Community Benefits Report

Fiscal Year 2020

Beth Israel Lahey Health
Beth Israel Deaconess Needham

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SECTION I: SUMMARY AND MISSION STATEMENT

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

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

The Board of Trustees, Board of Advisors, leadership, and staff at Beth Israel Deaconess Hospital–Needham (BID Needham) are also 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 Community Benefits 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.

The mission of Beth Israel Deaconess Hospital–Needham is to serve Beth Israel Deaconess Hospital–Needham patients compassionately and effectively and to create a healthy future for them and their families. BID 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. Beth Israel Deaconess Hospital–Needham is also committed to being active in the community. Service to community is at the core of BID Needham's mission.

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, and dozens of community partners** in the community health needs assessment process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy;

- **Engaging and learning from residents** throughout Beth Israel Deaconess Hospital–Needham's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention

to engaging those community members who are not patients of Beth Israel Deaconess Hospital–Needham and those who are often left out of assessment, planning, and program implementation processes;

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

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

- **Enhancing access to care** and providing financial counseling services to help vulnerable populations gain access to health care;

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

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

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

Target Populations

Beth Israel Deaconess Hospital–Needham's CBSA includes Dedham, Dover, Needham, and Westwood. BID Needham's FY19 Community Health Needs Assessment (CHNA) findings, on which this report is based, show that low- to moderate-income individuals and families, individuals with chronic/complex conditions, youth, and older adults face the greatest health disparities and are most at risk. Collectively, these geographic, demographic, and socio-economic population segments are Beth Israel Deaconess Hospital–Needham's 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, the Beth Israel Deaconess Hospital–

Needham's Implementation Strategy will focus on these populations.

Basis for Selection
Community health needs assessments, public health data available from government (MDPH, Boston Public Health Commission, federal agencies) and private resources (foundations, advocacy groups), and Beth Israel Deaconess Hospital–Needham's areas of expertise.

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in Beth Israel Deaconess Hospital Needham's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS). Fiscal Year 2020 was the first year of Beth Israel Deaconess Hospital Needham's 2020-2022 Implementation Strategy. The Community Benefits programs focused on the three priority areas highlighted in the FY2019 Community Health Needs Assessment: Social Determinants of Health and Access to Care, Chronic and Complex Conditions and their Risk Factors, and Mental Health and Substance Use.

For the FY20 reporting year, Beth Israel Deaconess Hospital–Needham dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. BID Needham was intentional when assessing risk factors within our CBSA and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19 to help slow the spread. BID Needham redeployed staff and procured tangible necessities for hospital staff such as Personal Protective Equipment (PPE), food, hand sanitizer, and other critical items.

Many of the Community Benefits programs originally planned for FY20 had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded or pivoted to address needs that are more urgent. In others, programs were cancelled or significantly reduced because of the COVID-19 pandemic. Additionally, the unexpected closure of Norwood Hospital put a significant strain on the physical and human resources at the hospital. It was certainly a year unlike any other, but the hospital relied on our staff, leadership, and incredible community partners to make it through the year.

The following highlights programs in each of the hospital's priority areas for FY20:

Social Determinants of Health and Access to Care
While planned Community Benefits programs for FY2020 focused on providing access to healthy food, health insurance enrollment counseling, and aging in place, these issues became even more important with the onset of the pandemic. Many organizations that BID Needham supports with grant funding had to pivot to deal with the urgent issues around food access and isolation. BID Needham, The Town of Needham, and The Needham Council on Aging continued the "Healthy Aging" partnership (in year two of five). Originally focused on maintaining the fitness center and personal trainers at the senior center and offering health-focused programming, the program transitioned to virtual classes and grocery delivery, and funds were used to cover additional funds needed for the Interface Mental Health Hotline.

Due to the increased need for food access due to COVID-19, the hospital supported food access programs in all four towns in its CBSA. In Westwood and Dover, local farm shares were distributed to 40 seniors from May to September. In Dedham, the Senior Center and Dedham Food Pantry partnered to provide food to seniors in the community with funding from BID Needham. BID Needham, Needham Bank, The Charles River Center, and Needham Community Farm continued to support a mobile market delivering fresh produce to residents living in public housing in Needham. The program continued to grow in FY20, with the market distributing over 1,900 pounds of fresh produce to more than 125 families. BID Needham also continued to partner with The Town of Needham to prepare meals for the town's traveling meals program, delivering more than 9,500 meals in FY20. Finally, the hospital continued support of food access organizations including the Needham Farmer's Market, Ripples of Hope, and Three Squares New England.

In the area of Access to Care, BID Needham continued to employ financial counselors to assist with insurance enrollment and navigation and to provide options for linguistically and culturally appropriate health care.

Chronic and Complex Conditions and their Risk Factors

BID Needham continued to support local organizations with grants to provide programming to the community for those suffering from chronic or complex conditions. These programs included the Charles River YMCA's LiveStrong program for cancer survivors, HESSCO's Medical Nutrition Therapy, and partnering with local EMTs to address strokes and other conditions. In addition, the hospital supports programs for homebound residents who are suffering from chronic conditions; these programs include The Needham Community Council's medical appointment transportation program, Charles River Center's group residential homes, and The Neighbor Brigade's delivery of health supplies to homebound residents during the pandemic.

Within the hospital, BID Needham works to address readmissions with a utilization review committee, partnerships with EMTs, and by offering CPR classes for the community. Within the community, BID Needham works to educate on chronic disease risk factors and prevention through community talks and education. In addition, the hospital supports the "Family Health Initiative" at Family Promise MetroWest, ensuring that homeless families have insurance coverage and their annual medical visits and screenings.

Mental Health and Substance Use

In the area of mental health and substance use, the hospital continues to integrate behavioral health into patient care, a need that has increased exponentially this year (particularly with the closing of Norwood Hospital). In order to address substance misuse, the hospital maintains a prescription drug kiosk and a sharps disposal kiosk in the main lobby. BID Needham's Pain Management and Opioid Taskforce continues its work on prescribing practices as well as patient and clinician education. Within the community, the hospital supports and is involved in several efforts, including serving on local committees and taskforces to address the needs of residents in crisis situations.

As access to behavioral health care continues to be an issue, the Hospital has provided funding for the Interface Mental Health Hotlines in Needham and Medfield; and collaborated with CHNA 18 to provide QPR training to public library staff in Dedham. Within the community, BID Needham provides funding for mental health and substance use programming for youth and families. In FY20, this included bringing "The Family Dinner Project" to Needham and continuing the partnership with Students Advocating for Life without Substance Abuse (SALSA) to provide a school curriculum based on behavioral health. The hospital had one program in this area that was discontinued–the integration of a PCP in a Needham Primary Care office. However, this was replaced by a Beth Israel Lahey Health Collaborative Care initiative that served the same purposed.

