Community Benefits Report

Fiscal Year 2025

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

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SECTION I: SUMMARY AND MISSION STATEMENT

Beth Israel Deaconess Plymouth (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 southern New Hampshire and advancing the science and practice of medicine through ground-breaking 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 5,900 physicians and 36,000 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 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 Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's and BID Plymouth's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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

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

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

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

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

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

- **Promoting health equity** by addressing inequities and ensuring that all patients are welcomed and received with respect and have access to culturally responsive 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 2025, 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 were in full compliance with the Commonwealth's updated Community Benefits Guidelines (February 2018). While BID Plymouth is committed to improving the health status and well-being of those living throughout its entire

CBSA, per the Commonwealth's updated community benefits guidelines, BID Plymouth's FY 2026 - 2028 Implementation Strategy (IS) will focus its Community Benefits resources focused 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 2025 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that 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 white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2026 – 2028 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
- Individuals Living with Disabilities
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations

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

Key Accomplishments for Reporting Year

BID Plymouth's most recent FY 25 CHNA and FY 26- 28 IS were approved and adopted, respectively, by the BID Plymouth Board of Trustees during the fiscal year ended September 30, 2025. That CHNA and IS will inform the Community Benefits mission and activities of BID Plymouth for the fiscal years ending September 30, 2026; September 30, 2027; and September 30, 2028.

This report covers BID Plymouth's fiscal year ending September 30, 2025. The previous FY 22 CHNA and accompanying FY 23- 25 IS were approved by the BID Plymouth Board

before September 30, 2022 and informed the BID Plymouth's Community Benefits initiatives for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits programs relate to the CHNA and Implementation Strategy approved as of September 30, 2022.

Program accomplishments include:

- The Behavioral Health team conducted 3,657 crisis consultations in the Emergency Department and medical floors of the hospital
- Overnights of Hospitality seasonal shelter supported through BID Plymouth, offered safe shelter, hot meals, and wraparound support services to 90 individuals and staff connected with 97 individuals living outdoors in Greater Plymouth
- BID Plymouth provided 19 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 the lifestyle changes, such as diet and exercise, even during times of stress.
- A total of 686 rides were provided in FY25 through the Taking People Places program: 410 rides were for people 60 and older, and 276 rides were for people with a Disability. Both groups did not have resources available to them for access to medical care.
- 492 consults were conducted by a Recovery Specialist in the Emergency Department, and 351 resulted in treatment (71%). There were 351 consults conducted on the medical floors and 295 resulted in treatment (84%)

Plans for Next Reporting Year

In FY 2025, 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 were in full compliance with the Commonwealth's updated Community Benefits Guidelines. In response to the FY 2025 CHNA, BID Plymouth will focus its FY 2026 - 2028 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in 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
- Complex and Chronic Conditions.

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use

Disorders). BID 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 2025 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 2025 CHNA and creating its FY 2026 - 2028 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 2025 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BID Plymouth's FY 2026 - 2028 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 diverse populations; and individuals living with disabilities.

BID Plymouth will partner 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 2026 – 2028 IS.

- **Equitable Access to Care**
  - BID Plymouth will continue to support the Taking People Places program, providing rides to medical care for older adults and people living with a disability
  - 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.

- **Social Determinants of Health**
  - BID Plymouth will continue to work with the South Shore Community Action Council and the Marion Institute to address food insecurity using upstream solutions.
  - BID Plymouth will continue to work with and support Father Bill's & MainSpring's shelter and outreach programs to address homelessness in the CBSA.

- **Mental Health and Substance Use**
  - BID Plymouth will work with grantees on Behavioral Health Navigator programs over the next 3 years
  - BID Plymouth will continue to support and be actively involved with Gosnold to address substance use disorders through prevention, intervention and recovery programs.

- **Complex and Chronic Conditions**
  - Beth Israel Deaconess Hospital Plymouth will build upon its partnership with the Old Colony YMCA to grow programs that support people living with chronic and complex conditions
  - BID Plymouth will continue to offer House Calls lectures to educate the community around chronic disease management and available resources.

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BID Plymouth Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 40). The BID Plymouth Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
BID Plymouth's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. Utilizing the integrated resources of the Beth Israel Lahey Health system, BID Plymouth will deliver the full continuum of healthcare services to the communities of southeastern Massachusetts. BID Plymouth's Community Benefits Department, under the direct oversight of BID Plymouth's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BID Plymouth's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

While BID Plymouth oversees local Community Benefits' programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact 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 Community Benefits and Community Relations Manager, who has direct access to 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 Community and Health Impact 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 serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BID Plymouth's community. The CBAC provides input into the development and implementation of BID Plymouth's Community Benefits programs in the 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 9, 2024
- March 26, 2025
- June 17, 2025
- September 25, 2025 (Public Meeting)

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 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)

- Affiliated Physicians Group (APG)
- AIDS Action Committee
- Algonquin Heights Housing Complex
- Baystate Community Services
- Beth Israel Deaconess Hospital – Plymouth
- Carver Council on Aging
- Child and Family Services
- Duxbury Council on Aging
- Duxbury Free Library
- Father Bill's and Mainspring
- Gosnold, Inc
- Greater Plymouth CHNA
- Harbor Health Services, Inc.
- HIV/AIDS Bureau
- Hope Floats Healing & Wellness Center
- Keville Foundation
- Kingston Council on Aging
- Kingston Health Department
- MAPP Academy
- NAMI Plymouth
- NeighborWorks Housing Solutions
- New Hope Chapel
- Old Colony YMCA
- Plymouth Area Coalition for the Homeless
- Plymouth Center for Active Living
- Plymouth County Outreach
- Plymouth County Sheriff's Department
- Plymouth County Suicide Prevention Coalition

