New England Baptist Hospital
Implementation Strategy
2020 - 2022

Between September 2018 and April 2019, New England Baptist Hospital (NEBH) conducted a comprehensive Community Health Needs Assessment (CHNA) that included an extensive review of existing quantitative data as well as the collection of qualitative information through interviews, focus groups and community meetings. A resource inventory was also completed to identify existing health-related assets and service gaps. During this process, the Hospital made substantial efforts to engage administrative and clinical staff at the Hospital (including senior leadership) and community health stakeholders throughout the Hospital's community benefits service area. A detailed review of the CHNA approach, data collection methods, and community engagement activities are included in Appendix A of NEBH's 2019 CHNA Report.

Once NEBH's CHNA activities were completed, the Hospital's Community Benefits (CB) Program staff convened the NEBH Community Benefits Advisory Committee (CBAC) and the Hospital's Senior Leadership Team (SLT) and conducted a series of strategic planning meetings. These meetings allowed Hospital staff and a representative group of external community health stakeholders to review the quantitative and qualitative findings from the CHNA, prioritize the leading community health issues, identify segments of the population most at-risk (Priority Populations), review existing community benefits programming, and begin to develop the Hospital's 2020 – 2022 Implementation Strategy (IS). After these strategic planning meetings, the Hospital's CB staff continued to work with the CBAC, SLT, and other community partners to develop a draft and a final version of NEBH's 2020-2022 Implementation Strategy (IS). Below is a summary of NEBH's IS.

CORE IMPLEMENTATION STRATEGY PLANNING PRINCIPLES AND STATE PRIORITIES

In developing the IS, care was taken to ensure that NEBH's community health priorities were aligned with the Commonwealth of Massachusetts priorities set by the Commonwealth's Department of Public Health (MDPH). The table below outlines the four Community Benefit focus issues identified by MDPH and the Executive Office of Health and Human Services. In addition to the four focus issues, MDPH identified six health priorities to guide investments funded through the Determination of Need Process. The Massachusetts Attorney General's Office encourages hospitals to consider these priorities in the Community Benefits planning process.

Also included below is a brief discussion of a series of guiding principles that informed the Hospital's IS development process.

State Community Health Priorities

Community Benefits Priorities	Determination of Need Priority Areas
Chronic disease with a Focus on Cancer, Heart Disease, and Diabetes	Built Environment
Housing Stability/Homelessness	Social Environment
Mental Illness and Mental Health	Housing
Substance Use Disorders	Violence
	Education
	Employment

The following are a range of programmatic ideas and principles that are critical to community health improvement and have been applied in the development of the IS provided below.

- **Social Determinants of Health:** With respect to community health improvement, especially for low income and disadvantaged populations, there is growing appreciation for the importance of addressing the underlying social determinants of health, "the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities."[1] The leading social determinants of health include issues such as poverty, housing, food access, violence, racism/bigotry, and transportation. It is important that hospital implementation strategies include collaborative, cross-sector initiatives that address these issues.

- **Health Education and Prevention:** Primary prevention aims to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aims to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared to helping people to manage health conditions, lessen a condition's impact, or slow its progress. Targeted efforts across the continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

[1] O. Solar and A. Irwin, World Health Organization, "A Conceptual Framework for Action on the Social Determinants of Health," Social Determinants of Health Discussion Paper 2 (Policy and Practice), 2010, available at http://www.who.int/social_ determinants/corner/SDHDP2.pdf.

- **Screening and Referral:** Early identification of those with chronic and complex conditions following by efforts to ensure that those in need of education, further assessment, counseling, and treatment are critical to preventing illness before it takes hold or managing illness so as to lessen or slow its impacts. A critical component of screening and referral efforts is taking steps to ensure that people are fully engaged in treatment, including linkages to a primary care provider.

- **Chronic Disease Management:** Learning how to manage an illness or condition, change unhealthy behaviors, and make informed decisions about your health can help you live a healthier life. Evidence-based chronic disease management or self-management education (SME) programs, implemented in community-based setting by clinical and non-clinical organizations, can help people to learn skills to manage their health conditions, improve eating and sleeping habits, reduce stress, maintain a healthy lifestyle.

- **Care Coordination and Service Integration:** Efforts to coordinate care and integrate services across the health care continuum are critical to community health improvement. These efforts involve bringing together providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care.

- **Patient Navigation and Access to Health Insurance:** One of the most significant challenges that people face in caring for themselves or their families across all communities is finding the services they need and navigating the health care system. Having health insurance that can help people to pay for needed services is a critical first step. The availability of Insurance enrollment support, patient navigation, and resource inventories are important aspects of community health improvement.

