Community Benefits Report

Fiscal Year 2024

Beth Israel Lahey Health

Beth Israel Deaconess Plymouth

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SECTION I: SUMMARY AND MISSION STATEMENT

BID-Plymouth 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-Plymouth'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-Plymouth 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 and BID Plymouth'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.*

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

- **Involving** BID-Plymouth'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-Plymouth'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-Plymouth'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-Plymouth is honoring its commitment and includes information on BID-Plymouth's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

BID-Plymouth's CBSA includes Carver, Duxbury, Kingston and Plymouth. In FY 2022, BID Plymouth conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BID-Plymouth's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities fully complied with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BID-Plymouth is committed to improving the health status and wellbeing of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BID-Plymouth'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-Plymouth's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in the CBSA were issues related to age, race/ethnicity, language, immigration status, and disability. While the majority of the residents in the CBSA were white and born in the United States, there were non-white, people of color, recent immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than young, white, English speakers who were born in the United States. Interviewees, focus groups, and listening session participants also identified barriers to care and disparities for individuals with disabilities. These segments of the population were impacted by barriers that limited access to appropriate services, 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-Plymouth is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall wellbeing and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.

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

Basis for Selection
BID-Plymouth selected the target populations for its Community Benefits programs based on the 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-Plymouth'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-Plymouth's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- In FY24, Overnights of Hospitality seasonal shelter provided safe shelter, hot meals, and wraparound support services to 84 unique individuals experiencing homelessness, which is a 17% increase over FY23. In addition to the "Overnights of Hospitality", case

managers connected with 87 individuals living outdoors in the Plymouth Area. Also, 99% of the residents in Father Bill's and MainSpring's permanent supportive housing, maintained housing during FY24.

- South Shore Community Action Council's "Emergency Assistance Program" supported households in need of food, fuel and financial assistance. During FY24, 138 families received case management support to address their individual needs.
- The Yellow Tulip Project is a program through Plymouth Community Intermediate School to expand awareness of mental health in the community. BID Plymouth supported the Yellow Tulip Walk as well as 2 gardens planted at the entrance to the hospital by students representing the Yellow Tulip project, helping raise awareness and reduce stigma around mental health.
- BID Plymouth collaborated with the Plymouth County Sheriff's Department to offer programs around suicide prevention for first responders. 24 first responders attended a 3-day Individual & Group Crisis (GRIN) class and 33 first responders attended a 2-day Suicide Prevention, Intervention and Post-vention class. Funds were also used to provide education and resources to the EMS providers in the CBSA during EMS Appreciation Week.
- The Community Nutrition Program emphasizes the delivery of nutrition education and resources for people at risk for or living with complex/chronic health conditions. In FY24, 33 nutrition programs were provided to older adults who presented with a chronic disease and living in the CBSA.
- The Cancer Patient Support Program is free to patients living with cancer and provides support for patients and families through a social worker, resource nurse, and nurse navigator to provide counseling, support, and other resources to help alleviate out-of-pocket expenses. In FY24, 19 participants took part in the Bridge to Wellness program, 45 participants received wigs, 4 cancer survivors were trained to provide support as mentors, and 610 rides were provided to patients needing transportation.

Plans for Next Reporting Year

In FY 2022, BID-Plymouth conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BID-Plymouth's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities fully complied with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA BID-Plymouth 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 BID-Plymouth'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
- Chronic and Complex 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-Plymouth'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-Plymouth's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BID-Plymouth 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-Plymouth'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-Plymouth'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 linguistically diverse populations; and individuals with disabilities.

BID-Plymouth 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-Plymouth will continue to support the Enrollment/Counseling Assistance and Patient Navigation Support programs, to uninsured/underinsured patients and increase access to culturally appropriate and responsive care.
  - BID-Plymouth will continue to support the Taking People Places program that provides medical transportation for older adults and people living with a disability.

- **Social Determinants of Health**
  - BID-Plymouth will continue to work with and support Father Bill's & MainSpring's shelter and outreach programs to address homelessness in the CBSA.

- BID-Plymouth will continue to support the South Shore Community Action Council with funding for their Emergency Assistance Program helping families in need of food, fuel and financial assistance.

- **Mental Health and Substance Use**
  - BID-Plymouth will continue to support and be actively involved with Gosnold and Plymouth County Outreach to address substance use disorders through prevention, intervention and recovery programs.
  - BID-Plymouth will continue to support the growth of the Yellow Tulip Project within Plymouth and to other schools in the CBSA.

- **Complex and Chronic Conditions**
  - BID-Plymouth will continue its partnership with the Old Colony YMCA to support programs like Keep the Beat Post-Cardiac Program for individuals recovering from cardiac surgeries to build their capacity to recover and build healthy habits.
  - BID-Plymouth will continue to offer HouseCalls lectures to educate the community around chronic disease management and resources.

Hospital Self-Assessment Form
Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BID-Plymouth Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 45) The BID-Plymouth Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BID-Plymouth's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. Utilizing the integrated resources of the Beth Israel Lahey Health system, BID-Plymouth will deliver the full continuum of healthcare services to the communities of southeastern Massachusetts. BID-Plymouth's Community Benefits Department, under the direct oversight of BID-Plymouth'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-Plymouth's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

While BID-Plymouth 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-Plymouth Community Benefits program is spearheaded by the Manager of Community Benefits and Community Relations. The Manager of Community Benefits and

Community Relations has direct access and is accountable to the BID-Plymouth 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-Plymouth's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The BID-Plymouth Community Benefits Advisory Committee (CBAC) works in collaboration with BID-Plymouth's hospital leadership, including the hospital's governing board and senior management to support BID-Plymouth's Community Benefits mission to deliver the full continuum of world-class healthcare services to all the communities of southeastern Massachusetts, utilizing the integrated resources of the Beth Israel Lahey Health system. The CBAC provides input into the development and implementation of BID-Plymouth's Community Benefits programs in furtherance of BID-Plymouth's Community Benefits mission. The membership of BID-Plymouth's CBAC aspires to be representative of the constituencies and priority cohorts served by BID-Plymouth'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-Plymouth CBAC met on the following dates:

- December 11, 2023
- March 25, 2024
- June 10, 2024
- September 18, 2024

Community Partners
BID-Plymouth's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with BID-Plymouth'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-Plymouth's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BID-Plymouth's mission.