- Plymouth Economic Development Foundation
- Plymouth Family Network
- Plymouth Family Resource Center
- Plymouth Health & Human Services
- Plymouth Public Library
- Plymouth Public Schools
- Plymouth Resource Center
- Quincy Asian Resources
- Quincy College
- Salvation Army Plymouth
- South Shore Community Action Council
- Terra Cura
- The Local Seen
- Town of Plymouth

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2025 Community Health Needs Assessment (CHNA) along with the associated FY 2026-2028 Implementation Strategy was developed over a fifteen-month period from June 2024 to September 2025. 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 2025. FY 2025 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 2025 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2025 assessment and planning process was conducted in three phases between June 2024 and September 2025, 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. 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.

Through the FY 2025 Community Health Needs Assessment process, BID Plymouth conducted 15 interviews with key collaborators in the community, facilitated 5 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 500 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 600 community residents, clinical and social service providers, and other community partners.

The articulation of each specific community's needs (done in partnership between BID 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 2025 CHNA Key Health-Related Findings

Equitable Access to Care

- Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system-level, meaning that the issues stemmed from the ways in which the system did or did not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was 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 housing, food insecurity, economic insecurity, education, access to care/navigation issues, and other important social There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, surveys, and the listening session reinforced 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, transportation and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults; trauma experienced by immigrants, migrants, and refugees, and social isolation among older adults.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for assistance navigating a complex behavioral health system, as it can be overwhelming for individuals experiencing mental health challenges. Providing navigation assistance ensures people can access the right services at the right time, improving continuity of care and health outcomes.
- Youth mental health was a concern in the CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Complex and Chronic Conditions

- Chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. 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 2025 BID Plymouth Community Health Needs Assessment Report and Implementation Strategy on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, BID Plymouth offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to interpretation and translation services at no cost to BID Plymouth patients	
Goal Status	During FY25, 10,131 interpreter sessions were provided to patients and families at BID Plymouth. In FY25, of the total 10,131 interpreter sessions, 1,131 were in person/on site (25 ASL), 3,544 were telephonic/over the phone (OPI), and 5,456 were video remote interpretations (VRI). Interpreter Services Top 5 requested languages and number of sessions are: 1) Portuguese-Brazilian: 5,811; 2) Haitian Creole: 1,807; 3) Spanish: 1,499; 4) Portuguese-European: 391; Vietnamese:156	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Benefits Administration and Infrastructure** **Health Issue: Chronic Disease; Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**		
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs.	
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area Offer evaluation capacity workshops to partner organizations and grantees to increase and better understand impact.	
Goal Status	BID Plymouth supported and implemented 10 programs in partnership with Community-based Organizations. BILH offered five (5) evaluation workshops in FY25 focusing on data collection, analysis, interpretation, reporting and storytelling, with 96% of attendees reporting increased knowledge.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Addressing BILH Patient Health Disparities** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BILH Health Equity division sits within the Office of Community and Health Impact. BILH's Health Equity team's focus is on addressing health disparities to ensure equitable health outcomes across the patient populations served by BILH	
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)	Meet or exceed goal of 76.5% of BILH patients 18-85 years of age diagnosed with diabetes (Type 1 and Type 2) who had a hemoglobin A1c (HbA1c) level of <= 9.0% during the measurement period ending September 30, 2025 Meet or exceed goal of 74.8% of BILH patients 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period ending September 30, 2025 Meet or exceed goal of 69.6% of BILH patients 18-85 years of age with a diagnosis of both diabetes and hypertension who meet control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period ending September 30, 2025 Meet or exceed goal of 2.65% reduction the occurrence of Severe Maternal Morbidity-Blood Transfusions during the measurement period ending September 30, 2025.
Goal Status	The average percentage, of the identified population above, whose hemoglobin A1c (HbA1c) level was <= 9.0% during the measurement period was 78.4% which exceeded the target average goal of 76.5 75% of the focus population had blood pressure that was adequately controlled (< 140/90 mmHg) during the measurement period 70.4% of the focus population met the control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period through September 2025 2.91% of BILH patients received Severe Maternal Morbidity-Blood Transfusions

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

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Additional Health Needs (Access to Care)**	
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs.

Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	To assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs, and Hospital Charity programs.	
Goal Status	FY 2025 BID Plymouth Hospital screened 2,484 patients and had 3,228 encounters. The number of MassHealth applications completed was 80 of which 68 were approved. 142 patients applied for Charity Care of which 53 were approved. The number of uninsured patients who utilized the Health Safety Net was 1,220.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: CARAT Program Food Mapping** **Health Issue: Additional Health Needs (Access to Healthy Food)**		
Brief Description or Objective	The CARAT Program is a regional effort to strengthen the food system by conducting a Plymouth County wide food assessment. The tool being used is the Community and Agriculture Resilience Audit Tool (CARAT), which relies on self-assessment of community partners and how they utilize their resources for food production, processing, distribution, access, waste and policy.	
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 funding to complete the amount needed to start the process of conducting a regional food system assessment to self-assess how the region currently utilizes the assets of their local food system to achieve a substantial level of community resilience.	
Goal Status	BID Plymouth finished out the funding needed to start the program using the CARAT (The Community & Agriculture Resilience Audit Tool)	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**
Program Goal(s)	Launch the new initiative through the Marion Institute and the Old Colony Planning Council.	
Goal Status	The process began in June of 2025, by engaging community stakeholders and subject matter experts and will utilize the CARAT tool as an ongoing platform for building the food mapping assessment	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Carver COA Access to Care** **Health Issue: Additional Health Needs (Access to Care)**			
Brief Description or Objective	The Carver COA offers programs to residents that are unable to access healthcare services that are not affordable, such as dental hygiene.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Support access to care for health programs for older adults that don't have access to services		
Goal Status	Funding was given to support a total of 3 days of dental hygiene services at the Carver COA. 18 participants received care who did not otherwise have access.		
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process**	

