Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

Beth Israel Lahey Health

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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 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.*

BID-Plymouth's Mission: Utilizing the integrated resources of the Beth Israel Lahey Health system, Beth Israel Deaconess Hospital–Plymouth delivers the full continuum of world-class healthcare services to all the communities of southeastern Massachusetts.

The core values that BID Plymouth holds as central to the success of its staff and thus its mission include:

Integrity

- We speak and act with honesty.
- We own our individual actions and behaviors.

Respect

- We create a professional work environment, wherein we support, acknowledge and depend on the contributions of each member of the hospital team.
- We are caring and compassionate in all that we do.

Trust

- We engage in open, honest and timely communications.
- We rely on one another to deliver individual and team responsibilities to the highest standards.

Teamwork

- We work together to achieve shared goals.
- We appreciate the diversity of our co-workers and those we serve.

Excellence

1. We pursue the highest quality and best practices in all we do.
2. We anticipate and meet the needs and expectations of our patients, their families and the community.

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):

Social Determinants of Health
BID Plymouth helps fund full-time case managers in Father Bills & MainSpring's (FBMS) Plymouth office to provide services to people experiencing housing insecurity with wraparound support services to help them avoid or permanently end their homelessness. These support services include seasonal emergency shelter called "Overnights of Hospitality" from November through March utilizing local churches. In FY23, Overnights of Hospitality seasonal shelter provided safe shelter, hot meals, and wraparound support services to 72 unique individuals experiencing homelessness.

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. youth, and their families, and those living in poverty. This program served 889 adults and families presenting with food insecurity attended programs to learn about low-cost, healthy nutrition resources and tools for food preparation.

Mental Health and Substance Use
The Yellow Tulip Project is a program through Plymouth Community Intermediate School to expand awareness of mental health in the community. Through various outreach activities, they tirelessly engage with their schools and communities to spread YTP's mission of smashing the stigma surrounding mental health. 6 gardens were planted in the Plymouth community by students representing the Yellow Tulip project, helping raise awareness and reduce stigma around mental health.

PCO Hope is a non-profit 501(c) (3) that offers real-time support to anyone needing help or information about drug and alcohol addiction through collaboration with representatives from local treatment centers and counselors. In addition to offering support and linkages to treatment, PCO Hope identifies high-risk areas, including sober homes and housing developments with PCO, for outreach education specific to harm reduction. BID Plymouth's Director of Social Work visits these sites with another representative from PCO Hope to discuss strategies and distribute Naloxone. In partnership with PCO Hope's harm reduction program to prevent an overdose, 958 Narcan kits were distributed during the year, equaling 1,916 doses.

Chronic and Complex Conditions
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 FY23, 30 nutrition programs were provided to older adults who 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.

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). In FY23, 35 participants from the cancer support program took part in the Bridge to Wellness program at Plymouth Fitness, and 700 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 Town of Plymouth Senior Task Force in its ongoing efforts to implement Age and Dementia Friendly programs and services.

- **Mental Health and Substance Use**
  - BID-Plymouth will continue to support and be actively involved with Plymouth County Outreach, Plymouth County Outreach Hope and Plymouth County HUB to address substance use disorder 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 the 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 work with the Old Colony Elder Services to promote access to chronic disease education and self-management programs.

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 who participated in BID-Plymouth's CHNA 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 12, 2022
- March 20, 2023
- June 12, 2023
- September 11, 2023