BID-Plymouth currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BID-Plymouth collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. BID-Plymouth has a particularly strong relationship with Father Bill's & MainSpring. This relationship includes providing support for seasonal housing and a case worker who provides links to services for those experiencing homelessness in the greater Plymouth area. Another

strong relationship is with the South Shore Community Action Council and the support received provides emergency assistance, to the Latinx community.

The following is a full listing of the community partners with which BID-Plymouth joins in assessing community needs and planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 45)

Algonquin Heights
Bay State Community Services, Inc.
BID-Plymouth Community Business Partners (approximately 69 businesses)
Brazilian Church
Brazilian Market (Uai Brazil)
Carver CARES Coalition
CleanSlate Centers
Child & Family Services
Community Health Network Area (CHNA 23)
Councils on Aging in the CBSA
Community Servings
Duxbury Free Library
EMS providers in the CBSA
Father Bills & MainSpring
Food Pantries in the CBSA
Gosnold Behavioral Health
Greater Attleboro Taunton Regional Transit Authority (GATRA)
Greater Plymouth Community Health Network Alliance (CHNA 23)
Harbor Health Services, Inc.
Health Imperatives
Health Resource & Services Administration (HRSA)-Ryan White Part C
Herring Pond Wampanoag Tribe
High Point Treatment Center
Jett Foundation
Laurelwood at the Pinehills
Libraries in the CBSA
Marshfield Council on Aging
National Alliance on Mental Illness (NAMI) - Plymouth
NeighborWorks Housing Solutions
New Hope Chapel
Old Colony Elder Services
Old Colony YMCA
Plymouth Area Community Access Television (PAC TV)
Plymouth Area Chamber of Commerce
Plymouth Area Coalition for the Homeless
Plymouth Boys & Girls Club
Plymouth Center for Active Living
Plymouth County District Attorney's Office
Plymouth County Sheriff's Office

Plymouth County Suicide Prevention Coalition
Plymouth County HUB
Plymouth County Outreach
Plymouth Department of Developmental Services
Plymouth Economic Development Corp.
Plymouth Family Network
Plymouth Family Resource Center
Plymouth Fitness Center
Plymouth Health and Human Services
Plymouth Pride
Plymouth Public Library
Plymouth Recovery Center
Plymouth Youth Development Collaborative (PYDC)
Police Departments in the CBSA
Public Health Departments in the CBSA
Rotary Club of Plymouth
Salvation Army
Schools in the CBSA
Senior Housing in the CBSA
South Shore Chamber of Commerce
South Shore Community Action Council
Taking People Places/The Alternative Board
Terra Cura, Inc.
The Farmhouse
To the Moon and Back
Town of Plymouth
Quincy Asian Resources, Inc. (QARI)
U-Mass Extension
United Way Greater Plymouth

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-Plymouth'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-Plymouth'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-Plymouth'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-Plymouth'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-Plymouth 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-Plymouth'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-Plymouth'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-Plymouth serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically

underserved. BID-Plymouth'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-Plymouth conducted 17 one-on-one interviews with key collaborators in the community, facilitated 4 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 460 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-Plymouth and community partners) is used to inform BID-Plymouth's decision-making about priorities for its Community Benefits efforts. BID-Plymouth 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-Plymouth's Implementation Strategy that is adopted by the BID-Plymouth's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified several barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning the issues stem from how 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 on 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-Plymouth Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, BID Plymouth offers free interpreter services for 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 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)	Provide access to interpretation and translation services at no cost to BID Plymouth patients	
Goal Status	During FY24, 12,303 interpreter sessions were provided to patients and families at BID Plymouth compared to 8,723 in FY23. In FY24, of the total 12,303 interpreter sessions, 1,693 were in-person/on-site (compared to 1,317 in FY23), 4,023 were telephonic/over the phone (OPI), (compared to 3,005 in FY23), and 6,587 were video remote interpretations (VRI), (compared to 4,401 in FY23)	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care, Social Determinants of Health, Mental Health and Substance Use; Chronic and Complex Conditions **Program Name: Community Benefits Administration and Infrastructure** **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	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.	
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)	• Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area • Offer evaluation capacity workshops to partner organizations and grantees to increase better understand impact.	
Goal Status	• BID Plymouth supported and implemented 10 programs and granted $64,000 to local organizations. • BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced and BIPOC populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance 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)	To assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs and Hospital Charity programs.	
Goal Status	In FY 2024 Plymouth screened 3,458 patients for eligibility and submitted 325 applications for entitlement programs. Of these applications 218 patients were approved for a State Assistance Program and overall 203 uninsured patients utilized the Health Safety Net.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care Program Name: Diversity Equity and Inclusion Health Issue: Additional Health Needs (Access to Care)		
Brief Description or Objective	BILH Community Benefits sits within the Office of Diversity, Equity and Inclusion (DEI). BILH's Office of Diversity, Equity, and Inclusion 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)	• Increase spend with diverse businesses by 25% over the previous fiscal year across the system. • Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation.	
Goal Status	• More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY24. This is a 28% increase over FY23. • Across BILH there was an 18% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care Program Name: Facilitating Primary Care Access Health Issue: Chronic Disease, Additional Health Needs (Access to Care)		
Brief Description or Objective	Throughout BID Plymouth's Community Benefits Service Area, BID Plymouth subsidizes primary care services provided by BILH Primary Care	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to primary care for uninsured and underinsured patients	
Goal Status	In FY24, BID Plymouth provided primary care in four practices in CBSA, serving 1,584 new patients.	
Time Frame Year: Year 2	**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, Recovery Coaches 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.		
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. In FY24 between the months of January and September, the team provided a total of 2,174 screenings.		
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**	
Program Goal(s)	By the end of FY24, 60% of consults conducted by a Recovery Specialist will result in a transfer to treatment		
Goal Status	There were 2,074 consults conducted in the ED and 1,277 resulted in treatment (62%) There were 1,659 consults conducted on the Medical floors and 892 resulted in treatment (54%)		
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs**		
Brief Description or Objective	To support increased access to mental health and substance use services and support. BID Plymouth participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
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 Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).	
Goal Status	More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**
Program Goal(s)	Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	
Goal Status	28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2 | Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Integrated Care Initiative** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	This initiative is a co-located behavioral health model that embeds licensed clinical social workers in the hospital with access to primary care practices. They work with primary care providers, an advanced practice nurse practitioner with mental health training, and a psychiatrist to integrate behavioral health screening, assessment, and treatment services into the primary care practice operations. With behavioral health services available in the Emergency Department (ED), patients may begin treatment in this setting rather than waiting until psychiatric beds are available. Medical staff in primary care, inpatient settings, and the ED have on-site access to behavioral health support so that they can provide comprehensive healthcare that is convenient, efficient, and cost effective.		
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 depressive symptoms via PHQ9 scores (Patient Health Questionnaire-9) and anxiety via GAD7 scores (General Anxiety Disorder-7) by 50%		
Goal Status	PHQ9 scores dropped by an average of 59% and GAD7 scores dropped by an average of 60%		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	Refer 1,000 patients to behavioral health providers.		
Goal Status	1119 patients were referred to BH providers accounting for 2,879 appointments and 2,361 actual sessions		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Plymouth County Outreach (PCO)** **Health Issue: Substance Use Disorders**			
Brief Description or Objective	Plymouth County Outreach (PCO) is a collaboration of 27 municipal police departments in Plymouth County working together to make treatment more accessible for individuals living with substance use disorder and their families. PCO provides home visits with a plainclothes officer and recovery coach or clinician following an overdose to discuss treatment options with the individual and help them engage with a treatment program as soon as possible. The program is not limited to those addicted to opiates, but rather everyone impacted by addiction. Referrals come from BID Plymouth and other community partners.		
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 least 50% of patients experiencing a non-fatal overdose in the Emergency Department (ED) accept treatment for substance use disorder (SUD)		
Goal Status	60% of patients experiencing a non-fatal overdose referred from the ED accepted treatment for SUD and 76% of family & friends accepted support services		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	Overdose follow-up to individuals with a non-fatal overdose with a 50% success rate in making contact with the individual and/or family and friends.		
Goal Status	A total of 176 individuals attempted follow-ups with individuals who had a non-fatal overdose with 41% (73) successfully contacted. of the 73 contacted, 60% were with the individual, 34% were with family and friends and 6% were contact with both the individual and family and friends.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Prescription Drug Takeback** **Health Issue: Substance Use Disorders**		
Brief Description or Objective	The hospital has receptacles in the hospital for unused prescription drugs. The goal is to remove unused drugs from people's homes that could potentially be taken and used by people other than the subscriber. The total number of pounds are tracked every year.	
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)	Remove over 300 gallons of unused prescription drugs from the community through the BID Plymouth Repository	
Goal Status	395 gallons of prescription drugs were removed from the community in FY24	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Yellow Tulip Project** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	The Yellow Tulip Project (YTP) is a program through Plymouth Community Intermediate School to expand awareness of mental health in the community. Through various outreach activities, the program engages with their schools and communities to spread YTP's mission of smashing the stigma surrounding mental health.	
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)	Support the Yellow Tulip Project for mental health awareness through community events and new gardens planted	
Goal Status	BID Plymouth supported the Yellow Tulip Walk on April 27, 2024 BID Plymouth supported the planting of 2 gardens at the entrance of the hospital	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Suicide Prevention for First Responders** **Health Issue: Mental Health/Mental Illness**