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary Care Access** **Health Issue: Chronic Disease, Additional Health Needs (Access to Care)**			
Brief Description or Objective	Throughout BID Plymouth's Community Benefits Service Area, BID Plymouth subsidizes primary care services provided by BILH Primary Care.		
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Provide access to primary care for uninsured and underinsured patients		
Goal Status	In FY25, BID Plymouth provided primary care in four practices in CBSA, with 3,833 new patients.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, Recovery Coaches and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. In FY25, the team provided a total of 3,657 screenings.	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs**		
Brief Description or Objective	To support increased access to mental health and substance use services and support. BID Plymouth participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).	
Goal Status	More than 146 community residents and BILH staff attended one of 11 MHFA trainings (9 Adult and 2 Youth, with 1 of the Adult trainings conducted in Spanish)	

	provided across the BILH CBSA, of which 53% (78) completed all pre- and post-training requirements to receive Mental Health First Aid certification.		
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**	
Program Goal(s)	Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.		
Goal Status	Two (2) Behavioral Health Navigation and Digital Literacy workshops were conducted in FY25 with 13 participants, including RNs, CHWs/Navigators, Social Workers, and a Housing Case Manager. In the program evaluation, 82% of participants felt confident to help navigate patients to appropriate behavioral health care, and 70% felt confident to guide patients to web-based apps to help them meet their behavioral health needs.		
Time Frame Year: Year 2	**Time Frame Duration: Year 2 | Goal Type: Process Goal**		

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Integrated Care Initiative** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	This initiative is a co-located behavioral health model that embeds licensed clinical social workers in the hospital with access to primary care practices. They work with primary care providers, an advanced practice nurse practitioner with mental health training, and a psychiatrist to integrate behavioral health screening, assessment, and treatment services into the primary care practice operations. With behavioral health services available in the Emergency Department (ED), patients may begin treatment in this setting rather than waiting until psychiatric beds are available. Medical staff in primary care, inpatient settings, and the ED have on-site access to behavioral health support so that they can provide comprehensive healthcare that is convenient, efficient, and cost effective.		
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Refer 1,000 patients to behavioral health providers.		
Goal Status	6647 patients were referred to BH providers accounting for 4496 completed sessions		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	Decrease PHQ-9 (Patient Health Questionnaire-9) and GAD-7 (General Anxiety Disorder-7) scores by 50%		
Goal Status	PHQ-9 scores dropped by 24.77% and GAD-7 scores dropped by 22.89%		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Recovery Coach Program** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	A Gosnold Recovery Specialist works in the Emergency Department to assist and intervene with individuals in the hospital following a non-fatal overdose event. BID Plymouth clinicians and peer recovery specialists work cooperatively to improve the screening, identification, intervention and referral of substance dependent patients admitted to the Emergency Department. The goal is to motivate the patient to accept treatment and facilitate referral to the appropriate level of care. Treatment modalities include inpatient detox, hospital transfer, intensive outpatient programs, and Medication Assisted Treatment.	
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY25, 60% of consults conducted by a Recovery Specialist will result in a transfer to treatment	
Goal Status	There were 492 consults conducted in the ED and 351 resulted in treatment (71%) There were 351 consults conducted on the medical floors and 295 resulted in treatment (84%)	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Prescription Drug Takeback** **Health Issue: Substance Use Disorders**		
Brief Description or Objective	The hospital has receptacles in the hospital for unused prescription drugs. The goal is to remove unused drugs from people's homes that could potentially be taken and used by people other than the subscriber. The total number of pounds is tracked every year.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Remove over 300 gallons of unused prescription drugs from the community through the BID Plymouth Repository	
Goal Status	342 gallons of prescription drugs were removed from the community in FY25	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process**

Priority Health Need: Mental Health and Substance Use **Program Name: Yellow Tulip Project** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	The Yellow Tulip Project (YTP) is a program through Plymouth Community Intermediate School to expand awareness of mental health in the community. Through various outreach activities, the program engages with their schools and communities to spread YTP's mission of smashing the stigma surrounding mental health.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Support the Yellow Tulip Project for mental health awareness through community events and new gardens planted	
Goal Status	BID Plymouth supported the Yellow Tulip Walk on May 3, 2025. Over 100 people showed up for the walk to promote mental health awareness for youth and the larger community.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: ACCESS Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	BID Plymouth's ACCESS Program (AIDS Comprehensive Care, Education & Support Services) provides medical care, education, support, medical case management, and medical transportation services to people living with HIVAIDS in the Greater Plymouth area. In addition to patient care, the program offers HIV education to the community and free and anonymous HIV counseling and testing. The ACCESS Program provides primary medical care to HIV/AIDS clients. Care includes physical examinations; adherence and treatment counseling; laboratory testing; immunizations and screening; referrals to specialty care and clinical trials; medical nutrition therapy, and medical case management.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	100% of ACCESS Program clients are on antiretroviral treatment (ART) 5 clients to be enrolled in medical care Enroll 3 new clients in Non-Medical Case Management Services	
Goal Status	100% of ACCESS Program clients are on ART	