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
American Heart Association
Anchor House, Inc.
Bay State Community Services, Inc.
BID-Plymouth Community Business Partners (approximately 69 businesses)
Boston Public Health Commission-Ryan White Part A
Boston Medical Center
Bourne Substance Use Coalition
Brazilian Church
Brazilian Point Store
Brazilian Silva Store
Brazilian Steakhouse
Brazilian Market (Uai Brazil)
Cape Cod Canal Region Chamber of Commerce
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
Francis Keville Memorial Trust Fund
Food Pantries in the CBSA
Gosnold Behavioral Health
Great Island Social Club
Greater Attleboro Taunton Regional Transit Authority (GATRA)
Greater Plymouth Food Warehouse
Hadassah
Harbor Health Services, Inc.
Health Imperatives
Healthy Plymouth
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
McLean Hospital
National Alliance on Mental Illness (NAMI) - Plymouth
National Institutes of Health, HEAL Initiative – Plymouth
NeighborWorks Housing Solutions
New Hope Chapel
Office of Adolescent Health and Youth Development
Old Colony Elder Services
Old Colony YMCA
Plymouth Area Community Access Television (PAC TV)
Peer Group Advisors, Inc. DBA TAB-Plymouth
Pilgrims Hope
Plymouth Area Chamber of Commerce
Plymouth Area Coalition for the Homeless
Plymouth Bay House
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 County Outreach – Hope
Plymouth Department of Developmental Services
Plymouth Family Network
Plymouth Family Resource Center
Plymouth Fitness Center
Plymouth Housing Authority
Plymouth Lions Club
Plymouth Police Department
Plymouth Pride
Plymouth Public Library
Plymouth Recovery Center
Plymouth Recreation Department
Plymouth Youth Development Collaborative (PYDC)
Police Departments in the CBSA
Public Health Departments in the CBSA
Red Cross Blood Drive
Rotary Club of Plymouth
Salvation Army
Schwartz Center Rounds
Signature Healthcare / Brockton Hospital

Schools in the CBSA
Senior Housing in the CBSA
South Shore Alliance of LGBTQ+ Youth (SShAGLY)
South Shore Chamber of Commerce
South Shore Community Partners in Prevention
South Shore Community Action Council
South Shore Continuum of Care
South Shore Partners in Prevention (CHNA 23)
Taking People Places/The Alternative Board
Terra Cura, Inc.
To the Moon and Back
Town of Plymouth
Quincy Asian Resources, Inc. (QARI)
U-Mass Extension
United Way Greater Plymouth
Zion Lutheran Church Associates

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	BID Plymouth is committed to meeting the needs of all our patients and to serving our community. We strive to honor all cultural preferences and work diligently to communicate effectively with all our patients, English speaking, non-English speaking and limited-English speaking as well as our deaf and hard of hearing patients.	
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)	During FY23, the number of interpreter sessions for patients and families at BID Plymouth will increase due to the provision of Video Remote Interpretation (VRI) and an increased demand through an influx of migrant families to the CBSA.	
Goal Status	Goal met: During FY23, 8,723 interpreter sessions were provided to patients and families at BID-Plymouth compared to 8,111 in FY22. In FY23, of the total 8,723 interpreter sessions, 1,317 were in person/on-site (compared to 1,410 in FY22), 3005 were telephonic/over the phone (OPI) (Compared to 3,775 in FY22), and 4,401 were video remote interpretations (VRI), (Compared to 2,296 in FY22).	
Time Frame Year: Year 1	**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: Infrastructure to Support Community Benefits Collaborations across BILH Hospitals** **Health Issue: Chronic Disease; Housing Stability/Homelessness; Mental Illness and Mental Health; Substance Use Disorders; and Additional Health Needs (Food Insecurity and Access to Care)**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Community Benefits staff continued to understand state and federal regulations, build community engagement and evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	• By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. • By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. • By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter quarterly to communicate community benefits activities to community partners, residents, and vested parties.
Goal Status	Goals met: • All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops. • All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. • BID-Plymouth launched and sent 2 newsletters to a mailing list of over 200 organizations and people.