Plans for Next Reporting Year

In FY19, 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. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, Beth Israel Deaconess Hospital–Needham will focus its FY20-22 Implementation Strategy on three priority areas; these 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 priority areas are:

- Social Determinants of Health & Access to Care
- Chronic/Complex Conditions and their Risk Factors
- Mental Health and Substance Use

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). 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 FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions are being used to inform and refine Beth Israel Deaconess Hospital–Needham's efforts. In completing the FY19 CHNA and FY20-22 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 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that Beth Israel Deaconess Hospital–Needham's FY20-22 Implementation Strategy should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care and service gap, as well as other

adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that targeted low- to moderate-income populations, youth, older adults, and those 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, CHNA 18, local substance prevention and crisis prevention committees, and businesses.

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the Beth Israel Deaconess Hospital–Needham Community Benefits team completed a hospital self-assessment form (Section VII, page 95). The Beth Israel Deaconess Hospital–Needham Community Benefits team also shared the Community Representative Feedback Form with CBAC members and community stakeholders who participated in the Beth Israel Deaconess Hospital–Needham's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

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

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

Beth Israel Deaconess Hospital–Needham is a member of 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 are integrated with local and system strategic and regulatory priorities.

The Director of Community Relations spearheads the Beth Israel Deaconess Hospital–Needham Community Benefits program. The Director of Community Relations 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 reports directly to the BILH Chief Strategy Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

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

Community Benefits Committee Meetings
BID Needham held three Community Benefits Advisory Committee meetings in Fiscal Year 2020. The meetings occurred on February 11, 2020; June 18, 2020; and September 10, 2020. The meeting on September 10, 2020, also served as the Hospital's Annual Community Benefits meeting.

Community Partners

Beth Israel Deaconess Hospital–Needham recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. Beth Israel Deaconess Hospital–Needham's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with Beth Israel Deaconess Hospital–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 Beth Israel Deaconess Hospital–Needham'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 in 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, chronic disease management, food access, and transportation. The hospital also supports 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.

Beth Israel Deaconess Hospital–Needham is also an active participant in several local coalitions and committees, including The Needham Community Crisis Intervention Team (CCIT), Youth Resource Network, and the Needham Local Emergency Planning Committee. Joining with such grass-roots community groups, public health and first responders, Beth Israel Deaconess Hospital–Needham strives to create a vision for health improvement and preparedness, and to address on-going crises for residents in the community. Also important are partnerships to address substance use and mental health, including BID Needham's involvement with the Substance Prevention Alliance of Needham (SPAN), Charles River Opioid Taskforce, and CHNA 18.

Beth Israel Deaconess Hospital–Needham's Board of Directors along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise, education, and research, along with an underlying commitment to health equity, are the primary tenets of its mission. Beth Israel Deaconess Hospital–Needham's Community Benefits Department, under the direct oversight of Beth Israel Deaconess Hospital–Needham's Board of Directors, 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 may be found in the Hospital Self-Assessment (Section VII, page 95).

Community Partners

Charles River Center
Charles River YMCA
CHNA 18
Circle of Hope
Dedham Council on Aging
Dedham Food Pantry
Dover Council on Aging
Family Dinner Project
Family Promise MetroWest
Greater Boston JCC
HESSCO
Language Line
Livable Dedham
LiveStrong at the YMCA
Medfield Coalition for Suicide Prevention
Medfield Public Schools
Needham Bank
Needham Clergy Association
Needham Community Council
Needham Community Education
Needham Community Farm
Needham Council on Aging
Needham Emergency Management
Needham Farmer's Market
Needham Fire Department
Needham History Center and Museum
Needham Sports Boosters
Needham Housing Authority
Needham Police Department
Needham Public Health
Needham Public Schools
Needham Traveling Meals Program
Needham Youth & Family Services
Neighbor Brigade
Newton Needham Regional Chamber
Newton Wellesley Hospital
Parent Talk
Plugged In Band
Ripples of Hope
Riverside Community Care
Students Advocating Life without Substance Abuse (SALSA)
Sean D. Biggs Memorial Foundation
Substance Prevention Alliance of Needham (SPAN)
Three Squares New England
Town of Needham
VNA Care Network
Walker
Westwood Council on Aging
Westwood Fire Department
Westwood Youth & Family Services
William James College

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment (CHNA), along with the associated FY20-22 Implementation Strategy, was developed over a 10-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service (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 Beth Israel Deaconess Hospital–Needham's dedication to its mission, its covenant with the underserved, and its commitment to community health improvement.

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

Approach and Methods

The FY19 CHNA was conducted in three phases, which allowed Beth Israel Deaconess Hospital–Needham to:

- Compile an extensive amount of quantitative and qualitative data,
- Engage and involve key stakeholders, Beth Israel Deaconess Hospital–Needham clinical and administrative staff, and the community at large,
- Develop a report and detailed strategic plan, and
- 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). The hospital also worked collaboratively with Needham Public Health to share information from its respective needs assessment activities relative to its

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, and surveys. 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 the 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) was 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 FY19 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 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 barriers. These issues affect 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 have difficulty providing or linking 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 need.

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 (IS) includes activities that will support residents throughout its service area and 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: youth, older adults, low- to moderate-income individuals and families, and individuals with chronic and complex conditions.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Social Determinants of Health/Access to Care - 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. The farm also provides gardening programming and education in the Needham Housing Authority units at Linden Chambers (for elderly and disabled) and a 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: 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; Chronic Disease – Overweight & Obesity, Diabetes

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

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
Increase access to low-cost healthy foods with an emphasis on priority populations.	NCF served more than 125 families through the Mobile Market in 2020. At the Mobile Market, NCF distributed more than 1,900 pounds of fresh produce, valued at over $14,000, an increase of 40% over 2019 numbers. In addition, the farm increased distribution in 2020, delivering to each neighborhood weekly to address the increased need for food caused by the pandemic. The mobile market also served as a social-emotional check-in during the pandemic, an unplanned benefit.	5	8	Process Goal
Increase access to low-cost healthy foods with an emphasis on priority populations.	The program at Captain Robert Cook focused on making the gardens an inviting place for residents to learn about growing and eating vegetables. While the program was delayed due to the pandemic, it engaged 10 youth in planting, maintaining, and harvesting from the communal garden bed with weekly support from the farm. Harvests from the garden, about 100 pounds of vegetables, were distributed to families from the neighborhood.	5	8	Process Goal
Increase access to low-cost healthy foods with an emphasis on priority populations.	At Linden Chambers, $100 of seeds and organic vegetables starts were donated to their Garden Club, an important social interaction for the residents.	5	8	Process Goal