	14 clients were enrolled into medical care during FY25 9 clients were enrolled in Non-Medical Case Management Services		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	The ACCESS HIV/AIDS program will maintain viral suppression in 85% of our clients.		
Goal Status	99.2% of clients are virally suppressed (Massachusetts viral load suppression rate is 83.3%)		
Time Frame Year: Year 3	**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 for patients living with cancer whenever sources of support are available. BID Plymouth provides support for patients and families through a social worker, registered dietician, 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 associated with a cancer diagnosis.
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Provide transportation both to and from appointments for cancer treatment. Provide wigs for the Wig Share Program for patients with assistance on fit and care. Offer nutrition appointments to help patients during and after treatment to maintain their health and weight Train cancer survivors to be mentors for the mentorship program to provide support for those actively involved in cancer treatment
Goal Status	304 rides were given to patients needing rides to and from treatment. 53 wigs were provided to patients using a wig specialist 2 days per month to provide assistance.

	A total of 129 patients received nutrition services: 19 patients who finished treatment and are still being counseled, and 110 patients currently in treatment who are being followed and receive services regularly. 4 cancer survivors were trained to work with patients to provide support as mentors through the treatment process.

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

Priority Health Need: Chronic and Complex Conditions **Program Name: Community Nutrition Program** **Health Issue: Chronic Disease and Additional Health Needs (Food Insecurity)**	
Brief Description or Objective	The Community Nutrition Program emphasizes the delivery of nutrition education and resources for people experiencing food insecurity and includes people at risk for, or living with, complex/chronic health conditions.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY25, BID Plymouth Nutrition Education will reach 1,000 community members indirectly through Delicious and Nutritious shows on PAC TV as well as other channels. By the end of FY25, monthly Nutrition Notes will be sent to at least 10 local agencies serving individuals living in the CBSA and reach over 20,000 residents with the education and tips for healthy eating. By the end of FY25, 20 nutrition education programs focused on Healthy Food Access will directly impact over 800 participants who are experiencing food insecurity with ways to access and prepare healthy food options. By the end of FY25, 20 nutrition education programs focused on preventing and managing chronic conditions will be provided to adults living in the CBSA, directly impacting over 500 people. During FY25, 20 programs focused on developing healthier eating habits will be provided to youth and families also presenting with food insecurity and living in the CBSA. During FY25, 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	6 Delicious & Nutritious shows were provided in collaboration with PCAL, PACTV, local Chef Jerry Levine, and BID-P. Marcia Richards RD presents nutrition information in concert with Jerry Levine's monthly recipe demonstration. 773 watched the show on Zoom either live or on YouTube. 2 shows on YouTube also garnered support of over 300 views. Nutrition Notes were sent to 18 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 within their newsletters and other social media platforms. Monthly topics included inflammation, diabetes, fat facts, using spices, hydration, packing a health lunch, and the recent Community Health Needs Assessment. All information is based on evidence-based data and reached over 30,000 people living in the CBSA. 25 programs were provided to adults and families living in the CBSA and presenting with food insecurity. Over 900 adults and families attended these programs in person. Each session also provides healthy nutrition resources and tools for food preparation. Over 800 adults attended 22 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. 23 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 eating health on a budget. Several programs included experiential learning through recipe creation. 33 nutrition programs were provided to older adults who were also presented with a chronic disease and living in the CBSA. They were taught label reading, healthy protein, heart health tips, and more. Many of these sessions involved a food demonstration and recipe to be given out.

Time Frame Year: Year 3	**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 funds graduates of any Cardiac Rehab program, who would like to continue to improve their heart health, to participate in the 12-week "Keep the Beat" program at the Old Colony YMCA. The program offers small group classes that provide support and education to maintain a heart healthy lifestyle, focusing on exercise, diet, and stress management.
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Modifying/improving in key cardiac risk factors: Weight loss: Goals is for participants to lose average of 0.5 lbs. for each week in the program benchmark goal is 6lbs weight loss
Goal Status	Participants lost an average of 3.4 lbs. and 50% of participants maintained their weight.

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

Program Goal(s)	Provide up to 20 graduates of BID Plymouth's Cardiac Rehab Program with the opportunity to attend the 12-week, Old Colony YMCA's Keep the Beat post-cardiac rehab program if they are unable to pay the fee. Comfort level of fitness: Goal is for participants to report by the end of the program that they "agree or "strongly" to "More confidence to make changes in my lifestyle to improve my medical conditions" and "Confident that I can maintain these lifestyle changes such as diet, exercise even during times of stress" based upon responses to post satisfaction survey provided to patients at end of program.
Goal Status	BID Plymouth provided 19 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 the lifestyle changes, such as diet and exercise, even during times of stress.