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

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BID Plymouth works to provide underserved and uninsured patients with information on all insurance programs offered by the Executive Office of Health and Human Services (EOHHS) and the MA Health Connector. Financial counselors also provide financial counseling, benefit enrollment assistance and payment planning. Additionally, throughout BID-Plymouth's Community Benefits Service Area, BID-Plymouth subsidizes primary care services provided by BID-Plymouth's Affiliated Physicians Group.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	To help individuals with limited financial resources find options to cover the cost of their care and to help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.	
Goal Status	Goal met: In FY 23 Plymouth screened 4,582 patients for eligibility and submitted 201 applications for entitlement programs. Of these applications, 140 patients were approved for a State Assistance Program and overall 235 uninsured patients utilized Health Safety Net.	
Time Frame Year: Year 1	**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's Diversity, Equity, and Inclusion (DEI) office develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent." The DE&I Council for BID-Plymouth is comprised of colleagues representing different identities, voices, perspectives, backgrounds and experiences, will help enhance a culture of inclusion throughout the hospital.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	• Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation. Support organizational DE&I strategy and determine initiatives • Increase spending with diverse businesses by 25% over the previous fiscal year across the system. • Expand system-wide DEI learning, in alignment with enterprise learning management solution. • Support creation or expansion of local DEI committees/resource groups.
Goal Status	Goals met: • Across BILH there was a 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. • More than $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22. • 8 system-wide DEI trainings were conducted for all BILH staff and hospitals. • BID-Plymouth created a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for our patients, our employees and our communities.

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

Priority Health Need: 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 and specialty 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, specialty care, 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	Depressive symptoms (PHQ9) decreased by 59% and anxiety score (GAD7) decreased by 66%		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Refer 1,000 patients to behavioral health providers.		
Goal Status	Goal met: Of the 1,478 patients seen, 879 were scheduled to meet with behavioral health providers 240 were given resources, 3 received care coordination at a higher level, 276 did not respond to outreach efforts, 53 declined services and 24 were already in treatment.		
Time Frame Year: Year 1		**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. BID Plymouth's Chief of Psychiatry is on the Chief Advisory Board and the Director of Social Work provides triage for this program, routing the appropriate care responder to each call.		
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 in the Emergency Department (ED) and inpatient accept treatment for substance use disorder (SUD)		
Goal Status	58% of patients referred from the ED accepted treatment and 48% of in-patients referred accepted treatment for SUD		
Time Frame Year: Year 1		**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 contacting the individual and/or family and friends.		
Goal Status	Goal met: A total of 960 attempted follow-ups with individuals who had a non-fatal overdose with 475 (49%) successfully contacted. of the 475 contacted, 53% were with the individual, 39% were with family and friends and 8% were contact with both the individual and family and friends.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Plymouth County Outreach (PCO) Hope** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	PCO Hope is a non-profit 501(c)(3) that offers real-time support to anyone needing help or information about drug and alcohol addiction through a collaboration with representatives from local treatment centers, as well as counselors. In addition to offering support and linkages to treatment, PCO Hope identifies high-risk areas, including sober homes and housing developments with PCO, for outreach education specific to harm reduction. BID Plymouth's Director of Social Work visits these sites with another representative from PCO Hope to discuss strategies and distribute Naloxone.
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)	• Distribute 75 Narcan kits following the trainings each month for a total of 900 for the year. • Decrease the availability of unused prescription drugs by 300 gallons for the year through BID-Plymouth depository. • Support education and awareness efforts in the community around substance use prevention and stigma.
Goal Status	Goals met: • In partnership with PCO Hope's harm reduction program to prevent an overdose, 958 Narcan kits were distributed during the year, equaling 1,916 doses. • The availability of unused prescription drugs was decreased by 366 gallons for the year • Organized by PCO Hope, BID-Plymouth financially supported the second year

	of Recovery Fest which brought together 3 organizations along with resources providing support for those in need and awareness for the community at large.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Plymouth County HUB** **Health Issue: Substance Use Disorders**			
Brief Description or Objective	Plymouth County HUB, in partnership with Police Assisted Addiction Recovery Initiative (PAARI) and BID Plymouth, received a grant from South Shore Health to integrate a team approach to provide Behavioral Health Services to residents of Plymouth County. This approach brings together collaborations between law enforcement, behavioral health providers, and other resources to deal with social determinants that factor into one's behavioral health needs. BID Plymouth's Director of Social Work is on the Executive Committee which guides program development and oversight.		
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)	Rate of 50% of situations closed due to connection to services leading to a decreased risk.		
Goal Status	Goal met: 50% of situations were closed due to connection to services leading to a decreased risk. The top 3 risk factors and reason for referrals were mental health, housing and basic needs.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Outcome 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)	At least 4 Yellow Tulip gardens will be planted by the community youth group to promote mental health awareness and reduce the stigma.	
Goal Status	Goal met: 6 gardens were planted in the Plymouth community by students representing the Yellow Tulip project, helping to raise awareness and reduce stigma around mental health.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Grant Professional Services** **Health Issue: Mental Health/Mental Illness and Substance Use Disorders**	
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 ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	Work with community-based organizations (CBOs) to help them become grant ready and/or submit funding grants in substance use prevention/intervention and mental health.
Goal Status	Goal met: Contracted Grant Professionals worked with organizations that provide services to people in the community dealing with mental health and substance use concerns: • The Boston Bulldogs is an organization that engages people in recovery in running and social activities. They worked towards becoming grant ready and identifying best prospects for grant funding. One application was submitted with a request of $100,000 to the Cummings Foundation but to date, they don't know if they were awarded funding. • The Parish Nurses Team provides support for those experiencing mental health concerns. The grant writer helped them to build template language for a narrative that can be used for multiple applications. They also have gathered the necessary documents for these applications and started the process of

