276,860 and includes BID Needham's payment of $687,383.75 to the Health Safety Net; $2,991,063 in unreimbursed Medicare Services; $2,515,413 in unreimbursed MassHealth Services; $935,657 in bad debt; and $83,000 in BID Needham's voluntary PILOT payment to the Town of Needham, which contributes to the health and well-being of individuals residing in its Community Benefits Service Area. Additionally, BID Needham paid $50,745 to the Center for Health Information and Analysis (CHIA) and $17,511 to the Health Policy Commission (HPC).

Section VI: Contact Information

Alyssa Kence

Director, Community Benefits

Beth Israel Deaconess Hospital–Needham

148 Chestnut Street, Needham, MA 02492

781-453-5460

akence@bidneedham.org

Section VII: Self-Assessment Form

Hospital Self-Assessment Form – Year 1

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

I. <u>Community Benefits Process:</u>

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

Beth Israel Deaconess Hospital–Needham (BID Needham) is a member of Beth Israel Lahey Health (BILH). While BID Needham oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities.

2. <u>Community Benefits Committee (CBC):</u>
   - Members (and titles):
     Leslie Medalie, Chair, Trustee and CBSA Resident. Lina Arena DeRosa, Westwood Council on Aging. Carol Burak, Dedham Food Pantry and CBSA Resident. Janet Claypoole, Dover Council on Aging. Sue Crossley, Family Promise MetroWest and CBSA Resident. Lise Elcock, Newton Needham Regional Chamber and CBSA Resident. Jeanne Goldberg, Beth Israel Deaconess Healthcare and CBSA Resident. Valerie Lin, Dover Parks & Recreation and CBSA Resident. Marsha Medalie, Riverside Community Care and CBSA Resident. Tim McDonald, Needham Division of Public Health. Sheila Pransky,

Dedham Council on Aging. Diane Barry Preston, Livable Dedham and CBSA Resident. Sandy Robinson, Needham Community Council and CBSA Resident. Susan Shaver, Needham Community Farm and CBSA Resident. Hien Tran, Needham Housing Authority.

- Leadership:

  Amy Andre, Supervisor, Cardiology. Janet Barrett, Advisor and CBSA Resident. Virginia Carnahan, Trustee and CBSA Resident. Helen M. Chan, Controller. Ming Cheung, Nutrition. Kathy Davidson, Chief Nursing Officer and CBSA Resident. John Fogarty, President. Joe Giovangelo, Director, Pharmacy and CBSA Resident. Bill Jackson, CRT, AAS, Chief of Respiratory Therapy. Alyssa Kence, Director, Community Benefits and CBSA Resident. Wanita Kennedy, Advisor and CBSA Resident. Amy Krushell, R.N., Nurse Education and Falls Committee and CBSA Resident. Anna Marinilli, R.T. (T), BS, MHA, Operation Practice Manager, Cancer Center. Gregory McSweeney, M.D., Chief Medical Officer and CBSA Resident. Elaine Rousseau, RN, MSN, Case Management. Sam Sherman, Chief External Relations Officer and CBSA Resident. Rebecca Stone, M.D., Chair, Opioid Task Force. Meghan York, M.D., Cardiovascular Institute, Advisor and CBSA Resident.

- Frequency of meetings:
  The Beth Israel Deaconess Hospital Needham Community Benefits Committee (CBC) met three times during FY 2019.

3. Involvement of Hospital's Leadership in Community Benefits:
   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

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

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

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

Hospital Board:
Board members serve on the CBLT/CBAC and participated in the prioritization process for the CHNA and Implementation Strategy. The BID Needham Board of Trustees reviewed, approved and adopted the CHNA and Implementation Strategy.