Time Frame Year: Year 3	**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 the 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 who 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 a stroke, and provide resources through at least 2 community events and presentations.	
Goal Status	Stroke education was shared with staff and visitors at the hospital via the TV monitors. A PSA was taped and shared through Plymouth Area Community Access TV Stroke information was shared at the Plymouth Health & Safety Fair	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: House Calls – Community Health Education Lectures** **Health Issue: Chronic Disease**		
Brief Description or Objective	House Calls 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 include 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 ten free community health lectures on topics related to priority health care needs utilizing clinical staff from BID Plymouth	
Goal Status	18 HouseCalls presentations were provided in person in community settings and over 450 participants joined in. Topics ranged from spine and joint care to oncology to mental health to senior care and more.	
Time Frame Year: Year 3	**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 offer health education and resources for the community of all ages.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Engage families with children and older adults to provide health education and resources around priority health care needs with a goal of 30 vendors from the community and over 300 participants of all ages.		
Goal Status	The fair had 36 vendors serving more than 400 participants for the event, and a majority were families with young children. Activities included free health screenings and education, free snow cones and face painting, free bags of fresh produce, health education and many resources for all. Education related to nutrition, skin cancer, addiction, parenting and cardiovascular health, as well as resources for older adults and healthy aging were provided. The event collaborated with the Plymouth County Sheriff's Office Farm Day event, as well as the South Shore Community Action Council for transportation between the 2 events.		
Time Frame Year: Year 3	**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	Funding through BID Plymouth helps support the Overnights of Hospitality seasonal shelter through Father Bills and MainSpring (FBMS), which provides emergency shelter from November through March while also helping people obtain skills, jobs, housing, and services. The funding also includes street outreach to those living outside by the FBMS case manager.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	FBMS will serve at least 15 individuals annually via Overnights of Hospitality seasonal emergency shelter. Case managers will connect with at least 15 unsheltered individuals annually via street outreach services.
Goal Status	The seasonal shelter opened for the season at the end of November 2024 and remained open during the winter months until the first week of April 2025. During this time period, safe shelter, hot meals, and wraparound support services were provided to 90 individuals. Staff connected with 97 individuals living outdoors in Greater Plymouth. There is a growing number of people living outside across our region, and Greater Plymouth is no exception. FBMS has increased their staff in Plymouth in an effort to meet the growing demand. Case managers meet participants where they are outdoors and provide for their basic needs, before bringing them into our programs, and referring them to more specialized services.

Time Frame Year: Year 3	**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	98% of residents, who are often participants with the greatest needs, have maintained housing during this grant period. The majority of residents exiting FBMS permanent supportive housing, do so for a more independent home of their own (Section 8 unit, unsubsidized unit, etc). Staff work with any participant exiting housing to ensure a successful transition, and continued progress toward self-sufficiency.

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

Priority Health Need: Social Determinants of Health **Program Name: Grant Professional Services** **Health Issue: Additional Health Needs (SDoH)**	
Brief Description or Objective	BID Plymouth partners with many community organizations and coalitions in its efforts to address and prevent identified health needs in the community. By offering grant writing services to smaller organizations that do not have access to these specialized skills, BID Plymouth engages experts in grant writing and organizational readiness to provide needed support for these CBOs and coalitions to become more community driven and led.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Offer workshops to Community Based Organizations to educate them on Grant readiness, organizational structure and grant writing.

Goal Status	Certified Grant Professional Cyndi MacKenzie offered 2 workshops and 2 open office hours sessions for Community-based Organizations, which were done in partnership with the Greater Plymouth CHNA. Over 10 Community Based Organizations took advantage of these free trainings.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Emergency Assistance Program** **Health Issue: Additional Health Needs (Food Insecurity) and (Financial Security)**	
Brief Description or Objective	The goals of the South Shore Community Action Council's (SSCAC) Emergency Assistance Program are to work with and empower individuals and families to achieve greater financial stability and long-term well-being. Food, financial and social service assistance for individuals and families that are low-resourced are provided with tailored outreach to under resourced 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)	• 45 individuals will receive financial assistance with rent/mortgage payments. • 40 households in the BID Plymouth service area will access emergency food • 100% of applicants with utility shut-off notice from BID Plymouth service area will be referred to SSCAC's Home Energy Assistance program • 400 individuals from BID Plymouth service area will receive case management • 100% of participants in SSCAC's money management workshop series will learn about SMART money goals and how to set them • 1,600 low-income individuals will increase food security due to emergency food received SSCAC • 50 individuals will increase food security due to receipt of emergency grocery cards • 600 individuals from BID Plymouth service area will receive referrals for internal and community services • 7 individuals in the BID Plymouth service area will receive financial assistance with utility bills
Goal Status	• 49 individuals from BID Plymouth service area will receive financial assistance with rent/mortgage • 39 households in the BID Plymouth service area accessed emergency food • 100% of applicants with utility shut-off notice from BID Plymouth service area were referred to SSCAC's Home Energy Assistance program • 410 individuals from BID Plymouth service area received case management