	identifying grant opportunities but did not submit any applications in FY23. • Plymouth County Outreach (PCO) Hope engages people experiencing substance use addiction with harm reduction services and recovery scholarships. During this process, they worked on organizational structure, which included: a 3-year strategic plan, new and updated job descriptions, grant review, revised policies & procedures, revised board agreement and assessed sustainability. Two applications were submitted, but not awarded. A sustainability plan was put into place, which involved collaborations with larger non-profits. • The Farmhouse is a new non-profit whose focus is on youth mental health and empowerment. To become grant ready, they developed a 3-year strategic plan, 4 philanthropic cases of support, formalized budgets, an indicator tool for tracking grant outcomes, a Go–No-Go tool, and an operational budget. They applied for the Farm-to-School grant, which will be awarded in July 2024. They received $35,000 from Plymouth Public Schools to help support the Health & Wellness 8-week program. • South Shore Conservatory works with people of all ages and abilities to enrich their lives through music and dance. They were seeking funding to enhance mental health & wellness for people with disabilities. The support they received included: training for grant writing staff, prospect research, cases of support & annual report and capacity building for future grants. There were 2 applications submitted: one was a capital grant that will not be decided until 2024 and one through the Greater Plymouth CHNA, which was received in the amount of $2,500.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** | **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 help them deal with potential suicide ideation, both in the communities they serve, and with their co-workers and other emergency professionals.

Goal Status	Goal met: The first training was held in person at Bridgewater State University in March of 2023. 60 participants signed up and 38 attended the full session from 9:30am to 3pm. Survey data revealed that 99% of the participants agreed or strongly agreed that they had a better understanding of how to deal with suicide ideation for themselves and others.		
Time Frame Year: Year 1		**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Community Mental Health Series** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	BID-Plymouth partnered with the Duxbury Public Library and South Shore Hospital to engage the community in a variety of mental health topics, as a response to a few traumatic events in town.		
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 mental health education and resources to Duxbury and surrounding towns after experiencing traumatic events in the community.		
Goal Status	Goal met: 6 presentations attracted over 48 participants in person and on Zoom. Topics were Community Behavioral Health Centers Services for Those in Crisis, Children and Grief, Trauma Response During a Crisis, Social and Emotional Wellness in Times of Crisis and Roadmap through the Mental Health System in Massachusetts.		
Time Frame Year: Year 1		**Time Frame Duration: Year 1**	**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. Parts A and C

	funding are received for these services through the Ryan White CARE Act. Part C funding is provided through the U.S. Health Resources and Services Administration (HRSA) for Early Intervention Services. Part A funding is provided through the Boston Public Health Commission (BPHC) for nonmedical case management and medical transportation. 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 ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	Five clients will be enrolled in care during FY23 (October 1, 2022 - September 30, 2023). 100% of ACCESS Program clients are on antiretroviral treatment (ART).
Goal Status	Goals met: 14 clients were enrolled in care during FY 23. 100% of ACCESS Program clients are on antiretroviral treatment (ART).
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	85% of ACCESS Program clients are virally suppressed.
Goal Status	Goal met: 100% are virally suppressed.
Time Frame Year: Year 1	**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 ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
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 YMCA's 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	Goals met: • 400 rides were given to patients needing rides to and from treatment. • 50 wigs were provided to patients using a wig specialist 2 days per month. • Approximately 35 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 1	**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 ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention

Program Goal(s)	• By the end of FY23, BID-Plymouth Nutrition Education will reach 2,000 community members indirectly through Delicious and Nutritious shows on PAC TV and radio appearances. • By the end of FY23, monthly Nutrition Notes will be sent to at least 10 local agencies serving individuals living in the CBSA. • By the end of FY23, 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 FY23, 25 nutrition education programs focused on Healthy Food Access will directly impact over 800 participants who are food insecure with ways to access and prepare healthy food options. • During FY23 20 programs focused on developing healthier eating habits will be provided to youth and families also struggling with food insecurity and living in the CBSA. • During FY23, 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	Goals met: • 9 Delicious & Nutritious shows were provided in collaboration with Plymouth Center for Active Living, PAC-TV, local Chef Jerry Levine, and BID-Plymouth. 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. 2,663 people were reached indirectly. • Nutrition Notes were sent to 22 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. • 1,428 adults attended 39 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. • 25 programs were provided in person to adults and families living in the CBSA who were experiencing food insecurity, with 889 adults and families attending. Each session also provided healthy nutrition resources and tools for food preparation.

	• 25 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. • 30 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 with the recipe provided to participants.

Time Frame Year: Year 1	**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 ☐Access/Coverage Supports ☒Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
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	Goal met: Participants lost an average of 2 lbs.

Time Frame Year: Year 1	**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 of $105. • 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	Goals met: • BID Plymouth provided 11 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 1	**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	Goal partially met: BID-Plymouth staff attended the Rising Tide Health Fair, educating 29 individuals on stroke symptoms and notification. They also educated staff and visitors at the hospital via the TV monitors.

Time Frame Year: Year 1	**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 a health topic of interest.		
Goal Status	Goal met: Two HouseCalls presentations were provided in person in community settings. One presentation took place at the Senior Center in Duxbury to 22 older adults and the second presentation took place at the PineHills in Plymouth to 25 active older adults topics. The topics discussed were joint pain and replacement options with time for general questions about overall health. Two more presentations engaged members from the community representing the BID-Plymouth advisory group of 65 participants. The topics discussed were Behavioral Health: resources at the hospital and in the community, and Community Benefits: how the hospital helps support the community through grants and community collaborations. Both in-person events were well received with time at the end of each for comments and questions.		
Time Frame Year: Year 1	**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 with a goal of 30 vendors from the community and over 200 participants of all ages.	
Goal Status	Goal met: The fair had 32 vendors serving over 250 participants, and most were families with young children. Activities included a DJ, free snow cones and face painting, free bags of fresh produce, health screenings and many resources for all. The event hosted a book reading from the Wampanoag tribe designed to educate young children on the history of the tribe along with fun activities that are age appropriate.	
Time Frame Year: Year 1	**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	Goals met: • The seasonal shelter opened for the season at the end of November 2022 and remained open during the winter months until the first week of April 5, 2023. During this time period, FBMS provided safe shelter, hot meals, and wraparound support services to 72 unique individuals. Overnights of Hospitality will reopen	

	again for the 2023/2024 season at the end of November. • Staff connected with 107 individuals living outdoors in Greater Plymouth. Case managers meet participants where they are outdoors and provide for their basic needs, before bringing them into FBMS programs, and referring them to more specialized services.

Time Frame Year: Year 1	**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	Goal met: 98% of residents, who are often participants with the greatest needs, 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 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome 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)	• 37 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. • 75 households in the BID-Plymouth service area will access emergency food.
Goal Status	Goals partially met: • SSCAC provided referrals, case management, and financial assistance with rent or mortgage arrearages for 61 households (composed of 181 household members), including 42 households (composed of 119 household members) in Carver, Duxbury, Kingston, and Plymouth. Of these, 14 households (37 household members) avoided eviction.