Brief Description or Objective	First Responders are at a heightened risk for suicide due to high stress situations and exposure to traumatic events. In response to this, BID-Plymouth received funding from the Hahnemann Foundation to offer free trainings using the Columbia Protocol through the Lighthouse Project to give them tools to help their peers and the community to determine risk and 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)	• To train 50 First Responders to train them to deal with potential suicide ideation, both in the communities they serve. their co-workers and other emergency professionals. • Support EMS week with T-shirts and educational resources around Suicide prevention	
Goal Status	• 24 students attended the 3-day GRIN class (Assisting Individuals in Crisis & Group Crisis) and 33 students attended the 2-day Suicide Prevention, Intervention and Post-vention class, resulting in 57 first responders trained. • T-shirts and educational resources around suicide prevention were given to all of the EMS providers in the BID Plymouth CBSA	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Directors of Personal Economy – Plymouth Foundation** **Health Issue: Mental Health/Mental Illness & Additional Health Needs (Workforce Development)**		
Brief Description or Objective	The Plymouth Economic Development Foundation, in partnership with the Plymouth Department of Health and Human Services , requested funding to launch a program that will directly address economic mobility impediments to Plymouth area residents in recovery who are actively working to improve their quality of life and support impactful programs and evidence-based strategies to increase employment and earnings and increase financial security. HHS and the Foundation observed a gap in the network of care being provided to recovering adults. This funding will support a program called Directors of Personal Economy (DPE) to serve a small cohort group of recovering adults (clients) eager to advance their personal economic development. A team of DPE's will be trained to become knowledgeable in available resources, assets, partnerships and troubleshooting. Clients will work with DPE's to create a plan to achieve personal economic growth. DPE's will triage Client base skills, living conditions, income (base) and earning potential, spending habits and gaps to achieving stated goals. For example, if education and job training is needed in order to achieve a higher earning potential, DPE's will connect Clients with academic partners to enroll in workforce training 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)	Provide seed funding to start the workforce development program for those in recovery	
Goal Status	Funding was provided to the Plymouth Economic Development Foundation in partnership with the Town of Plymouth Health & Human Services.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: ACCESS Program** **Health Issue: Chronic Disease**			
Brief Description or Objective	BID Plymouth's ACCESS Program (AIDS Comprehensive Care, Education & Support Services) provides medical care, education, support, medical case management, and medical transportation services to people living with HIVAIDS in the Greater Plymouth area. In addition to patient care, the program offers HIV education to the community and free and anonymous HIV counseling and testing. The ACCESS Program provides primary medical care to HIV/AIDS clients. Care includes physical examinations; adherence and treatment counseling; laboratory testing; immunizations and screening; referrals to specialty care and clinical trials; medical nutrition therapy, and medical case management.		
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)	• Enroll 3 new clients in Non Medical Case Management Services between October 1, 2023 and September 30, 2024 • 100% of ACCESS Program clients are on antiretroviral treatment (ART) • 5 clients are enrolled in medical care during FY24 (October 1, 2023 - September 30, 2024)		
Goal Status	• 6 clients were enrolled in Non-Medical Case Management Services between October 1, 2023 and September 30, 2024 • 100% of ACCESS Program clients are on antiretroviral treatment (ART). • 15 clients were enrolled into medical care during FY24		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	• The ACCESS HIV/AIDS program will maintain viral suppression in 85% of our clients.		
Goal Status	• 100% are virally suppressed.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Chronic and Complex Conditions **Program Name: Cancer Patient Support Services Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	A cancer diagnosis often creates financial and emotional stress for patients and families. The Cancer Patient Support Program identifies patients living with cancer with extreme emotional and financial hardship and matches them with counseling and financial support when possible. This program is free to patients living with cancer whenever sources of support are available. BID Plymouth provides support for patients and families through a social worker, resource nurse, and nurse navigator. This team provides counseling, support and works to find resources to help alleviate out-of-pocket expenses typically not covered by insurance. The team may also help to find funding sources to cover the cost of household expenses (e.g., groceries, car payments, heating, and electricity). Finally, this program finds resources to promote cancer screenings and education about wellness and prevention to help keep the community healthier and decrease risk factors that are associated with a cancer diagnosis.	
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)	• Due to the nature of the visits, patients who need it are offered transportation both to and from appointments for cancer treatment. • The Wig Share Program will provide wigs for patients and assistance on fit and care. • After diagnosis, provide every cancer survivor a free option to join Plymouth Fitness' Bridge to Wellness Program that helps build their physical strength without any injuries. • Continue to offer the mentorship program where cancer survivors provide support for those actively involved in cancer treatment	
Goal Status	• 610 rides were given to patients needing rides to and from treatment. • 45 wigs were provided to patients using a wig specialist 2 days per month. • 19 participants took part in the Bridge to Wellness program at Plymouth Fitness. • 4 cancer survivors were trained to work with patients to provide support as mentors through the treatment process.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: Community Nutrition Program** **Health Issue: Chronic Disease and Additional Health Needs (Food Insecurity)**

Brief Description or Objective	The Community Nutrition Program emphasizes the delivery of nutrition education and resources for people experiencing food insecurity and includes people at risk for, or living with, complex/chronic 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)	• By the end of FY24, BID-Plymouth Nutrition Education will reach 2,000 community members indirectly through Delicious and Nutritious shows on PAC TV as well as other channels. • By the end of FY24, monthly Nutrition Notes will be sent to at least 10 local agencies serving individuals living in the CBSA and reach over 20,000 residents with the education and tips for healthy eating • By the end of FY24, 30 nutrition education programs focused on preventing and managing chronic conditions will be provided to adults living in the CBSA, directly impacting over 1,000 people • By the end of FY24, 20 nutrition education programs focused on Healthy Food Access will directly impact over 800 participants who are experiencing food insecurity with ways to access and prepare healthy food options. • During FY24, 20 programs focused on developing healthier eating habits will be provided to youth and families also presenting with food insecurity and living in the CBSA. • During FY24, at least 25 nutrition programs focused on healthier eating and chronic disease management will be provided to older adults living in the CBSA
Goal Status	• 9 Delicious & Nutritious shows were provided in collaboration with PCAL, PACTV, local Chef Jerry Levine, and BID-P. Marcia Richards RD presents nutrition information in concert with Jerry Levine's monthly recipe demonstration. 663 watched the show on zoom either live or on YouTube. Also, the RD presented via radio through Plymouth Fitness to 2,000 listeners about healthy nutrition habits and misperceptions. A total of 2,663 people were reached indirectly. • Nutrition Notes were sent to 17 agencies serving individuals living in the CBSA including COAs, Salvation Army, Father Bill's, Plymouth Family Resource Center and Algonquin Heights. Agencies can place nutrition information in their newsletters and other social media. Monthly topics included inflammation, diabetes, fat facts, using spices, hydration, packing a health lunch, and the recent Community Health Needs Assessment. All information is based on evidence-based data and reached over 30,000 people living in the CBSA.