	• 89% of participants in SSCAC's money management workshop series learned about SMART money goals and how to set them • 1,498 low-income individuals increased food security due to emergency food received from SSCAC • 467 individuals increased food security due to receipt of emergency grocery cards Note: SSCAC exceeded its goal due to a donation of Stop & Shop cards. • 467 individuals from BID Plymouth service area received referrals for internal and community services • 21 individuals in the BID Plymouth service area received financial assistance with utility bills
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal(s)	• 20% of applicants with shut-off notice in BID Plymouth service area will avoid utility shut-off • 30% of applicants for rent assistance with eviction notice from BID Plymouth service area will avoid eviction
Goal Status	• 45% of applicants with shut-off notice in BID Plymouth service area avoided utility shut-off due to case management and financial assistance provided by SSCAC. • 32% of applicants for rent assistance with eviction notice from BID Plymouth service area avoided eviction
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Taking People Places-TPP** **Health Issue: Additional Health Needs (Transportation)**	
Brief Description or Objective	Taking People Places or TPP consists of a group of 17 Social Services Agencies, including BID Plymouth. Funds donated by organizations are matched through a state grant (up to 40K limit) to provide defrayed transportation costs to clients through LYFT. BID Plymouth funds TPP to provide transportation for people over the age of 60 and people living with disabilities to medical care.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	Provide 360 rides per year to adults ages 60 or older and/or with a disability who need access to medical care and who do not have any other resources.	
Goal Status	A total of 686 rides were provided in FY25: 410 rides were for people 60 and older, and 276 rides were for people with a disability. Both groups did not have resources available to them for access to medical care.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Plymouth Center for Active Living Senior Task Force** **Health Issue: Additional Health Needs (Access to Care/SDoH)**		
Brief Description or Objective	The Plymouth Center for Active Living is leading a Senior Task Force that collaborates to address any community concerns affecting the growing older adult population, which started as an effort to become an Age and Dementia Friendly community.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Support programs through the Senior Task Force and the Center for Active Living that provide education and resources for aging adults that are in line with the Age and Dementia Friendly efforts	
Goal Status	BID Plymouth supported a series of presentations on health care decisions and resources for making end-of-life decisions. BID Plymouth supported the Senior Health Fair with financial support and staff time for education for older adults.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3 | Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Greater Plymouth Community Health Network Alliance (CHNA) Support** **Health Issue: Additional Health Needs (Access to Care/SDoH)**		
Brief Description or Objective	The Greater Plymouth CHNA (Community Health Network Alliance) works to improve health outcomes based upon identified health needs through collaboration among other organizations providing services, programs and resources within the communities they serve. BID Plymouth supported the process of identifying new areas of focus and funding sources for long-term sustainability and impact in the community.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	Report on the number and type of new protocols implemented for sustainability Provide skill-building and education topics shared with number of participants at general meetings Provide mini grants to small non-profits as seed money for a new program or service to the community Track and report out on number of Community Organizations represented at Steering Committee and General Public Meetings Grow awareness and report out on total and new members that receive emails
Goal Status	The group implemented the following: * A new website and Facebook page * An internship program for program support * A sponsorship opportunity for CBOs that will help with sustainability Skill-building and education topics were: * Grant writing skills * Navigating the healthcare system & Hospitalization * National Healthcare Decisions panel *Older Americans month mini-health fair * Health Literacy awards * End of Life presentation * Period Poverty discussion * Wellness presentation and activity There were an average of 28 participants at these presentations There were 3 mini-grants in the amount of $2,500 each given to: Manomet Community Garden, Console Peer Support Group, PFN Postpartum Doula Program There were an average of 35 organizations represented as members and meeting participants (up from 28 in FY24) The Steering Committee is made up of representation from 12 Community & Municipal Organizations There is a total of 351 unduplicated emails from community representatives which are up from 341 the prior year.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health
Program Name: BILH Workforce Development
Health Issue: Additional Health Needs Identified by the Community (Access to Care)

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's 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 Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits		
Program Goal(s)	In FY25, Workforce Development will continue to encourage community referrals and hires.		
Goal Status	In FY25, 306 job seekers were referred to BILH, and 79 were hired across BILH hospitals.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	In FY25, Workforce Development will hire interns hired after internships and place in BILH hospitals.		
Goal Status	In FY25, 36 interns were hired permanently in BILH hospitals.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	In FY25, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.		
Goal Status	In FY25, 126 employees across BILH were enrolled in ESOL classes.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	In FY25, Workforce Development will offer internships in BILH hospitals to community members over the age of 18		
Goal Status	In FY25, 131 community members were placed in internships across BILH hospitals to learn valuable skills.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	In FY25, Workforce Development will offer paid trainings for community members across BILH.		

Goal Status	In FY25, BILH trained total of 97 community members to pipeline programs, including Patient Care Technician/ Nursing Assistant, Pharmacy Tech, Medical Assistant, CPT, Surg Tech, Research Admin, Endoscopy Tech, and the Associate Degree Nursing Residency program.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will attend events and give presentations about employment opportunities to community partners.	
Goal Status	In FY25, 42 events and presentations were conducted with community partners across the BILH service area.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Support, Engagement and Collaboration** **Health Issue: Additional Health Needs-Access to Care, Food Insecurity, Mental Health/Mental Illness**		
Brief Description or Objective	As a large provider of health care and a major employer in its Community Benefits Service Area (CBSA), it is important for BID Plymouth to be engaged in the larger community and support efforts to make the region a healthier, safer, and more vibrant place to live, work and play. To fulfill this objective, the hospital provides financial sponsorships and direct staff engagement to organizations and initiatives which support the goals and strategies identified in BID Plymouth's Implementation Strategy.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Provide community support to organizations that further BID Plymouth's community benefits mission	
Goal Status	BID Plymouth provided financial support to 13 community organizations in its community benefits service area (CBSA)	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$4,787,969
Community-Clinical Linkages	$535,669
Total Population or Community Wide Interventions	$293,242
Access/Coverage Supports	$357,235
Infrastructure to Support CB Collaborations	$26,154
Total Expenditures by Program Type	$6,000,269
CB Expenditures by Health Need	
Chronic Disease	$2,240,982
Mental Health/Mental Illness	$1,461,754
Substance Use Disorders	$1,143,171
Housing Stability/Homelessness	$33,577
Additional Health Needs Identified by the Community	$1,120,786
Total Expenditures by Health Need	$6,000,269
Leveraged Resources	
Total Leveraged Resources	$332,296
Net Charity Care Expenditures	
HSN Assessment	$1,671,759
Free/Discounted Care	N/A
HSN Denied Claims	$116,647
Total Net Charity Care	$1,788,406
Total CB Expenditures	$8,120,971

