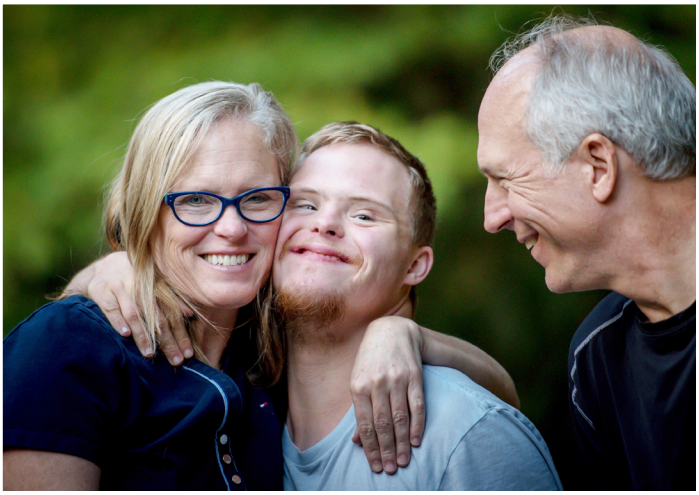
Beth Israel Lahey Health

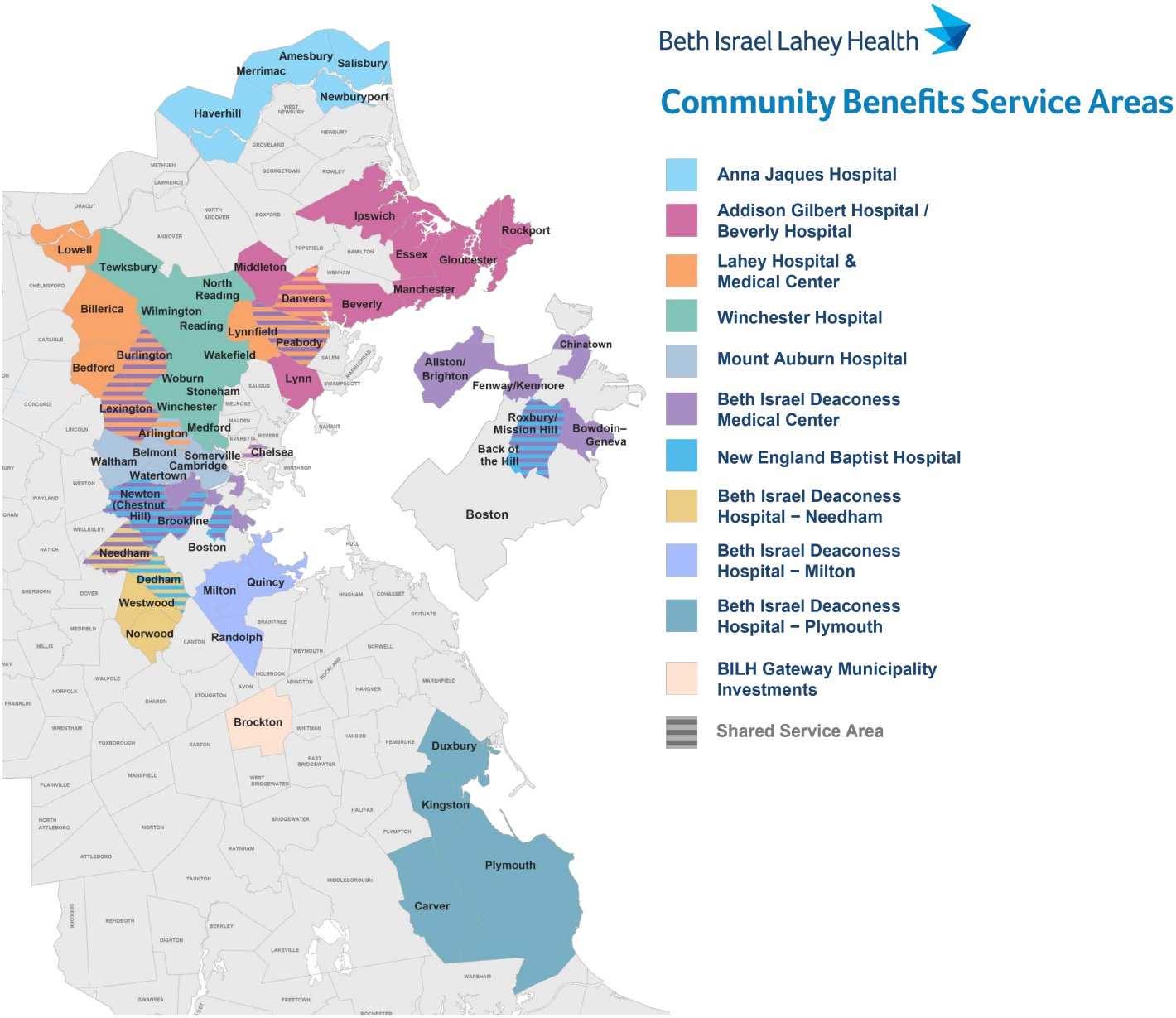
Community Benefits Strategy FY 23-25



Beth Israel Lahey Health (BILH) Community Benefits Service Area

BILH's primary service area includes nearly 100 cities and towns across eastern Massachusetts. With respect to BILH's community benefits activities and the Community Health Needs Assessment (CHNA), the service area is defined in a more targeted way. The BILH Community Benefits Service Area—made up of the individual Community Benefits Service Areas from each of its licensed hospitals—includes 49 municipalities and six Boston neighborhoods. Focusing the geographic area enhances BILH's opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities.

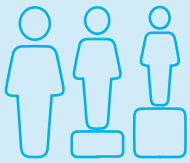
Figure 1: BILH Community Benefits Service Area



BILH Community Health Needs Assessment

The triennial CHNA and planning process are integral parts of BILH's population health and community engagement activities. All of these initiatives are essential to the organization's commitment to promoting health, enhancing access and delivering the best care to the people and families in the communities it serves. This system-wide effort was informed by guiding principles that serve as a roadmap for the entire organization and help to ensure an equitable, collaborative, engaged and intentional process that builds community capacity and fosters community cohesion.

Figure 2: BILH Community Health Needs Assessment Guiding Principles



Equity:

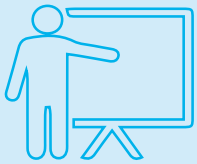
Work toward the systemic, fair and just treatment of all people

Collaboration:

Leverage resources to achieve greater impact by working with community residents and organizations

Engagement:

Intentionally outreach to and interact with underserved populations; including but not limited to people impacted by trauma, people with disabilities, people most impacted by inequities and others



Capacity Building:

Build community cohesion and capacity by co-leading community listening sessions and training community residents on facilitation

Intentionality:

Be deliberate in requests for and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit

BILH's dedication and commitment to the communities it serves and to partnership—both across its system and with its community partners, including local service providers, public health departments, social service agencies, community health centers and other community stakeholders—will remain strong and continue to be the cornerstones of its ability to make a difference for patients, families and communities in the years to come.

Throughout the CHNA process, each BILH hospital assessed the community health needs of its community benefits service area (CBSA) by reviewing secondary data and engaging community leaders and residents in interviews, focus groups, surveys and listening sessions.