	• 1,580 adults attended 35 sessions focused on meal planning for health, benefits of fish, healthy eating 101, and more. Education also focused on decreasing overall sugar and sodium in the diet. Educational models were available to strengthen education and participants received associated handouts and resources. • 20 programs were provided to adults and families living in the CBSA and presenting with food insecurity. 858 adults and families attended these programs in person. Each session also provides healthy nutrition resources and tools for food preparation. • 20 programs were provided to youth & families living in the CBSA, who also were seeking access to healthy and affordable food options. Topics included label reading, building a healthy lunch/snack, and energy drink concerns. Several programs included experiential learning through recipe creation. • 33 nutrition programs were provided to older adults who also presented with a chronic disease and living in the CBSA. They were taught label reading, healthy protein, heart health tips and more. Many of these sessions involved a food demonstration and recipe to be given out.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: Keep the Beat - Post-Cardiac Program** **Health Issue: Chronic Disease**			
Brief Description or Objective	BID Plymouth wants to ensure that any patient graduating from their Cardiac Rehab program can continue their journey, despite the cost. BID Plymouth funds graduates of its Cardiac Rehab program, who would like to continue to improve their heart health, to participate in the 12-week "Keep the Beat" program at the Old Colony YMCA. The program offers small group classes that provide support and education to maintain a heart healthy lifestyle, focusing on exercise, diet and stress management.		
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)	Modifying/improving in key cardiac risk factors: Weight loss: Goals is for participants to lose average of 0.5 lbs. for each week in the program benchmark goal is 6lbs weight loss Improvement in cardiovascular fitness: measured using METS (metabolic equivalent of a task) by 50%.		
Goal Status	Participants lost an average of 3.6 lbs.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	• Provide up to 20 graduates of BID Plymouth's Cardiac Rehab Program the opportunity to attend the 12-week, Old Colony YMCA's Keep the Beat post-cardiac rehab program if they are unable to pay the fee. • Comfort level of fitness: Goal is for participants to report by the end of the program that they "agree or "strongly" to "More confidence to make changes in my lifestyle to improve my medical conditions" and "Confident that I can maintain these lifestyle changes such as diet, exercise even during times of stress" based upon responses to post satisfaction survey provided to patients at end of program.		
Goal Status	• BID Plymouth provided 17 patients with a scholarship to attend the post-cardiac program, Keep the Beat, at the Old Colony YMCA at no cost to them. • All patients who completed the program agreed or strongly agreed to feeling confident to maintain lifestyle changes, such as diet and exercise, even during times of stress.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Chronic and Complex Conditions **Program Name: Stroke Community Education** **Health Issue: Chronic Disease**		
Brief Description or Objective	BID Plymouth provides community education for older adults population around chronic disease, particularly strokes. The education covers types of strokes, effects of strokes, stroke prevention and how to recognize the signs of a stroke (for the individual or for someone else is having a stroke).	
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 education on stroke risk, how to identify one and resources through at least 2 community events and presentations.	
Goal Status	• Stroke education was shared with staff and visitors at the hospital via the TV monitors. • A PSA was taped and shared through Plymouth Area Community Access TV • Stroke information was shared at the Plymouth Health & Safety Fair.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: Housecalls – Community Health Education Lectures** **Health Issue: Chronic Disease**		
Brief Description or Objective	HouseCalls are free community health educational lectures provided by hospital physicians and clinicians who volunteer to present. The event is one hour and allows attendees to ask questions. The Community Benefits Manager collects data through an evaluation that attendees complete at the end of each lecture. The evaluation includes their feedback on the lecture, what other future topics they are interested in, and how they heard about the lecture. A light dinner or refreshments are available at no cost to the attendee when done in person. Programs have included snoring and sleep apnea, lung cancer, weight loss surgery, back pain, behavioral health and orthopedic concerns.	
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 three free community health lectures on topics related to priority health care needs.	
Goal Status	Three HouseCalls presentations were provided in person in community settings and 120 participants joined in. Duxbury Senior Center hosted Dr. Siqueira to educate the group on knee and hip arthritis. Oakpoint 55+ community hosted Dr. Thomas to educate the group on the future of healthcare on the South Shore. The Pinehills community hosted Dr. Trecartin to educate the group on the need for expanded Emergency Services	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions and Social Determinants of Health **Program Name: Fall Fun Fest: Health & Wellness Fair** **Health Issue: Chronic Disease and Additional Health Needs (SDoH)**		
Brief Description or Objective	A free family friendly event sponsored by BID-Plymouth in partnership with the Plymouth Public Library and the Greater Plymouth CHNA. Activities and vendors offered health education and resources for the community of all ages.	
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)	Engage families with children and older adults to provide health education and resources around priority health care needs with a goal of 30 vendors from the community and over 200 participants of all ages.	
Goal Status	The fair had 35 vendors serving more than 300 participants for the event and a majority were families with young children. Activities included a DJ, free snow cones and face painting, free bags of fresh produce, health education and many resources for all. Education related to nutrition, stroke awareness and cardiovascular health as well as resources for older adults and healthy aging were provided We collaborated with the Plymouth County Sheriff's Office Farm Day event and sponsored the Wampanoag tribal dance. We also collaborated with the South Shore Community Action Council for transportation between the 2 events.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Father Bill's and MainSpring (FBMS) Overnights of Hospitality & Outreach** **Health Issue: Housing Stability/ Homelessness**			
Brief Description or Objective	For four decades, Father Bills and MainSpring (FBMS), a registered 501(c)3 charitable organization, has been a leading innovator of ending homelessness. Their mission is to end and prevent homelessness in Southern Massachusetts with programs that provide emergency and permanent housing and help people obtain skills, jobs, housing, and services. Funding through BID-Plymouth helps support the Overnights of Hospitality seasonal shelter and street outreach through their case manager.		
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)	• FBMS will serve at least 15 individuals annually via Overnights of Hospitality seasonal emergency shelter. • Case managers will connect with at least 15 unsheltered individuals annually via street outreach services.		
Goal Status	• The seasonal shelter opened for the season at the end of November 2023 and remained open during the winter months until the first week of April 2024. During this time period, safe shelter, hot meals, and wraparound support services were provided to 84 individuals. This is a 17% increase in the number of individuals served in FY23. • Staff connected with 87 individuals living outdoors in Greater Plymouth. There is a growing number of people living outside across our region and Greater Plymouth is no exception. FBMS has increased their staff in Plymouth in an effort to meet the growing demand. Case managers meet participants where they are outdoors and provide for their basic needs, before bringing them into our programs, and referring them to more specialized services.		
Time Frame Year: Year 2		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	90% of residents in FBMS' 70+ units of permanent supportive housing in Greater Plymouth will remain housed for a year or more.		
Goal Status	99% of residents, who are often participants with the greatest needs, have maintained housing during this grant period. The majority of residents exiting FBMS permanent supportive housing, do so for a more independent home of their own (Section 8 unit, unsubsidized unit, etc). Staff work with any participant exiting housing to ensure a successful transition, and continued progress toward self-sufficiency.		
Time Frame Year: Year 2		**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Grant Professional Services** **Health Issue: Additional Health Needs (SDoH)**		
Brief Description or Objective	BID Plymouth partners with many community organizations and coalitions in its efforts to address and prevent identified health needs in the community. By offering grant writing services to smaller organizations that do not have access to these specialized skills, BID Plymouth engages experts in grant writing and organizational readiness to provide needed support for these CBOs and coalitions to become more community driven and led.	
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 workshops to Community Based Organizations to educate them on Grant readiness, organizational structure and grant writing. • Work with small Community Based organizations to help them become grant ready and/or submit grants for funding in one of the priority areas of the CHNA/IS	
Goal Status	• Certified Grant Professional Cyndi MacKenzie offered 3 workshops which were done in partnership with the Greater Plymouth CHNA. The feedback was overwhelmingly positive. The workshops were: Using Artificial Intelligence Ethically to Assist with Grants: 3.19.24: 8 Community Organizations represented; Finding & Applying to the Right Funders: 4.16.24: 5 Community Organizations represented; Community Voices: Sharing Stories of Empowerment: 5.21.24: 6 Community Organizations represented • 2 Community Organizations were given funding to work with a local grant writer to become grant ready	
Time Frame Year: 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Emergency Assistance Program** **Health Issue: Additional Health Needs (Food Insecurity) and (Financial Security)**		
Brief Description or Objective	The goals of the South Shore Community Action Council's (SSCAC) Emergency Assistance Program are to work with and empower individuals and families to achieve greater financial stability and long-term well-being. Food, financial and social service assistance for individuals and families that are low-resourced are provided with tailored outreach to Latinx and Brazilian households living in the CBSA.	
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)	• 30 households will receive financial assistance with rent/mortgage payments. • 5 households in the BID-Plymouth service area will receive financial assistance with utility bills and avoid a utility shut-off. • 40 households in the BID Plymouth service area will access emergency food • 85 households from BID Plymouth service area will receive referrals for internal and community services • 100% of applicants with utility shut-off notice from BID Plymouth service area will be referred to SSCAC's Home Energy Assistance program • 75 households from BID Plymouth service area will receive case management	
Goal Status	• 27 households from BID Plymouth service area received financial assistance with rent/mortgage • 1 household in the BID Plymouth service area received financial assistance with utility bills • 36 households in the BID Plymouth service area accessed emergency food • 140 households from BID Plymouth service area received referrals for internal and community services • 100% of applicants with utility shut-off notice from BID Plymouth service area were referred to SSCAC's Home Energy Assistance program • 138 households from BID Plymouth service area received case management	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	• 30 households will have stable housing for 3 months. • 20% of applicants with shut-off notice in BID Plymouth service area will avoid utility shut-off • 30% of applicants for rent assistance with eviction notice from BID Plymouth service area will avoid eviction	