Social Determinants of Health/Access to Care – Community Access to Healthy Foods

Brief Description or Objective	BID Needham is committed to providing nutrition and health information not only within the hospital, but also within the community. The hospital supported several local efforts to provide healthy food to seniors and families through The Dedham Food Pantry and the Dover, Needham, and Westwood Councils on Aging. The hospital also supports the Needham Farmer's Market, Three Squares New England, and Ripples of Hope.
Target Population	• **Regions Served: Needham, Dedham, Westwood, Dover** • **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; Chronic Disease – Overweight/Obesity, Diabetes

Partners	
Partner Name, Description	**Partner Web Address**
Needham Farmer's Market	www.homesharetours.com/needhamfarmersmarket-2/
Dedham Food Pantry	https://dedhamfoodpantry.org/
Dedham Council on Aging	https://www.dedham-ma.gov/departments/council-on-aging
Westwood Council on Aging	https://www.townhall.westwood.ma.us/government/boards-committees/council-on-aging
Dover Council on Aging	https://www.doverma.org/182/Council-on-Aging-COA
Three Squares New England	https://www.threesquaresne.org/
Ripples of Hope	http://www.ripplesofhope.org/
Circle of Hope	https://www.circleofhopeonline.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
Increase access to healthy food by supporting the Needham Farmer's Market.	The hospital provided funding to the Needham Farmer's Market in FY20, bringing fresh produce to Needham's town center every Sunday from mid-June to late November. NFM serves low-income individuals, families, and seniors through SNAP, EBT, HIP, WIC, Senior Coupons, and other State programs.	4	5	Outcome Goal
Address food insecurity related to COVID-19 by working with local Councils on Aging to provide fresh produce to homebound seniors.	BID Needham provided a mini-grant to the Westwood and Dover Councils on Aging to purchase produce from a local farm and delivery to at-risk, homebound seniors. The produce was delivered bi-weekly to 40 seniors in Westwood and Dover, from May to September. The program was supplemented by funding from The Cares Act.	1	3	Process Goal
Address food insecurity related to COVID-19 by supporting the Dedham Food Pantry.	BID Needham collaborated with The Dedham Food Pantry and Dedham Council on Aging to provide emergency food access for seniors, families, and individuals in Dedham during the COVID-19 pandemic. The Dedham Food Pantry was able to provide 1,000 bags of food to 250 households with the funding provided.	1	5	Process Goal
Increase access to healthy food by supporting local hunger relief organizations.	BID Needham is an ongoing supporter of The Three Squares Ride for Food. In FY2020, the event had nearly 450 riders, supporting 25 local hunger relief organizations, and raised $608,000 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 usually provides free first aid at the event, but the event was virtual for 2020.	6	10	Process Goal

Increase access to healthy food by supporting local hunger relief organizations.	The hospital provided grant support to Ripples of Hope to assist with their food access program for underserved residents in Dedham Housing Authority. The organization supported 100 families during the 2020 holiday season with drive-by food pick-up and centralized delivery stations for those who were unable to pick up food.	1	1	Process Goal
Increase access to healthy food and other necessities, by supporting social service organizations.	BID Needham awarded $1,000 to Circle of Hope for their health and dignity project with The Dedham Food Pantry. The organization donated 720 essential health and hygiene items (shampoo, body wash, deodorant, menstrual pads, and body lotion) to the Dedham Food Pantry for efficient distribution to Dedham families and individuals in need.	1	5	Process Goal

Social Determinants of Health/Access to Care – Traveling Meals

Brief Description or Objective	BID Needham continued to support the Traveling Meals program in Needham, which provides healthy meals for homebound seniors. The meals are made at BID Needham and delivered Monday-Friday, year around. The staff of the culinary team at BID Needham prepare and package the meals and volunteers deliver them to the members of the community.
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, Nutrition

Partners

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

Contact Information	Rebecca Lennon, Dietary Services 781-453-3000 148 Chestnut Street, Needham, MA 02492 rlennon@bidneedham.org

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 9,556 healthy meals delivered to homebound seniors in 2020.	27	40	Process Goal

Social Determinants of Health/Access to Care – 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

Partners	
Partner Name, Description	**Partner Web Address**
Contact Information	Tracy Murphy 781-453-5499 148 Chestnut Street, Needham, MA 02492 tvmurphy@bidneedham.org

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports, by offering a volunteer program at the hospital for aging adults.	There are 65 volunteers in the older adult volunteer program, however the program was on hold starting in March 2020 due to COVID-19.	16	20	Process Goal

Social Determinants of Health/Access to Care – 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 in DON funds annually, for five years, to a healthy aging initiative in Needham. In its second year, the program includes funding for fitness training, health and balance classes, and social programming. In 2020, food access initiatives were added due to the increased need caused by COVID-19.
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, Health Behaviors; Mental Health, Other – Senior Challenges/Care Coordination, Social Determinants of Health – Access to Care, Nutrition, Access to Healthy Food

Partners

Partner Name, Description	Partner Web Address
Town of Needham / Needham Council on Aging	https://www.needhamma.gov/519/Council-on-Aging

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
Reduce falling or fear of falls and increase activity level in older adults by providing access to fitness facilities, personal trainers, and classes for the aging population.	DON funds were used to support fitness activities, including the fitness center, personal trainers, and balance/fitness programs. Prior to COVID, the Senior Center's fitness center saw an average of 65 users per day. The programs transitioned to virtual in April.	2	5	Process Goal
Reduce falling or fear of falls and increase activity level in older adults by providing access to health and balance classes for the aging population.	Free, ongoing, evidence-based programs for balance, fall prevention, and bone health were offered on a weekly basis. The classes had an average of 35 people attend.	2	5	Process Goal
Reduce elder health isolation 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. Five events were held in FY20 before meetings were temporarily halted due to COVID-19. The students and seniors would watch a Ted Talk or video, then have dinner together conversing about the videos. After dinner, the students and seniors would play board games, pool, or ping-pong.	2	5	Process Goal
Reduce elder health isolation adults by offering social programming for aging adults.	Social programs such as art and music classes were offered as additional reasons for seniors to visit the Center to reduce isolation and encourage socializing. An average of 15 people participated in these classes.	2	5	Process Goal
Reduce elder health isolation and provide access to healthy foods for older adults by offering a grocery delivery program during COVID-19.	A grocery delivery program for seniors was added in March 2020 after the need arose due to COVID-19. The grocery delivery occurs three times per week and serves 36 seniors per week with food from a local grocery store.	1	2	Process Goal