BILH Blueprint 2030

At the same time that BILH embarked on the CHNA process, the organization also undertook a system-wide strategic planning initiative. Blueprint 2030 is a bold plan that outlines BILH's vision and action plan for the future and BILH's commitment to the patients and communities it serves. Importantly, Blueprint 2030 includes a number of strategies to address the needs of the communities with the highest social risk factors, particularly due to mental health, economic instability and systemic racism. Specifically, it identifies five strategic priorities for community impact:

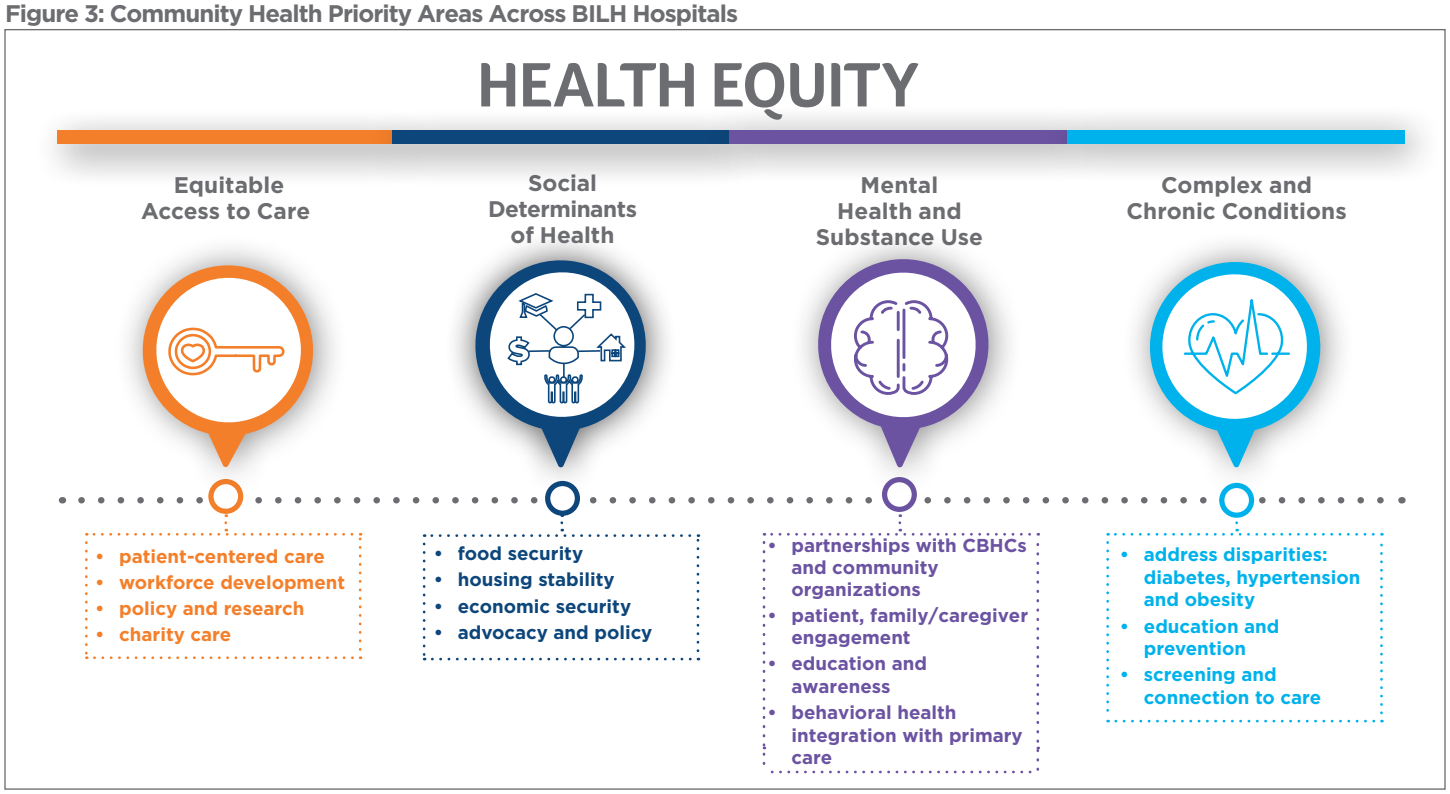
- Comprehensive and standardized screening for the Social Determinants of Health, integrated into the electronic medical record.
- Integrated, system-wide social services platform and dedicated staff to match patients with resources.
- Scalable investment in top Social Determinants of Health domains (e.g., food, housing, etc.).
- Expanded behavioral health and mental health services within the BILH CBSA with high social risk factors.
- Multicultural, multilingual behavioral health and mental health telehealth services.