Senior Leadership:
The BID Needham Operations Team provided input on identifying the CBSA, and on the CHNA and Implementation Strategy. The team participated in meetings with the CBAC, participated in the prioritization process, and served as a focus group for the CHNA. The Operations Team consists of Robert Ackerman, Chief Information Officer; Heidi Alpert, Senior Director, Clinical Services; Wingman Cheung, Legal Counsel; Connie

Crowley Ganser, Senior Director, Health Care Quality and Patient Safety; Kathy Davidson, Chief Nursing and Operations Officer; John Fogarty, President; Nancy Hoffman, Chief Financial Officer; Gregory McSweeney, M.D., Chief Medical Officer; Samantha Sherman, Chief Development and External Relations Officer; Julie Welch, Senior Director, Human Resources; Andrea Williams, Compliance Officer.

Staff-level managers:
Alyssa Kence, Director, Community Benefits, designed, managed and conducted the CHNA, including managing the prioritization process and drafting the Implementation Strategy. The BID Needham Leadership Team (all staff-level managers) reviewed the CHNA and Implementation Strategy and the staff level managers who serve on the CBLT were also involved with the prioritization process and review of the final CHNA and Implementation Strategy.

Community Benefits Committee:
The BID Needham CBAC guided the community engagement process and selected/recommended priorities. Members of the CBAC are listed on page one.

4. Hospital Approach to Assessing and Addressing Social Determinants of Health
    - How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)
      Beth Israel Deaconess Hospital–Needham undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative (age, race, ethnicity, language, sexual orientation/gender identity, income, violence/crime, food access, housing, transportation, etc.) and qualitative (focus groups, community forums, community survey) data collection and substantial efforts to engage community residents, with special emphasis on hidden population segments often left out of assessments. Additionally, the CBAC oversaw the assessment, vetted findings and prioritized leading health issues and the communities and cohorts most in need. Beth Israel Deaconess Hospital–Needham's Implementation Strategy reflects the hospital and the CBAC's prioritization of the social determinants of health, including housing, transportation, poverty/employment and food insecurity.

    - How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)
      Beth Israel Deaconess Hospital–Needham and BILH are committed to health equity, the attainment of the highest level of health for all people, requiring focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout BID Needham's assessment process, the hospital worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. BID Needham's Implementation Strategy was developed as a result of these processes and focuses on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's community benefits service area.

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

      The Beth Israel Deaconess Hospital–Needham Implementation Strategy includes a diverse range of programs and resources to address the prioritized needs within the hospital's community benefits service area. The majority of BID Needham's community benefits initiatives are focused on cohorts and sub-populations due to

identified disparities or needs. Likewise, the hospital's strategies for Total Population and Community-Wide Interventions focus on partnering with local organizations to offer education and programming related to needs identified in our CHNA. Examples include mental health programming, life skills, and domestic violence and sexual abuse programming. The hospital also supported a critical partnership with the local substance prevention group to continue providing a prescription drug disposal kiosk in the hospital, for residents to properly dispose of unwanted or un-needed prescriptions. Additionally, BID Needham collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions such as programming and educational events at local Councils on Aging and schools, and community events that support health-based initiatives and social determinants of health.

II. Community Engagement:

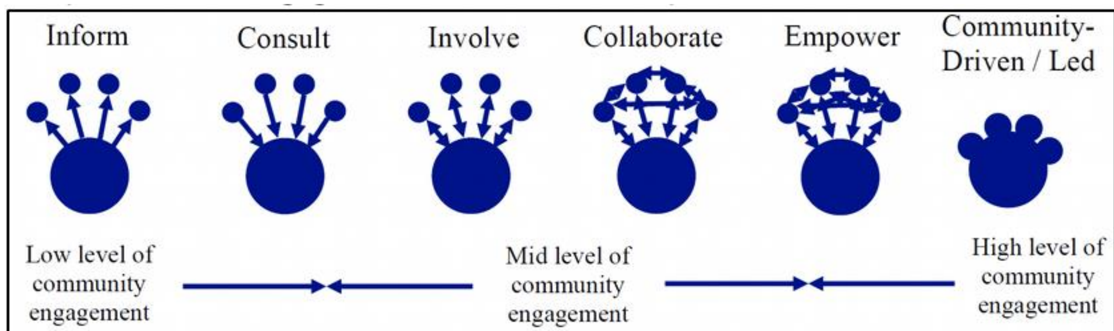
1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Needham Public Health Division	Tim McDonald, Director	Local Health Department	BID Needham partnered with the Needham Public Health Division as part of their PHAB accreditation process. The hospital and Health Department held joint focus groups and collaborated on the community forum as part of the qualitative data collection process. Collaboration also exists in the Implementation Strategy, as the hospital has provided DON funds to Needham Public Health for a "healthy aging initiative," in which the Division has decision making power to use the funds in ways that they see will benefit older adults in the community. In addition, partnership with the department exists in several areas including substance prevention, traveling meals and mental health.