Additional Information	
Net Patient Services Revenue	$372,348,435
CB Expenditure as % of Net Patient Services Revenue	2.18%

Approved CB Budget for FY26 (*Excluding expenditures that cannot be projected at the time of the report)	**$7,358,945**
Bad Debt	**$1,888,082**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	$533,195 subsidizing BH services outside of its CBSA.

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Year 1

Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:

- Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
    - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not:

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

Wellbeing - We provide a health-focused workplace and support a healthy work-life balance
Empathy - We do our best to understand others' feelings, needs and perspectives
Collaboration - We work together to achieve extraordinary results
Accountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals
Respect - We value diversity and treat all members of our community with dignity and inclusiveness
Equity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.

2. Community Benefits Advisory Committee (CBAC):

- Michael Babini, Former BID Plymouth Board Member and Plymouth Resident
- Lyle Bazzinotti, Former BID Plymouth Board Member and Plymouth Resident
- Chris Campbell, Superintendent, Plymouth Public Schools

- Dennis Carman, CEO, United Way of Greater Plymouth
- Christina Degazon, Practice Manager, BILH Primary Care
- Alisa DeLage, Chief Programs Officer, Old Colony Elder Services
- Marc Duphily, Chief, Carver Police Department
- Nikki Galibois, Director of Planning and Development, South Shore Community Action Council
- Susan Giovanetti, CEO, Plymouth Area Coalition for the Homeless
- Meaghan Groves, Director of Practice Operations, Harbor Community Health
- Angela Harrington, Interpreter Services Coordinator, BID Plymouth
- Vedna Heywood, Plymouth Resident
- Nate Horwitz-Willis, BID Plymouth Board of Directors
- Michael Jackman, District Director, US Representative Bill Keating's Office; Chair, Greater Plymouth CHNA
- Karen Keane, Public Health Director, Town of Plymouth
- Malissa Kenney, President, Healthy Plymouth
- Anna Marini, BID Plymouth Board of Directors, Board of Trustees Liaison
- Amy Naples, Executive Director, Plymouth Chamber of Commerce
- Sharon O'Brien, Grants Manager, Greater Attleboro Taunton Regional Transit Authority
- Derek Paiva, Vice President, Old Colony YMCA
- Marcia Richards, RD, Community Dietician, BID Plymouth
- Minhtram Tran, Chief Legal Counsel for Community Initiatives, Plymouth County District Attorney's Office
- DeeDee Winterson, Resident Services Director, Algonquin Heights

Leadership

- Kevin Coughlin, President
- Luis Rivera, Interim Executive Director, HR Business Partner
- Donna Doherty, Senior Vice President of Patient Care Services and Chief Nursing Officer
- Sheilah Rangaviz, Market Chief Financial Officer
- Jennifer Rice, Vice President of Philanthropy
- Erin Yale, Chief Operating Officer

Frequency of meetings: Quarterly

3. Involvement of Hospital's Leadership in Community Benefits: Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

	Review Community Health Needs Assessment	Review Implementation Strategy	Review Community Benefits Report
Senior leadership	☒	☒	☒
Hospital board	☒	☒	☒
Staff-level managers	☒	☒	☒
Community representatives on CBAC	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

Hospital Board:
BID Plymouth's Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy.

Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process.

Senior Leadership:
•Kevin Coughlin,President: Designated a member of the senior leadership team to the CBAC and participated in the approval process.
•Erin Yale, COO, participated on the CBAC
• Nancy Kasen, Vice President of Community Benefits and Community Relations, and Community Benefits team: designed, directed and oversaw the CHNA and IS, managed prioritization process, drafted Implementation Strategy
•Karen Peterson, Manager of Community Benefits and Community Relations: led BID Plymouth'scommunity engagement efforts
• BILH Board of Trustees Community Benefits Committee (CBC): guided the process for the system

4. Hospital Approach to Assessing and Addressing Social Determinants of Health

- How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)

BID Plymouth undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special

emphasis on population segments often left out of similar efforts. The assessment was supported by BID Plymouth's Community Benefits Advisory Committee (CBAC). The CBAC is comprised of community members, service providers, and other stakeholders who live and/or work in BID Plymouth's CBSA. BID Plymouth's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: economic stability, education, food insecurity and nutrition, housing, and transportation

How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

BID Plymouth and BILH are committed to health equity, the attainment of the highest level of health for all people. Throughout the assessment process, BID Plymouth worked to understand the needs of all populations in the Community Benefits Service Area, including those who have been historically underserved. Health equity is an overarching lens applied to all four pillars within the BID Plymouth's Implementation Strategy. The Implementation Strategy is designed to address the underlying social determinants of health and barriers to accessing care

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)

BID Plymouth's Implementation Strategy includes a range of programs and resources to address the prioritized needs within the hospital's Community Benefits Service Area. The majority of BID Plymouth's community benefits initiatives are focused on cohorts and geographies based on identified needs. Additionally, BID Plymouth collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions.