BILH Community Benefits Prioritization and Strategy

Each BILH hospital, working with their Community Benefits Advisory Committees (CBACs), prioritized the needs identified through the CHNA and developed a three-year Implementation Strategy. While each hospital's Implementation Strategy is focused on addressing the most pressing needs in their local community, the Community Benefits staff worked to align strategies, identify common themes and adopt or design standard approaches across the system, as appropriate. Over time, such alignment will enhance efficiency and program effectiveness at the hospital and system levels and create opportunities for greater impact of local and system-level community initiatives and investments.

Seeking to promote alignment and foster greater impact at the system-level, the Community Benefits staff also shared common themes with the BILH CHNA Management Advisory Group and the BILH Board of Trustees Community Benefits Committee. Among all of the community health priorities (see Figure 3), the BILH Board of Trustees Community Benefits Committee was ultimately responsible for selecting a single system-wide priority for collective action. The BILH Board of Trustees Community Benefits Committee selected community mental health as the priority on which the system will focus its collective action across business units and community benefits investments over the next several years. For more in-depth information on process, methods, and findings, please see the 2022 BILH Community Health Needs Assessment report.

Figure 3: Community Health Priority Areas Across BILH Hospitals



The BILH Community Benefits Strategy draws upon the commonalities and strengths of the individual hospitals' implementation strategies, the community mental health system priority, the BILH Diversity, Equity and Inclusion Roadmap and the BILH Blueprint 2030 strategic plan's community impact priorities. The following plan summarizes the actions that BILH and its hospitals will undertake over the next three years to set the foundation for supporting impactful, evidence-based and evidence-informed strategies and moving BILH's community benefits work more upstream by focusing on the root sources and causes of health status. The Community Benefits Strategy is organized around the four priorities identified across the hospitals' CHNAs to drive impact at the local hospital and system levels. All four priorities are anchored to health equity; the attainment of the highest level of health for all people; and ensuring that initiatives focus on reaching the geographic, demographic and socioeconomic segments of populations most at-risk, as well as those with physical and behavioral health needs.

Table 1 (below) contains a summary of the BILH Community Benefits goals and expected outcomes. Following the table are more details about the action steps that BILH and its hospitals and business units will take to achieve these goals, engage communities and ultimately promote health, enhance access, address disparities and deliver the best care for those who live within the BILH CBSA.

 **Equitable Access to Care**	 **Social Determinants of Health**	 **Mental Health and Substance Use**	 **Complex and Chronic Conditions**
Goal	**Goal**	**Goal**	**Goal**
Implement innovative care delivery models to best meet the needs of BILH patients and provide equitable and comprehensive access to high-quality health care services, including primary care, specialty and urgent care, particularly for those facing cultural, linguistic and economic barriers.	Enhance the built, social and economic environments where people live, work, play and learn in order to improve health and quality-of-life outcomes.	Promote social and emotional wellness by fostering resilient communities and building equitable, accessible and supportive systems of care.	Improve health outcomes and reduce disparities for individuals at-risk of or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications and other resources.
Expected Outcomes	**Expected Outcomes**	**Expected Outcomes**	**Expected Outcomes**
• Increase access to health care services for cohorts who are racially, ethnically and linguistically diverse. • Increase knowledge and understanding of health equity and unconscious bias among staff. • Increase in staff hired and promoted that reflect the diverse communities served by the hospitals.	• Increase knowledge of resources to address health-related social needs among patients. • Increase housing stability among participants in community benefits programs. • Increase access to food resources among participants in community benefits programs. • Increase spend on diverse suppliers and vendors. • Increase community capacity to address local needs.	• Increase referrals and access to timely mental health and substance use services. • Increase screening, assessment and engagement in appropriate treatment. • Increase youth resiliency skills. • Decrease mental health and substance use stigma.	• Increase chronic disease management and reduce disparities for metabolic diseases. • Decrease time between abnormal cancer finding and treatment.