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement (including any decision-making power given to organization)
CHNA 18	Jhana Wallace, Director	Local health community organizations (CHNAs)	BID Needham worked with CHNA 18 to distribute the CHNA survey to residents and social service organizations throughout the CBSA. The hospital has a representative on the CHNA 18 board and will work with the CHNA through the Implementation Strategy to address mental health needs and training in the area.
Local Councils on Aging	Lina Arena DeRosa, Westwood COA ; Sheila Pransky, Dedham COA; Janet Claypoole, Dover COA; LaTanya Steele, Needham COA	Social service organizations	The hospital worked with local Councils on Aging in the CBSA to distribute paper and online surveys during the CHNA. The hospital will continue to work with these organizations throughout the Implementation Strategy to offer programming to older adults in the community. The hospital provides support to the organizations and allows them to submit grant proposals based on what will help the local residents in their community.
Needham Public Schools	Kathy Pinkham, Director of Wellness, Needham Public Schools	Social service organizations	The hospital worked with the public schools to distribute the CHNA survey via their electronic newsletters. The hospital works with Needham and other public schools, as part of the Implementation Strategy, to integrate health-based curriculum, supplies and programming into the schools for youth and parents.

2. Level of Engagement Across CHNA and Implementation Strategy

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



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

A. **Community Health Needs Assessment**
Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Empower	The goal was met.	Not applicable
Collecting data	Empower	In certain communities and with specific cohorts, Beth Israel Deaconess Hospital–Needham was able to have community members/residents and organizations field the survey. This was not consistent across communities.	Not applicable
Defining the community to be served	Involve	Beth Israel Deaconess Hospital–Needham worked with Senior Leadership and the CBAC to review the CBSA. CBAC members and community partners identified hard-to-reach cohorts and those facing disparities.	Not applicable

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Establishing priorities	Collaborate	The CBAC worked with CB staff and Beth Israel Deaconess Hospital–Needham Senior Leadership to prioritize health needs and recommend health priorities and priority cohorts.	Consult

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

Beth Israel Deaconess Hospital–Needham remains committed to community engagement. During FY 19, Beth Israel Deaconess Hospital–Needham undertook its triennial community health needs assessment and prioritization process. Guided by BID Needham's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative employed a comprehensive community engagement process. In FY 20, BID Needham will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, BID Needham will engage with our community by serving on the regional Community Crisis Intervention Team, facilitating at least one other meeting of community organizations, and through involvement with CHNA 18.

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	Community forums, community meetings and the CBAC worked with the CBLT to identify priorities and sub priorities.	Involve
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Involve	BID Needham will work to better inform and consult with its CBAC on the proportion of CB resources allocated to different priorities	Consult

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Implementing Community Benefits programs	Consult	2019 was the last year of Beth Israel Deaconess Hospital–Needham's FY 2017-2019 Implementation Strategy (IS). BID Needham will be collaborating with the community on new and existing programs for its FY 20-22 IS.	Collaborate
Evaluating progress in executing Implementation Strategy	Consult	2019 was the last year of BID Needham's FY 2017-2019 Implementation Strategy (IS). BILH Community Benefits will be hiring a Director of Evaluation which will work with all hospitals to build staff and community evaluation capabilities. BID Needham will be collaborating with the community on evaluation of CB programming and the execution of the FY 20-22 IS.	Collaborate
Updating Implementation Strategy annually	Inform	2019 was the last year of Beth Israel Deaconess Hospital Needham's FY 2017-2019 Implementation Strategy (IS). BID Needham will work with its CBAC, its community partners and the BILH Evaluator to review its IS and update, as appropriate at the end of FY 20.	Consult