Goal Status	• 27 households out of 30 that received financial assistance with rent or mortgage from BID Plymouth service area had stable housing for 3 months. • 15% of households with shut-off notice in BID Plymouth service area avoided utility shut-off • 25% of applicants for rent assistance from BID Plymouth service area avoided eviction		
Time Frame Year: Year 2		**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health Program Name: Taking People Places-TPP Health Issue: Additional Health Needs (Transportation)			
Brief Description or Objective	Taking People Places or TPP consists of a group of 17 Social Services Agencies, including BID Plymouth. This program is a replication of a successful transportation pilot program in the Attleboro area that provided ride hailing services to qualified users at no or low cost when public transportation was not available. Funds donated by organizations are matched through a state grant (up to 40K limit) to provide defrayed costs of transportation to clients through LYFT. BID Plymouth can determine eligibility for rides as part of the TPP and each participating organization may not exceed the number of rides their contribution entitles the organization (based on an average ride cost of about $21).		
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 360 rides per year to adults ages 60 or older and/or with a disability who need access to medical care and who do not have any other resources.		
Goal Status	A total of 345 rides were provided in FY24; 117 rides to adults age 60 or older and 228 rides for those with a disability to medical care who do not have any other resources.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Plymouth Center for Active Living Senior Task Force** **Health Issue: Additional Health Needs (Access to Care/SDoH)**			
Brief Description or Objective	The Plymouth Center for Active Living is leading a Senior Task Force that collaborates to address any community concerns affecting the growing older adult population. Towards the end of FY22, this group began applying for Plymouth to become an Age and Dementia Friendly community. BID-Plymouth has two staff members on the task force, contributing their time and expertise along with funding to support the process.		
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-Plymouth staff to contribute time and expertise for the Senior Task Force in the Town of Plymouth to address the needs of the older adult population and to continue the process of the Age and Dementia Friendly designations with a needs assessment as the first step.		
Goal Status	In-kind time and expertise from the Chief of Psychiatry and the Manager of Community Benefits was provided to the Senior Task Force to address the needs of the growing population of older adults and to aid in the process of obtaining the Age & Dementia Friendly designation. The needs assessment was completed as the first step in this process.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	Support programs through the Center for Active Living that provide education and resources for aging adults		
Goal Status	Both financial support and staff expertise were provided for the Live Well Age Well Program. This consisted of a 4-part educational series about planning how to care for a loved one or themselves through the aging process. Each presentation was full with 40 participants from the community.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3 | Goal Type: Process Goal**		