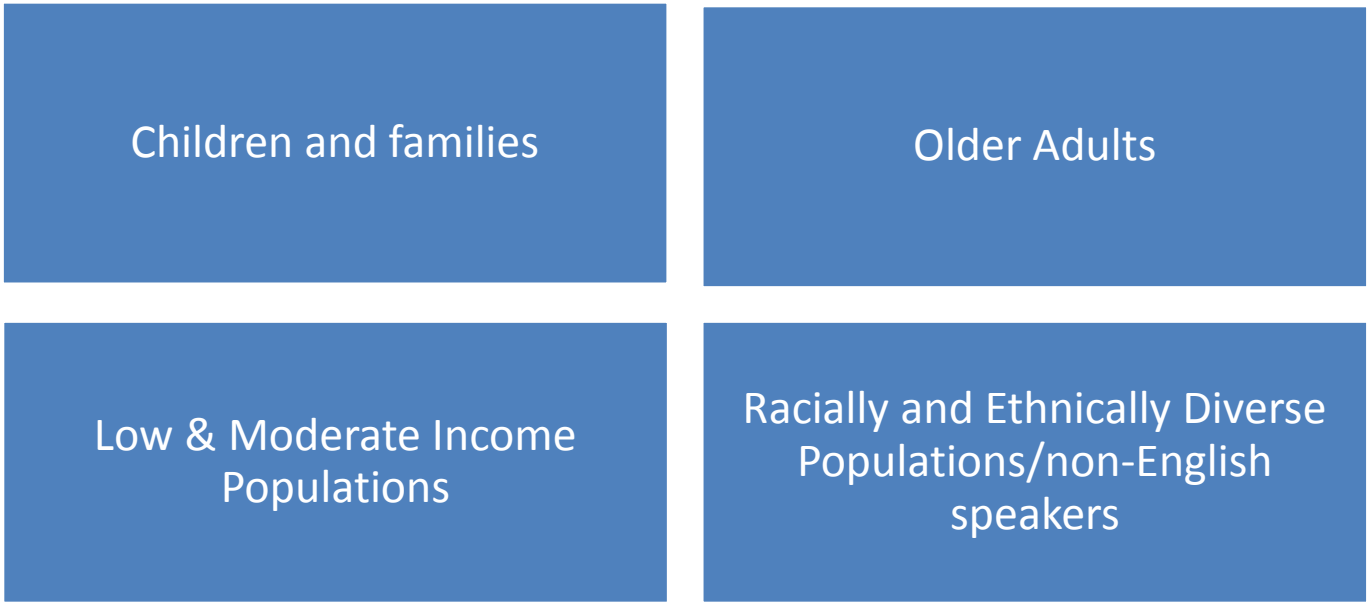
- **Cross-sector Collaboration and Partnership:** When it comes to complex social challenges, such as community health improvement, there is a clear consensus that success will only be achieved through collective action, partnership and collaboration across organizations and health-related sectors. No one organization or even type of organization can have a sustained impact on these types of issues on their own. Hospital implementation strategies need to be collaborative and include partnerships with service providers across multiple sectors (e.g., health, public health, education, public safety, and community health)

COMMUNITY HEALTH PRIORITY POPULATIONS AND NEEDS

NEBH is committed to improving the health status and well-being of all residents living throughout its service area. Certainly all geographic, demographic, and socioeconomic segments of the population face challenges of some kind that can hinder their ability to access care or maintain good health.

Regardless of age, race/ethnicity, income, family history, or other characteristics, everyone is impacted in some way by health-related risks. With this in mind, NEBH's IS includes activities that will support residents throughout its service area, across all segments of the population.

However, based on the assessment's quantitative and qualitative findings there was broad agreement that NEBH's IS should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health that put them at greater risk. More specifically, the assessment identified: 1) Youth and families, 2) Older adults, 3) Low to moderate-income populations, and 4) Racially and ethnically diverse populations / non-English speakers that deserve special attention.



NEBH's CHNA approach and process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the Hospital's Community Benefit Staff, along with the CBAC, SLT, and other stakeholders identified four community health priority areas, which together embody the leading health issues facing residents living in NEBH's Community Benefit Service Area. These four strategic domains are: 1) Social Determinants of Health and Access to Care and 2) Chronic/Complex Conditions and Risk Factors.

During the strategic planning sessions, the CBAC and the SLT took the prioritization process even further and identified a more detailed set of programmatic priorities within each strategic domain. These sub-priorities provide further guidance to the Hospital and its partners in the development and implementation of NEBH's IS. Above is a diagram detailing NEBH's IS community health priorities.

