Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health
Beth Israel Deaconess Milton

Beth Israel Lahey Health

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SECTION I: SUMMARY AND MISSION STATEMENT

Beth Israel Deaconess Hospital-Milton (BID Milton) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

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. BID Milton's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

While BID Milton oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

- ***W****ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E****mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C****ollaboration - We work together to achieve extraordinary results*
- ***A****ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R****espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E****quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

The mission of BID Milton is to provide free or low-cost programs that address unmet health and wellness needs of racially, ethnically, and linguistically diverse communities in Milton, Randolph and Quincy, in a manner shaped by community input, aligned with hospital

resources, and guided by our objective to deliver high-quality care with compassion, dignity, and respect.

More broadly, BID Milton's Community Benefits mission is fulfilled by:

- **Involving** BID Milton**'s staff**, including its leadership and dozens of community partners in the Community Health Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout BID Milton's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in BID Milton's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

- **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., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

The following annual report provides specific details on how BID Milton is honoring its commitment and includes information on BID Milton's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

BID Milton's CBSA includes Milton, Randolph and Quincy. In FY 2022, BID Milton conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA)

that included extensive data collection activities, substantial efforts to engage BID Milton's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BID Milton is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BID Milton's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BID Milton's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in BID Milton's CBSA were issues related to age, race/ethnicity, language, and immigration status. All three communities were diverse; the percentages of Black/African American residents in Randolph and Milton were significantly high compared to the Commonwealth, as was the percentage of Asian residents in Quincy. There was consensus among interviewees, focus group participants, and listening session attendees that immigrants, individuals best served in a language other than English, people of color, and individuals with disabilities face systemic challenges that limited their ability to access health care services. Participants reported that these segments of the population were impacted by language, racism, cultural barriers, and stigma that posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes.

For its FY 2023 – 2025 IS, BID Milton will work with its community partners, with a focus on Milton, Randolph and Quincy to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BID Milton's Community Benefits investments and resources will focus on the improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- Individuals with Disabilities

Basis for Selection
Community health needs assessments; public health data available from government (public school districts, Massachusetts Department of Public Health, federal agencies) and private resources (foundations, advocacy groups); and BID Milton's areas of expertise.

Key Accomplishments for Reporting Year
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in BID Milton's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- Assisted 520 community members to enroll in and receive health insurance benefits.
- Grant funding provided to Quincy Community Action Program rental assistance and eviction prevention program prevented 25 individuals from 15 households from becoming homeless. The grant provided an average of $900 to each household for rental assistance.
- The Peer Recovery Coach Program in the hospital's Emergency Department conducted 418 consults with 48% resulting in transfer to treatments.
- BID Milton's Determination of Need Community-based Health Initiative (CHI) funds were directly awarded to the Friendly Food Pantry in Randolph. Funding has been used to digitize operations, increase pantry capacity and improve access. New electronic database software has been purchased and over 3,000 client records have been converted from paper to digital format. Food pantry informational brochures and registrations have also been translated into five different languages.
- Grant funding was awarded to the May Institute to improve on-site vocational job training to enhance life skills and communication for teenagers and young adults with disabilities.
- The hospital's first year of its Palliative Care program performed 108 consults to better manage patient's symptoms and provide support to caregivers.

Plans for Next Reporting Year

In FY 2022, BID Milton conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BID Milton's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, BID Milton will focus its FY 2023 - 2025 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in BID Milton's CBSA who face the greatest health disparities. These four priority areas are:

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BID Milton's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BID Milton's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BID Milton, along with its other

health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BID Milton's FY 2023 - 2025 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BID Milton's Community Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; and individuals with disabilities.

BID Milton partners with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - BID Milton will continue to provide enrollment counseling and assistance and patient navigation support services to uninsured/underinsured residents and increase access to culturally appropriate and responsive care
  - Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.
  - Work with BILH Workforce Development to continue to provide and promote career support services and career mobility programs to hospital employees and increase training and mentorship programs and employment opportunities for youth and young adults in the community.

- **Social Determinants of Health**
  - Continue to provide grant funding for local partners and social service agencies such as Quincy Community Action Programs (QCAP), Father Bills & Main Spring and DOVE (Domestic Violence Ended) who address social determinants of health to help individuals and families who are low-resourced maintain housing and prevent eviction.
  - Partner with local agencies and community partners such as Brookwood Community Farm, Asian American Service Association, Friendly Food Pantry to promote and provide access to healthy food.
  - Work with South Shore Elder Services to provide transportation options for older adults.
  - Continue to provide grant funding to the May Institute to improve vocational work opportunities to individuals with disabilities.

- **Mental Health and Substance Use**
    - BID Milton will continue to be an active member of the Milton Substance Abuse Prevention Coalition and work alongside the local public health department and law enforcement to provide staff and financial resources to coordinate education, community health improvement activities and referral services.
    - Continue to enhance access to mental health and substance use screening, assessment, and treatment services with its Peer Recovery Coach programs in its Emergency Department to link individuals with recovery, case management, and navigation support.
    - Continue to build community members' capacity to help reduce negative stereotypes, bias and stigma around mental illness and substance use disorders by providing grants to Aspire Health Alliance and other local partners to provide access to Mental Health First Aid training and other mental health supports.

- **Complex and Chronic Conditions**
    - Ensure older adults have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.
    - BID Milton will partner will local service agencies including the YMCA to provide evidence-based health education and self-management support programs.
    - Provide educational programming to older adults at local health departments, senior centers, and retirement communities to provide access to preventative health information and services.