Social Determinants of Health/Access to Care – Health Insurance Enrollment	
Brief Description or Objective	To ensure that patients are getting the proper care and coverage, BID Needham employs two 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

Partners	
Partner Name, Description	**Partner Web Address**
Contact Information	Wendy Leong-Lum 781-453-3841 148 Chestnut Street, Needham, MA 02492 wleonglu@bidneedham.org

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase the number of people assisted with insurance and other public program enrollment and patient navigation, by providing assistance with insurance enrollment.	In FY20, BID Needham's financial counselors successfully enrolled 125 patients in MassHealth. Financial assistance applications and information are available in English, Spanish, Chinese, and Russian.	8	10	Process Goal

Social Determinants of Health/Access to Care – Financial Assistance

Brief Description or Objective	BID Needham is dedicated to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for Emergency Care, Urgent Care, or other Medically Necessary Care based on their individual financial situation. Patients eligible for Financial Assistance will receive discounted care received from qualifying BID Needham providers.
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

Partners

Partner Name, Description	**Partner Web Address**

Contact Information	Kathy Heffernan 781- 453 3079 148 Chestnut Street, Needham, MA 02492 kheffer1@bidneedham.org

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Increase the number of people assisted with insurance other public program enrollment, and patient navigation.	BID Needham provided $679,000 in free care in FY20.	8	10	Process Goal

Social Determinants of Health/Access to Care – Primary Care Support

Brief Description or Objective	To ensure access to primary care and screening, the hospital supports Beth Israel Deaconess Healthcare offices in their Community Benefits service area, including Needham and Westwood.
Target Population	• **Regions Served: 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

Partners

Partner Name, Description	**Partner Web Address**
Beth Israel Deaconess Healthcare	www.bidmc.org/centers-and-departments/bidhc-primary-care

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**
Increase partnerships and collaboration with social service and other community-based organization to provide access to care.	BID Needham provides financial support to Beth Israel Deaconess Healthcare Primary Care Offices within the Community Benefits Service area to ensure access to care for local residents.	7	10	Process Goal

Social Determinants of Health/Access to Care – 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, Dedham, Dover, 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	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	Lynne Crane 781-453-5252 148 Chestnut Street, Needham, MA 02492 Lcrane1@bidneedham.org

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Increase the number of people assisted with insurance other public program enrollment, and patient navigation by offering culturally responsive care, including interpreter services.	LanguageU video remote interpretive services were accessed 1,060 times in FY20 at BID Needham, allowing ESL patients to access care in a culturally competent way.	7	30	Outcome Goal
Increase the number of people assisted with insurance other public program enrollment, and patient navigation by offering culturally responsive care, including interpreter services.	Face-to-face interpretations were used 33 times in FY20 at BID Needham, allowing ESL patients to access care in a culturally competent way.	21	30	Outcome Goal
Increase the number of people assisted with insurance other public program enrollment, and patient navigation by offering culturally responsive care, including interpreter services.	Telephonic interpretation sessions were used 919 times in FY20 at BID Needham, allowing ESL patients to access care in a culturally competent way.	16	30	Outcome Goal

Chronic & Complex Conditions and their Risk Factors - 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, Councils on Aging, and local schools and coalitions, these workshops educate their residents and members about pertinent health issues.
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	Health Behaviors/Mental Health – Physical Activity; Social Determinants of Health – Nutrition; Smoking/Tobacco Use; Health Behaviors – Physical Activity; Social Determinants of Health – Access to Healthcare

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/
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

Goal Description	Goal Status	Program is in X Year	Of X Years	Goal Type
Increase the number of people who are educated about chronic disease risk factors and protective behaviors, through a series of health talks with the Boston JCC.	Collaborating with the Boston JCC and BIDMC, two education talks were held for the community in FY20. "Youth Vaping: The New Look of Nicotine Addiction" was held on Wednesday November 13, 2019, with 12 attendees. "Reducing Anxiety with Tai Chi" was held on December 4, 2019, with 17 attendees. The third talk in the series was cancelled due to the pandemic. The talks were free of charge and open to the community. The hospital also provided a $3,500 grant toward staffing for chronic disease programs.	8	10	Process Goal
Increase the number of people who are educated about chronic disease risk factors and protective behaviors through participation in Healthy Kids Day.	Healthy Kids Day was cancelled in 2020 due to the pandemic. There are plans to resume in 2021.	5	10	Process Goal
Increase the number of people who are educated about chronic disease risk factors and protective behaviors at community fairs.	BID Needham participated in the Needham Harvest Fair, focusing on preventative care, screening, and PCP visits. Approximately 500 people attended the fair. All other fairs were cancelled due to the COVID-19 pandemic.	8	10	Process Goal
Increase the number of people who quit smoking cigarettes, vaping, or using e-cigarettes.	An information table was held by the respiratory team at Needham High School for students and teachers to demonstrate the effects of vaping on the lungs. Approximately 15 people received information. The intention was to expand this program, but it was suspended due to COVID-19.	1	1	Process Goal

Chronic & Complex Conditions and their Risk Factors – 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

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.	While the hospital usually conducts CPR classes for the community, many of the classes were cancelled due to COVID-19, including parents and youth classes that typically happen in spring and summer. Some community members and emergency response workers were trained in FY20 prior to the pandemic.	9	15	Process Goal

Partners

Partner Name, Description	Partner Web Address

Contact Information	Cristina Allen 781-453-3000 148 Chestnut Street, Needham, MA 02492 cmallen@bidneedham.org

Chronic & Complex Conditions and their Risk Factors– 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 are usually set up in February for heart month, March for colorectal cancer awareness month and nutrition month, and in May for stroke month; however, some were cancelled due to COVID. In addition, the hospital displayed information on digital screens throughout the hospital, and this health information was also posted 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/