Community Health Needs Not Prioritized by NEBH's CBAC

It is important to note that there are community health needs that were identified by NEBH's assessment that, due to the limited burden that these issues present and/or the feasibility of having an impact in the short- or long-term on these issues, were not prioritized for investment. Namely, education and behavioral health were identified as community needs but these issues were deemed by the CBC and the CBSLT to be outside of NEBH's primary sphere of influence and have opted to allow others in its CBSA and the Commonwealth to focus on these issues. This is not to say that NEBH will not support efforts in these areas. NEBH remains open and willing to work with hospitals across Beth Israel Lahey Health's network and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

The following is NEBH's Implementation Strategy and provides details on NEBH's goals, priority populations, objectives, strategic activities, and measures of performance by priority area. Also included, is a listing of the state priorities that align with the activities included in the IS as well as a listing of the core partners that NEBH has been and will continue to work with to implement these activities. With respect to the core community partners listed, this is certainly not a complete list but rather many of its core partners. NEBH collaborates and partners with dozens of public and private service providers, community-based organizations, and advocacy organizations spanning all sectors and CBSA communities. NEBH is extremely appreciative of the efforts of all of its partners and looks forward to expanding this list as it implements its community benefits and CHI activities in the years to come.

Community Health Priorities

Priority Area 1: Social Determinants of Health and Access to Care

Brief Description: Quantitative and qualitative data showed clear geographic and demographic disparities related to the leading social determinants of health (e.g., economic stability, housing, transportation, violence, food access, education, and community cohesion). These issues influence and define quality of life for many segments of the population in NEBH's service area. A dominant theme from key informant interviews and community forums was the significant impact that the underlying social determinants, particularly housing, poverty, food access, violence, and transportation have on residents in the service area.

Resources / Financial Investment: NEBH will commit direct, community health program investments, and in-kind resources of staff time and materials.

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Enhance Access to Care and Reduce the Impact of social Determinants	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase partnerships and collaboration with social service and other community-based organizations • Increase educational opportunities related to the importance and impact of social determinants • Decrease the number of people who struggle with financial insecurity • Increase access to low cost healthy foods with an emphasis on priority population segments • Increase access to affordable, safe transportation options with an emphasis on priority population segments • Increase training and employment opportunities for low to moderate income residents with an emphasis on priority population segments	• Community Benefit and other Hospital staff (e.g., nursing) Participate in Coalition and Other Community Meetings to promote collaboration, share knowledge, and coordinate community health improvement activities • Maintain McLaughlin Field to engage youth and promote physical activity • Make community improvements to walkways and other public areas to address transportation issues and promote physical activity • Provide trash truck and clean public areas after move-in day to promote community engagement and physical activity • Support Food Access and Nutrition Programming to low and moderate income populations living in public housing, Councils on Aging, and other community venues • Provide essential household items to support those living in poverty or low income households	• # of community meetings attended by nursing to share best practices (Document best practices shared) • # of times McLaughlin Field maintained • # of community improvements made to walkways and other public areas • # of times provided trash and clean-up services • # of people provided transportation support • Amount of $ distributed • # of people in need provided with food	• Boston CHNA/CHIP Collaborative • Boston Public Health Commission • Public Schools • Elder Services Providers • Action for Boston Community Development (ABCD) • Sociedad Latina • Madison Park High School • Morgan Memorial Goodwill • Roxbury Tenants of Harvard (RTH) • Tobin

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
		• Increase access to social experiences for those who are isolated and lack family/caregiver and other social supports • Educate individuals and families about healthy eating, meal planning, household budgeting, etc. • Decrease the number of individuals and families who suffer from food insecurity and/or lack basic household items	• Provide Transportation Support to community residents to enhance access to affordable, safe, accessible transportation options • Organize and support Workforce Mentorship and Training Programs for youth and adults to job training, skills development, and career advancement with an emphasis on priority populations • Continue to support the Meredith Cameron Youth Opportunity Internship Program to support skills development and career advancement • Provide Linguistically and Culturally Appropriate Health Education and Care Management Support though targeted community events for those with or identified as at-risk of chronic/ complex conditions with an emphasis on priority populations • Support activities sponsored by Mission Hill Senior Legacy Project • Support community food pantries	or other essential household items • # of workforce partnership programs supported • # of people supported by Workforce Partnership by program and priority population • # of health literacy events scheduled • # of non-English speakers supported through health literacy events	Community Center • Alice Taylor Housing Development • Mission Hill Senior Legacy Project • Maria Sanchez House • One Gurney St. Apartments • Fair Foods • Private Industry Council (PIC) • Friends of McLaughlin Park • Problem Properties Task Force • NEBH hospital staff and other specialty staff
Reduce Elder Falls and Promote Aging in Place	• Older Adults	• Reduce fear of falling • Reduce Falls • Increase activity levels • Increase the number of older adults living independently in their homes	• Support or organize Matter of Balance workshops for priority populations	• # of Matter of Balance events organized • # of people participating in Matter of Balance events • Pre- and post-test assessment of those participating in Matter of Balance events	• Elder Services Agencies • Mission Hill Senior Legacy Project • Roxbury Tenants of Harvard • Maria Sanchez House