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), BID Milton Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 44). The BID Milton Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BID Milton's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BID Milton's Board of Trustees along with its clinical and administrative staff is committed to improving the health of our community by providing exceptional, personalized health care with dignity, compassion and respect. BID Milton's Community Benefits Department, under the direct oversight of BID Milton's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BID Milton's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the BID Milton's Board of Trustee members and senior leadership who are held accountable for fulfilling BID Milton's Community Benefits mission. Among BID Milton's core values are 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 BILH and BID Milton's structure and reflected in how care is provided at the hospital and in affiliated practices.

While BID Milton oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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The BID Milton Community Benefits program is spearheaded by the Community Benefits and Relations Manager. The Community Benefits and Relations Manager has direct access and is accountable to the BID Milton President and the BILH Vice President of Community

Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are 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 BILH and BID Milton's Community Benefits program.

Community Benefits Advisory Committee (CBAC)

The BID Milton Community Benefits Advisory Committee (CBAC) works in collaboration with BID Milton's hospital leadership, including the hospital's governing board and senior management to support BID Milton's Community Benefits mission to serve its patients compassionately and respectfully, to improve the health and well-being of residents in BID Milton's community. The CBAC provides input into the development and implementation of BID Milton's Community Benefits programs in furtherance of BID Milton's Community Benefits mission. The membership of BID Milton's CBAC aspires to be representative of the constituencies and priority cohorts served by BID Milton's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The BID Milton CBAC met on the following dates:

- December 16, 2022
- March 23, 2023
- June 22, 2023
- September 22, 2023

Community Partners

BID Milton recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BID Milton's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BID Milton's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. BID Milton's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BID Milton's mission.

BID Milton currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BID Milton collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations.

The hospital collaborates with South Shore Elder Services (SSES) frequently to assist patients in discharge planning and obtaining needed resources and services. SSES assisted BID Milton during the CHNA process to engage with older adults who are either home-bound or with limited transportation by distributing BID Milton's community health survey to their Meals on Wheels clients. SSES has been an active participant providing input into the formation of BID Milton's CHNA and IS, especially in how to best address the social determinants of health and aging in place.

BID Milton regularly engages with the Milton Public School System on a variety of initiatives throughout the year. The hospital funds two grants with the school system focused on improving students' social emotional and mental health and training curriculum to implement a Trauma Informed/Sensitive School learning approach. Hospital staff also provide CPR Training and certification to all Milton Public School Nurses free of charge.

BID Milton is a proud supporter of Quincy Asian Resources, Inc. (QARI) and regularly sponsors their events throughout the year that celebrate cultural diversity, workforce development, mental health and education initiatives that engage the Asian community.

The hospital is also actively involved with the Town of Randolph's Community Wellness Plan. BID Milton has served on the town's Community Public Health Working Group and Schools Working Group since 2020 and acts as a partner organization working alongside municipal leaders, residents and community organizations to identify and implement strategies to address mental health, access to healthcare, food insecurity while promoting health equity to meet the needs of those most impacted by chronic disease and poor health outcomes such as immigrants, youth, and older adults.

Another important partnership is BID Milton's involvement with the Milton Coalition (formerly known as the Milton Substance Abuse Prevention Coalition). BID Milton works alongside the coalition's community stakeholders, professionals, students, and town leaders to work collaboratively on reducing, preventing, and addressing substance abuse and related mental health challenges in the Town of Milton, primarily amongst youth. The Coalition actively supports the Milton Youth Advocates for Change, a community-based youth-led, adult-supported group for 6th – 12th graders, with a mission to help teens find their voices, celebrate diversity and differences, as well as to make a more aware, accepting community and improve mental, emotional, social, and physical health.

The following is a comprehensive listing of the community partners with which BID Milton collaborated with on its FY 2020 – 2022 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 44).

- A New Way Recovery Center
- Asian American Service Association
- Aspire Health Alliance
- Bay State Community Services

- BID Milton Patient Family Advisory Council
- Blue Hills Regional Coordinating Council
- Blue Hills Regional Health Network (CHNA 20)
- Brookwood Community Farm
- Choice Community Supports
- Curry College
- DOVE, Inc
- Enhance Asian Communities on Health
- Father Bills & Mainspring House
- Friendly Food Pantry
- Fuller Village
- Gosnold Recovery Services
- Interfaith Social Services
- Manet Community Health Centers
- May Institute
- Metropolitan Area Planning Council
- Milton Board of Health
- Milton Chamber of Commerce
- Milton Council on Aging
- Milton Coalition formerly known as Milton Substance Abuse Prevention Coalition
- Milton Early Childhood Alliance
- Milton Housing Authority
- Milton Police Department
- Milton Public Library
- Milton Public Schools
- Milton Youth Advocates for Change
- Quincy Asian Resources
- Quincy Board of Health
- Quincy Chamber of Commerce
- Quincy Commission on Disabilities
- Quincy Community Action Programs
- Quincy Family Resource Center
- Quincy Public Schools
- Quincy Police Department
- Randolph Board of Health
- Randolph Community Wellness Plan Steering Committee
- Randolph Community Partnership
- Randolph Educational Collaborative
- Randolph Intergenerational Community Center
- Randolph Public Schools
- Randolph Veteran Affairs
- Signature Healthcare
- Simon C. Fireman Community

- South Cove Community Health Center
- South Shore Chamber of Commerce
- South Shore Elder Services
- South Shore YMCA
- United Parkway Methodist Church

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the BID Milton's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by BID Milton's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BID Milton's most recent CHNA was completed during FY 2022. FY 2023 Community Benefits programming was informed by the FY 2022 CHNA and aligns with BID Milton's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed BID Milton to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and BID Milton's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

BID Milton's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that BID Milton serves, especially the population segments that are often

disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. BID Milton's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, BID Milton conducted 19 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 500 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers and other community partners.

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

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research

shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.

- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2022 BID Milton Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

qSECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Certified Application Counselors & System Navigation** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	The Certified Application Counselors (CACs) program provides underserved and uninsured patients with information on all insurance programs offered by the Executive Office of Health and Human Services and the MA Health Connector (or simply The Commonwealth). The CACs also provide financial counseling, benefit enrollment assistance, and payment planning. The program's goals are to increase the number of patients served, to have more financial counseling staff become CACs in accordance with state regulations, and for all financial counseling staff to attend ongoing training to maintain state certification. Additionally, throughout BID Milton's Community Benefits Service Area, BID Milton subsidizes primary care services provided by the hospital's Affiliated Physicians Group.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of people assisted with insurance and other public program enrollment, and patient navigation.	
Goal Status	In FY23, BID Milton's CACs assisted 520 community members and successfully enrolled 416 individuals in Mass Health, and 104 through other Health Connector plans.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Culturally Responsive Care – Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	Free interpreter services (IS) are available to non-English speaking, limited English speaking, deaf, and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team, and an interpreter; and through a video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase Interpreter Services department interactions.	
Goal Status	In FY23, there were 9,169 encounters conducted in 57 languages, an increase of 28% from the previous year.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Office of Diversity, Equity and Inclusion** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent."	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Across BILH, increase Black, Indigenous and other People of Color representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation. Increase spend with diverse businesses by 25% over the previous fiscal year across the system.	
Goal Status	Across BILH there was a 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. More than $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Expand system-wide DEI learning, in alignment with enterprise learning management solution. Support creation or expansion of local DEI committees/resource groups.	
Goal Status	8 system-wide DEI trainings were conducted for all BILH staff and hospitals.	

	BID Milton is forming a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture and to make meaningful and lasting change for our patients, our employees and our communities.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Social Determinants of Health (Education/Jobs), Social Determinants of Health (Income/Poverty)**	
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners. In FY23, Workforce Development will continue to encourage community referrals and hires. In FY23, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. In FY23, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. In FY23, Workforce Development will offer paid trainings for community members across BILH.
Goal Status	In FY23, 67 events and presentations were conducted with community partners across the BILH service area.

	In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. In FY23, 20 BILH employees attended citizenship classes, 135 BILH employees attended career development workshops and 189 BILH employees attended financial literacy classes. BID Milton employees participated in these offerings. In FY23, 45 employees across BILH were enrolled in ESOL classes. BID Milton employees participated in these classes. In FY23, BILH trained total of 89 community members to Patient Care Technician or Nursing Assistant (30), Pharmacy Tech (16), Perioperative LPN (3), Medical Assistant (21), Behavioral Health roles (4) or into the Associate Degree Nursing Residency program (15). BID Milton participated in offering these trainings.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Advancing Healthcare Equity at BID Milton** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	Health equity is a foundational element across the hospital system. BID Milton's newly formed Healthcare Equity Committee's goal is to design and operationalize policies that support health for all patients, with the aim to eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved and provide the care that our patient population needs to thrive.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐Total Population or Community Wide Intervention ☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY23, BID Milton will appoint executive leaders to lead health equity efforts across the hospital and create a multidisciplinary committee to advance health equity directives. In FY23, BID Milton will identify health care disparities in our patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients (examples: age, gender, race, ethnicity) and develop an action plan to address those disparities. In FY23, BID Milton will develop and implement a policy to assess patients' health-related social needs (HRSN) and provide information about community resources and support services.