	• 4 households (composed of 11 household members) in Plymouth, Duxbury, and Carver received financial assistance with utility bills and avoided a utility shut-off. • 34 households (composed of 51 household members) in the BILH service area accessed emergency food.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	37 households will have stable housing for 3 months.		
Goal Status	Goal met: 58 households out of 60 that received financial assistance with rent or mortgage had stable housing for 3 months.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: The Greater Plymouth Area Transportation Consortium (Taking People Places-TPP)** **Health Issue: Additional Health Needs (Transportation)**			
Brief Description or Objective	The Greater Plymouth Area Transportation Consortium, also known as 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	388 rides were provided in FY23; 83 rides to adults ages 60 and older and 305 rides for those with a disability who needed access to medical care and who did not have any other resources.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process 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 in an effort 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 4 workshops to community-based organizations to educate them on grant readiness, organizational structure and grant writing.		
Goal Status	Goal met: Four workshops were offered: • Aspects of the Proposal: 3/22/23: 46 attended (78 registered) • Relationships with Funders & Stewardship: 4/26/23: 24 attended (63 registered) • Prospect Research: 5/11/23: 22 attended (65 registered) • Grant Readiness: What do Organizations Need to be Ready to Apply for Grants? 5/24/23: 26 attended (69 registered) The feedback was overwhelmingly positive and there was an ASL interpreter present at all 4 workshops.		
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**	
Program Goal(s)	Work with community-based organizations to help them become grant ready and/or submit grants for funding in Food Insecurity. Work with community-based organizations to help them become grant ready and/or submit grants for funding in Transportation.		
Goal Status	Goals met: Foodscribe Consulting worked with two organizations that provide food to local food pantries and social service organizations: • Terra Cura, Inc was given support to become grant ready, which included: an in-depth narrative, a budget for Plymouth Food Access projects, and two logic models (Algonquin Heights & Plymouth Public Schools Community Gardens). Together they identified 10 potential grant opportunities for food access and applied for 3: Baycoast Bank, the McCarthy Family Foundation (through the		

	Bank of America Charitable Trust Portal) and the Greater Plymouth CHNA. They were successfully awarded funding through the Greater Plymouth CHNA for $3,500. • The Plymouth County Sheriff's Department received support as well, resulting in an in-depth narrative, budget and logic model. One grant application was submitted to the MA Dept. of Agricultural Resources' Urban Agriculture Grant Program. The grant was awarded: $20,000 to support the Local Food Action Plan to increase food access. Salient Health Grant Services worked with one organization that provides transportation services to 11 social service organizations: • Taking People Places is a 501c3 that works with Lyft and Greater Attleboro Transportation Regional Authority (GATRA) to provide low-cost transportation to older adults and people with disabilities. 3 grants were submitted and all 3 were funded. o MA Dept. of Transportation awarded them $110,000 o Old Colony Planning Council awarded them $10,000 o Town of Plymouth awarded a block grant for $20,000 o All this funding is used to support the fiscal agent (South Shore Community Action Council) as well as providing a 50% discount on rides for these 2 populations through the various partner organizations.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Family Housing Programs & Support** **Health Issue: Housing Stability/ Homelessness**	
Brief Description or Objective	NeighborWorks® Housing Solutions (NHS) is a non-profit organization that helps find and maintain safe, affordable, high-quality housing and growing financial skills and resources, supporting individuals and families need. Services include rental assistance; emergency financial help; shelter and homelessness prevention; first-time homebuyer education and counseling; financial coaching; foreclosure prevention; affordable residential and small business loans; and construction and management of high-quality rental housing across Southern Massachusetts. BID Plymouth supports programs from NeighborWorks with a focus on the BID-Plymouth CBSA. The two programs supported are: **Family Self-Sufficiency Program:** provides families who have a housing subsidy with services that promote deeper financial security—financial education, credit repair, and assistance with setting and pursuing goals such as higher education, job training, and