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
Enhance access to health education, screening, referral, and chronic disease management services in clinical and non-clinical settings, by holding annual information tables for hospital patients and the community on pertinent health topics.	An information table was held by the respiratory team in the hospital to demonstrate the effects of smoking and vaping on the lungs. Approximately 30 people received information. The information tables for heart health, colorectal cancer prevention, and stroke prevention were cancelled in 2020 due to COVID-19.	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 hospital did not hold National Nutrition Month events due to COVID-19.	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 uses digital screens in public waiting areas of the hospital to increase communication to staff, patients and the public about health-related community events, health tips, and other hospital information. Much of the information in the second half of 2020 was focused on COVID practices and policies.	2	20	Process Goal

Chronic & Complex Conditions and their Risk Factors – 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

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

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
Increase the number of people who are educated about chronic disease risk factors and protective behaviors by supporting local road races where the community can be active.	BID Needham usually provides free first aid services to local road races that encourage the community to be active and to 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. BID Needham did provide first aid for the BIGGSteps 5K, but all other races were cancelled due to COVID-19.	8	10	Process Goal

Chronic and Complex Conditions and their Risk Factors - EMT Partnerships

Brief Description or Objective	BID Needham works closely with local EMTs to provide the best possible care in the community. The hospital provides training for local EMTs and works with local Fire Departments to provide medications and training.
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	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
Increase the number of people with chronic/complex conditions whose conditions are under control, 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 FY20.	8	10	Process Goal
Increase the number of people with chronic/complex conditions whose conditions are under control, by collaborating 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 $10,000 worth of medications in FY20.	5	10	Process Goal

Partners

Partner Name, Description	Partner Web Address
Needham Fire Department	www.needhamma.gov/63/Fire
Westwood Fire Department	https://www.townhall.westwood.ma.us/departments/fire

Contact Information	Leeann Wood 781-453-5407 148 Chestnut Street, Needham, MA 02492 Lwood3@bidneedham.org

Chronic and Complex Conditions and their Risk Factors – Family Health Initiative

Brief Description or Objective	BID Needham collaborated 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
Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services, by supporting "The Family Health Initiative" for homeless families through Family Promise MetroWest.	While Family Promise MetroWest continued to run their Family Health Initiative in 2020, the pandemic hindered access to medical appointments and created significant challenges for this program. The organization was forced to meet more immediate needs such as safe housing and nutritional needs. While 50 families were served by the Family Health Initiative, the results did not achieve all benchmarks: 100% of uninsured families obtained health insurance. 71% of families secured a primary care physician for each family member. 78% of families addressed outstanding medical and dental needs. 82% of families participated in health and safety training.	5	5	Process Goal

Chronic & Complex Conditions and their Risk Factors – Reduce Readmissions

Brief Description or Objective	The hospital is working toward 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**
Increase the number of people with chronic/complex conditions whose conditions are under control 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.	5	10	Outcome Goal
Increase the number of people with chronic/complex conditions whose conditions are under control, 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.	4	5	Outcome Goal

Chronic & Complex Conditions and their Risk Factors – Community Medication 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 EpiPens to school nurse offices throughout the district.
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	Chronic Disease – Asthma/Allergies, Cardiac Disease; Social Determinants of Health – Access to Healthcare; Other – Senior Health Challenges; Health Behavior - Immunizations

Partners

Partner Name, Description	**Partner Web Address**
Needham Public Schools	http://www.needham.k12.ma.us/
Needham Public Health	https://www.needhamma.gov/85/Public-Health/

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**
Increase the number of people with chronic/complex conditions whose conditions are under control, by providing local schools with essential medical supplies, enabling them to be prepared for emergency care.	BID–Needham provides EpiPens to the Needham Public School Nurse Office for use in case of emergency. The EpiPen costs for FY20 were approximately $5,300.	6	10	Outcome Goal
Increase the number of people with chronic/complex conditions whose conditions are under control, by providing local health departments with syringes and other supplies needed to provide community health care.	BID–Needham provides syringes and needles to the Needham Public Health Nurses Office for public vaccination clinics. The costs for FY20 were approximately $340.	6	10	Outcome Goal

Chronic & Complex Conditions and their Risk Factors – 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, 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	Chronic Disease - Cancer, Health Behaviors/Mental Health – Physical Activity

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

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Increase the number of people with chronic/complex conditions whose conditions are under control.	The LiveStrong Program ran as planned through February 2020. Due to COVID-19, LiveStrong was temporarily discontinued for a few months in March, but moved to a virtual platform in August. The virtual program consists of two weekly 75- to 90-minute sessions comprised of approximately 15-25 minutes of discussion and supervised 30- to 60-minute workouts. BID Needham provided a grant to cover scholarships, which allowed the YMCA to offer the program free of charge to cancer patients. 34 individuals graduated from the program in FY20, regaining strength and the ability to return to activity after cancer.	4	8	Process Goal

Chronic & Complex Conditions and their Risk Factors – Charles River Center

Brief Description or Objective	The Charles River Center provides employment and job training, residential homes, day habilitation, and recreational programs for children and adults with Down syndrome, autism, cerebral palsy, and other developmental disabilities. This organization is critical to the community, and BID Needham provides the organization with an annual grant to address one of their outstanding health needs. For the organization's residential programs, monitoring the health of the residents, particularly during COVID-19, was of the utmost importance in order to keep the programs running.
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

Partners

Partner Name, Description	**Partner Web Address**
Charles River Center	https://www.charlesrivercenter.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
Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services.	Charles River Center purchased ear lobe pulse oximeters and portable vital sign machines for 5 residential programs, serving 32 residents. The ability to measure persons with symptoms using these devices was extremely beneficial in determining whether to seek additional medical support, including early testing and treatment of COVID-19. In addition, the organization has been able to transfer the equipment to other residential programs, when situations warrant to the need to use the equipment.	1	1	Outcome Goal

Chronic & Complex Conditions and their Risk Factors – 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 Community Council 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. A 2019 survey indicated that 60% of these riders would have cancelled their medical appointment if it were not for the ride.
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; Chronic Disease; Other – Senior Health Challenges/Care Coordination

Partners

Partner Name, Description	**Partner Web Address**
Needham Community Council	http://needhamcommunitycouncil.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**
Increase access to affordable, safe transportation options to health care, through a medical appointment transportation program with the Needham Community Council.	During FY20, the Community Council Lyft Ride Program provided approximately 375 rides to medical appointments for underserved residents. While this was a decrease in number of rides from FY19, this was likely due to the suspension of the program in late March, April, and May due to COVID-19. BID Needham supported this program with a grant of $5,000.	3	5	Process Goal
Increase access to affordable, safe transportation options to health care by providing taxi and Uber vouchers to those who need a ride home from medical appointments at the hospital.	The hospital spent $1,000 on taxi vouchers and provided 28 taxi vouchers in FY20. The hospital spent $1,900 on Uber vouchers and provided 80 rides in FY20.	12	20	Process Goal