	In FY23, BID Milton provides staff training on disabilities, unconscious/implicit bias, and Culturally and Linguistically Appropriate Services (CLAS) Standards, and sensitivity training.
Goal Status	BID Milton's Chief Medical Officer and Chief Nursing Officer were appointed to oversee health equity work and a multidisciplinary committee, consisting of leaders from nursing, social work, information services, medical staff, community benefits, healthcare quality, interpreter services and patient experience, was formed. A committee charter was developed, and the committee met three times over the course of FY23. In FY23, BID Milton reviewed and analyzed hospital data and identified a a disparity during the discharge process amongst racial and ethnic populations. An action plan to address these disparities was developed and work is in progress to monitor change. In June of 2023, BID Milton developed a new policy to implement health-related social needs (HRSN) screening to all admitted patients. Work processes were developed, and community resources identified on what to do when a patient screens positive. Training was provided to all medical staff and all hospital staff on health equity. All staff received training on disabilities, unconscious/implicit bias and sensitivity training.
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Rental Assistance/Eviction Prevention Grant** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	Financial assistance provided by BID Milton supports Quincy Community Action Programs (QCAP) to help prevent homelessness for local families and individuals at greatest risk. QCAP's Housing Program works to secure and stabilize housing for renters and homeowners, thereby reducing the number of individuals and families experiencing homelessness. The program, through the agency's Strategic Prevention Initiative, utilizes Homeless Prevention Specialists to help provide landlord negotiation/mediation, fair housing counseling, emergency rent payments or resolution of lease compliance issues.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By end of FY23, decrease the number of people who struggle with financial insecurity/rent insecurity to prevent at a minimum 12 families/households from eviction. By the end of FY 23 (September 30), 50% of the BID Milton funded families referred will have engaged with one or more area resources, including QCAP resources and services.
Goal Status	Direct rental assistance averaging $900 was provided to 15 households, preventing 25 individuals from experiencing homelessness. By the end of FY 23 (September 30), 86% of families referred have engaged with one or more area resources, including QCAP resources and services.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Outcome Goal**
Program Goal(s)	By the end of FY 23 (September 30), QCAP will refer 80% of the BID Milton funded families to other area resources (including QCAP services). By the end of FY 23 (September 30), QCAP will have expended 100% of BID Milton funds for the purpose of retaining tenancies and stabilizing housing for residents in Milton, Quincy and Randolph.
Goal Status	At the end of FY23, QCAP referred 93% of BID Milton funded families to other area resources (including QCAP resources and services). Since October 1, 2022, QCAP expended 100% of BID Milton funds to support 14 families to retain their tenancy and stabilize housing and provided 1 individual formerly experiencing homelessness with start-up costs to attain housing.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Emergency Flex Funding for Domestic Violence Survivors** **Health Issue: Additional Health Needs (SDOH)**			
Brief Description or Objective	DOVE is committed to partnering with diverse communities, families and individuals impacted by domestic violence or partner violence by promoting hope, healing, safety, and social change by providing a broad range of preventive and responsive services. The grant will be used to provide emergency financial assistance or "flex funds" to domestic violence survivors, helping to address immediate concerns for well-being including housing security and access to healthy food. For example, funds may cover rental assistance and landlord negotiation.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Enhance the financial safety and stability of victims of domestic violence through providing emergency economic support to approximately 8 survivors annually.		
Goal Status	Due to inflation and rising costs, financial support was provided to 5 domestic violence survivors.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	80% of clients that receive emergency flex funds will participate in some form of economic empowerment (budgeting, career support, enrolling in school/work programs, enrolling in other eligible benefits). 80% of program participants will gain knowledge of forms of affordable housing or will begin the application process to obtain various forms of affordable housing.		
Goal Status	100% of survivors served participated in economic empowerment support activities. 40% of program participants began the application process and received financial support for rental assistance.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Social Determinants of Health **Program Name: CSA Farm Shares for Local Food Pantries** **Health Issue: Additional Health Needs (Access to Healthy Foods)**		
Brief Description or Objective	Partnering with Brookwood Community Farm, BID Milton provides three full Community Supported Agriculture (CSA) shares of both locally grown and organic fruits and vegetables to benefit the Randolph Friendly Food Pantry.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to fresh locally grown produce to underserved populations in Randolph.	
Goal Status	Three full vegetable and four full fruit shares of organic produce were purchased through Brookwood Community Farm and distributed to Friendly Food Pantry clients in Randolph for 14 weeks in the summer of 2023. A total of 420 lbs. of produce was distributed.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Learning Through Play Preschool Playgroup Series** **Health Issue: Additional Health Needs (Education)**		
Brief Description or Objective	The Milton Early Childhood Alliance (MECA), a program of Discovery Schoolhouse and mainly funded through the MA Department of Early Education and Care, is a community-wide organization that provides families and children access to locally available comprehensive services and supports that strengthen families, promote optimal child development, and bolster school readiness. This grant will support an 8-week developmentally appropriate preschool playgroup series for 20-25 children with a focus on supporting and enhancing gross and fine motor skills and development. The series is aimed at providing quality early learning experience for children whose opportunity for an education preschool experience was interrupted by the COVID-19 pandemic.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the 8-week program, children will successfully demonstrate improvement in fine motor skills, gross motor skills, personal and social	

	communication, and problem-solving skills by participating in specifically designed weekly activity plans and at-home extension activities with parents.
Goal Status	A total of 26 children and 19 parents participated in the weekly activities. The learning experiences offered varied in challenge and complexity as the programming progressed. Observational and anecdotal evidence demonstrated growth in both fine and gross motor domains and developmental skills. The mix of formal and informal activities provided ample opportunities for children to be actively engaged in cooperative play episodes, enhancing the children's problem solving and communication skills.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Grab N Go Chinese Lunch Box Program** **Health Issue: Additional Health Needs (Access to Healthy Food)**	
Brief Description or Objective	In partnership with the Asian American Service Association (AASA), BID Milton provides funding for the organization to prepare culturally appropriate Chinese style lunches for seniors at Wollaston Senior Center in Quincy.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY23, provide 500 culturally appropriate grab-n-go meals to Chinese seniors.
Goal Status	500 meals were distributed.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Expanding Reach and Access of Food Resources in Randolph** **Health Issue: Additional Health Needs (Access to Healthy Food)**	
Brief Description or Objective	BID Milton's Community-based Health Initiative (CHI) funding awarded to The Friendly Food Pantry will improve operations and logistics and increase the number of residents served, create efficiencies by digitizing operations, increase cold/frozen storage capacity, improve outreach to residents, provide culturally responsive information and facilitate collaborative relationships with service partners.

Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	By June 2024, The Friendly Food Pantry will obtain and install equipment required to support upgraded digital access, train volunteer staff, and transfer 100% of current client paper records to electronic format.
Goal Status	This goal is in progress. As of November 2023, computer and Wi-Fi equipment were purchased, configured and installed: two laptops, two iPads, a bar code scanner and stock for ID cards, to support digitization. Pantry staff completed a five-week training on the new database, OASIS Insight. All prior client records were uploaded to OASIS and staff began to update certain fields, create new labels for indicating client food choice, and learn how to run reports. Job aides were created for pantry staff who will be using laptops and iPads for data entry.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Program Goal(s)	By June 2026, The Friendly Food Pantry will increase client satisfaction and knowledge of pantry services as evidenced through community feedback and client surveys.
Goal Status	In the current period, client satisfaction and knowledge of the pantry's presence and services were improved through upgrades to the pantry website where information and forms have been made available in five different languages, including English, Haitian Creole, Vietnamese, Portuguese and Spanish. Food pantry service brochures were translated and made available throughout the community, including an additional access point outside of the pantry building. Client outreach was also more robust via updated social media presence and blog. A newly created Amazon wish list included food items that are culturally relevant.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Healthcare Career Exposure and Internship Program** **Health Issue: Additional Health Needs (Education/Jobs)**