	homeownership. The goal is to help families move to market-rate housing and put them on the path to financial security and family wellbeing. **Family Shelter Program:** provides families fleeing domestic violence with a safe and stable living environment while case managers work to help them develop the economic and life skills needed to establish long term stability.
Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	Focusing on the Family Self-Sufficiency program, the goal is to work with families willing to commit to the program helping them to learn and save, eventually giving up their housing voucher due to financial stability. When needed, provide financial support for the Family Shelter Program in Plymouth.
Goal Status	Goals met: Family Self Sufficiency Program: • Number of families currently served in the BID-Plymouth CBSA: 29 (21 Plymouth, 4 Kingston, 1 Carver, 3 Duxbury) • Most participants were from low-resourced populations, single family/female head of household, from racially, ethnically and linguistically diverse populations and were seeking employment and educational opportunities. • Average amount of savings among families was $7,446 • Two participants are no longer receiving Housing Assistance Payments and are now paying market rent. • Quarterly one-on-one case management was provided to each participant in the program. Family Shelter Program • 30 families were placed in Plymouth, all of whom were low-resourced and qualified for Emergency Shelter through the state shelter system. • 85% of the families did not speak English and most were migrant families. • Weekly one on one Case Management was provided including assistance to access DTA benefits, MA Health benefits, school enrollment for children, budgeting, ESL classes, with transportation, and connections to medical and prenatal care,

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

Priority Health Need: Social Determinants of Health Program Name: Aquaponics Lab Initiative Health Issue: Additional Health Needs (Food Insecurity) and (Jobs & Financial Security)	
Brief Description or Objective	The Plymouth County Sheriff's Department (PCSD) owns and operates a farm that contains a successful Horticulture Center. This initiative provides approximately 30,000 lbs. of food for the local food bank annually while also providing job skills for individuals incarcerated at the jail.
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)	Conduct a feasibility study for converting an existing greenhouse into an Aquaponics Lab to support the food bank and job skills training.
Goal Status	Goal met: The funding provided by BID-Plymouth was used to support the growth of the existing horticulture program and to conduct a feasibility study for the conversion of one of the existing greenhouses to support an Aquaponics Lab. 21,629 lbs. of food was donated through the enhanced horticulture program to the food bank at the South Shore Community Action Council. The result is the Environmental Justice Education Center (completed in November 2023) which will offer education and training on Aquaponics ~ Hydroponics ~ Vertical Growing Systems.

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 obtaining the Age and Dementia Friendly designations.

Goal Status	Goal met: In-kind time and expertise from the Director of Social Work 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 1	**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	Throughout the year, the BID-Plymouth Director of Social Work and her team provided clinical linkages for families to needed clinical care through referrals and transportation. The pharmacy provided needed over-the-counter medications during the Fall and Winter for colds, flu and pain. The birth center provided free infant formula. The Community Benefits department provided $1,500 in funds for diapers and wipes and other supplies that were not covered by the state.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: BILH and BID-Plymouth 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 associate degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• In FY23, Workforce Development will continue to encourage community referrals and hires. • Reduce barriers to BID-Plymouth staff wanting or needing to learn English in order to be successful in their work and day-to-day living. • In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners. • In FY23, Workforce Development will offer paid training for community members across BILH. • In FY23, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.
Goal Status	Goals met: • In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. • Weekly classes were offered for free to BID-Plymouth staff and contracted workers, both in-person and online with an attendance of up to 20 participants per class. • In FY23, 67 events and presentations were conducted with community partners across the BILH service area. • In FY23, BILH trained total of 89 community members to Patient Care Technician or Nursing Assistant (30), Pharmacy Tech (16), Perioperative LPN (3), Medical Assistant (21), Behavioral Health roles (4) or into the Associate Degree Nursing Residency program (15). BID-Plymouth participated in offering these trainings. • In FY23, 20 BILH employees attended citizenship classes, 135 BILH

	employees attended career development workshops and 189 BILH employees attended financial literacy classes. BID-Plymouth employees participated in these offerings.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	2,648,115	
Community-Clinical Linkages	129,495	16,897
Total Population or Community Wide Interventions	207,667	49,300
Access/Coverage Supports	270,855	64,278
Infrastructure to Support CB Collaborations	131,082	
Total Expenditures by Program Type	3,387,214	130,475
CB Expenditures by Health Need		
Chronic Disease	1,149,714	
Mental Health/Mental Illness	1,433,530	
Substance Use Disorders	85,711	
Housing Stability/Homelessness	53,673	
Additional Health Needs Identified by the Community	664,586	
Total by Health Need	3,387,214	
Leveraged Resources		
Total Leveraged Resources	333,766	
Net Charity Care Expenditures		
HSN Assessment	1,451,805	
Free/Discounted Care		
HSN Denied Claims	(65,675)	
Total Net Charity Care	1,386,130	
Total CB Expenditures	5,107,110	