Equitable Access to Care

Goal: Implement innovative care delivery models to best meet the needs of BILH patients and provide equitable and comprehensive access to high-quality health care services, including primary, specialty and urgent care, particularly for those who face cultural, linguistic and economic barriers.

Expected Outcomes:

- Increase access to health care services for cohorts who are racially, ethnically and linguistically diverse.
- Increase knowledge and understanding of health equity and unconscious bias among staff.
- Increase in staff hired and promoted that reflect the diverse communities served by the hospitals.

BILH will achieve this by:

1. Promoting access to health insurance, patient financial counselors and needed medications for patients who are insured or underinsured.

   Actions:

   - Disseminate information on hospital financial counselors, health insurance options, transportation and pharmacy programs to all patients.

2. Promoting equitable care, health equity, health literacy and cultural humility for patients, especially those who face cultural and linguistic barriers.

   Actions:

   - Ensure patients have access to Interpreter Services for all appointments.
   - Form and integrate Diversity, Equity and Inclusion (DEI) committees at each hospital.
   - Deploy system-wide anti-bias policies and codes of conduct.
   - Launch system-wide culture of safety employee survey, incorporating DEI and stratifying results to address disparities in employee experience.
   - Establish the Center for Health Equity Research and Innovation (CHERI).

3. Supporting and/or offering initiatives that provide job readiness and career development opportunities to employees.

   Actions:

   - Establish upskilling programs for early career individuals and leadership development for diverse talent (e.g., academic advising, hospital-sponsored community college courses and English Speakers of Other Languages (ESOL) classes).
   - Deploy DEI talent acquisition and development strategy across BILH (e.g., diverse slate policy and inclusive hiring guide).
   - Expand pipeline programs for Underrepresented in Medicine* medical students, interns, residents and fellows, as well as programs and internships for health care administrators.

4. Advocating for and supporting policies and programs that address health care access.

   Action:

   - Identify and support relevant local, state and federal policies that increase access to health care.

*The Association of American Medical Colleges defines Underrepresented in Medicine as "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."

Social Determinants of Health

Goal: Enhance the built, social and economic environments where people live, work, play and learn in order to improve health and quality-of-life outcomes.

Expected Outcomes:

- Increase knowledge of resources to address health-related social needs among patients.
- Increase housing stability among participants in community benefits programs.
- Increase access to food resources among participants in community benefits programs.
- Increase spend on diverse suppliers and vendors.
- Increase community capacity to address local needs.

BILH will achieve this by:

1. Supporting programs and initiatives that stabilize or create access to affordable housing.

   Actions:
   - Partner with and provide grant support to organizations that address homelessness, flexible funding for emergent housing needs and housing stability.

2. Alleviating food insecurity and promoting active living by advocating for system changes, increasing opportunities for physical activity and providing healthy and low-cost food resources to communities.

   Actions:
   - Provide support for farmers markets, food pantries and community-supported agriculture shares.
   - Explore installation of Freight Farms™ (hydroponic container farming programs) to bring fresh produce to urban communities.
   - Offer opportunities for fitness activities to community residents.

3. Participating in multi-sector community coalitions to convene partners to identify and advocate for policy, systems and environmental changes to address the Social Determinants of Health.

   Actions:
   - Provide support and expertise on local community coalitions.
   - Promote collaboration, share knowledge and coordinate activities with internal colleagues and external partners.

4. Supporting evidence-based programs, strategies and partnerships to increase employment and earnings and increase financial security.