Priority Health Need: Social Determinants of Health **Program Name: Migrant Family Support** **Health Issue: Additional Health Needs (Access to Care/SDoH)**		
Brief Description or Objective	Migrant families began relocating to Kingston and Plymouth in October of 2022. Immediately, BID-Plymouth brought together all the relevant community partners including public health, social service organizations, Harbor Community Health and public officials in addition to internal clinicians to develop a plan of 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)	Provide needed support for migrant families through resources, clinical connection and basic supplies.	
Goal Status	Support was given to the migrant families in the form of funding for supplies not covered by the state as well as over-the-counter medications during the cold and flu season.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Greater Plymouth Community Health Network Alliance (CHNA) Support** **Health Issue: Additional Health Needs (Access to Care/SDoH)**	
Brief Description or Objective	The Greater Plymouth CHNA (Community Health Network Alliance) works to improve health outcomes based upon identified health needs through collaboration among other organizations providing services, programs and resources within the communities they serve. Historically, this group called CHNA 23, was funded through the Department of Public Health and the Determination of Need (DoN) process, as a mechanism for distributing the Community Health Initiative (CHI) funds to the community. This funding mechanism is no longer in place and they are in need of funding to support the process of identifying new areas of focus and funding sources for long-term sustainability and impact in the community.
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)	• Report on the number and type of new protocols implemented for sustainability • Provide skill-building and education topics shared with number of participants at general meetings • Provide mini-grants to small non-profits as seed money for a new program or service to the community • Track and report out on number of Community Organizations represented at Steering Committee and General Public Meetings • Grow awareness and report out on total and new members that receive emails
Goal Status	• There was discussion regarding adding in membership fees and sponsorship opportunities, but nothing was implemented in FY24 • Skill-building and education topics were: o Grant writing skills o New local developments in Health & Human Services in Plymouth o Nutrition & Diabetes o Mindfulness exercises o Housing Insecurity o Food Insecurity o Recovery Resources o Substance Use Continuum o There were an average of 28 participants at each of these presentations • There were 4 mini-grants in the amount of $2,500 each given to: o South Shore Conservatory o JC PANS/PANDAS o Duxbury Library & True Center for the Arts o Visiting Dental Hygiene

	• There were an average of 28 organizations represented at the six general meetings and the Steering Committee is made up of representation from 12 Community & Municipal Organizations • The membership consists of 341 unduplicated community representatives, which is a 5% increase over the year prior.

Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health Program Name: BILH Workforce Development Health Issue: Additional Health Needs (Education/Jobs)			
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 an 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 FY24, Workforce Development will continue to encourage community referrals and hires. • In FY24, Workforce Development will attend events and give presentations about employment opportunities to community partners. • In FY24, Workforce Development will offer employees career development services. • In FY24, Workforce Development will hire interns after internships and place in BILH hospitals.		
Goal Status	• In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals. • In FY24, 33 events and presentations were conducted with community partners across the BILH service area. • In FY24, 1,044 BILH employees received career development services • In FY24, 37 interns were hired permanently in BILH hospitals. BID Plymouth participated in these hirings.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Community Support & Engagement** **Health Issue: Additional Health Needs (Access to Care), Food Insecurity, Mental Health/Mental Illness**		
Brief Description or Objective	As a large provider of health care and a major employer in its Community Benefits Service Area (CBSA), it is important for BID Plymouth to be engaged in the larger community and support efforts to make the region a healthier, safer, and more vibrant place to live, work and play. To fulfill this objective, the hospital provides financial sponsorships and direct staff engagement to organizations and initiatives which support the goals and strategies identified in BID Plymouth's Implementation Strategy.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Provide community support to organizations that further BID Plymouth's community benefits mission	
Goal Status	BID Plymouth provided financial support to 10 community organizations in its community benefits service area (CBSA)	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	4,432,714
Community-Clinical Linkages	146,530
Total Population or Community Wide Interventions	305,725
Access/Coverage Supports	450,065
Infrastructure to Support CB Collaborations	24,007
Total Expenditures by Program Type	5,359,041
CB Expenditures by Health Need	
Chronic Disease	1,764,346
Mental Health/Mental Illness	1,315,088
Substance Use Disorders	1,139,964
Housing Stability/Homelessness	30,253
Additional Health Needs Identified by the Community	1,109,390
Total by Health Need	5,359,041
Leveraged Resources	
Total Leveraged Resources	332,072
Net Charity Care Expenditures	
HSN Assessment	1,431,197
Free/Discounted Care	
HSN Denied Claims	497,406
Total Net Charity Care	1,928,603
Total CB Expenditures	7,619,716