Additional Information	
Net Patient Services Revenue	358,095,192
CB Expenditure as % of Net Patient Services Revenue	1.4%

Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	**5,000,000**
Bad Debt	**5,299,837**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments: $800K 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:
      Representing housing, DeeDee Winterson replaced Ami Tanner, both from Algonquin Heights; Representing Transportation, Kerri Victorio replaced Joanne LaFerrera both from GATRA (Greater Attleboro Taunton Regional Transit Authority); Representing Community-based Health, Meaghan Groves replaced Adrienne Ing, both from Harbor Community Health Center; Representing Municipal staff, Marc Duphily, Carver Police Chief replaced Mike Boteiri, Plymouth Police Chief. Also Anna Marini joined as the new Board of Trustees liaison and Michael Babini (previous liaison) remained as a resident of Plymouth.

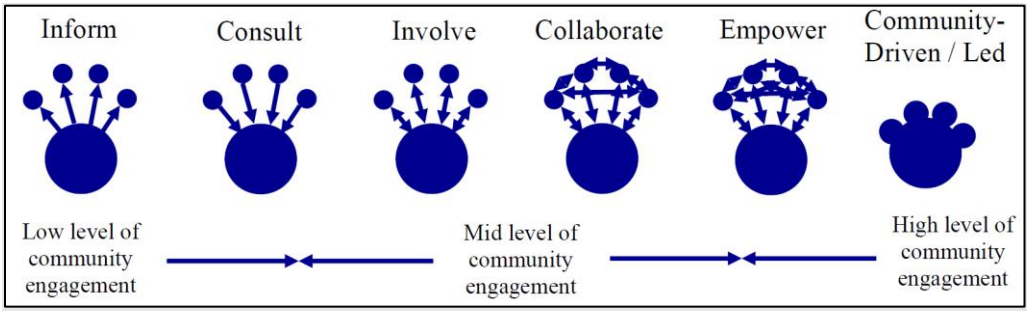
II. Community Engagement

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 Dept through providing direct financial support for its new aquaponics program ... and also collaborated on the region's Fall Health Fairs.
NeighborWorks Housing Solutions	Rob Corley, President and CEO	Housing organizations	BID-Plymouth invested in their Family Self-Sufficiency Program and emergency assistance that went to support migrant families in Plymouth as well as families in the CBSA working

			towards financial security.
Father Bill's & MainSpring	Lauren Zaremba, Corporate & Foundation Relations Gift Officer	Housing organizations	BID-Plymouth collaborates with Father Bill's through providing direct financial support for its Nights of Hospitality program that provides shelter to those experiencing homelessness through direct funding.
South Shore Community Action Council	Nikki Galibois, Director of Planning and Development	Social service organizations	BID-Plymouth provides direct financial support for their emergency assistance program to engage participants who have language barriers to services. Nikki also serves on the Community Benefits Advisory Committee.

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	Collaborate	Goal was met: Members of the	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.

and implementing filer's plan to address significant needs documented in CHNA		CBAC members were instrumental in providing links to resources around transportation and other SDoH.	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Involve	Goal was met: Members on the CBAC that were involved with the migrant families met regularly to address their needs through services and resource allocation.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met: CBAC members helped to engage CBOs in Grant Readiness & Writing workshops offered by BID-Plymouth	Collaborate
Evaluating progress in executing Implementation Strategy	Empower	Goal was met: Partners were offered free Evaluation Workshops provided by BILH to build/increase their Collaborate evaluation skills and capacity.	Collaborate
Updating Implementation Strategy annually	Involve	Goal was met: CBAC members give continuous feedback through meetings and other community meetings.	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, 2023 at the Plymouth Public Library.

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