Chronic & Complex Conditions and their Risk Factors – Medical Nutrition Therapy

Brief Description or Objective	BID Needham provided funding to the Westwood Council on Aging (COA) and HESSCO to pilot a Medical Nutrition Therapy (MNT) program. MNT is a comprehensive and holistic assessment of an older adult's 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

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/

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
Increase the number of people with chronic/complex conditions whose conditions are under control with a Medical Nutrition Therapy program at the Westwood Council on Aging.	With a $2,100 grant from BID Needham, the program served 12 individuals in FY20 before having to discontinue the program due to COVID-19. HESSCO was unable to transition to a virtual program due to other priorities for seniors during the pandemic.	2	3	Process Goal

Chronic & Complex Conditions and their Risk Factors – Home Health Patient Navigation Services

Brief Description or Objective	VNA Care Network trained their home health staff to provide health resources available in the community in order to assist home health patients with navigating the health care system.
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

Partners

Partner Name, Description	Partner Web Address
VNA Care Network	https://vnacare.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
Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services by providing support for home health aide training.	BID Needham supported VNA Care Network's home-health services with a $2,500 grant. This grant provided training to clinicians and social workers to educate them on resources available to at-risk patients. This may include accessing and navigating community resources and government relief programs, education, and counseling to support the patient's health goals. Specific examples may include food deliveries, finding transportation to medical appointments, offering guidance on applying for public housing, giving assistance with legal, medical-legal and financial documents, and securing free medications through drug companies.	1	3	Outcome Goal

Chronic & Complex Conditions and their Risk Factors – Neighbor Brigade

Brief Description or Objective	Neighbor Brigade organizes volunteers that can be mobilized to help underserved residents facing sudden crisis, such as cancer diagnosis or other illness, to manage day-to-day tasks such as meal preparation, rides, and basic household chores.
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

Partners

Partner Name, Description	**Partner Web Address**
Neighbor Brigade	https://www.neighborbrigade.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**
Increase the number of people with chronic/complex conditions whose conditions are under control.	Neighbor Brigade saw a dramatic increase in service requests in 2020 due to the pandemic. The organization has shifted its model to collaborate with local food pantries, school districts, councils on aging, housing authorities and town officials to deliver food and health supplies safely and securely to residents who are homebound, low income, disabled, or somehow impacted by health crisis. The grant from BID Needham covered three months of the organization's increased costs to facilitate services, including national background checks for volunteers, creation of a new toll free number to manage school district food distribution, and purchases of PPE and cleaning supplies for our volunteers. Over a three-month period, 917 volunteer activities were completed by 325 different volunteers, serving 212 unique households with direct services.	2	3	Outcome Goal

Mental Health and Substance Use – Integrated Behavioral Health Care

Brief Description or Objective	BID Needham continues to integrate behavioral healthcare into patient care. 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 the Director of Clinical Liaison Psychiatry provides 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

Partners

Partner Name, Description	**Partner Web Address**
Riverside Community Care	https://www.riversidecc.org/

Contact Information	Gregory McSweeney, MD 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**
Increase access to screening, education, referral, and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and non-clinical settings, 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. 247 patients were seen through this partnership in FY20. While there was a sharp decline in behavioral health patients during the spring lockdown, this was followed by a sharp increase.	16	20	Process Goal
Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing mental health services in the hospital.	A Psychologist is employed to provide consultations on the inpatient units, and a Director of Clinical Liaison Psychiatry provides weekday telephone support for providers.	7	20	Outcome Goal
Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing mental health services in the hospital.	The hospital provides staff to provide supervision to behavioral health patients in the Emergency Room who may be a risk to themselves or others.	3	15	Outcome Goal

Mental Health and Substance Use – Collaborative Care

Brief Description or Objective	In order to address the growing need for mental health providers and resources in the community, Beth Israel Deaconess Healthcare adopted the Collaborative Care Model (CoCM). The model will be expanded to additional communities throughout the Beth Israel Lahey Health service area. Collaborative Care is a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services are provided by a licensed behavioral health clinician and they include counseling sessions, phone consultations with a psychiatrist, and coordination and follow up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of medical and mental health conditions.
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

Partners

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

Contact Information	Gregory McSweeney, MD 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**
To increase access to behavior health services	In FY20, BIDHC provided behavioral health clinicians at two primary care practices, reaching patients.	1	3	Process Goal

Mental Health and Substance Use – 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 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**
Decrease the availability of unused prescription drugs and promote collaboration across the health system to address substance use through a Pain Management & Opioid Taskforce.	In FY20, the Pain Management & Opioid Taskforce continued educating clinicians and patients about prescribing practices. These initiatives included patient fact sheets and non-opioid directives, creating pain and alternative therapy resources, and distributing to clinicians to educate on alternatives to opioids. Other initiatives included conducting an on-going prescribing query to review and modify prescribing practices within the hospital, reassessing outpatient surgical prescribing practices, and creating a new tool using our electronic medical records to better assess patient pain and timing/delivery of medications to address patient pain.	4	5	Outcome Goal

Mental Health and Substance Use – Prescription Drug Disposal

Brief Description or Objective	The Hospital maintained the prescription drug disposal kiosk and sharps disposal in the lobby, as a safe way for the community to dispose of unwanted or unneeded prescription drugs and sharps.
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

Partners

Partner Name, Description	**Partner Web Address**
Contact Information	Joe Giovangelo 781-453-3640 148 Chestnut Street, Needham, MA 02492 jgiovang@bidneedham.org

Goal Description	**Goal Status**	**Program is in X Year**	**Of X Years**	**Goal Type**
Increase the number of opportunities that residents of the service area can give back unused prescriptions by providing a place for the public to dispose of unused and unwanted prescription drugs.	The kiosk was closed for some of 2020 due to COVID-19. 89 pounds of prescription drugs were disposed of in FY20.	3	10	Process Goal
Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose sharps.	The kiosk was closed for some of 2020 due to COVID-19. Five containers of sharps were disposed of in FY20.	2	10	Process Goal

Mental Health and Substance Use – 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; and the Needham Local Emergency Planning Committee, which meets monthly to address and plan for crisis situations. The hospital 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: 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, 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
Get Connected Needham	http://www.needhamma.gov/4879/Get-Connected-Needham-Resource-Guide-for