Additional Information	
Net Patient Services Revenue	370,451,146
CB Expenditure as % of Net Patient Services Revenue	2.06%
Approved CB Budget for FY25 (*Excluding expenditures that cannot be projected at the time of the report)	6,717,721
Bad Debt	3,237,797
Bad Debt Certification	Yes
Optional Supplement	
Comments: $650,750 subsidizing Behavioral Health Services outside of its CBSA	

SECTION VI: CONTACT INFORMATION

Karen Peterson, Manager, Community Benefits & Community Relations
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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:
      Sarah Cloud, Director of Social Work left her position, but remained as a community member; Minhtram Tran, DEI Legal Counsel for the Plymouth County DA's Office was added

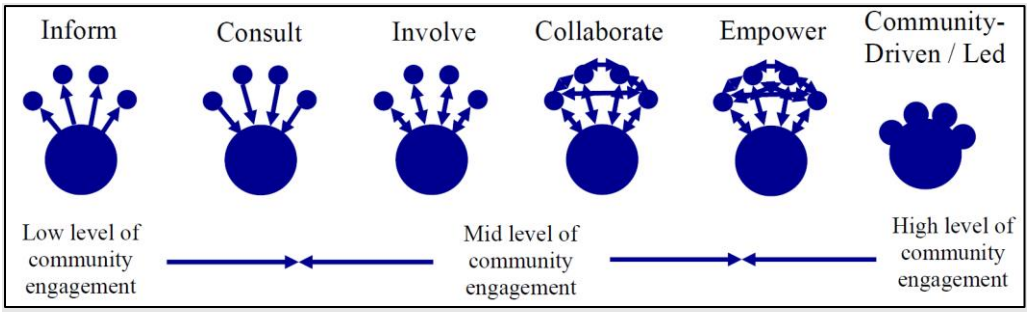
II. Community Engagement

1. 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)
Plymouth County Sheriff's Department	Karen Barry, Director of External Affairs	Other	BID-Plymouth collaborates with the Plymouth County Sheriff's Department through providing direct financial support for its Suicide Prevention for First Responders as well as the Fall Community Events.
Greater Plymouth Community Health Network Alliance (CHNA)	Mike Jackman, Chair and District Director for US Rep Bill Keating	Social service organizations	The Greater Plymouth CHNA provides educational and networking opportunities for area non-profits as well as small seed funding grants. BID Plymouth provides funding for the group in order to continue their work and develop a plan for sustainability.
Plymouth Health & Human Services	Michelle Bratti, Commissioner	Local health department	Plymouth Health & human Services is a new town

			department that has been very involved in helping to facilitate the CHNA process as well as collaborations with other Plymouth CBOs.
Plymouth Economic Development Corporation	Stephen Cole, Executive Director	Other	The Plymouth Foundation is a non-profit dedicated to enhancing quality of life through fostering economic growth. BID Plymouth partnered with the Foundation and Plymouth HHS on a workforce development initiative for those in recovery.

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



Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal was met: BID Plymouth met regularly with the CBAC and other community partners to provide updates and seek	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.

		input on strategies to address needs in the community.	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met: BID Plymouth consulted with the CBAC as well as responded to emerging needs in the community through new community partnerships that were facilitated through current CBAC members.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met: BID Plymouth collaborated with community partners from the CBAC to address needs and support programs around food insecurity, homelessness, mental health and workforce development.	Collaborate
Evaluating progress in executing Implementation Strategy	Empower	Goal was met: BID Plymouth partners were offered free Evaluation Workshops provided by BILH to build/increase their evaluation skills and capacity. There were additional workshops centered around grant writing skills that engaged community partners.	Collaborate
Updating Implementation Strategy annually	Involve	Goal was met: BID Plymouth gave the CBAC continuous feedback and updates through meetings and other community meetings. Reports included both qualitative and quantitative data from community activities and programs.	Collaborate

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

  N/A

2. 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.

Yes. It took place on September 11, 2024 at the Plymouth Salvation Army.

- Maternal Health Focus
    - How does your organization assess maternal health status in the Community Health Needs Assessment Process? (150-word limit)

BID Plymouth's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under Reproductive Health" and include low birth weight , Mothers with late or no prenatal care, Births to adolescent mothers (%, and mothers receiving publicly funded pre-natal care as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA BID Plymouth engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

    - How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)

      BID Plymouth partners with both Outer Cape Health Services (OCHS) and Women, Infant and Children Nutrition Program (WIC) on maternal health initiatives and have done so for over 20 years. Additionally, BID Plymouth is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?

  BID Plymouth currently works with both Outer Cape Health Services (OCHS) and Women, Infant and Children Nutrition Program (WIC) on maternal health initiatives. BID Plymouth's maternal health work will be guided by the MHQEC and BID Plymouth looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

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**.

   No updates