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

Beth Israel Deaconess Hospital–Needham has a comprehensive implementation strategy to respond to identified community health priorities. BID Needham engaged with the CBLT and the community to identify and select priorities for the new (FY 20-22) Implementation Strategy. While the Implementation Strategy (IS) was shared with the CBAC, the CBLT, and adopted by the Board of Directors and widely distributed, delays in obtaining secondary data and the significant commitment to the comprehensive community engagement for the CHNA and the prioritization process, lead to less community engagement on the drafting of the Implementation Strategy. Going forward, BID Needham will review the workplan and timeline of our triennial CHNA to allow more time for engagement and vetting of the IS. During the FY 20 annual meeting, BID Needham will make the IS available to participants, highlight new programs, priorities and activities,

explain sunsetted programs and seek input from the community. Any feedback will be considered as the Implementation Strategy is updated annually.

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

Beth Israel Deaconess Hospital–Needham held a public meeting in conjunction with its CBAC on June 17, 2019. Additionally, BID Needham shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the triannual CHNA. A CHNA community forum was held on March 27, 2019. Focus groups for the CHNA were held on December 3, 2018, December 11, 2018, February 6, 2019, and March 8, 2019.

The hospital shares highlights from the Community Benefits program on its website: https://www.bidneedham.org/about/community-involvement, and in internal and development newsletters. BID Needham hosts a "Community Resource Group" consisting of local non-profits, health-related and social service organizations. The group meets twice a year to allow for opportunities to share news, updates and needs and to seek out collaborations and partnerships on health-related initiatives, programming and activities. The group also serves as a place to solicit feedback on the hospital's community benefits program. This meeting is held twice a year, with the hospital's Annual Meeting serving as one of the meetings.

4. Best Practices/Lessons Learned
The AGO seeks to continually improve the quality of community engagement.

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

  Beth Israel Deaconess Hospital–Needham is most proud of our committed CBAC, the long-standing relationships we have with many community-based organizations, our public health departments, Councils on Aging, schools, and our local CHNA. We are most proud of the collaboration with these and other organizations that allowed us to engage with hard-to-reach cohorts. We are proud of our partnership and collaboration with Needham Public Health on our CHNA, and of our participation in community organizations such as the Needham Youth Resource Network and Community Crisis Intervention Team, which allow our community partners to work together to address the needs of the underserved and those facing crisis in our community.

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

Working collaboratively with other hospitals, community-based and social service organizations, public health, Councils on Aging and schools enhances the level and quality of our community engagement efforts.

III. Regional Collaboration:

1. Is the hospital part of a larger community health improvement planning process? ☒ Yes ☐ No
   - If so, briefly describe it. If not, why?
     Beth Israel Deaconess Hospital Needham is involved with CHNA 18. The hospital also partnered with the Needham Division of Public Health on their PHAB accreditation during the 2019 Community Health Needs Assessment.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.
   - Collaboration:
     BID Needham collaborated with the Needham Public Health Division to collect data for our CHNA and their PHAB Accreditation.

   - Institutions Involved:
     Needham Public Health Division

   - Brief description of goals of the collaboration:
     BID Needham and Needham Public Health needed to collect qualitative data from the community. In order to avoid duplication of efforts, we partnered on conducting focus groups and the community forum. We also partnered to offer dinner, childcare and transportation for the community forum, though the YMCA and Council on Aging.

   - Key communities engaged through collaboration:
     Aging adults, leadership for community youth-based groups, public housing residents.

   - If you did not participate in a collaboration, please explain why not:

     N/A