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**
Increase access to clinical and non-clinical support services for those with mental health and substance use issues, 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.	4	10	Process Goal
Promote cross-sector partnership, collaboration, and information sharing across the broad health system to address access to substance use services, through a regional, multi-disciplinary taskforce.	Hospital pharmacy staff participated in the Charles River Opioid Taskforce in order to identify ways to work together to address opioid misuse in the region.	2	5	Process Goal
Promote cross-sector partnership, collaboration, and information sharing across the broad health system through participation in the Community Crisis Intervention Team.	Staff from BID Needham serve on the Local Emergency Planning Committee (LEPC) in Needham. This committee has taken on a particularly important role in FY20 with the COVID-19 pandemic.	4	8	Outcome Goal
Promote cross-sector partnership, collaboration, and information sharing across the broad health system by facilitating a meeting for local social service and health-focused organizations.	The hospital convenes local organizations twice per year to share resources, ideas and partnership opportunities. The “Community Resource Group” meetings have been very successful. Only one meeting was held in FY20 due to COVID-19 and more pressing priorities for the group.	4	10	Outcome Goal

Promote cross-sector partnership, collaboration, and information sharing across the broad health system.	As COVID-19 hit and residents were scrambling to find resources, Needham social service providers convened to centralize information and resources for mental and physical health and social determinants of health. "Get Connected Needham" is housed on the Town of Needham website and was shared by many organizations in Needham to make resources easier to locate.	1	5	Outcome Goal
Increase access to clinical and non-clinical support services for those with mental health and substance use issues, through participation in the Youth Resource Network.	A hospital representative participated in Youth Resource Network roundtable discussions, which served five Needham families in FY20. Some of the meetings were canceled due to COVID-19. The goal of the meeting is to identify specific needs and identify potential resources that will help the family and change their current situation.	4	5	Outcome Goal

Mental Health and Substance Use – Interface Mental Health Hotline

Brief Description or Objective	BID Needham continued the ongoing partnership with Needham Public Health 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.
Target Population	• **Regions Served: Needham** • **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
Increase access to clinical and non-clinical support services for those with mental health and substance use issues, through assistance with finding mental health services.	Needham's Interface Helpline served 141 cases in calendar year 2020. The majority of the calls were from parents calling on behalf of their children, but the number of adult callers continued to increase. Anxiety and depression was the top self-reported issue for callers. It is expected that as the pandemic draws on, that calls will increase in FY21.	6	10	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/

Contact Information

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

Mental Health and Substance Use – 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

Partners

Partner Name, Description	**Partner Web Address**
Walker	http://www.walkercares.org/
Riverside Community Care	www.riversidecc.org
Plugged In Band	https://pluggedinband.org/
CHNA 18	www.chna18.org
Dedham Public Library	https://dedhamlibrary.com/

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
Increase access to clinical and non-clinical support services for those with mental health and substance use issues, for those experiencing significant behavioral, emotional and learning challenges.	BID Needham provided a $2,500 grant to Walker that was used for their re-opening plan after COVID-19. The funds were used to purchase pens/pencils, art supplies, technology, and other individual learning supplies to support students at The Walker School. The program serves 115 children annually, between the ages 5 to 13, who are facing complex emotional, behavioral, and learning challenges.	2	5	Process Goal
Increase access to screening, education, referral and patient engagement services for those identified with or at-risk of mental health and substance use issues in clinical and non-clinical settings, with an emphasis on priority populations.	Riverside was awarded a $2,500 grant to support the two students and two staff members at The Riverside School, Needham. The funds were used to purchase cleaning supplies and PPE, including special masks for staff, and individual educational kits that were sent to each youth's home and were used for virtual activities and team building.	1	5	Process Goal
Increase access to peer support and one-on-one mentorship program for income-eligible high school students.	Needham Steps Up did not request grant support in FY20.	3	5	Process Goal
Increase access to peer support, through extracurricular programming for underserved students.	The hospital provided Plugged In Band program with a $1,400 grant, which provided spring virtual band programming scholarships for 2 underserved students.	2	5	Process Goal
Increase community education and awareness of substance use and healthy mental, emotional and social health.	A $600 grant to CHNA 18 provided mental health QPR training for local librarians. The event was hosted at Dedham Public Library and was attended by 40 staff members from area libraries.	2	2	Process Goal

Mental Health and Substance Use – Mental Health Prevention Programming

Brief Description or Objective	BID Needham collaborated 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. The hospital also supported a "life skills" conference at Needham High School, which prepared students for life outside of a parent's home. The intention of the program is to help with the transition from school to college or independent living.
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	Health Behaviors/Mental Health – Mental Health, Stress Management

Partners	
Partner Name, Description	**Partner Web Address**
Parent Talk	www.parenttalk.info/
Needham Public Schools	http://www.needham.k12.ma.us/
Needham Education Foundation	www.nefneedham.org
SPAN	https://www.spanneedham.org/
Needham High School	http://www.needham.k12.ma.us/

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
Increase community education and awareness of substance use/misuse and mental, emotional and social health.	The hospital partnered with the Substance Prevention Alliance of Needham to offer "The Family Dinner Project" to Needham families. The evening involved a catered dinner for the families, including an appetizer made together by each family, games, and guided conversation during dinner, and a parent workshop while kids made dessert. More than 50 family members attended the event.	1	1	Process Goal
Increase community education and awareness of substance use/misuse and mental, emotional and social health.	Prior to "The Family Dinner Project," the keynote speaker provided workshop for teachers and youth leaders in the community. Thirteen community members attended the workshop.	1	1	Process Goal
Reduce the stigma associated with 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. Three families were given a scholarship in FY20.	4	5	Process Goal
Increase community education and awareness of substance use/misuse and mental, emotional and social health.	Programming with Westwood Youth & Family Services and Needham Education Foundation was not held in FY20 due to COVID-19.	1	5	Process Goal
Reduce the stigma associated with mental health.	BID Needham provided a grant to Needham High School to offer a "Life Skills Conference" to graduating seniors. This program offered classes on real life skills to help with the transition to independent living after graduation, a major stressor for graduates. 393 students participated.	2	5	Process Goal