Brief Description or Objective	BID Milton provides opportunities for young adults to gain greater exposure to healthcare careers and additional training to those pursuing a career in the healthcare industry. Local high school and college students serve as either volunteers, interns or earn college clinical hours working directly in patient care. The program's ultimate goal is to increase the number of individuals who wish to pursue a career in the healthcare field and provide a pathway to job opportunities.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	BID Milton will partner with Milton High School Career Services to provide non-paid internship opportunities to at least three students to gain greater insight into various healthcare careers and opportunities. BID Milton will provide volunteer opportunities to a minimum of 10 adolescents during the months of July and August each year.	
Goal Status	Four students from Milton High School completed over 200 hours of service. The students volunteered their time at the hospital in between and after classes Monday through Friday from April 17 through May 19, 2023. Students were exposed to a wide variety of clinical and non-clinical departments including the Operating Room, Emergency Department, Human Resources, Physical Therapy, Radiology and Dietary Services. The students presented a summary presentation at the high school of their experience during the program. All students noted new and increased knowledge of available careers including phone operators, nurse anesthetists, ED techs and surgical techs. Ten students from various high schools in BID-Milton's CBSA completed over 500 hours of service. The students volunteered over the course of seven weeks from July 6 through August 18, 2023. Students were selected based on their interest in a career in healthcare. While the students were at the hospital, they assisted in the Emergency, Dietary, Human Resources, Surgical Services, Radiology, Pharmacy, Outpatient Rehabilitation, and Patient Experience Departments. Various tasks performed included, but were not limited to, stocking, cleaning, filing, copying, inventory management, serving meals, preparing medical records, writing confirmation slips, greeting and escorting patients.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Provide mentorship and training for college students majoring in the healthcare field to earn practicum and curriculum hours toward a degree and offer employment opportunities for eligible participants.	
Goal Status	In FY23, four students from Northeastern University's Doctor of Physical Therapy Program completed inpatient/outpatient clinicals at BID Milton. Students worked full-time hours alongside a BID Milton preceptor for 14 weeks from April-July 2023. Two out of the four students were hired by BID Milton upon completion of their program.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Enhancing the Todd Fournier Center for Employment Training and Community Inclusion** **Health Issue: Additional Health Needs (Education/Jobs)**		
Brief Description or Objective	The May Institute provides the youth and young adult students with Autism or other developmental disabilities with the opportunity for a vocational training experience to address the two most critical aspects of adult independence: the ability to engage in meaningful employment and the ability to function as successfully as possible in day-to-day life in the community. Physical enhancements will be made to the vocational training space giving students opportunities to develop and strengthen skills that will help them live more independently and give them a sense of accomplishment and satisfaction. Students will be evaluated on improved communication, organizational and social skills.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By end of grant year one, purchase necessary equipment to make enhancements and open the Center's school store training space. Students will show an increased learning and identify strengths they developed through training and demonstrate improved social and organizational skills.	
Goal Status	The Center's school store opened for student training and storage, shelving and cash management system equipment were purchased. 50 students participated in the school store activities. Year 1 metrics are still being collected and will be reported in FY24.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Transportation Initiatives** **Health Issue: Additional Health Needs (Transportation)**	
Brief Description or Objective	South Shore Elder Services will utilize funding from BID Milton to provide transportation assistance for non-medical and/or medical transportation needs for clients in Milton, Quincy and Randolph. Services may include transportation to congregate meal settings, Councils on Aging, the residence of client's family and other locations as appropriate, with the goal of reducing senior isolation and depression. BID Milton also pays the transportation costs for patients discharged from inpatient units and the Emergency Department when they do not have the means to return home.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide at least 50 rides for older adults to either Councils on Aging, congregate meal sites or social settings. Provide transportation to patients without access	
Goal Status	Formal agreement with South Shore Elder Services was executed in September 2023. Rides are scheduled to begin November 2023 and reporting will be provided in FY24. $6,414 worth of free taxi vouchers were provided to patients without access to transportation.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	In order to increase access to mental health services, BID Milton has implemented the Collaborative Care Model, a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, 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 treat a variety of medical and mental health conditions.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to behavioral health services.	
Goal Status	In FY 23, behavioral health clinicians were provided at three BID Milton primary care practices, reaching 336 patients.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Recovery Coach Program** **Health Issue: Substance Use**

Brief Description or Objective	A Gosnold Recovery Specialist works in the emergency department to assist and intervene with individuals in the hospital following a non-fatal overdose event. BID Milton clinicians and peer recovery specialists work cooperatively to improve the screening, identification, intervention, and referral of substance dependent patients admitted to the Emergency Department. The goal is to motivate the patient to accept treatment and facilitate referral to the appropriate level of care. Treatment modalities include inpatient detox, hospital transfer, intensive outpatient programs, and Medication Assisted Treatment.		
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	By the end of FY23, 65% of consults conducted by a Recovery Specialist will result in a transfer to treatment.		
Goal Status	418 consults were performed by Recovery Specialists in the Emergency Department and on the Medical Floors with 200 (48%) of consults resulting in treatment.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Prescription Take-back Kiosk** **Health Issue: Substance Use**			
Brief Description or Objective	BID Milton is a registered collection site through the Drug Enforcement Agency to safely and securely gather and dispose of unused or expired prescription and non-prescription medications, including those that contain controlled substances.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Decrease the availability of unused prescription drugs by providing a safe place for the public to dispose of sharps.		
Goal Status	BID Milton formally installed a take-back kiosk in January of 2023 and collected 23.1lbs between Jan and April 2023.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Botvin Life Skills** **Health Issue: Mental Health/Mental Illness**