5. Maternal Health Focus

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

BID Plymouth's Community Health Needs Assessment (CHNA) process includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include the Center for Health Information Analysis (CHIA), Community Health Equity Survey (CHES), County Health Rankings, MA DPH, National Center for Health Statistics and U.S. Census Bureau. The hospital's data table has a section for Maternal and Child Health/Reproductive Health which includes infant mortality rate (%) and low birth weight (%). In addition to secondary data capture and review, throughout the CHNA, BID Plymouth engages with the community to collect primary data via a survey, focus groups and listening sessions to directly enable community residents to identify priorities.

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

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

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

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

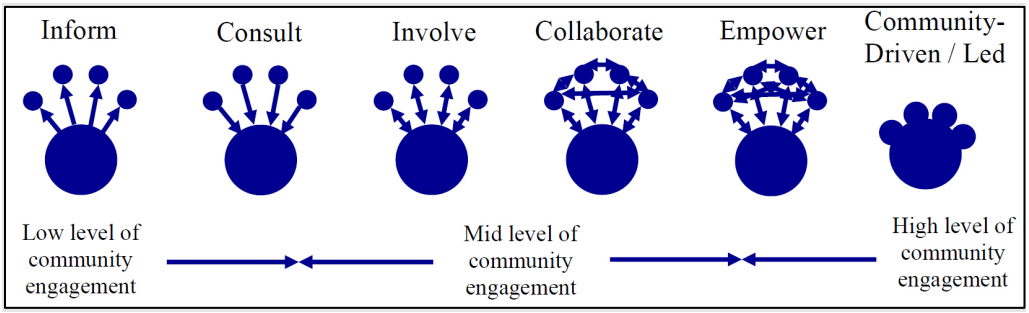
II. Community Engagement

1. Organizations Engaged in CHNA and/or Implementation Strategy

   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. 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)
Harbor Community Health	Meaghan Groves, Director of Practice Operations	Community health centers	Harbor Community Health serves on the Community Benefits Advisory Committee (CBAC) and they were actively involved in the survey process. They distributed surveys to patients in 4 different languages and put flyers in the exam rooms.
Algonquin Heights	DeeDee Winterson	Housing organizations	In addition to survey distribution, they conducted a focus group in Spanish for their vulnerable residents. They also have representation on the CBAC.
South Shore Community Action Council	Nikki Galibois, Director of Planning and Development	Social service organizations	SSCAC was very helpful during the CHNA process as they sat for an interview and distributed surveys to under resourced clients. They also have representation on the CBAC and have been grant recipients for their emergency assistance program.
South Shore Elder Services	Nicole Long	Executive Director	SSES distributed paper surveys to all of their residents that live in senior housing in the BID Plymouth CBSA. The organization has representation on the CBAC as well.
Town of Plymouth Health Department	Karen Keane, Public Health Director	Local health department	The Health department sits under the newly established Health and Human Services department. Karen Keane is active on the CBAC and the entire Plymouth HHS team helped with the survey distribution. HHS Commissioner Michelle Bratti was interviewed as well for the process

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



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

A. Community Health Needs Assessment: Please assess the hospital's level of engagement in developing 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 assessing community health needs	Involve	Goal was met	Involve
Collecting data	Involve	Goal was met	Involve
Defining the community to be served	Collaborate	Goal was met	Collaborate
Establishing priorities	Collaborate	Goal was met	Collaborate

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

[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.

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal was met	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	Goal was met	Consult
Implementing Community Benefits programs	Collaborate	Goal was met	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met	Consult

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

3. Opportunity for Public Feedback
   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.

   In FY25, BID Plymouth held four CBAC meetings, a community listening session and an annual meeting that were broadly advertised to the public. Additionally, four newsletters were distributed to inform the community about the Community Health Needs Assessment and Implementation Strategy process, including opportunities for input, and other Community Benefits updates.

The BID Plymouth CBAC met on the following dates:

- December 9, 2024
- March 26, 2025
- June 17, 2025
- September 25, 2025 (Public Meeting)

4. Best Practices/Lessons Learned: The AGO seeks to continually improve the quality of community engagement.

   What community engagement practices are you most proud of? (150-word limit)

   BID Plymouth is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. BID Plymouth is proud of its collaboration with these and other organizations that allow for meaningful community engagement. Increased focus was placed on reaching communities typically not engaged in assessments, as such, BID Plymouth saw a significant increase in community surveys from the following populations: Black/African American, Hispanic/Latino, people living with a disability and Non-English speakers.

   What lessons have you learned from your community engagement experience? (150-word limit)

   Working collaboratively with other hospitals, community-based organizations, public health agencies, residents, and area coalitions enhances the level and quality of BID Plymouth's community engagement efforts.

III. Regional Collaboration

1. Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No

   a. If so, briefly describe it. If not, why?

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.
   - Collaboration
   - Institutions Involved

- Brief description of goals of collaboration
- Key communities engaged through collaboration. If you did not participate in a collaboration, please explain why not:

For its FY 2025 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 11 licensed hospitals, including BID Plymouth. While BID Plymouth focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing significant barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.