Priority Area 2: Chronic and Complex Conditions and their Risk Factors

Brief Description: Heart disease, stroke and cancer are by far the leading causes of death in the nation, the Commonwealth, and in NEBH's service area. Roughly 7 in 10 deaths can be attributed to these three conditions. If you include respiratory disease (e.g., asthma, Congestive heart failure, and COPD) and diabetes, which are in the top 10 leading causes across nearly all geographies than one can account for all but a small fraction of causes of death. All of these conditions are generally considered to be chronic and complex and can strike early in one's life, quite often ending in premature death. In this category, heart disease, diabetes, and hypertension were thought to be of the highest priority, although cancer was also discussed frequently in the focus groups and forums. HIV/AIDS, other sexually transmitted diseases and Hepatitis C were also mentioned in the assessment's interviews and focus groups and should certainly be included in the chronic/complex condition domain. It is also important to note that the risk and protective factors for nearly all chronic/complex conditions are the same, including tobacco use, lack of physical activity, poor nutrition, obesity, and alcohol use.

Resources / Financial Investment: NEBH will commit direct, community health program investments, and in-kind resources of staff time and materials.

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	
Enhance Access to Health Education, Screening, Referral, and Chronic Disease Management Services in Clinical and Non-Clinical Settings	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who are educated about chronic disease risk factors and protective behaviors • Increase the number of adults who are engaged in evidence-based screening, counseling, self-management support, chronic disease management, referral services, and/or specialty care services for diabetes, hypertension, asthma, cancer, and other chronic/complex conditions • Increase the number of people with chronic/complex conditions whose conditions are under control	• Community Benefit and other Hospital staff (e.g., nursing) Participate in Coalition and Other Community Meetings to promote collaboration, share knowledge, and coordinate community health improvement activities • Support Little League and Summer Camp programs to engage youth and promote physical activity • Support Jr. and Sr. Celtics program to promote community engagement • Provide Evidence-based Health Education on risk/protective factors, and Self-Management Support Programs through partnerships with community-based organizations with an emphasis on Priority Population Segments • Fitness Classes • Support Screening, Education, and Referral Programs in clinical and non-	• # of community meetings attended by hospital staff to promote collaboration, share information, and integrate best practice ideas • # of health education and/or chronic disease management events organized by type, setting, and priority population • # of people participating in events by type, setting, and priority population • # of patients referred	• Boston CHNA/CHIP Collaborative • Boston Public Health Commission • Local Police, Fire, and EMS • Public Schools • BH Outpatient Service Providers • Elder Services Providers • Action for Boston Community Development (ABCD) • Sociedad Latina • Roxbury Tenants of Harvard (RTH)

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	
			clinical settings that screen, educate, and refer patients in need of further assessment and chronic disease management supports (e.g., Blood pressure, diabetes, Stroke, cancer) • Organize NEBH "House Call" events hosted by Hospital clinical staff related to awareness, education, and the management of chronic and complex conditions in targeted community-based settings • Support Yoga for older adults • Support and promote the development of community workshops, weight loss classes, and educational sessions.	for more intensive care management, or specialty care support • # of patients referred to a primary care provider for ongoing care • Amount of $ distributed • Other outcome related measures geared to assessing impact	• Tobin Community Center • Alice Taylor Housing Development • Mission Hill Senior Legacy Project • Maria Sanchez House • Fair Foods • NEBH hospital staff and other specialty staff
Reduce the prevalence of Tobacco Use	• Youth • Older Adults • Low to Moderate Income Populations • Individuals with Chronic/ Complex Conditions	• Increase the number of people who are able to stop smoking cigarettes vaping, or using e-cigarettes • Increase access to tobacco, vaping/e-cigarette cessation programs	• Organize, facilitate, or support Smoking Cessation Programs geared to reducing tobacco, vaping and e-cigarette use	• # of smoking cessation programs organized • # of people participating in smoking cessation programs • Pre- and post-test assessment of those participating in Freedom from Smoking Program	• American Cancer Association • Roxbury Tenants of Harvard • Tobin Community Center