Brief Description or Objective	BID Milton partners with the Milton Public Schools to implement the Botvin Life Skills health curriculum for fifth-grade students across the town's four elementary schools. The curriculum addresses all of the most important factors leading adolescents to use one or more drugs by teaching a combination of health content, general life skills, and drug resistance skills. The curriculum has been proven to help increase self-esteem, develop healthy attitudes, and improve student knowledge of essential life skills all of which promote healthy and positive personal development.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the school year, 80% of 5th grade students will report learning a new coping skill to better manage stress and anxiety, improve self-esteem and communication and problem-solving skills.	
Goal Status	164 students completed the curriculum with 80% reporting increased learning and coping mechanisms.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Support for Milton Coalition (formerly Milton Substance Abuse Prevention Coalition** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The Milton Coalition is a community coalition focused on preventing and reducing youth substance use and promoting mental health in Milton, MA. The Coalition brings together health, social service professionals, public leaders in education, religion, media, recreation, business, public safety, policy and planning, as well as diverse residents- including students, parents and affected family members – to work collaboratively on preventing and addressing substance use and preventable mental illness in the Town of Milton, with a focus on youth. Coalition leadership and volunteer members are committed to analyzing local community problems, raising community awareness, and supporting efforts to tackle these issues. The Coalition follows the Strategic Prevention Framework (SPF) to address youth substance use and developed strategies to reduce youth substance use, specifically underage usage of alcohol, nicotine (vaping), marijuana, and prescription drugs not prescribed to them and to increase the community capacity to address mental health issues among youth. Strategies include hosting webinars and presentations for parents to enhance their skills in addressing youth substance use and mental health, supporting its youth coalition, the Milton Youth Advocates for Change (MYAC), collaborating with local stakeholders such as the schools and police to provide resources for youth and families struggling with substance use, and implementing best practices for substance use prevention such as Sticker Shock. Through the Drug Free Communities grant from the Center of Disease Control (CDC), the Coalition primarily focuses on youth substance use prevention, but the coalition serves all Milton residents of any age.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By 12/29/2023, build capacity of the Coalition's new youth coalition by recruiting 5 additional students who attend Milton Youth Advocates for Change on a regular basis. By 9/29/2023, increase Coalition visibility and community awareness of youth substance use through the communication of research, community data, and coalition progress to 3,000 residents via social media, newsletters, and print media. By 8/30/2023, build staff, youth and community partners' knowledge, skills, and networks by attending 1 Community Anti-Drug Coalitions of America (CADCA)-sponsored national training and participating in 4 regional youth substance use collaboratives, as documented by meeting minutes and/or attendance sheets.
Goal Status	The youth coalition has now moved to Milton High School and operates as a school club under the supervision of both the Milton Coalition and the Milton Public Schools. Since moving to the schools, there have been 5 new youth who have joined the club.

	More than 3,000 residents were reached. A total of 5 youth and 2 adults attended the CADCA Mid-Year Training Institute in July 2023.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Mental Health First Aid** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	Free Mental Health First Aid trainings are taught by clinicians from Aspire Health Alliance. The course focuses on identifying risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY23, raise awareness, reduce stigma, and educate 20 residents about mental health and substance use.
Goal Status	A total of 49 community members were trained in how to recognize the signs of someone struggling with mental illness, assist someone who might be in distress, and recognize and correct misconceptions about mental illness. Of those trained, 10 people were trained to be a "Mental Health First Aider," who is now able to facilitate classes. Classes were provided in both English and Chinese.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Trauma Informed Schools** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	Grant funding will be used to implement curriculum and training on trauma and its effects on students to all staff at Milton's six public schools to improve social and emotional learning and resiliency.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the 2022-2023 school year, continue to implement trainings based on Trauma Sensitive School curriculum through identified Social Emotional Learning (SEL) staff members.	
Goal Status	12 staff members completed the training to be SEL leads to implement curriculum at each of the schools in the district. Staff completed the following training during the year: Strategies for Creating a Trauma Sensitive Classroom, Vicarious Trauma and Self Care. SEL leads also met during summer months to plan curriculum. Additional trainings will take place during 2023-2024 school year.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Getting the Teens Out** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	Grant funding provided by BID Milton to Quincy Asian Resources Inc. supports a series of social groups for foreign-born teens and their caregivers who are emergent bilinguals and belong to households with lower incomes, led by a youth development specialist and mental health specialist from Walker Therapeutic and Educational Programs to relieve emotional stress from social isolation and facilitate connections to further mental health resources.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase emotional well-being and decrease social isolation in teen youth by organizing a variety of social events to help youth cope with and recover from psychosocial stress of the COVID-19 pandemic.	
Goal Status	A total of 12 group events were held with a total of 116 participants.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Reducing the Burden of Behavioral Health** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	BID Milton continues its partnership with Aspire Health Alliance to care for behavioral health patients in its Emergency Department and reduce length of stay. An Aspire behavioral health clinician is embedded in BID Milton's Emergency Department to perform emergency psychiatric evaluations to prescreen patients for placement in an inpatient psychiatric unit and/or crisis stabilization unit. Interventions reducing risk of symptom escalation, more timely crisis evaluation, insurance verification and care transition management, and therapeutic interventions (i.e., cognitive behavioral therapy), medication management, music therapy, faith counseling, peer services, and familial counseling and support.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Enhance access to mental health and substance use screening, assessment, and treatment services.	
Goal Status	BID Milton formally ended its contract with Aspire in December 2022 and has transitioned the services provided into the Behavioral Health Crisis Consultation program.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Masters level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement. BID Milton also subsidizes inpatient psychiatric services for those most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others or who are unable to care for themselves due to mental illness.

Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital performing 571 screens in FY23.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Cancer Screenings** **Health Issue: Chronic Disease**		
Brief Description or Objective	BID Milton believes that prevention is the best medicine to combat chronic and complex conditions such as cancer. The hospital continues its low-dose computerized tomography screening program to identify early-stage lung cancers.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Continue to offer screenings to increase number of adults screened for cancer by 20% (675 screenings) as compared to previous year.	
Goal Status	The lung cancer screening program surpassed its FY23 goal of 675 by conducting 786 scans.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Palliative Care** **Health Issue: Chronic Disease**	
Brief Description or Objective	Palliative Care is a specialized medical approach to care for people with a serious or life-limiting illness. The aim is to improve quality of life by offering symptom relief and emotional support. Care is provided by a team of doctors, nurses and other specialists working together. Palliative care is based on the needs of the patient and their loved ones and not on their prognosis.

Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Ensure older adults have access to coordinated healthcare, supportive services and resources to support overall health and age in place.	
Goal Status	FY23 was the first year of the program. A total of 108 inpatient consults were performed to better manage patient's symptoms and provide support to caregivers.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Primary Care Navigation** **Health Issue: Chronic Disease**		
Brief Description or Objective	In collaboration with Beth Israel Lahey Health, primary care sites within the BID Milton network are enhancing their existing care model at the sites serving the largest number of Black and Hispanic patients with uncontrolled diabetes. These sites will embed a clinical pharmacist and a patient navigator within the care team to improve patient access and reduce barriers to implementing diabetes care plans.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	At the participating primary care sites, achieve at least a 20% reduction in A1c level among Black and Hispanic patients with A1c > 9% in FY23.	
Goal Status	As of October 2023, the percentage of Black patients with A1c level > 9% decreased by 4.3%, and the percentage of Hispanic patients with A1c level > 9% decreased by 5%.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	At the participating primary care sites, achieve at least a 20% reduction in rates of non-documented A1c-test among Black and Hispanic patients.	
Goal Status	As of October 2023, the percentage of Black patients with missing A1c tests did not change with 1.2% of patients missing tests, and the percentage of Hispanic patients with missing A1c tests also did not change, with 1.8% of patients missing tests.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Matter of Balance Classes** **Health Issue: Social Determinants of Health-Nutrition**		
Brief Description or Objective	Matter of Balance is an evidence-based program designed to reduce the fear of falling and increase activity levels among older adults.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Promote independence and aging in place and reduce fear of falling by hosting at least two Matter of Balance Workshops for older adults.	
Goal Status	One class was held at Milton Council on Aging with 8 participants, with majority of participants noting a decreased fear of falling, increased physical activity and changes made at home to reduce fear of falling after taking the class. 6 participants were provided with free 3-month memberships to continue their fitness journeys.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: My Life, My Health: Diabetes Self-Management Education** **Health Issue: Chronic Disease**		
Brief Description or Objective	To assist community members with how to better manage their diagnosis of Type 2 diabetes or pre-diabetes, BID Milton continues its partnership with the South Shore YMCA to implement the My Life, My Health: Diabetes Self-Management Education workshop at the hospital. This free 6-week workshop, developed by Stanford University Medical Center, is an evidence based self-management program for those living with or caring for someone with diabetes or pre-diabetes to learn skills to prevent, manage, and cope with the disease.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Offer at least two My Life, My Health Diabetes workshops to increase the number of adults who are able to better manage their diabetes.	
Goal Status	One workshop was conducted, resulting in 8 community members taking the class with 80% indicating a change in behavior to better manage their diabetes. Two participants were provided with the free 3-month membership to the YMCA to continue on a healthy lifestyle.	

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Outcome Goal

Priority Health Need: Complex and Chronic Conditions Program Name: Health Education and Social Programming for Older Adults at Milton Council on Aging Health Issue: Chronic Disease	
Brief Description or Objective	BID Milton has a long-standing relationship with the Milton Council on Aging by providing support for activities and programming. Hospital staff and physicians provide health education lectures, and the hospital provides financial assistance for a variety of programs including meditation classes, congregate lunch meals or physical education classes, with the ultimate goal of reducing senior social isolation and overall health and the ability to age in place.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Offer programming to older adults aimed at combatting loneliness and foster well-being.
Goal Status	With financial support from the hospital, meditation classes were held weekly (for 22 weeks), averaging 15-20 older adults in attendance. Music therapy classes were offered for 14 weeks with 15 participants in each class.

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Process Goal

Priority Health Need: Social Determinants of Health Program Name: Nutritional Support for Older Adults in Affordable Housing Health Issue: Social Determinants of Health-Nutrition	
Brief Description or Objective	Simon C. Fireman Community offers older adults affordable, independent living that supports personal wellness. Through a BID Milton grant, a part-time nutritionist provides one-on-one and group nutritional support classes for older adults living in affordable housing and the greater community helping to create healthier eating habits to better manage chronic medical conditions and decrease social isolation.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Nutritionist will implement healthy eating programs and one-to-one nutrition counseling sessions aimed at improving chronic conditions
Goal Status	Nutritionist met with 25 individual clients. In addition, two cooking demonstrations were conducted for the residents. Healthy recipes and samples of food are shared with attendance (averaging 15 residents per demonstration). From post program surveys, the

	majority of residents indicated “agree” or “strongly agree” when asked the question, “I am confident in my ability to self-manage my chronic health conditions and I understand how to eat to help manage my chronic health conditions.”

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Equitable Access to Care **Program Name: Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals** **Health Issue: Chronic Disease, Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter on a quarterly basis to communicate community benefits activities to community partners, residents, and vested parties.
Goal Status	BID Milton launched and sent 1 newsletter in July of 2023 to a mailing list of over 60 organizations and individuals.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Program Goal(s)	By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise.
Goal Status	All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Program Goal(s)	By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.