Reduce elder health isolation and depression by offering a safe outdoor space for older adults to gather during COVID-19.	BID Needham, the Dover Council on Aging and Dover Parks & Recreation provided funding for outdoor tents in the parking lot behind Dover's Caryl Community Center. This provided a safe, ventilated space for seniors and youth to gather following health protocols of wearing masks and social distancing. Goals were exceeded as more seniors and youth attended programs under the tents than originally anticipated. The tents were also utilized for curbside pick-up by seniors of farm fresh vegetables from a local farm, donated bread, bagels, and pastries from a bakery, and Grab & Go meal pick up, all done in a drive-through manner. 50 seniors and 30 children attended programming.	1	1	Process Goal

Mental Health and Substance Use - 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

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
Increase community education and awareness of substance use/misuse and mental, emotional, and social health, 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. 100 high school students teach 500 8th graders each year.	5	10	Outcome goal
Increase community education and awareness of substance use/misuse and mental, emotional and social health, by providing access to a safe and alcohol-free event on New Year's Eve.	New Year's Needham was cancelled for 2021 due to the pandemic.	3	5	Process goal

SECTION V: EXPENDITURES

CB Expenditures by Program Type	Amount	Subtotal Provided to Outside Organizations (Grants/Other Funding)
Direct Clinical Services:	$893,087	$104,999
Community-Clinical Linkages:	$76,685	$76,245
Total Population or Community-Wide Interventions:	$26,219	$18,357
Access/Coverage Supports:	$94,700	$7,900
Infrastructure to Support CB Collaborations Across Institutions:	$38,627	$0

CB Expenditures by Health Need	Amount
Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes:	$783,600
Mental Health/Mental Illness:	$219,885
Housing/Homelessness:	$6,386
Substance Use:	$5,241
Additional Health Needs Identified by the Community:	$114,206
Other Leveraged Resources:	$111,672

Net Charity Care Expenditures:	Amount
HSN Assessment:	$605,566
HSN Denied Claims:	$73,956
Free/Discount Care:	$0
Total Net Charity Care:	$679,522

Total CB Expenditures: $1,920,512

Additional Information:	**Amount**
Total Revenue:	$164,930
Net Patient Service Revenue:	$91,920,000
CB Expenditure as Percentage of Net Patient Services Revenue:	2.09%
Approved CB Program Budget for FY21: **(*Excluding expenditures that cannot be projected at the time of the report)**	$1,129,000
Bad Debt:	**$895,867**
Bad Debt Certification:	**$0**

Optional Supplement:

Comments:

BID Needham paid a voluntary PILOT payment to the Town of Needham in the amount of $93,000 in FY20, which contributed to the health and well-being of individuals residing in its Community Benefits Service Area. The hospital also supported the Interface Mental Health Hotline in Medfield. 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. Furthermore, Norwood Hospital had been funding a portion of the program and the funding was lost with the closure of the hospital. Medfield's Interface Helpline served 86 cases in calendar year 2020.

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: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year?

☒ **Yes** ☐ **No**

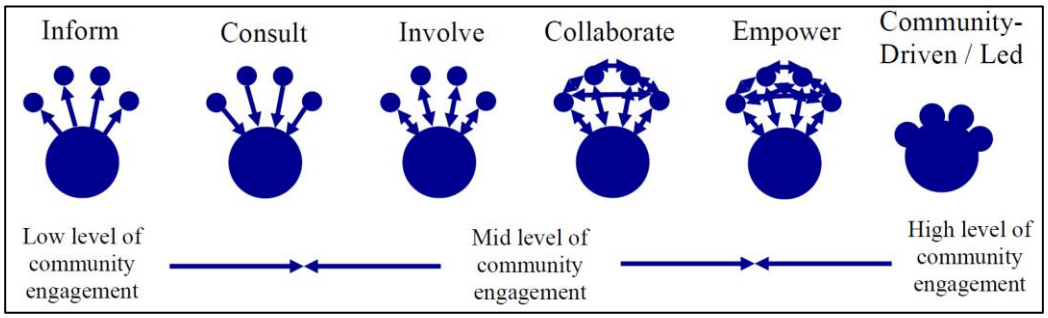
If so, please list updates:

In FY20, BID Needham transitioned from a Community Benefits Committee made up of internal and external partners, to a Community Benefits Advisory Committee made up of external partners with hospital leadership on the committee. The external partners mostly remained the same, with the following exceptions: Hien Tran from Needham Housing Authority left and was replaced by Deb Tambeau, who agreed to join our CBAC. Sarah Baroud from Westwood Youth and Family Services joined. Current Community Members include Lina Arena DeRosa, Westwood Council on Aging. Sarah Baroud, Westwood Youth and Family Services. 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. Deb Tambeau, Needham Housing Authority. The BID Needham Executive representatives are Kathy Davidson, Chief Nursing Officer and Samantha Sherman, VP Philanthropy. Members from the BID Needham Board of Trustees include Leslie Medalie (Chair), Virginia Carnahan and Samantha Trotman Burman. Members from the BID Needham Board of Advisors include Janet Barrett and Wanita Kennedy. Alyssa Kence, BID Needham, Director of Community Benefits, oversees the committee.

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

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Dedham Food Pantry	Carol Burak, Board Member	Social service organizations	With the increase in food insecurity with COVID-19, Dedham Food Pantry had a dire need for assistance.
Livable Dedham	Diane Barry Preston, Board Member	Other	Livable Dedham seeks to create an "age friendly" community. BID Needham partnered to support their adult outdoor fitness equipment installation at Gonzalez Field in Dedham.

Please use the spectrum below from the Massachusetts Department of Public Health1 to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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	The CBAC was involved in developing and implementing the plan. The goal was met.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	BID Needham will continue to work on involving its CBAC in the allocation of resources.	Involve

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

Implementing Community Benefits programs	Collaborate	BID Needham provided grants to community organizations, collaborating to address unmet health needs	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	BID Needham collaborated with the CBAC and Community Partners to evaluate progress and measurement of programs.	Collaborate
Updating Implementation Strategy annually	Consult	Updates to the Implementation Strategy were discussed at the hospital's annual Community Benefits meeting.	Involve

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

Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? **If so, please provide the date and location of the event. If not, please explain why not.**
BID Needham held CBAC meetings on February 11, 2020 and June 18, 2020 and held a CBAC/Public Annual Community Benefits Meeting on September 10, 2020.

III. Updates on Regional Collaboration:
If the hospital reported on a collaboration in its Year 1 Hospital Self-Assessment, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.
BID Needham is part of the Beth Israel Lahey Health (BILH) system community health improvement planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government payer patient populations in the communities. Guided by the CBC, hospitals' Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.

Optional FY20 Q: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits program.

As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.