   Actions:
   - Establish and implement policies to expand hospital contracts with diverse suppliers and vendors.
   - Invest in jobs and financial security programs to strengthen the local workforce and address underemployment.
   - Provide youth with summer jobs and internships at the hospitals.

5. Advocating for policies, systems, programs and environmental changes that address the Social Determinants of Health.

   Actions:
   - Identify and support relevant local, state and federal policies that address the Social Determinants of Health.
   - Advise on and support the implementation of screening for health-related social needs of all patients and establish a coordinated system for warm referrals to services.

Mental Health and Substance Use

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible and supportive systems of care.

Expected Outcomes:

- Increase referrals and access to timely mental health and substance use services.
- Increase screening, assessment and engagement in appropriate treatment.
- Increase youth resiliency skills.
- Decrease mental health and substance use stigma.

BILH will achieve this by:

1. Supporting focused activities in partnership with the Commonwealth's Community Behavioral Health Centers (CBHCs), clinical service providers and other community-based organizations, which interact with or serve individuals, families and caregivers experiencing disparities in access, to promote screening, assessment, and engagement in behavioral health services.

   Actions:

   - Engage with primary care clinics, faith-based organizations, YMCAs, elder services agencies and other community organizations to support outreach, raise awareness and promote engagement in care.
   - Enhance relationships and partnerships with schools, youth-serving organizations and other community partners to increase resiliency, coping and prevention skills by providing community health grants to implement evidence-based activities and curricula for youth and families.
   - Support education and training on Screening, Brief Intervention, Referral to Treatment (SBIRT), Question, Persuade, Refer (QPR™), Mental Health First Aid™ and/or other evidence-based programs.

2. Creating and supporting strategic partnerships with the Commonwealth's Community Behavioral Health Centers (CBHCs) and clinical and non-clinical partners in the community, with the goal of supporting those with mental health and substance use issues to access the screening, assessment, treatment and recovery support services they need, when and where they need them.

   Action:

   - Collaborate with clinical and non-clinical partners in the community to support those with mental health and substance use issues to access and engage in the screening, assessment, treatment and recovery support services they need, when and where they need them.

3. Raise awareness about mental health and substance use issues, promote screening and assessment and encourage those in need to access services.

   Actions:

   - Create collateral materials that foster understanding of new models and how to access to care.
   - Promote screening, assessment and engagement in appropriate, timely care and treatment to the general public to drive access and engagement in mental health services (screening, assessment and treatment).

4. Fostering mechanisms for families, caregivers and consumers with behavioral health conditions to share their perspectives and ideas to ensure that information and services provided are tailored and meet their needs.

   Actions:

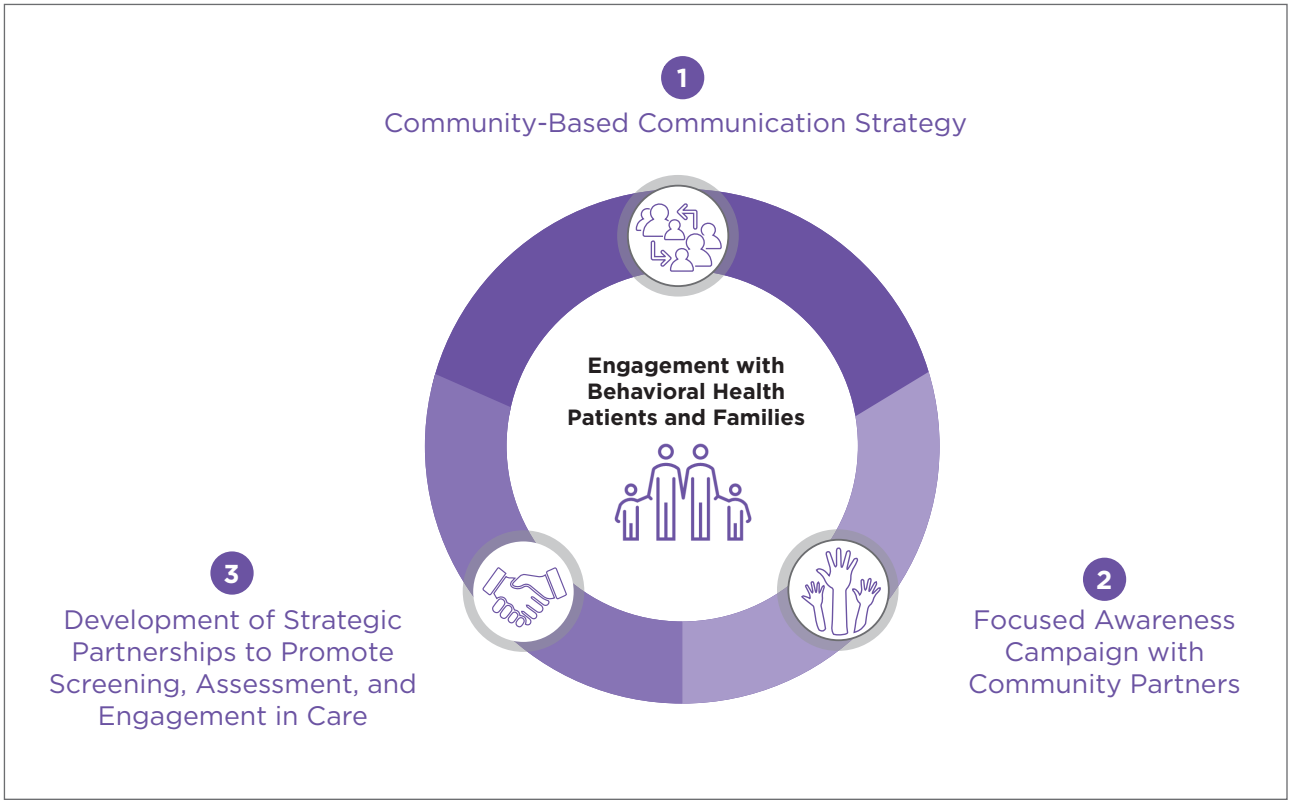
   - Support the creation of thoughtful processes in which diverse families, caregivers and consumers with behavioral health conditions are invited to express their satisfaction and concerns based on their personal experiences with behavioral health care and services.
   - Incorporate recommendations from families, caregivers and consumers with behavioral health conditions and report back to individuals who participate.

5. Providing access to high-quality culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation and treatment.

   Actions:

   - Provide a Collaborative Care model that integrates behavioral health into primary care practices across BILH.
   - Support substance use treatment through centralized bed management, community-based care, medication assisted treatment (MAT) and outpatient programs.
   - Explore options to expand and scale multicultural and multilingual behavioral health and mental health telehealth services.

Figure 4: BILH Community Mental Health System Initiatives



Complex and Chronic Conditions

Goal: Improve health outcomes and reduce disparities for individuals at-risk of or living with chronic and/or complex conditions and caregivers, by enhancing access to screening, referral services, coordinated health and support services, medications and other resources.

Expected Outcomes:

- Increase chronic disease management and reduce disparities for metabolic diseases.
- Decrease time between abnormal cancer finding and treatment.

BILH will achieve this by:

1. Providing preventive health information, services and support for those at-risk for complex and chronic conditions and supporting evidence-based chronic disease treatment and self-management programs.

   Actions:

   - Implement culturally and linguistically-oriented programs to address chronic disease, specifically diabetes and hypertension.
   - Implement interventions to close racial/ethnic disparities for metabolic diseases (e.g., diabetes, hypertension and obesity).
   - Offer culturally and linguistically-oriented cancer screenings and navigation to needed appointments.
   - Ensure older adults have access to coordinated health care, supportive services and resources that support overall health and the ability to age in place.
   - Offer opportunities for community members to decrease their risk of developing and/or improve their management of complex and chronic conditions.

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