Goal Status	All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$3,270,911.00	$9,000.00
Community-Clinical Linkages	$132,622.00	$90,416.00
Total Population or Community Wide Interventions	$300,296.00	$142,432.00
Access/Coverage Supports	$326,884.00	
Infrastructure to Support CB Collaborations	$8,255.00	
Total Expenditures by Program Type	$4,038,968.00	
CB Expenditures by Health Need		
Chronic Disease	$2,474,531.80	
Mental Health/Mental Illness	$210,423.75	
Substance Use Disorders	$236,597.00	
Housing Stability/Homelessness	$47,114.75	
Additional Health Needs Identified by the Community	$1,070,300.70	
Total by Health Need	$4,038,968.00	
Leveraged Resources		
Total CB Programming	$4,038,968.00	
Net Charity Care Expenditures		
HSN Assessment	$662,566.00	
Free/Discounted Care		
HSN Denied Claims	$258,100.00	
Total Net Charity Care	$920,666.28	
Total CB Expenditures	$4,959,634.28	

Additional Information	
Net Patient Services Revenue	$146,980,473.00
CB Expenditure as % of Net Patient Services Revenue	3.4%

Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	**$4,000,000.00**
Bad Debt	**$2,890,692.00**
Bad Debt Certification	**yes**
Optional Supplement	
Comments	**BID Milton also contributed $255,029 to subsidize behavioral health services outside of its community benefits service area.**

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☐Yes ☐No
    - If so, please list updates: Since FY22, some new members have joined the Community Benefits Advisory Committee, either in a new capacity or to replace a member who had stepped down. The following individuals were new for FY23: Janice Sullivan, Interim CEO, Aspire Health Alliance, Lisa Scanlon, Director of Communications and Development, Baystate Community Services, Deb Schopperle, Marketing Director, Quincy Credit Union, Andrea Huwar, Coordinator of Health Services, Quincy Public Schools The following individuals no longer serve on the committee: Melissa Horr Pond, Planner, City of Quincy Jeannette Travaline, Executive Director, Randolph Chamber of Commerce Rev. Baffour Nkrumah-Appiah, Pastor, First Baptist Church Randolph Daurice Cox, CEO, Baystate Community Services Marian Girouard-Spino, Chief System Integration Officer, Aspire Health Alliance

II. Community Engagement

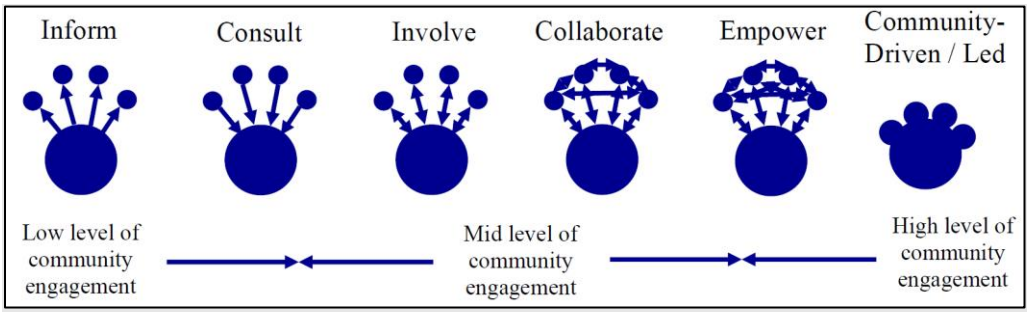
- Organizations Engaged in CHNA and/or Implementation Strategy
  If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Quincy Board of Health	Marli Cassli, Commissioner of Public Health, Quinc	Local health department	BID Milton has worked to enhance its partnership with the Quincy Board of Health. On a bi-monthly basis, physicians and staff from the hospital participate and provide health education classes for older adults and residents. The Board of Health was

			also a key informant interview during the hospital's CHNA.
South Shore Elder Services	Tim Carey, Director of Program Development	Social service organizations	Shore Elder Services (SSES) recommends and coordinates resources for elders to help them to remain as independent as possible. The hospital collaborates with the agency frequently to assist patients in discharge planning and obtaining needed resources and services. SSES assisted BID Milton during the CHNA process to engage with older adults who are either home-bound or with limited transportation by distributing BID Milton's community health survey to their Meals on Wheels clients. SSES has been active participant providing input into the formation of BID Milton's CHNA and IS, especially in how to best address the social determinants of health and aging in place.
Milton Public Schools	Jennie Beliveau, LICSW,School Adjustment Counselor	Schools	BID Milton regulary engages with the Milton Public School System on a variety of initiatives throughout the year. The hospital currently funds two grants with the school system focused on improving social emotional and mental health of students and also training curriculum to implement a Trauma Informed/Sensitive School approach to learning. Hospital staff also provides CPR Training and certification to all Milton Public School Nurses free of charge.
Simon C. Fireman Community	Stephanie Small, Executive Director	Housing organizations	BID Milton collaborates with Simon C. Fireman community in providing funding and nutrition education to older adults who are low-resourced. Simon C. Fireman Community assisted BID Milton in community engagement efforts by distributing and collecting the hospital's

			community health survey during the CHNA process

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



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

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal met - BID Milton met regularly throughout the year with its CBAC to seek input and provide updates on	Collaborate

[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.

		additional needs of the community	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal met - BID Milton consulted with its CBAC to select programs to invest its resources and grant funding for FY23. The hospital also engaged the CBAC in selecting the CHI health priority and strategy and advised on funding allocation methodology	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met. Beth Israel Deaconess Hospital-Milton collaborated with community partners from its CBAC to continue to implement programs surrounding housing, food insecurity, and mental health. BID Milton will continue to involve its partners in the community to implement programming	Collaborate
Evaluating progress in executing Implementation Strategy	Empower	Goal met- BID Milton Community partners were provided with the opportunity to attend free workshops to build/increase their capacity program evaluation and progress.	Empower
Updating Implementation Strategy annually	Consult	Goal met- BID Milton developed, tracked and shared data on a routine basis with the CBAC.	Consult

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

- <u>Opportunity for Public Feedback</u>
  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 Milton held an annual public meeting at the hospital and via Zoom on September 22, 2023.

III. Updates on Regional Collaboration

1. 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.

   No updates

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